DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410 and 419

[CMS–1206–P]

RIN 0938–AL19

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

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

ACTION: Proposed rule.

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

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 8, 2002.

ADDRESSES: In commenting, please refer to file code CMS–1206–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1206–P, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

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

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

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

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

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

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

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7197.

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

Outline of Contents

Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP American College of Emergency Physicians
AMA American Medical Association
APC Ambulatory payment classification
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA Balanced Budget Refinement Act of 1999
CCR Cost center specific cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT (Physician's) Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CSW Clinical social worker
CY Calendar year
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ERCP Endoscopic retrograde cholangiopancreatography
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HIPAA Health Insurance Portability and Accountability Act of 1996
ICU Intensive care unit
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
LTC Long Term Care
MedPAC Medicare Payment Advisory Commission
MDH Medicare Dependent Hospital
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
OT Occupational therapist
PHP Partial hospitalization program
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
RVUs Relative value units
SCH Sole Community Hospital
TEFRA Tax Equity and Fiscal Responsibility Act
USPDI United States Pharmacopoeia Drug Information

Comparison of Proposed 2003 Payment Rates to 2002 Payment Rates

The outpatient pass-through provisions of the BBRA and BIPA have been exceptionally difficult to implement, arguably the most complex and difficult in the history of the Medicare program. In CY 2002, the pass-through payments, and the APC rates were calculated on the best information available. This was often manufacturer list prices, which may not reflect not actual prices paid by hospitals. For CY 2003, far more data is available on the actual charges for hospital OPDs, and these are reflected in the rates in this proposed rule. In many cases these new rates are significantly different from CY 2003 rates, but they are based on actual hospital charges, and on far more complete data than were the CY 2002 rates. Nevertheless, CMS is actively seeking comment on all aspects of these rates, given the significant changes in the proposed rule, and the agency is open to making changes, perhaps significant, in the final rule based on comments.

The 2003 payment rates proposed in this proposed rule are, for many items and services, significantly higher or lower than the payment rates for the same items and services for 2002, particularly for APCs which use medical devices, and for APCs for drugs that will no longer be eligible for pass-through status in 2003 and paid under separate APCs. Some proposed payments for 2003 are far lower than the 2002 payment amounts (and some are higher).

For example, as can be seen in Addenda A, the proposed rate for APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrilator Leads) shows a dramatic decrease in payment compared to the 2002 rate. This reduction for a number of APCs is of concern to us because of the potential impact on access to care. We invite public comment and suggestions on how to address the potential for adverse impact of these proposed changes.

The proposed 2003 payment rates reflect the use of updated data, as required by the statute, in calculating payment rates in accordance with the methodologies set forth in the statute and regulations. The proposed payment rates reflect mathematical calculations based on the latest available program data.

Our goal in this proposed rule is to explain the methodology and to solicit comments on our rate-setting methods and the effect on beneficiary access, provider participation and the fiscal integrity of the Medicare Trust Fund.

Devices

We believe that there are several factors that may explain the differences between the proposed payment amounts for 2003 and the payment amounts for 2002 (some, but not all of which, are significant).

First, we believe that the payment rates for the device related procedures for 2002 may in some cases have been higher than they would have been had actual hospital acquisition cost data been available for us to use. Specifically, because we lacked hospitals' cost data for devices, we used the best data available to us at the time which was manufacturer data regarding the hospitals' acquisition costs in providing the devices. We assumed that a device would be provided with a related procedure and packaged 75 percent of these manufacturer estimated

costs for the devices into the APCs for the procedures.

The costs that we packaged in for some devices may have been higher than actual hospital acquisition costs. The differences between the 2002 payment rate and the lower 2003 proposed payments are based on our data sources. While the 2003 rates are based on 2001 hospital claims and the latest available cost report data, the 2002 rates are based on manufacturer data for devices. We use charges on the hospital claims data to estimate hospital costs. We apply hospital-specific, department-specific cost-to-charge ratios (CCRs) from each provider's most recently submitted cost report to the charges to develop the estimate of costs. In most cases, the provider's most recently submitted cost report is from fiscal year 1999. An adjustment factor is applied in developing CCRs for cost reports that have not yet been settled, so that the CCRs will more closely reflect CCRs from a settled cost report.

Second, there may be problems in the data, particularly for coding of devices in 2001. As discussed later in this preamble, devices were to be coded using device specific C codes from the start of the OPPS on August 1, 2000 until the law changes required that we establish category codes by April 1, 2001. We then granted a grace period until July 1, 2001, during which we accepted both device specific codes and category codes. During a Town Hall meeting with the public on April 5, 2001, and in other contacts with hospitals (such as the open forum calls and visits to hospitals) we have been told that hospitals had difficulty in submitting proper HCPCS coding for services and for devices once OPPS began and that, in many cases, they did not bill for devices for which they should have claimed payment.

In some cases, hospitals were confused by the change from device specific codes to category codes; in other cases, the use of HCPCS codes was new and they had a long learning curve to learn how to use HCPCS codes. Our initial data analysis suggested that hospitals may not have billed for the devices using the device or category codes in all cases. If the charges were not on the claim, they would not have been picked up for calculation of the median cost for the service and the associated device, possibly resulting in a proposed payment rate for the APC that is inappropriately low and other rates that are inappropriately too high. However, based on our analysis which is described later, we believe that hospitals often showed the charges for the devices in the applicable revenue centers (such as, supplies) and that the charges for the devices often were on the claim, even if the HCPCS code was not.

We welcome public comments regarding these issues for these payment changes and proposals regarding how problems with claims data could be rectified for development of the final rule.

Drugs

As discussed later in this preamble, we propose to package the costs for lower cost drugs into the payment for the APC in which they are used and to pay specialty drugs and high cost drugs under separate APCs. Some of the APCs for separately paid drugs also show significant reductions in payments compared to the pass-through payments made in 2002. Several factors may help place these decreases in perspective.

These changes result largely because the payment method for items in transitional pass-through payment status differs significantly from other services paid under the OPPS, and as items lose transitional pass-through payment status they are subject to a different payment method. In particular, a drug in transitional pass-through payment status is paid based on 95 percent of the average wholesale price for the drug, possibly subject to a uniform reduction.[1]

In contrast, a drug not in transitional pass-through status is paid as are other services under the OPPS. The statute provides that services (other than transitional pass-through items) be paid on the basis of a service-specific relative weight multiplied by a conversion factor. The relative weight is determined based on the median hospital cost, where the cost on each claim is derived by multiplying the submitting hospital's charge by a cost-to-charge ratio (determined from the hospital's latest submitted cost report, usually from fiscal year 1999). We anticipate that a hospital's charges on particular services reflect, at least in relative terms, the hospital's resource use in providing that service.

Per the statute, the conversion factor was set at the initiation of the system to achieve budget neutrality relative to the prior system; it is updated each year by the rate of increase in the hospital market basket. This mechanism does reflect changes in input costs from the initial base, but the system is not rebased to reflect the absolute level of such costs.

This payment method was not intended to assure that hospitals, even on average, are reimbursed costs of particular services. In fact, because the conversion factor was calibrated to reflect prior reductions in hospital operating and capital costs that were built into the baseline for overall program expenditures, the OPPS is not set to pay full costs to hospitals.[2]

Further, nothing in the payment method prescribed by the statute requires or anticipates that hospitals would be reimbursed full costs of purchased inputs such as drugs, just as it does not anticipate that hospitals would be reimbursed for the full cost of any other services they deliver.

The payment methods are set out in section 1833(t) of the Act. This section does not permit continuation of a pass-through payment (at 95 percent of AWP or some other level) for drugs losing their transitional pass-through status. This section permits the Secretary to specify APC groupings, and we are proposing in 2003 to continue to pay separately for certain drugs that had transitional pass-through status in 2002 and that are no longer eligible for pass-through status in 2003. These drugs would be in separate APCs, rather than being packaged into other, procedure-related APCs; the payment method would be the same relative-weight payment method used for other APCs.

The resulting payment rates incorporate the best evidence we have regarding what hospitals charged in 2001. They may diverge, however, from payment rates based on the AWP, including those in use for 2002. As is discussed above, movement from pass-through payment rates to relative-weight based payment rates would be expected to lead to decreases in payments, even if AWP represented a reliable measure of hospital acquisition costs (As discussed above, we use hospital charges and hospital-specific, department-specific cost-to-charge ratios to estimate hospital costs. In most cases, cost-to-charge ratios are derived from 1999 cost reports).

However, we believe this outcome is also be due to deficiencies in AWP as a measure of hospital acquisition costs. AWP is not an accurate estimate of what

[1] In 2002, we apply a uniform reduction to the transitional pass-through portion of payments for drugs with transitional pass-through status. As a result, the OPPS now pays hospitals about 72 percent of AWP for drugs in this status. The uniform reduction, as discussed in the March 1, 2002 final rule, is to comply with section 1833(t)(6)(E) of the Act, which limits the total projected amount of transitional pass-through payments for 2002 to 2.5 percent of projected total payments under the OPPS in 2002.

[2] In fact, because of the effect of prior statutory reductions in payments, the OPPS system was calibrated at its initiation to pay only about 82 percent of hospital costs in the aggregate.

providers actually pay for drugs. Studies undertaken over the past decade by the Office of the Inspector General, the Department of Justice, and the General Accounting Office that compare AWP with actual drug acquisition costs have consistently shown that published AWPs considerably exceed these costs (See ''MEDICARE Payments for Covered Outpatient Drugs Exceed Providers' Costs'', GAO–01–1118). Therefore, it is to be expected that the proposed 2003 APC payment rates based on median hospital costs for these drugs will be lower than the 2002 payment rates for the same drugs that are based on AWP. The Administration has repeatedly stated its view that AWP inaccurately represents actual market pricing. The pass-through system pays based on AWP, creating further incentives for artificially high AWP listings. We believe the steep reductions in some drug prices reflect these incentives, and that the new rates more accurately reflect the actual acquisition costs for hospitals pay. Still, we are interested in soliciting comments on these costs, and the mechanisms to identify them.

I. Background

A. Authority for the Outpatient Prospective Payment System

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

B. Summary of Rulemaking for the Outpatient Prospective System

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services. On June 30, 1999, we published a correction notice (64 FR 35258) to correct a number of technical and typographic errors in the September 1998 proposed rule including the proposed amounts and factors used to determine the payment rates.
- On April 7, 2000, we published a final rule with comment period (65 FR 18434) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419.
- On June 30, 2000, we published a notice (65 FR 40535) announcing a delay in implementation of the OPPS from July 1, 2000 to August 1, 2000. We implemented the OPPS on August 1, 2000.
- On August 3, 2000, we published an interim final rule with comment period (65 FR 47670) that modified criteria that we use to determine which medical devices are eligible for transitional pass-through payments. The August 3, 2000 rule also corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.
- On November 13, 2000, we published an interim final rule with comment period (65 FR 67798). This rule provided for the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We implemented the 2001 OPPS on January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.
- On November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year 2002. In addition, it described the Secretary's estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.
- On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.
- On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. It addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.
- On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.
- On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.

C. Authority for Payment Suspensions for Unfiled Cost Reports

Authority for the provision regarding payment suspensions for unfiled cost reports is contained within the authority for subpart C of 42 CFR Part 405, that is, sections 1102, 1815, 1833, 1842,

1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 13951, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

D. Summary of Payment Suspensions for Unfiled Cost Reports

This provision is set forth in our existing regulations at 42 CFR 405.371 as follows:

Section 405.371 (a) provides that Medicare payments may be suspended, in whole or in part, following overpayments determined by the Medicare contractor when overpayment exists or when the payments to be made may not be correct.

Section 405.371(b) provides, in relevant part, that a payment suspension may proceed only after certain procedural requirements contained at § 405.372 are met.

Existing § 405.371(c) provides for suspension of payment if a provider has failed to timely file an acceptable cost report. Payment to the provider is immediately suspended until a cost report is filed and determined by the intermediary to be acceptable.

With the increased transition to the prospective payment systems, the cost report settlement process has become less determinative of an institutional provider's Medicare reimbursement. For instance, in the case of an inpatient acute care hospital, the base DRG payment (as opposed to any teaching or disproportionate share payments, or pass-through payments) is determined when a claim is initially adjudicated, and does not generally change at the time of cost report settlement. Similarly, the APC payment for an outpatient service is also based on the claim adjudication. For home health agencies, minimal changes to payment are made at the time of cost report settlement, and for skilled nursing facilities, the main cost report issues revolve around bad debt determinations. In all of these cases, a significant proportion of the institution's payments are determined based on the adjudication of claims, and do not change at the point of settling the cost report. However, the filing of cost reports remains important for settling some payments, such as medical education payments, even for providers that are fully transitioned to prospective payment systems. Also, cost reports for PPS providers are used for determining prospective payment rates for future years. For these reasons, tailored payment suspensions can still be an effective measure for ensuring that providers comply with their obligation to file timely and acceptable cost reports.

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

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 601, Mid-Level Clinic Visits. The APC weights are scaled to APC 601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

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

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

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

The APC groups that we are proposing in this rule as the basis for payment in 2003 under the OPPS have been analyzed within this statutory framework.

A. Recommendations of the Advisory Panel on APC Groups

1. Establishment of the Advisory Panel

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

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

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

2. General Issues Considered by the Advisory Panel

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

Content for Future Presentations to the Panel

During the 2001 meeting, the Panel heard many different types of oral presentations. The Panel members felt that requiring consistency for all presentations with regard to format, data submission, and general information would assist them in analyzing the submissions and presentations and making recommendations. Therefore, during the 2001 meeting, the Panel recommended the creation of a Research Subcommittee. The Research Subcommittee was established during the 2001 meeting and had regular conference calls to discuss the development and implementation of standards for written submissions and oral presentations to the Panel during its meetings. The Research Subcommittee also analyzed complex issues (such as the use of multiple procedure claims

data to set APC relative weights) that could not be addressed in the time allotted for the annual meeting.

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

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

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

Inpatient Only List

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

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

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

CPT	Description
21390	Treat eye socket fracture.
27216	Treat pelvic ring fracture.
27235	Treat thigh fracture.
32201	Drain, percut, lung lesion.
33967	Insert ia percut device.
47490	Incision of gallbladder.
62351	Implant spinal canal cath.
64820	Remove sympathetic nerves.
92986	Revision of aortic valve.
92987	Revision of mitral valve.
92990	Revision of pulmonary valve.
92997	Pul art balloon repr, precut.
92998	Pul art balloon repr, precut.

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

The Panel did recommend that we remove from the inpatient list CPT code 47001, Biopsy of liver, needle; when done for indicated purpose at time of other major procedure. Panel members stated that this add-on code is being billed with surgical procedures that are payable under the OPPS. The Panel noted that coding edits prevent payment for the other payable OPPS services if CPT code 47001 is on the claim. We agree with the Panel's recommendation and we propose to remove 47001 from the inpatient list. We further propose to assign it status indicator ''N'' so that costs associated with CPT code 47001 would be packaged into the APC payment for the primary procedure performed during the same operative session.

One presenter at the Panel meeting suggested removing CPT codes 53448, 54411, and 54417 from the inpatient list because he believed they were being performed in the outpatient setting. After discussing this suggestion, the Panel recommended that these codes remain on the inpatient list because they involve removing a prosthesis through an infected operative field and cannot be safely and effectively performed in the outpatient setting. We agree with the Panel's recommendation, and we are not proposing to remove these codes from the inpatient list.

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

Multiple Bills

During its February 2001 meeting, the Panel received oral testimony identifying CMS exclusive use of single procedure claims to set relative weights for APCs as a potential problem in setting appropriate payment rates for APCs. Therefore, the panel asked its Research Subcommittee to work with CMS staff, using the Endoscopic Retrograde Cholangiopancreatography (ERCP) code family as a case study, to explore the use of multiple procedure claims data for setting relative weights. This code family was selected because presenters had suggested that when procedures in this family are performed, it is typical to perform more than one procedure during a session.

The Subcommittee reviewed pre-OPPS claims data for these codes, paying particular attention to common code combinations and costs per procedure and per code combination. After lengthy review, the Panel concluded that (1) it could not determine whether findings based on review of pre-OPPS data could be extrapolated to post-OPPS claims data; (2) the variability in allocation of costs across ERCP line items and the existence of claims where the same ERCP code was billed more than once indicate that problems exist with the accuracy of facility coding for these procedures; and (3) analysis of multiple claims data for ERCP may not be applicable to other sets of services.

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

• We should continue to explore the use of multiple procedure claims data for setting payment rates but should continue to use only single procedure claims data to determine relative payment weights for CY 2003.

• We should work with the APC Panel to explore the use of multiple claims data drawn from OPPS claims for services such as radiation oncology in time for the next APC Panel meeting.

• We should educate hospitals on appropriate coding and billing practices to ensure that claims with multiple procedures are properly coded and that costs are properly allocated to each procedure.

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

We agree. We describe in section II.B.4 how we determined the number of single claims used to set the APC relative weights proposed for 2003 using this methodology. We ask for comments on our methodology.

Packaging

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

There are a number of reasons why we package the costs of certain procedures. For example, ''add-on'' procedures and radiologic guidance procedures should never be billed on a claim without the code for an associated procedure. A facility should not submit a claim for ultrasound guidance for a biopsy unless the claim also includes the biopsy procedure, because the guidance is necessary only when a biopsy is performed. A claim for a packaged guidance procedure (or a supervision and interpretation procedure whose descriptor requires it be performed in association with a surgical procedure) would be returned to the provider for correction and resubmission.

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

Several presenters to the panel requested that we not package any radiologic guidance or supervision and interpretation codes. They believe that hospitals will not use codes for which they do not receive a separate payment. If that were the case, it would be difficult to track utilization for these procedures and make it difficult for radiology departments to receive an appropriate payment for their services. A few presenters also pointed out that various forms of guidance with widely varying costs can be used for a single surgical procedure. Therefore, we might unintentionally create an incentive for inappropriate care by packaging several guidance procedures with varying costs into a single surgical code. Additionally, a manufacturer of ultrasound guidance equipment used for placement of radiation fields commented that, because guidance is rarely used for this purpose, its costs could not be adequately captured by packaging it into a common procedure where the vast majority of claims did not use guidance.

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

Add-On Codes

We presented for the Panel's consideration several options for payment of add-on codes, including assignment of status indicator ''N'' to package them into the payment for the base procedure. Add-on codes described additional procedures performed by the same physician that are associated with the primary procedure, and which cannot be billed without the primary procedure. Such a methodology would create a single, weight averaged payment for the parent procedure and the add-on procedure while addressing the problem that any ''single'' claim for an add-on procedure is, by definition, an error claim. After thorough review, the Panel concluded that we should continue to pay for add-on codes separately, setting relative weights with the use of single procedure claims in spite of the fact that these were error claims. The Panel asked us to continue exploring ways to most appropriately pay for these services. They requested that this item also be placed on the agenda for the next Panel meeting.

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

3. Recommendations of the Advisory Panel and Our Responses

In this section, we consider the Panel's recommendations affecting specific APCs. The most recent data available for the Panel to review in considering specific APC groupings were the 1999–2000 pre-OPPS claims data that were the basis of the CY 2002 relative payment weights. The APC titles are shown in this discussion of the APC Panel recommendations as they existed when the APC Panel met in January 2002. In a few cases the APC titles were changed for the proposed 2003 OPPS and therefore some APCs do not have the same title in Addenda A as they have in this section.

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

exceptions we implemented in 2001 and 2002. We refer to the exceptions as ''violations of the 2 times'' rule in the following discussion.

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

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

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

A presenter to the Panel who represented a device manufacturer noted that the resources used to provide 95921, Autonomic nerve function test, are not similar to the resources required for performing the procedures in APC 218, where we had suggested moving the device. He requested that the code be reassigned to APC 216 where it resided in calendar year 2000. Because there were very few claims for the code in the 1999 and 2000 data, the Panel voiced concern about making the change without sufficient data to support such a move.

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

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

The Panel's recommendations related to facility coding for clinic and emergency department visits are discussed below, in section VIII.A.

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

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

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

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

Option 3: Create a new APC, Level III Miscellaneous Radiology Procedures, by moving CPT codes 76080, 7036736, 76101, 70390, 74190, and 71060 from APC 263. Move CPT code 74327 from APC 296 to APC 263 and move CPT code 75980 from APC 297 to APC 296. APC 264 remains unchanged.

One presenter to the panel objected to the use of miscellaneous APCs in the OPPS. The presenter argued that we are charged with creating clinically coherent APCs and that miscellaneous APCs contradict the principle of clinical coherence. We noted that in spite of considerable effort to do so, we have not been able to incorporate the procedures assigned to miscellaneous APCs into other, more clinically homogeneous APCs. We asked the presenter to propose a configuration for consideration.

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

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

APC 230: Level I Eye Tests and Treatments
APC 231: Level III Eye Tests and Treatments
APC 232: Level I Anterior Segment Eye Procedures
APC 233: Level II Anterior Segment Eye Procedures
APC 234: Level III Anterior Segment Eye Procedures
APC 235: Level I Posterior Segment Eye Procedures
APC 236: Level II Posterior Segment Eye Procedures
APC 237: Level III Posterior Segment Eye Procedures
APC 238: Level I Repair and Plastic Eye Procedures
APC 239: Level II Repair and Plastic Eye Procedures
APC 240: Level III Repair and Plastic Eye Procedures
APC 241: Level IV Repair and Plastic Eye Procedures
APC 242: Level V Repair and Plastic Eye Procedures
APC 247: Laser Eye Procedures Except Retinal
APC 248: Laser Retinal Procedures
APC 698: Level II Eye Tests and Treatments
APC 699: Level IV Eye Tests and Treatments

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

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

No presenters commented on these APCs, and, after brief discussion, the Panel recommended concurrence with our suggested changes. We propose to accept the Panel's recommendations. We note that when we were able to use 2001 claims data to re-evaluate the changes recommended by the Panel for these APCs, we found violations of the 2 times rule in the reconfigured APCs. Nonetheless, we propose to accept the

Panel's recommendations because they result in more clinically coherent APCs. We solicit comments on further changes that would address the violations of the 2 times rule. We plan to place these APCs on the panel's agenda for 2003.

APC 110: Transfusion

APC 111: Blood Product Exchange

APC 112: Apheresis, Photopheresis, and Plasmapheresis

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

Representatives of two associations made presentations regarding these APCs. One recommended that all the plasma derivatives and recombinant analogs that currently receive transitional pass-through payments be assigned to permanent APCs in 2003, similar to the designations of other blood products. The representative of the second association supported this recommendation.

The second presenter also pointed out that, consistent with our billing instructions, every claim that a hospital submits for a blood transfusion should include codes for both the blood product and the transfusion. Therefore, payment for blood and blood products is another area affected by the use of single bills in setting payment weights. The Panel agreed to look specifically at blood in its work on the multiple claims issues.

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

In section III.C, we discuss our payment proposals for drugs and biologicals for which pass-through payments are scheduled to expire in 2003. Those proposals would affect payment for blood and blood products. We propose not to accept the Panel's recommendation to change current OPPS payment policy for transfusions. The current payment reflects weight averaging over the number of units transfused. Therefore, unless a hospital specializes in transfusing multiple units of blood, payments for this procedure should be, on average, appropriate.

Panel Recommendations to Defer Changes Pending Availability of 2001 Claims Data

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

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

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

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

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

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

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

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

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

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

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

APC 115: Cannula/Access Device Procedures

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

APC 93: Vascular Repair/Fistula Construction

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

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

APC 363: Otorhinolaryngologic Function Tests

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

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

The APC Panel recommended making no changes in the configuration of these APCs. Several groups made a joint proposal to reconfigure these APCs arguing that their proposal resulted in more clinically coherent APCs. However, several other presenters commented that the joint proposal did not include several physician groups who commonly perform these procedures.

Based on 2001 claims data, we propose to make several changes in order to resolve 2 times rule violations and to make these APCs more clinically coherent. Specifically, we propose to move CPT code 43499 from APC 0140 to APC 141; CPT code 93721 from APC 0096 to APC 368; CPT code 93740 from APC 0096 to APC 367; CPT code 93888 from APC 0267 to APC 266; and CPT code 93931 from APC 0267 to APC 266. We also propose to move CPT codes 78627, 76825, and 93320 from APC 0269 to new APC 0671 to achieve more clinical coherence. We also propose to create new APC 0670 for intravascular ultrasound and intracardiac echocardiography consisting of CPT codes 37250, 37251, 92978, 92979, and 93662.

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

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

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

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

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

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

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

2002 APC 26	2003 APC 25	2003 APC 27
11960		11960
11970		11970
12037	12037	
12047	12047	
12057	12057	
13150	13150	
13160		13160
14000		14000
14001		14001
14020		14020
14021		14021
14040		14040
14041		14041
14060		14060
14061		14061
14300		14300
14350		14350
15000	15000	
15001	15001	
15050	15050	
15101		15101
15120		15120
15121		15121
15200		15200
15201	15201	
15220		15220
15221	15221	
15240		15240
15241	15241	
15260		15260
15261	15261	
15351		15351
15400	15400	
15401	15401	
15570		15570
15572		15572
15574		15574
15576		15576
15600		15600
15610		15610
15620		15620
15630		15630
15650		15650
15775	15775	
15776	15776	
15819	15819	
15820		15820
15821		15821
15822		15822
15823		15823

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

2002 APC 26	2003 APC 25	2003 APC 27
15825		15825
15826		15826
15829		15829
15835	15835	
20101		20101
20102		20102
20910		20910
20912		20912
20920		20920
20922		20922
20926		20926
23921	23921	
25929		25929
33222		33222
33223		33223
44312		44312
44340		44340
15580—Code Deleted.		
15625—Code Deleted.		

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

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

B. Other Changes Affecting the APCs

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

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

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

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

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

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

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

TABLE 2.—TABLE OF EXEMPTED CODES

NPRM APC	Description
0012	Level I Debridement & Destruction
0019	Level I Excision/ Biopsy
0020	Level II Excision/ Biopsy
0025	Level II Skin Repair
0032	Insertion of Central Venous/Arterial Catheter
0043	Closed Treatment Fracture Finger/Toe/Trunk
0046	Open/Percutaneous Treatment Fracture or Dislocation
0058	Level I Strapping and Cast Application
0074	Level IV Endoscopy Upper Airway
0080	Diagnostic Cardiac Catheterization
0081	Non-Coronary Angioplasty or Atherectomy
0093	Vascular Repair/Fistula Construction
0097	Cardiac and Ambulatory Blood Pressure Monitoring
0099	Electrocardiograms
0103	Miscellaneous Vascular Procedures
0105	Revision/Removal of Pacemakers, AICD, or Vascular
0121	Level I Tube changes and Repositioning
0140	Esophageal Dilation without Endoscopy
0147	Level II Sigmoidoscopy
0148	Level I Anal/Rectal Procedure
0155	Level II Anal/Rectal Procedure
0165	Level III Urinary and Anal Procedures
0170	Dialysis
0179	Urinary Incontinence Procedures
0191	Level I Female Reproductive Proc
0192	Level IV Female Reproductive Proc
0203	Level VI Nerve Injections
0204	Level I Nerve Injections
0207	Level III Nerve Injection
0218	Level II Nerve and Muscle Tests
0225	Implantation of Neurostimulator Electrodes
0230	Level I Eye Tests & Treatments
0231	Level III Eye Tests & Treatments

TABLE 2.—TABLE OF EXEMPTED CODES—Continued

NPRM APC	Description
0233	Level II Anterior Segment Eye Procedures
0235	Level I Posterior Segment Eye Procedures
0238	Level I Repair and Plastic Eye Procedures
0239	Level II Repair and Plastic Eye Procedures
0252	Level II ENT Procedures
0260	Level I Plain Film Except Teeth
0274	Myelography
0286	Myocardial Scans
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
0294	Level I Therapeutic Nuclear Medicine
0297	Level II Therapeutic Radiologic Procedures
0303	Treatment Device Construction
0304	Level I Therapeutic Radiation Treatment Preparation
0330	Dental Procedures
0345	Level I Transfusion Laboratory Procedures
0354	Administration of Influenza/Pneumonia Vaccine
0356	Level II Immunizations
0367	Level I Pulmonary Test
0368	Level II Pulmonary Tests
0370	Allergy Tests
0373	Neuropsychological Testing
0600	Low Level Clinic Visits
0602	High Level Clinic Visits
0660	Level III Otorhinolaryngologic Function Tests
0692	Electronic Analysis of Neurostimulator Pulse Generators
0694	Mohs Surgery
0698	Level II Eye Tests & Treatments

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

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

Effective in 2003, we propose to move several procedures from new technology APCs to clinical APCs. Those procedures and the clinical APCs to which we propose to assign the procedures for payment in 2003 are identified in Table 3. Based upon our review of the 2001 OPPS claims data, we believe we have sufficient information upon which to base assignment of these procedures to clinical APCs. In making this determination, we reviewed both single and multiple procedure claims. We compared median cost data for the new technology procedures with median cost data for procedures that are clinically similar and for which we would expect costs to be similar. We also compared median cost data for the new technology procedures with median cost data for clinically related procedures, such as different methods of treating prostatic hypertrophy, where expected median costs were lower or higher than those of the new technology procedure. In some cases we propose classification of a new technology procedure in an APC with procedures that are similar both clinically and in terms of resource consumption. In other cases, we propose to create a new APC for a new technology procedure because we do not believe any of the existing APCs contain procedures that are clinically similar and similar in terms of resource consumption. We solicit comments on our proposed reassignment of the new technology procedures listed in Table 3.

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

HCPCS	Description	2002 SI	2003 SI	2002 APC	2003 APC
19103	Bx breast percut w/device	S	T	0710	0658
33282	Implant pat-active ht record	S	S	0710	0680
36550	Declot vascular device	T	T	0972	0677
53850	Prostatic microwave thermotx	T	T	0982	0675
53852	Prostatic rf thermotx	T	T	0982	0675
55873	Cryoablate prostate	T	T	0982	0674
76075	Dual energy x-ray study	S	S	0707	0288
76076	Dual energy x-ray study	S	S	0707	0665
77520	Proton trmt, simple w/o comp	S	S	0710	0664
77522	Proton trmt, simple w/comp	S	S	0710	0664
77523	Proton trmt, intermediate	S	S	0712	0664

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

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

3. APC Assignment for New Codes Created During 2002

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

Table 4 does not include new codes for drugs and devices for which we established or intend to establish pass-through payment eligibility in July or October 2002. Furthermore, neither the new procedural HCPCS nor the new pass-through codes intended as of this publication for implementation beginning October 2002 or later are included in Addendum B of this proposed rule.

TABLE 4.—NEW G CODES FOR 2002 AND PROPOSED G CODES FOR 2003

Code	Long descriptor	APC	SI	Proposed effective date
G0245	Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include the procedure used to diagnose LOPS; a patient history; and a physician examination that consists of at least the following elements—* * *.	0600	V	7/01/02
G0246	Follow-up physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include the procedure used to diagnose LOPS; a patient history; and a physician examination that includes—* * *.	0600	V	7/01/02
G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present at least the following—* * *.	0009	T	7/01/02

TABLE 4.—NEW G CODES FOR 2002 AND PROPOSED G CODES FOR 2003—Continued

Code	Long descriptor	APC	SI	Proposed effective date
G0248	Demonstration, at initial use, of home INR monitoring for a patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample provision of instructions for reporting home INR test results and documentation of a patient's ability to perform testing.	0708	S	7/01/02
G0249	Provision of test material and equipment for home INR monitoring to patient wih mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.	0708	S	7/01/02
G0250	Physician review/interpretation and patient management of home INR test for patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service).	N/A	E	7/01/02
G0AAA	PET imaging for initial diagnosis of breast cancer and/or surgical planning for breast cancer (for example, initial staging of axillary lymph nodes), not covered by Medicare..	N/A	E	10/01/02
G0BBB	PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging after or prior to course of treatment.	0285	S	10/01/02
G0CCC	PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment.	0285	S	10/01/02
G0DDD	Current Perception Threshold/Sensory Nerve Conduction Test, (SNCT) per limb, any nerve..	N/A	E	10/01/02
G0EEE	Intravenous infusion(s) during separately payable observation stay, Per observation stay (must be reported with G0244).	0340	X	10/01/02
G0FFF	Bone marrow aspiration and biopsy performed through a single incision during a single session.	0003	T	1/01/03
G0GGG	Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.	0170	S	1/01/03
G0HHH	Injection procedure for sacroiliac joint; arthrography	N/A	N	1/01/03
G0JJJ	Injection procedure for sacroiliac joint; provision of anesthetic, steroid, and/or other therapeutic agent.	0204	T	1/01/03
G0KKK	Prostate brachytherapy, including transperineal placement of needles or catheters into the prostate, cystoscopy, and interstitial radiation source application..	0684	T	1/01/03
G0LLL	Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma..	N	N	1/01/03
G0MMM	Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain or asthma..	0706	S	1/01/03
G0NNN	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel..	0656	T	01/01/03
G0OOO	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel..	0656	T	01/01/03

HCPCS Codes Created During CY 2002

The G codes G0245 through G0250 were created to implement payment for newly covered Medicare services due to national coverage determinations. The G codes G0AAA–G0DDD will be established October 1, 2002 as a result of national coverage policies that will be effective October 1, 2002. These codes were created to accurately describe the services covered, to ensure they were reported correctly, to track their utilization, and to establish payment. We solicit comments on the APC assignment of these services. The codes describing evaluation and management services were assigned to clinic visit APCs containing similar services, and the codes describing procedural services were assigned to new technology APCs or to APCs containing procedures requiring similar resource consumption. Because G0250 is a professional service furnished by a physician, it is not payable under OPPS.

We expect to implement HCPCS code G0EEE (Intravenous Infusion(s) During Separately Payable Observation Stay) effective October 1, 2002 to describe infusion therapy given during a separately payable observation stay. This code is discussed in detail in section VIII.B of this proposed rule. We have assigned it to APC 0340. We believe APC 0340 appropriately accounts for the resources used for infusion during observation. This is because we believe that Q0081, which represents the same service as G0EEE, is typically billed with an APC that has a higher relative weight, therefore making APC 0120 payable at 50 percent of its payment rate.

HCPCS Codes Proposed in This Rule for January 1, 2003

We are proposing the creation of several new HCPCS codes for 2003 in order to address issues that have come to our attention, to describe new technology procedures, to implement policy proposals discussed in this rule, and to allow more appropriate reporting of procedures currently described by CPT (HCPCS Level I) codes.

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

FR 43846). This code would facilitate proper reporting of this procedure.

(2) G0GGG—Unscheduled and Emergency Treatment for ESRD Patients—we are proposing this code in order to facilitate payment for dialysis provided to ESRD patients in the outpatient department of a hospital that does not have a certified ESRD facility. This code is described in detail in section VIII.G of this proposed rule.

(3) G0HHH and G0JJJ—Sacroiliac Joint Injections—we are proposing to create these two codes to replace CPT code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid. CPT code 27096 describes two distinct procedures requiring different resource consumption. Moreover, our policy of packaging injection procedures required packaging of this procedure even when it was used to report injection of a steroid or anesthetic. In these cases, it was appropriately billed without another procedure and should have been payable. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096, we propose to create G0HHH, Injection procedure for sacroiliac joint, arthrography, and G0JJJ, Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid. G0HHH would be given status indicator N, and G0JJJ would be assigned to APC 0204.

(4) G0KKK—Prostate Brachytherapy—we are proposing this code to implement our policy decision discussed in section III.C.3 of this proposed rule.

(5) G0LLL and G0MMM—Observation Care—we are proposing to create these codes to describe observation care provided to a patient who is directly admitted from a physician's office to a hospital for observation care. These codes are discussed in detail in section VIII.B of this rule.

(6) G0NNN, G0OOO; Drug Eluting Stents—

Drug-Eluting Stents

Drug-eluting coronary artery stents (referred to as ''drug-eluting stents'' in the discussion that follows) have been developed to combat the problem of restenosis of blood vessels previously treated for stenosis. The drug is coated on a stent with a special polymer, and after the stent is placed in the vessel, the drug is slowly released into the vessel wall tissue over a period of 30 to 45 days. The drug coating on the stent is intended to prevent the build-up of scar tissue that can narrow the reopened artery. The FDA has not yet approved this technology for general use. We understand the earliest date that a decision from the FDA is anticipated is late 2002.

We received an application to establish a new medical device category eligible for transitional pass-through payment under the OPPS for drug-eluting stents from a manufacturer of these stents. In the application for the new device category, the manufacturer asserts that drug-eluting stents meet the criteria for establishing a new device category that were set forth in the November 2, 2001 **Federal Register**. Specifically, the manufacturer believes a new device category is appropriate because drug-eluting stents meet the cost significance thresholds for a new device category, and they provide substantial therapeutic benefit to Medicare beneficiaries compared to other available therapies for coronary atherosclerosis.

Based on our review of the application as well as other information pertaining to drug-eluting stents, we determined that drug-eluting stents are described by an existing pass-through device category. As we discuss in section III.D of this preamble, section 1833(t)(6)(B)(ii)(IV) of the Act requires that a new category must include medical devices for which no existing category, or one previously in effect, is appropriate. In the program memorandum that we issued to our contractors on March 22, 2001 (Transmittal A–01–41) with instructions for the implementation of category codes for use in making transitional pass-through payments for devices, we established two categories that describe and could be used to bill for drug-eluting stents: HCPCS code C1874, Stent, coated/covered, with delivery system, and HCPCS code C1875, Stent, coated/covered, without delivery system. These two categories were based on devices that previously qualified for transitional pass-through payment on an item-specific basis. Although these two device categories are among those that will sunset after December 31, 2002, as we discuss in section III.C of this preamble, the fact that they exist precludes the establishment of a new device category for drug-eluting stents.

Payment for drug-eluting stents is not allowed under the OPPS until they receive FDA approval for general use. If the drug-eluting stents are approved for general use by the FDA, payment would be packaged into the APC payment for the procedures with which the stents are used. The cost of drug-eluting stents would be incorporated within the APC relative payment weights when we recalibrate the payment weights in CY 2005 using CY 2003 claims data.

In considering how we would pay for drug eluting stents under OPPS we thought carefully about how the payment should relate to payment for these stents under IPPS. Section 533 of BIPA added sections 1886(d)(5)(K) and (d)(5)(L) to the Act (as implemented by § 42 CFR 412.87 and 412.88) to reduce the time needed under the hospital inpatient PPS for the DRG system to recognize the higher costs of new technologies that meet certain criteria. Drug-eluting stents did not meet the inpatient PPS new technology cost threshold criterion in the May 9, 2002 proposed rule to update the hospital inpatient PPS for FY 2003. Therefore, in that proposed rule, we listed a new ICD–9 procedure code 36.07 (Insertion of drug-eluting coronary artery stent(s)) that would be effective for use October 1, 2002. We also proposed to add ICD–9 code 00.55 (Insertion of drug-eluting noncoronary artery stent) (67 FR 31630). To be consistent with our prior practice of assigning new technology to the same DRGs to which its predecessor technologies were assigned, we proposed in the May 9 inpatient PPS proposed rule to assign inpatient cases involving ICD–9 code 36.07 to DRG 517 (Percutaneous Cardiovascular Procedure with Coronary Artery Stent without AMI).

However, comments to the May 9, 2002 proposed IPPS rule and our own further consideration of this issue persuaded us that a different approach was needed for the IPPS given the preliminary evidence that drug-eluting stents could prove potentially to be transformational technology in the treatment of coronary artery disease. While this technology is not yet approved for general use by FDA, commenters to the May 9 hospital inpatient PPS proposed rule reported that drug-eluting stents have shown promise to significantly advance the treatment of coronary artery disease, and they encouraged CMS to consider the available data to determine the most appropriate DRG payment. Commenters supported reassignment of the new procedure codes for drug-eluting stent insertions to higher paying DRGs or, if necessary, the modification of all affected DRGs, once verifiable data on the costs associated with drug-eluting stents become available.

Many of the commenters who supported higher payment under the inpatient PPS for this technology were clinical practitioners and hospitals, who expressed great anticipation for the potential benefits of this technology. In addition, commenters referred to the likelihood that, once approved, patients would demand to have these new drug-

eluting stents, putting tremendous financial strain on hospitals.

Commenters to the proposed rule for the inpatient PPS for FY 2003 also argued there should be long-term cost savings to the Medicare program and the health system generally from this technology after approval by the FDA. Specifically, if dramatically fewer patients require restenting, savings will result from fewer repeat angioplasty procedures. And, to the extent bypass surgeries are reduced, savings would result from that outcome as well.

In responding to these commenters in the inpatient final rule published in the **Federal Register** on August 1, 2002 (67 FR 50003), we noted that, although the FDA has not yet approved this technology for general use, public presentation of the results from recent clinical trials have found virtually no in-stent restenosis in patients treated with the drug-eluting stent. Therefore, we recognize the potentially significant impact this technology may conceivably have on the treatment of coronary artery blockages.

We are concerned that, if the FDA does approve this technology and the predictions of its rapid, widespread use are accurate, significant strain on hospital financial resources would result. In particular, we are concerned that the higher costs of this technology would create undue financial hardships for hospitals due to the high volume of stent cases and the fact that a large proportion of these cases could involve the new technology soon after FDA approval. Therefore, in the final rule for the FY 2003 inpatient PPS, we implemented an unprecedented approach in response to the unique circumstances surrounding the potential breakthrough nature of this technology and we created two new DRGs to reflect cases involving the insertion of a drug-eluting coronary artery stent. We discuss in detail in the final inpatient PPS rule our rationale for establishing these DRGs (67 FR 50003–50005).

Although the clinical trials for drug-eluting stents are being conducted on hospital inpatients, our 2001 hospital outpatient claims data included nearly 18,000 claims for procedures utilizing other types of coronary stents in the hospital outpatient setting. Every indication points to a steady increase in the future volume of coronary stent procedures performed on an outpatient basis. The same concerns that we express above about the impact of the advent of drug-eluting stents on hospital resources apply to procedures performed in the outpatient setting as well as the inpatient setting. We created these new DRGs for drug-eluting stents to ensure and promote beneficiary access to the best care possible by ensuring that our payment system keeps pace with what we believe will be a growing volume of coronary stent procedures if FDA approves drug-eluting coronary artery stents. We want to ensure that the costs of drug-eluting stents will be recognized sufficiently quickly to ensure beneficiary access in the outpatient setting over the 2 years that it will take for the costs of these devices to appear in the Medicare data on which we will base Medicare payments for them.

Drug-eluting stents may have been commercially marketed for 2 years by the time cost data for stent insertion procedures performed in CY 2003 are incorporated into the APC relative weights under the OPPS for CY 2005. Therefore, as we have done under the inpatient PPS for FY 2003 under these exceptional circumstances, we propose to deviate from our standard OPPS payment methodology to ensure consistent payment for drug-eluting stents in both the inpatient and outpatient settings; to ensure that hospital resources are not negatively affected by a sudden surge in demand for this new technology if FDA approval is received; and, to ensure that Medicare payment does not impede beneficiary access to what appears to be a potentially landmark advance in the treatment of coronary disease. Consistent with the special approach we implemented in the inpatient PPS final rule, we propose to create two new HCPCS codes and a new APC that may be used to pay for the insertion of coronary artery drug-eluting stents under the OPPS, to be effective if these stents receive FDA approval for general use. Of course, as with other new procedures, FDA approval does not mean that Medicare will always cover the approved item. Medicare coverage depends upon whether an item or service is medically necessary to treat illness or injury as determined by Medicare contractors based on the specifics of individual cases.

The new HCPCS codes that we propose are as follows: G0NNN—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel G0OOO—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.

We propose to assign G0NNN and G0OOO to new APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, with a status indicator of T.

To establish a payment amount for the proposed new APC, we propose to apply the same assumptions that we used in establishing the weights for DRG 526 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI) and DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI) as described in the final rule implementing the FY 2003 inpatient PPS. That is, based on prices in countries where drug-eluting stents are currently being used, manufacturer information and information furnished in response to the May 9, 2002 IPPS proposed rule, and the average price of currently available stents, we assume a price differential of approximately $1,200. Using an average of 1.5 stents per procedure, we propose to add $1,200 to the median costs established for APC 0104 based on 2001 claims data. We would then calculate a relative payment weight and payment rate for APC 0656 in accordance with the methodology that we discuss in section II.B. of this preamble. By taking this approach, we believe that payment for drug-eluting stents would be balanced between the OPPS and the inpatient PPS, minimizing the incentive to use payment as the basis for determining where to furnish this new technology.

We are taking the extraordinary temporary measure of establishing this APC and pricing it as we propose only because we have been advised by experts that these stents can be expected to revolutionize the provision of coronary care and can be expected to supplant use of existing stents. While the statute contemplates the difficulties of setting OPPS payments for new devices by providing the transitional pass-through mechanism, that mechanism does not work in this circumstance since these devices fall into a previously existing device category and do not meet the test for inclusion in new technology APCs. However, the law permits us to take into account changes in technology and the addition of new factors (See section 1833(t)(9)(A)) of the Act. In this case, we think the impact of this new technology will be so great compared to other new technologies that, to ensure beneficiary access to state-of-the-art medical care, we believe that we need to create new codes and a separate APC, paid based on the best information currently available, to ensure adequate payment to providers and access to care during the first 2 years of the device's existence. To undertake this methodology in other cases, we would

have to be similarly convinced that the technology would not qualify for pass-through payment nor new technology APC payment, that it will revolutionize the provision of care and that it will replace an existing technology. As indicated previously, this payment mechanism would be a temporary one that would exist only until 2005, at which point we would have sufficient data to determine how to pay for these devices under the standard OPPS methodology for setting payment amounts.

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

We are proposing to establish the new HCPCS codes and APC group for coronary artery drug-eluting stents to allow close tracking of the utilization and costs associated with these services. Once we obtain adequate cost data for coronary artery drug-eluting stents, we propose to incorporate these data into the current CPT codes for coronary stent placement. We invite comments on this proposed methodology for recognizing the additional costs of drug-eluting stents under the OPPS.

It is important to emphasize that we anticipate that the vast majority of new technologies in the future will continue to be routinely incorporated into the existing DRGs or through the new technology add-on payments under the inpatient PPS. Similarly, we expect in the future to continue to make payment under the OPPS for the vast majority of new technologies through the existing provisions for transitional pass-through payments for new devices, drugs, and biologicals and through new technology APCs.

4. Recalibration of APC Weights for 2003

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

To recalibrate the relative APC weights for services furnished on or after January 1, 2003 and before January 1, 2004, we are proposing to use the same basic methodology that we described in the April 7, 2000 final rule. That is, we would recalibrate the weights based on claims and cost report data for outpatient services. We propose to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for 2003, the most recent available claims data are the approximately 110 million final action claims for hospital outpatient department services furnished on or after January 1, 2001 and before January 1, 2002 and processed through March 2002. Many of these 110 million claims were for services that are not paid under OPPS (such as, clinical laboratory tests). We matched the claims that are paid under OPPS to the most recent cost report filed by the individual hospitals represented in our claims data. The APC relative weights would continue to be based on the median hospital costs for services in the APC groups.

a. Data Issues

(1) Treatment of ''Multiple Procedure'' Claims

We have received many requests (through an April Town Hall meeting and other sources of contact with the public) asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the 2003 relative payment weights. They believe that relying solely on single procedure claims to recalibrate APC weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures.

We agree that optimally, it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. We identified certain multiple procedure claims that could be treated as single procedure claims, enabling us to greatly increase the number of services used to develop the APC payment weights for 2003. However, several inherent features of multiple bill claims prevented us from using all of them to recalibrate the payment weights. We discuss these obstacles below.

There are four scenarios that occur when multiple procedures are billed on a claim that result in our being unable to use all of those claims to recalibrate the APC weights. In each case, the underlying problem is that there are charges on the claim that we are unable to correctly associate with the HCPCS codes for the procedures on the claim (that is, payable HCPCS codes). In general, we are unable to determine with confidence what portion of those charges should be packaged into the charges for each of the procedures on the claim. The different scenarios that we describe below may occur singly or in combination on the same claim.

In the first scenario, costs associated with outpatient hospital services are reported in revenue centers that cannot be associated with individual HCPCS codes because they are ancillary and supportive of some or all services furnished to the beneficiary. We do not require that hospitals assign a HCPCS code to each revenue center and charge or that they split the charges within revenue centers by HCPCS code because they advise us that they are unable to account for costs in this manner. In addition, to collect and report this information would be burdensome and costly.

Where there is only one HCPCS code for a procedure on the claim, we can assign supporting charges in revenue centers to the single HCPCS code. However, when there are two or more HCPCS codes for procedures on the claim, we have no basis for allocating appropriately the ancillary charges reported under revenue centers to the HCPCS codes for separately payable procedures. For example, a claim containing HCPCS codes for a visit and a surgical procedure may show charges under the revenue center for family clinic (517) for the visit and under operating room (360) for the surgery. But in addition, the claim could show charges under the following revenue centers without assigning a HCPCS code to the revenue center: recovery room (710), charge A for sterile supplies (272), charge B for sterile supplies (272), anesthesia (370), and pharmacy (250). If only a single HCPCS code was billed, we could sum the charges shown under the ancillary revenue centers and attribute those charges to the HCPCS code for the single HCPCS code that was billed. However, because there is more than one separately payable code on the claim (clinic visit and surgery), we do not know which charge for sterile supplies should be mapped to the visit and which should be assigned to the surgery. Similarly, there is nothing on the claim to indicate whether the total pharmacy charge is associated with the surgery or with the clinic visit, or split between them. For this type of multiple procedure claim, we have chosen to

exclude the claim from the pool of charges used to calculate median APC costs rather than risk assigning the ancillary revenue center charges incorrectly. This type of multiple procedure claim, often much more complex than this example, accounts for a significant portion of the multiple procedure claims that we are unable to use to recalibrate payment weights.

In the second scenario, we are unable to correctly assign to procedures the charges for HCPCS codes that we package into other procedures. HCPCS codes with status indicator ''N'' are not paid separately. Rather, the payment for these packaged items or services is recognized in the payment for a service or services billed on the same claim for which there is an APC payment rate. In calculating the median costs, we have to know where to incorporate the charges shown for the HCPCS code with status indicator ''N.'' When a packaged HCPCS codes is on a claim that also bills for more than one primary procedure (that is, procedures for which we make separate payment), we do not know with which of the procedures the charges for the packaged HCPCS code should be associated, or whether the charges for the packaged HCPCS code should be apportioned on some basis among the multiple primary procedures.

In the third scenario, in the case of multiple surgical procedures, our billing instructions permit hospitals to show charges for only one surgical procedure code although they report more than one surgical HCPCS code. Specifically, this billing convention has long been permitted in Medicare Intermediary Manual section 3626.4B3 and was reconfirmed by Medicare Transmittal A–01–50, which was issued on April 12, 2001 *(http://www.hcfa.gov/pubforms/transmit/A0150.pdf)* in response to hospital requests that we clarify whether they were required to create and report charges for each HCPCS code for each surgical service billed on a claim. We believe that to report charges for each HCPCS code for surgical services would have imposed an additional accounting and billing burden on hospitals that had not previously existed. This would have been in addition to the changes to the claims format and instructions that hospitals had recently made to accommodate OPPS and our other initiatives. As in the case of the ancillary services billed under revenue centers, the charges for each HCPCS code for the surgery were not needed to ensure that correct payment was made on the claim (since payment was made based on the code's APC assignment and not on reported charges).

However, because hospitals are permitted to report operating room charges for only one of the multiple surgical procedures on a claim, we are unable to identify a valid means of apportioning the operating room charges to the other procedures that were performed. We are not aware of any research on comparative hospital outpatient department (OPD) resource consumption by HCPCS codes that would indicate how to apportion a total charge among the individual codes on the claim. Moreover, these multiple surgical procedure claims frequently have problems similar to those discussed above in scenario one. Therefore, we are unable to use data from multiple surgery claims that are submitted in this form to calculate APC median costs.

In the fourth scenario are claims with multiple units of the same HCPCS code billed with charges in revenue centers or packaged HCPCS codes. In this case, we cannot determine the appropriate distribution of charges on the claim between the first and subsequent units of the HCPCS code. To approximate the charges that would occur if single rather than multiple units of the HCPCS code were billed, we would have to inflate the charges for the second and subsequent units of the service, which would eliminate the impact of the efficiencies that we believe occur when second and subsequent units of a procedure are performed. There are no data to suggest an appropriate factor to apportion charges for the second and subsequent units.

We considered several methods of apportioning charges from revenue centers and packaged HCPCS codes to enable us to use charge data from multiple procedure claims in the calculation of APC weights, but none of these methods was sufficient to yield cost data that we could be assured were valid. Specifically, we considered dividing the total charges in a revenue center or for a packaged HCPCS code by the number of payable HCPCS codes for multiple procedures on the claim. In the example of a claim for a visit code and a surgical code with the revenue center for sterile supplies billed twice on the same claim, we would sum the charges for sterile supplies, divide the sum by 2, and add the resulting divided charges for sterile supplies to the charges for each HCPCS code. The single pharmacy charge would be divided by 2, and half of the pharmacy charge would be added to each HCPCS code. We rejected this approach because of concern about whether it is likely to be sufficiently accurate to serve as a reasonable means of apportioning charges.

We also considered apportioning the charges among the codes based on physician work relative value units (RVUs) because time is a major factor in the establishment of physician work RVUs under the Medicare fee schedule for physician services. Time may be reflective of the comparative amount of resources used by the hospital for different surgical procedures, particularly charges for operating rooms, recovery rooms, and observation rooms. However, physician work RVUs also depend in part on the intensity and difficulty of the work of a physician in providing a service and would therefore not necessarily reflect accurately the relative resources a hospital would expend for the same procedure. Moreover, we do not believe that time appropriately reflects the use of resources such as pharmacy and supplies.

We then considered apportioning the charges among the codes based on physician nonfacility practice expense RVUs because practice expense RVUs reflect relative resource utilization for these services. However, we have no evidence that the relative practice expenses of physicians correlate with the resources that a hospital would use for the same service. Moreover, physician practice expenses are minimal for the many services typically furnished in a facility rather than the physician's office. For these services, the practice expense RVU reflects only minimal expenses for services, such as the physician's billing costs. They are, therefore, an inadequate proxy for the facility costs, such as supplies, drugs, equipment, nursing services, and overhead costs incurred by hospitals.

In summary, we concluded that the inherent drawbacks of these methodologies would outweigh any potential advantages accrued from the resulting increase in data used to calculate APC median costs. Without evidence to the contrary, we believe that applying these arbitrary methods of apportioning costs to multiple procedure claims would yield results that are less reliable and valid than continuing to rely on single procedure claims in calculating APC median costs.

We solicit public comment on the methods we considered for apportioning the total charges to individual HCPCS codes as described above. We also invite suggestions of other alternative means of apportioning the total costs on multiple procedure claims to the HCPCS codes for the procedures so that we can use more data from multiple procedure claims in the 2004 update of the OPPS.

We also solicit information on existing studies that would provide

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

Further, we ask for comments on the feasibility of requiring hospitals to apportion all charges currently shown in revenue centers to the HCPCS codes billed so that we could use all multiple services claims in the calculation of the relative weights. For example, where the patient received multiple surgeries on the same day or received a visit and a procedure on the same day, the hospital would have to create a charge for each billable HCPCS code and that charge would have to encompass all charges for OR, recovery room, pharmacy, supplies, etc. that were relevant to that code. No charges would be billed under revenue centers alone or with packaged HCPCS codes (that is, HCPCS codes having a status indicator of N) since all charges would be reported under associated payable HCPCS codes. There would have to be corollary changes in completion of the cost report. Also, because hospitals must have a uniform charge structure, providers would need to charge all other payers and private pay patients in the same manner as they would be required to charge Medicare.

We are particularly interested in the views of hospitals and billing experts weighing the burden that could be created by these changes in billing rules relative to the potential benefit of calculating more precise OPPS payment rates that incorporate data from multiple procedure claims.

Finally, we solicit information regarding the extent to which efficiencies are realized when multiple services are furnished during the same visit or operative session. We currently discount the APC payment for the second and subsequent procedures performed during a single encounter by 50 percent in the expectation that the same efficiencies of service that are demonstrated to exist in the provision of physician services also exist in the provision of outpatient hospital services. In general, when a second or subsequent service is performed at the same time as an initial service, we believe that the combined resource costs associated with operating room time, recovery room time, anesthesia, supplies, and other services are less than if the procedures were performed separately. However, we are interested in empirical data regarding the extent to which these efficiencies of resource consumption actually occur.

(2) Calendar Year 2002 Charge Data for Pass-Through Device Categories

HCPCS coding for medical devices that qualified for transitional pass-through payment for services furnished in 2001 occurred in two different ways. (A detailed discussion of the provisions authorizing transitional pass-through payments for certain medical devices and drugs and biologicals can be found in section III of this preamble.) From August 1, 2000 until April 1, 2001, claims for medical devices that were paid on a pass-through basis were coded using device specific codes that were often manufacturer specific. BBRA required that, effective April 1, 2001, claims for medical devices eligible for transitional pass-through payment were to be billed using codes that applied to categories of devices. We issued the applicable category codes in Program Memoranda, Transmittals A–01–40 and A–01–41. We posted them on our web site at *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf*, respectively. The change to the use of category codes, rather than device specific codes, simplified coding and also expanded the number of devices that were eligible for transitional pass-through payment. The expansion occurred because devices that fit the categories but that had previously not met the criteria for transitional pass-through payments could now be billed for a transitional pass-through payment.

Moreover, in recognition of the impact of the change on hospital billing and in recognition of the short time between the passage of legislation (December 14, 2000) and the effective date for the new codes (April 1, 2001), we gave hospitals a 90-day grace period during which they could bill using either the device specific codes they had previously been using or the new category codes. For this reason, only services furnished on or after July 1, 2001 were required to be billed using the new device category codes.

We have been advised that during the period in which the 2001 OPPS was in effect, hospitals may not have billed properly for devices eligible for transitional pass-through payments. We understand that the changes in billing format and systems for implementation of the OPPS compounded the problems of billing using the device specific codes during the first 9 months of the OPPS. We have been informed that these problems were further compounded by the creation and requirement to use category codes on and after April 1, 2001. In general, we have been advised that hospitals may have been underpaid for transitional pass-through devices (because they did not bill separately for them and therefore did not get the pass-through payment) and that our data will not correctly show the charges associated with the devices (because the devices were not coded with device category codes on the claim).

We agree that where hospitals failed to show the code for the transitional pass-through device (whether the device specific code or the category code as applicable), they will not have received payment for the device as a transitional pass-through device. For many years, there have been processes in place for hospitals to submit adjustment bills so they can receive payment for all applicable services they furnished if they subsequently determine that their original bills were deficient. Notwithstanding, there is no method by which we can infer a charge on a claim for a service that is not billed by the hospital.

Regarding the impact of the absence of coding for devices on the data from claims submitted for July 2001 and later, we looked at the claims data for a sample of services for which we thought there should have been a device category billed because of the nature of the procedure (for example, insertion of a pacemaker). We found that there were many instances when a device category code was not billed when we would have expected it. However, we found that when we summed the charges for revenue centers with the charges for the procedure on claims where no category code was reported and compared those totals with the sum of charges from claims where both a device category code and the associated procedure code were billed, the results were very similar. From this analysis, we conclude that in many cases, particularly during the first half of the calendar year, hospitals included charges for transitional pass-through devices in the revenue center for supplies. Therefore, we believe cost data for transitional pass-through devices are contained in the charges of most claims, even where they are not separately identified by the code for the device category, which should have been reported.

We believe that this absence of category codes in the claims data and our data analysis, and the issues surrounding multiple procedure claims argue strongly for packaging the cost of these devices into the payment for the procedures with which they were used and to then create weights for

procedures for the 2003 OPPS. Incorrect device coding could lead to skewed weights for the retired transitional pass-through devices, if we were to establish individual APCs for the expired device categories.

We believe that packaging the charges billed under the revenue centers into the charges for the procedures before setting the weights for the APCs will allow us to capture all of the cost data for services in which devices were used which will result in the most valid payment for the APC. This approach assures that the payment rate for the procedure includes accurate payment for the devices used in the procedure. Further discussion of our proposal to package payment for sunsetting transitional pass-through devices is contained in section III.C of this preamble.

b. Description of How Weights Were Calculated for 2003

The methodology we followed to calculate the APC relative payment weights proposed for CY 2003 is as follows:

- We excluded from the data approximately 15 million claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 301 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services).
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.
- We excluded from our data approximately 3 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We eliminated 1.2 million claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- We matched revenue centers from the remaining universe of approximately 92.2 million claims to CCRs hospitals.
- We separated the 92.2 million claims that we had matched with a cost report into the following three distinct groups: (1) single-procedure claims, (2) multiple-procedure claims, and (3) claims on which we could not identify at least one OPPS covered service. Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims in this manner yielded approximately 30.4 million single-procedure claims and 20.1 million multiple-procedure claims. Approximately 41.5 million claims without at least one covered OPPS service were set aside.

We converted 10.7 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for chest X-rays (HCPCS codes 71010 and/or 71020) and/or EKGs (HCPCS code 93005) on these claims. If only one procedure (other than HCPCS codes 71010, 71020, and 93005) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single claim if the line item was billed as a single unit. (4) If the claim had no packaged HCPCS codes on the claim but had packaged revenue centers for the procedure, we ignored the line item for chest X-rays and/or EKG codes (as identified above) and if only one HCPCS code remained, we treated the claim as a single procedure claim. We created an additional 31.3 million single-procedure bills through this process, which enabled us to use these data from multiple-procedure claims in calculation of the APC relative payment weights.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section II.B.4.a.(1) of this preamble, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple-procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.
- For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').
- To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing the service. We observed the packaging provisions set forth in the April 7, 2000 final rule with comment period that were in effect during 2001 (65 FR 18484). For instance, in calculating the cost of a surgical procedure, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organs. To determine medical visit costs, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances where they are still packaged. Table 5 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in 2003.

TABLE 5.—PACKAGED SERVICES BY REVENUE CODE

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

TABLE 5.—PACKAGED SERVICES BY REVENUE CODE—Continued

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

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2003 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. See 65 FR 18496, the April 7, 2000 final rule for a complete description of how we derived this percentage.

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

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of 3 standard deviations from the geometric mean.

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

• We calculated the median cost for each APC.

• Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using 2001 data, the median cost for APC 0601 is $56.77.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes and wage index changes be made in a manner that assures that aggregate payments under the OPPS for 2003 are neither greater

than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2002 relative weights to aggregate payments using the CY 2003 proposed weights. Based on this comparison, we are proposing to make an adjustment of 1.04227 to the weights. The weights that we are proposing for 2003, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

5. Procedures That Will Be Paid Only As Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 and the November 30, 2001 final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

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

We update the inpatient list as often as quarterly through program memoranda to reflect current advances in medical practice. We last updated the inpatient list in the November 30, 2001 final rule. As we discuss in section II.A.2, above, the APC Panel at its January 2002 meeting reviewed certain procedures on the inpatient list for which we had received requests that they be made payable under the OPPS. The Panel recommended that we solicit comments and further information about all these procedures except for CPT code 47001, which they recommended be removed from the inpatient list (see section II.A.2 above for a discussion of this and the other codes that the Panel considered for removal from the inpatient list). These procedures are included in Table 6, with the exception of CPT code 33967, which we are not proposing to pay for under the OPPS for reasons that we explain in section II.A.2.

In preparing this proposed rule to update the OPPS for CY 2003, we compared procedures with status indicator ''C'' (status indicator ''C'' is assigned to inpatient procedures that are not payable under the OPPS) to the list of procedures that are currently on the ambulatory surgical center (ASC) list of approved procedures, to procedures that we proposed to add to the ASC list in a proposed rule published in the **Federal Register** on June 12, 1998 (63 FR 32291), and to procedures recommended for addition to the ASC list by commenters in response to the June 12, 1998 proposed rule. We found that there are procedures on the current ASC list, or procedures proposed for addition to the ASC list, or procedures recommended by commenters for addition to the ASC list that are assigned status indicator ''C'' under the OPPS. A review of 2001 physician claims data also revealed that physicians are performing some of these ''C'' status indicator procedures on Medicare beneficiaries on an outpatient basis. We concluded that it was appropriate to propose removal of procedures from the OPPS inpatient list that are being performed on an outpatient basis and/or that we had determined could be safely and appropriately performed on a Medicare beneficiary in an ASC under the applicable ASC rules that are set forth in 42 CFR 416.22. We believe that our payment policies for surgical procedures provided in an outpatient hospital setting and in the ASC setting should be consistent to the extent possible within the limitations imposed by statutory or regulatory requirements. So, we propose to add the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

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

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

Following our review of the comments that we receive about the procedures in Table 6, we propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments do not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2003 meeting.

TABLE 6.—PROCEDURES ON THE INPATIENT LIST PROPOSED FOR PAYMENT UNDER THE OPPS IN CY 2003.

CPT code	Proposed status indicator	Proposed APC	Description
21390	T	0256	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE; PERIORBITAL APPROACH, WITH ALLOPLASTIC OR OTHER IMPLANT.
22100	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; CERVICAL.
22101	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; THORACIC.
22102	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; LUMBAR.
22103	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE).
23035	T	0049	INCISION, BONE CORTEX (EG, OSTEOMYELITIS OR BONE ABSCESS), SHOULDER AREA.
23125	T	0051	CLAVICULECTOMY; TOTAL.
23195	T	0050	RESECTION, HUMERAL HEAD.
23395	T	0051	MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; SINGLE.
23397	T	0052	MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; MULTIPLE.
23400	T	0050	SCAPULOPEXY (EG, SPRENGELS DEFORMITY OR FOR PARALYSIS).
24150	T	0052	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS;.
24151	T	0052	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
24152	T	0052	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK;.
24153	T	0052	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
25170	T	0052	RADICAL RESECTION FOR TUMOR, RADIUS OR ULNA.
25390	T	0050	OSTEOPLASTY, RADIUS OR ULNA; SHORTENING.
25391	T	0051	OSTEOPLASTY, RADIUS OR ULNA; LENGTHENING WITH AUTOGRAFT.
25392	T	0050	OSTEOPLASTY, RADIUS AND ULNA; SHORTENING (EXCLUDING 64876).
25393	T	0051	OSTEOPLASTY, RADIUS AND ULNA; LENGTHENING WITH AUTOGRAFT.
25420	T	0051	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
27035	T	0052	DENERVATION, HIP JOINT, INTRAPELVIC OR EXTRAPELVIC INTRA-ARTICULAR BRANCHES OF SCIATIC, FEMORAL, OR OBTURATOR NERVES.
27216	T	0050	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC RING FRACTURE AND/OR DISLOCATION (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM).
27235	T	0050	PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE, PROXIMAL END, NECK, UNDISPLACED, MILDLY DISPLACED, OR IMPACTED FRACTURE.
31582	T	0256	LARYNGOPLASTY; FOR LARYNGEAL STENOSIS, WITH GRAFT OR CORE MOLD, INCLUDING TRACHEOTOMY.
31785	T	0254	EXCISION OF TRACHEAL TUMOR OR CARCINOMA; CERVICAL.
32201	T	0070	PNEUMONOSTOMY; WITH PERCUTANEOUS DRAINAGE OF ABSCESS OR CYST.
38700	T	0113	SUPRAHYOID LYMPHADENECTOMY.
42842	T	0254	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; WITHOUT CLOSURE.
43030	T	0253	CRICOPHARYNGEAL MYOTOMY.
47490	T	0152	PERCUTANEOUS CHOLECYSTOSTOMY.
47001	N		BIOPSY OF LIVER, NEEDLE; WHEN DONE FOR INDICATED PURPOSE AT TIME OF OTHER MAJOR PROCEDURE.
62351	T	0208	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG-TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITH LAMINECTOMY.
64820	T	0220	SYMPATHECTOMY; DIGITAL ARTERIES, EACH DIGIT.
69150	T	0252	RADICAL EXCISIONS EXTERNAL AUDITORY CANAL LESION; WITHOUT NECK DISSECTION.
69502	T	0254	MASTOIDECTOMY; COMPLETE.
92986	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; AORTIC VALVE.
92987	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; MITRAL VALVE.
92990	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; PULMONARY VALVE.
92997	T	0081	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; SINGLE VESSEL.
92998	T	0081	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

C. Partial Hospitalization

Payment Methodology

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in the place of inpatient care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, effective for services furnished on or after August 1, 2000, we established a per diem payment methodology for the PHP 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. We were unable to use CMHC data in computing the per diem because up until April 1, 2000, CMHCs were not required to report HCPCS codes. In addition, 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 and the most recent available cost report data. This analysis resulted in a per diem payment of $202.19 effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to $206.82 and $212.27.

Although we did not use CMHC data in establishing the initial APC for partial hospitalization (or in the updates made since then), in the April 7, 2000 final rule we made a commitment to analyze future data from hospitals and CMHCs to determine if refinements to the per diem are warranted. Based on our review of 2001 claims data submitted under the OPPS, we have developed a payment rate for partial hospitalization following the same methodology used to establish all the APC payment amounts. However, because a day of care is the unit for PHP services, we computed the median cost of furnishing a day of partial hospitalization. Other than the unit of service being a day of care, the method we used to determine median costs for PHP is no different than that used for all other APCs as described in other sections of this proposed rule. The CY 2003 proposed payment rate for the partial hospitalization APC is $256.96 per day, of which $51.39 is the beneficiary's coinsurance.

We used calendar year 2001 bills from both hospitals and CMHCs. We used data from all the hospital bills reporting condition code 41, which identifies the claim as partial hospitalization. Since section 1866(e)(2) of the Act specifies that a CMHC is a provider of service ''* * * only with respect to the furnishing of partial hospitalization services * * *,'' we used all bills from CMHCs. We used cost-to-charge ratios from the most recently available hospital and CMHC cost reports to develop costs from line item charges reported on bills. Since hospitals and CMHCs are now required to report line item dates of service on claims, we used that data to refine our estimates of line item costs.

We then computed per diem costs by summing the line item costs on each bill and dividing by the number of days on each bill. Using this method of determining costs, preliminary per diem cost estimates for CMHCs were much higher than expected, in many cases more than twice the average per diem for inpatient psychiatric care and more than three times the hospital median PHP per diem cost. The data strongly suggests that the costs were reported incorrectly. We believe that the data are unusable without adjustment.

Closer examination of the CMHC cost report data showed that costs from CMHC finalized cost reports were considerably lower than costs from ''as submitted'' CMHC cost reports. To account for the difference between settled and as-filed cost report data, we computed the ratio of total final costs to total as-filed costs over a 3-year period (FYs 1998–2000) and calculated an average adjustment factor which we applied to the costs on each claim. The adjusted costs were summed, then divided by the number of days on that bill.

Treatment of Professional Services Under PHP

Section 410.43 describes the conditions and exclusions of partial hospitalization services. That section lists the services that are separately covered and not paid as partial hospitalization services. The list includes—

- Physician services that meet the requirements of 42 CFR 415.102(a) for payment on a fee schedule basis;
- Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act;
- Qualified psychologist services, as defined in section 1861(ii) of the Act; and
- Services furnished to SNF residents as defined in 42 CFR 411.15(p).

Based on this section, in the April 7, 2000 OPPS rule, we stated that the APC for partial hospitalization 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 Medicare payment is made to the provider. Before implementation of the OPPS, the services of CSWs and OTs in a PHP were billed by the hospitals to the fiscal intermediaries and paid on a reasonable cost basis.

We have looked carefully at the differences between the cost experiences of CMHCs and of hospitals with respect to PHP services, as well as how payment is made for other hospital outpatient psychiatric services, to identify areas where improvements can be made in OPPS. One of the areas in which we identified discrepancies was in the coverage of CSW services. The way in which CSW services are currently billed and paid depends upon the circumstances under which CSW services are provided. In some settings, payment for CSW services is part of a bundled payment. In other settings, separate payment for CSW services is made.

Generally, CSW services furnished to hospital outpatients are bundled, which means that only the hospital may bill for such services. However, payment for CSW professional services furnished to hospital outpatients is made under the physician fee schedule. Therefore, the hospital outpatient department bills separately the Part B carrier for CSW services furnished to outpatients who are not in a PHP. CSW professional services are paid at 75 percent of the clinical psychologist fee schedule.

However, when CSWs furnish services to hospital outpatients or a CMHC under a partial hospitalization program, hospitals may not bill separately for the services of a CSW. Instead, for coverage and payment purposes, the services are recognized as partial hospitalization services. Partial hospitalization services are billed by hospitals and CMHCs to the fiscal intermediaries and paid the OPPS PHP APC per diem amount.

The different methodologies for payment of CSW services has proven both confusing and burdensome for hospitals because they must implement separate billing schemes for CSW services depending upon whether an

individual outpatient is admitted to a PHP program or to any other hospital outpatient psychiatric program. We believe that these challenges have resulted in incorrect reporting by hospitals which has led to an under-representation of CSW services in the OPPS PHP APC per diem amount.

To facilitate proper billing and to ensure comparable reporting of costs by hospitals and CMHCs, we are proposing to allow separate payment for CSW services furnished in CMHCs. This means that both hospitals and CMHCs will bill the carrier for CSW services furnished to PHP patients. Therefore, we are proposing to amend § 410.43(b) to add clinical social worker services that meet the requirements of section 1861(hh)(2) of the Act to the list of professional services not considered to be PHP services. We believe this change will allow CSW services to be more appropriately reflected in both settings as part of PHPs.

III. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biologicals. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act, Pub. L. 107–186; current drugs, biologic agents, and brachytherapy devices used for the treatment of cancer; and current radiopharmaceutical drugs and biological products.

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

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

Section 1833(t)(6)(B)(i) of the Act required that we establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum. On March 22, 2001, we issued two Program Memoranda, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our web site at *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf*, respectively.

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

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

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

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

B. Discussion of Pro Rata Reduction

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

We will make an estimate of pass-through spending in 2003 using the methodology described below. Making an estimate of pass-though spending in 2003 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data (that is, items that were eligible in 2001 and that will continue to be eligible in 2003). The second group consists of those items for which we have no direct claims data (that is, items that became or will become eligible in 2002 and will retain pass-through status and items that will be newly eligible beginning in 2003).

To estimate 2003 pass-through spending for device categories in the first group, we will use volume and hospital cost (derived from charges on claims using cost-to-charge ratios) information from 2001 claims data. This information will be projected forward to 2003 levels using appropriate inflation and utilization factors. For existing categories with no claims data in 2001 that are or will be active in 2002, we will follow the method described in the November 2, 2001 final rule (66 FR 55857). We will use price information from manufacturers and volume estimates from claims related to procedures that use the devices in question. This information will be

projected forward to 2003 using appropriate inflation and utilization factors to estimate 2003 pass-through spending for this group of categories. For categories that become eligible in 2003, we will use the same method as described for categories that are newly active in 2002. Any new categories for 2003 will be announced after the publication of this proposed rule but prior to the publication of the final rule. Therefore the estimate of pass-through spending will incorporate pass-through spending for categories made effective January 1, 2003.

To estimate 2003 pass-through spending for drugs, biologicals, and radiopharmaceuticals, in the first group, we will use volume data from 2001 claims and the average wholesale price (AWP) as published in the July 2002 Red Book. This information will be projected forward to 2003 using the appropriate utilization factor. (Because 2003 payment rates for pass-through drugs will be based on the July 2002 AWPs, we do not apply an inflation factor.) The pass-through amount for drugs, biologicals, and radiopharmaceuticals is the difference between the payment rate (that is, 95 percent of the AWP) and the amount that would have been included in the payment rate of its associated APC had the drug, biological, or radiopharmaceutical been packaged. Section V.E. describes this methodology. To estimate pass-through spending for drugs in this group, for each drug we will multiply the drug's estimated utilization times the pass-through amount (for example, the difference between 95 percent of AWP for the drug and the amount included in the payment rate for its associated APC). For most drugs, the pass-through amount will be based on the weighted average ratios described in Section IV.E. However some drugs may fall into two other classes. The first class includes a drug that is new and for which there are no previously existing costs in an associated APC. For such a drug, we propose that the pass-through amount would be 95 percent of the AWP (because there are no previously existing costs in an associated APC) and there will be no copayment (because there are no previously existing costs in an APC on which to base a copayment). The second class includes a drug that is new and is a substitute for only one drug whose cost is recognized in the OPPS through an unpackaged APC. For drugs in this second class, we propose that the pass-through amount would be the difference between 95 percent of the AWP for the pass-through drug and the payment rate for the comparable dose of the associated drug's APC. The copayment would be based on the payment rate of its associated APC.

For existing drugs, biologicals, and radiopharmaceuticals for which we have no claims data in 2001 and which are active or will be active in 2002 as well as for drugs, biologicals, and radiopharmaceuticals, we will derive volume estimates from information submitted by manufacturers as well as other sources (such as, peer-reviewed clinical studies) and the AWP as published in the July 2002 Red Book. This information will be projected forward to 2003 using the appropriate utilization factor. Again, because 2003 payment rates for pass-through drugs will be based on the July 2002 AWP, we do not apply an inflation factor. To estimate pass-through spending for drugs in this group, for each drug we will multiply the drug's estimated utilization times the pass-through amount. For most drugs, these amounts will be based on the weighted average ratios described in Section IV.E. However some drugs may fall into two other classes. The first class includes a drug that is new and has no previously existing costs included in an associated APC. For such a drug, we propose that the pass-through amount would be 95 percent of the AWP (because there are no previously existing costs included in an APC) and there would be no copayment (because there are no previously existing costs in an APC on which to base a copayment). The table below shows two such drugs, Y–90 Zevalin and IN–111 Zevalin. The second class includes a drug that is new and is a substitute for only one drug that is recognized in the OPPS, through an unpackaged APC. The table below shows one such drug, Darbepoetin alfa, which is a new substitute of epoetin. For drugs in this second class, the pass-through amount will be the difference between 95 percent of the AWP for the pass-through drug and the payment rate for the comparable dose of the associated drug's APC. The copayment will be based on the payment rate of its associated APC. For drugs, biologicals, and radiopharmaceuticals that may receive pass-through status effective January 1, 2003, we will use the same methodology as described for drugs, biologicals, and radiopharmaceuticals that received pass-through status in 2002. Any new pass-through drugs, biologicals, and radiopharmaceuticals effective beginning in 2003 will be announced after the publication of this proposed rule but prior to the publication of the final rule. Therefore the estimate of pass-through spending will incorporate pass-through spending for these drugs, biologicals, and radiopharmaceuticals made effective January 1, 2003.

Finally, we will incorporate an estimate of pass-through spending for items that become eligible later in 2003 (that is, April 1, 2003; July 1, 2003; and October 1, 2003) based on estimates for items that will become eligible for pass-through status January 1, 2003. Specifically, we will assume a proportionate amount of spending for items that become eligible later in the year while making an adjustment to account for the fact that items made eligible later in the year will not have received pass-through payments for the entire year.

After using the methodologies described above to determine projected 2003 pass-through spending for the groups of devices, drugs, biologicals, and radiopharmaceuticals described above, we would calculate total projected 2003 pass-through spending as a percentage of the total (that is, Medicare and beneficiary payments) projected payments under OPPS to determine if the pro rata reduction would be required.

Below is a table showing our current estimate of 2003 pass-through spending based on information available at the time this table was developed. We are uncertain whether pass-through spending in 2003 will exceed $457 million or 2.5 percent of total OPPS spending. We have not yet completed the estimate of pass-through spending for a number of drugs. In particular, we are in the process of obtaining additional information about the utilization volume for several pass-through drugs. We invite comments on the methodology described above as well as the assumptions shown in the table below including anticipated utilization and utilization not yet determined. More information regarding the assumptions used to create these estimates is available at *http://cms.hhs.gov/regulations/regnotices.asp.*

TABLE X.

HCPC	APC	DRUG, biological	2002 payment rate	2001 utilization	2003 Pass-through payment portion	2003 estimated utilization	2003 anticipated pass-through payment
Existing Pass-through Drugs/Biologicals							
A9700	9016	Echocardiography Contrast*	$118.75	300,000	$34.44	368,686	$12,696,607.35
C1774	734	Darbepoetin alfa, 1 mcg	4.74	6136252	1.37	7,541,157	10,366,074.10
C1058	1058	TC 99M oxidronate, per vial	36.74	4,000	10.65	4,916	52,375.96
C1064	1064	I–131 cap, each add mCi	5.86	4,575	1.88	5,622	485,208.00
C1065	1065	I–131 sol, each add mCi	15.81	4,575	5.06	5,622	1,309,068.00
C1775	1775	FDG, per dose (4–40 mCi/ml)	475.00	30,000	137.75	36,869	5,078,642.94
J9219	7051	Leuprolide acetate implant	5,399.80	66	1,565.94	81	127,014.83
J9017	9012	Arsenic Trioxide	23.75		6.89	TBD	To be determined
J7517	9015	Mycophenolate mofetil	2.40		0.70	TBD	To be determined
J0587	9018	Botulinum toxin type B	8.79		2.55	TBD	To be determined
C9019	9019	Caspofugen acetate, 5 mg	34.20		9.92	TBD	To be determined
C9110	9110	Alemtuzumab, per 10mg/ml	486.88		141.20	517	72,997.92
C9111	9111	Inj. Bivalrudin, 250 mg vial	397.81		115.36	TBD	To be determined
C9112	9112	Perflutren lipid micro, 2ml	148.20	300,000	42.98	368,686	15,845,365.98
C9113	9113	Inj Pantoprazole sodium, vial	22.80		6.61	TBD	To be determined
C9114	9114	Nesiritide, per 1.5 mg vial	433.20		125.63	TBD	To be determined
C9115	9115	Zoledronic acid, 2 mg	406.78		117.97	TBD	To be determined
C9200	9200	Orcel, per 36 cm2	1,135.25		329.22	TBD	To be determined
C9201	9201	Dermagraft, per 37.5 sq cm	577.60		167.50	TBD	To be determined
Pass-through Drugs/Biologicals Effective October 2002							
C9116	9116	Ertapenem sodium	36.24		10.51	TBD	To be determined
C9117	9117	Y–90 Zevalin	19,181.44		19,181.44	9,000	172,632,960.00
C9118	9118	IN–111 Zevalin	2,769.65		2,769.65	9,000	24,926,850.00
C9119	9119	Pegfilgrastim	2,802.50		2,367.13	85,258	201,815,396.40
Pass-through Devices							
C1765	1754	Adhesion barrier		256		261	20,011.00
C1783	1783	Ocular implant, aqueous drainage		2000		2042	1,327,300.00
C1888	1888	Endovascular, non-cardiac		184		188	136,300.00
C1900	1900	Lead, left ventricular		1000		1021	2,042,000.00
C2618	2618	Probe, cryoablation		1120		1144	531,106.00

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

1. Devices

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

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

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

TABLE 7.—LIST OF PASS-THROUGH DEVICE CATEGORIES WITH PROPOSED EXPIRATION DATES

	HCPCS codes	Category long descriptor	Date first populated	Expiration date
1	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/00	12/31/02
2	C1765	Adhesion barrier	10/01/00–3/31/01; 7/1/01.	12/31/03
3	C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/00	12/31/02
4	C1715	Brachytherapy needle	8/1/00	12/31/02
5	C1716	Brachytherapy seed, Gold 198	10/1/00	12/31/02
6	C1717	Brachytherapy seed, High Dose Rate Iridium 192	1/1/01	12/31/02
7	C1718	Brachytherapy seed, Iodine 125	8/1/00	12/31/02
8	C1719	Brachytherapy seed, Non-High Dose Rate Iridium 192	10/1/00	12/31/02
9	C1720	Brachytherapy seed, Palladium 103	8/1/00	12/31/02
10	C2616	Brachytherapy seed, Yttrium-90	1/1/01	12/31/02
11	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
12	C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/00	12/31/02
13	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
14	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
15	C1726	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02
16	C1727	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
17	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
18	C1729	Catheter, drainage	10/1/00	12/31/02
19	C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/00	12/31/02
20	C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	8/1/00	12/31/02
21	C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/00	12/31/02
22	C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip.	8/1/00	12/31/02
23	C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip.	10/1/00	12/31/02
24	C1887	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
25	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/00	12/31/02
26	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/00	12/31/02
27	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/00	12/31/02
28	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
29	C1754	Catheter, intradiscal	10/1/00	12/31/02
30	C1755	Catheter, intraspinal	8/1/00	12/31/02
31	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
32	C2628	Catheter, occlusion	10/1/00	12/31/02
33	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02
34	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
35	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
36	C1885	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
37	C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability).	8/1/00	12/31/02
38	C1714	Catheter, transluminal atherectomy, directional	8/1/00	12/31/02
39	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
40	C1758	Catheter, ureteral	10/1/00	12/31/02
41	C1760	Closure device, vascular (implantable/insertable)	8/1/00	12/31/02
42	L8614	Cochlear implant system	8/1/00	12/31/02
43	C1762	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02

TABLE 7.—LIST OF PASS-THROUGH DEVICE CATEGORIES WITH PROPOSED EXPIRATION DATES—Continued

	HCPCS codes	Category long descriptor	Date first populated	Expiration date
44	C1763	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
45	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
46	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
47	C1767	Generator, neurostimulator (implantable)	8/1/00	12/31/02
48	C1768	Graft, vascular	1/1/01	12/31/02
49	C1769	Guide wire	8/1/00	12/31/02
50	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
51	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
52	C2626	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
53	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
54	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away.	10/1/00	12/31/02
55	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away.	1/1/01	12/31/02
56	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/01	12/31/02
57	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser.	8/1/00	12/31/02
58	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/01	12/31/02
59	C1776	Joint device (implantable)	10/1/00	12/31/02
60	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/00	12/31/02
61	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/00	12/31/02
62	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/00	12/31/02
63	C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
64	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
65	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
66	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
67	C1779	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
68	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/01	12/31/02
69	C1780	Lens, intraocular (new technology)	8/1/00	12/31/02
70	C1878	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
71	C1781	Mesh (implantable)	8/1/00	12/31/02
72	C1782	Morcellator	8/1/00	12/31/02
73	C1784	Ocular device, intraoperative, detached retina	1/1/01	12/31/02
74	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
75	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
76	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
77	C2621	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
78	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/00	12/31/02
79	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
80	C1787	Patient programmer, neurostimulator	8/1/00	12/31/02
81	C1788	Port, indwelling (implantable)	8/1/00	12/31/02
82	C2618	Probe, cryoablation	4/1/01	12/31/03
83	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
84	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02
85	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
86	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
87	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
88	C1771	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
89	C2631	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
90	C1773	Retrieval device, insertable	1/1/01	12/31/02
91	C2615	Sealant, pulmonary, liquid (Implantable)	1/1/01	12/31/02
92	C1817	Septal defect implant system, intracardiac	8/1/00	12/31/02
93	C1874	Stent, coated/covered, with delivery system	8/1/00	12/31/02
94	C1875	Stent, coated/covered, without delivery system	8/1/00	12/31/02
95	C2625	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
96	C2617	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
97	C1876	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
98	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	12/31/02
99	C1879	Tissue marker (implantable)	8/1/00	12/31/02
100	C1880	Vena cava filter	1/1/01	12/31/02

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

We have carefully considered all the comments, concerns, and recommendations submitted to us regarding payment for devices and drugs and biologicals that would no

longer be eligible for pass-through payments in 2003. One consideration under the OPPS is the need to enable beneficiary access to new, and often costly, medical technology. We have also had to assess the extent to which the most recently available data that are the basis for prospectively setting payment rates for services within the APC system adequately reflect the costs incurred by hospitals to furnish this new technology. Having considered these factors, we propose to package the costs of medical devices no longer eligible for pass-through payment in 2003 into the costs of the procedures with which the devices were billed in 2001. (Our proposal to pay for pass-through drugs and biologicals whose pass-through status expires in 2003 is discussed below, in section III.C.2.)

The methodology that we propose to use to package pass-through device costs is consistent with the methodology for packaging that we describe in section II.B.4.b. That is, to calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator ''N.'' We also packaged the 2001 charges for devices that will cease to be eligible for pass-through payment in 2003 into the changes for the HCPCS codes with which the devices were billed. We relied on the hospitals to correctly code their bills for all costs, including pass-through devices, using HCPCS codes and revenue centers as appropriate to describe the services that they furnished.

We discuss in section II.B.4.a.(2), issues related to coding and billing for pass-through devices in 2001 and how our analysis of the claims data suggests that in some instances charges for devices were billed in revenue centers and in other instances with a device-specific or device category ''C'' code. We did not want to lose the device costs billed by hospitals through revenue centers in developing our relative weights for APCs, yet we were unable to separate the device costs from other costs included in the revenue centers. This problem is resolved by our proposal to package the costs of both the device ''C'' codes and the billed revenue centers, whichever appears on the claim. We are confident that this method will allow us to capture all device related costs billed by hospitals.

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

2. Drugs and Biologicals (Including Radiopharmaceuticals, Blood, and Blood Products)

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

Packaged Payment

As we explained in the April 7, 2000 final rule, we generally package the cost of drugs and biologicals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services). Hospitals bill for costs directly related and integral to performing a procedure or furnishing a service using a revenue center or packaged HCPCS code (status indicator ''N''). As discussed earlier in section II.B.4.a(2), we list the packaged services, by revenue center, that we use to calculate per-service costs.

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

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

There are certain new technology drugs and biologicals that are not eligible for transitional pass-through payments but for which we have made separate payment. Beginning with the April 7, 2000 rule (65 FR 18476), we created separate new technology APCs for these drugs and biologicals as well as devices. For example, we did not package into the emergency room visit APCs the various drugs classified as tissue plasminogen activators (TPAs)

and other thrombolytic agents that are used to treat patients with myocardial infarctions. We also did not package the costs of certain vaccines into the payment for visits or procedures. Rather, we created temporary individual APC groups for these drugs to allow separate payment so as not to discourage their use where appropriate. In the case of blood and blood products, wide variations in patient requirements convinced us that we should pay for these items separately rather than packaging their costs into the procedural APCs. Moreover, the Secretary's Advisory Council on Blood Safety and Access recommended that blood and blood products be paid separately to ensure that there were no incentives that would be inconsistent with the promotion of blood safety and access.

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

We based the payment rate for the APCs for these drugs and biologicals on median hospital acquisition costs. To determine the hospital acquisition cost for the drugs, we imputed a cost using the same ratios of drug acquisition cost to AWP that we discuss below in connection with calculating acquisition costs for transitional pass-through drug payments. That is, we multiplied the AWP for the drug by the applicable ratio (sole or multisource drug) based on data collected in an external survey of hospital drug acquisition costs.

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

Transitional Pass-Through Payments for Eligible Drugs and Biologicals

BBRA provided for special transitional pass-through payments for a period of 2 to 3 years for the following drugs and biologicals (pass-through payments for devices are addressed in section III.C.1 of this proposed rule):

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

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

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

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

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

As explained above, our policy has been to package payment for drugs and biologicals into the payment for the procedure or service to which the drug is integral and directly related. In general, packaging the costs of items and services into the payment for the primary procedure or service with which it is associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Packaging costs into a single aggregate payment for a service procedure or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. Our proposal to package the costs of devices that we discuss in section III.C.1 of this preamble is based on this principle. As we refine the OPPS in the future, we intend to continue to package, to the maximum possible extent, the costs of any items and services that are furnished with an outpatient procedure or service into the APC payment for services with which it is billed.

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

The options that we considered included packaging the costs of all drugs and biologicals, both those with status indicator ''K'' in 2002 and those that would no longer receive pass-through payments in 2003, or continuing to make separate payment for both categories of drugs and biologicals through separate APCs. After careful consideration of the various options for 2003, we propose to package the cost of many drugs for which separate payment is made currently. But

we also propose to continue making separate payment for orphan drugs (as defined below), blood and blood products, vaccines that are paid under a benefit separate from the outpatient hospital benefit (that is, influenza, pneumococcal pneumonia, and hepatitis B), and certain higher cost drugs as explained below. The payment rates for those drugs for which we would make separate payment in 2003 would be an APC payment rate based on a relative weight calculated in the same way that relative weights for procedural APCs are calculated.

Orphan Drugs

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

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

- The drug must be designated as an orphan drug by FDA and approved by FDA for the orphan condition.
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug had neither an approved use for other than an orphan condition nor an off label use for conditions other than the orphan condition. There are three orphan drugs that are used solely for orphan conditions for which we propose to make separate payment: J0205 Alglucerase injection (APC 0900); J0256 Alpha 1 proteinase inhibitor (APC 0901); and J09300 Gemtuzumab ozogamicin (APC 9004).

Blood and Blood Products

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

Vaccines Covered Under a Benefit Other Than OPPS

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

Higher Cost Drugs

While our preferred policy is to package the cost of drugs and other items into the cost of the procedures with which they are associated, we are concerned that beneficiary access to care may be affected by packaging certain higher cost drugs. For this reason, we propose to allow payment under separate APCs for high cost drugs for an additional year while we further study various payment options. Specifically, we propose to pay separately for drugs for which the median cost per line (cost per unit multiplied by the number of units billed on the claim) exceeded $150, as determined below.

To establish a reasonable threshold for determining which drugs we would pay under separate APCs rather than through packaging, we calculated the median cost per unit using 2001 claims data for each of the drugs for which transitional pass-through payment ceases January 1, 2003 and for those additional drugs that we have paid separately (status indicator ''K'') since the outset of OPPS. We excluded from these calculations the orphan drugs, vaccines, and blood and blood products discussed above. The unit median represents the cost per single unit dose of the drug as described by its HCPCS code. Because many drugs are used and billed in multiple unit doses, we then multiplied the median cost per unit for the drug by the average number of units that were billed per line. The average number of units per drug equals the total units divided by the total number of times the drug was billed. This calculation gave us an approximate median cost per line for the drug. We viewed this as being the approximate cost per administration because we believed that a single administration of a drug was billed as a single line item on a claim and that the correct number of units was placed in the ''units'' field of the claim form. We then arrayed the median cost per line in ascending order and examined the distribution. A natural break occurs at $150 per line, the midpoint of a $10 span between the drug immediately above and below the $150 point. Within the array, approximately 61 percent of the drugs fall below the $150 point and 39 percent of the array are above the point. Among the drugs that we propose to package are some radiopharmaceuticals, vaccines, anesthetics, and anticancer agents. After including the costs of packaged drugs in the services with which they were provided, we noted that the median costs of those services increased. For example, based on 2001 data, APC 117, Chemotherapy Administration by Infusion Only, showed a median cost before packaging of $129.53 and showed a median cost after packaging of $210.36. Similarly, APC 118, Chemotherapy administration by both infusion and another technique, showed a median cost before packaging of $136.00 and a median cost after packaging of $309.65. We believe that this appropriately represents the cost of packaged drugs on a per administration basis. However, in particular, we solicit comments that address specific alternative protocols we might use when several packaged drugs whose total cost significantly exceeds the applicable APC payment amount may be administered to a patient on the same day (for example, multiple agent cancer chemotherapy).

We request comments on the factors we considered in determining which drugs to package in 2003. We are particularly interested in comments with respect to the exclusion of high cost drugs from packaging. We are continuing to analyze the effect of our drug packaging proposal to assess whether the $150 threshold should be adjusted to avoid significant overpayments or underpayments for the base APCs relative to the median costs of the individual drugs packaged into the APCs. Depending on this analysis, we may revise our threshold or criteria for packaging in the final rule for 2003.

We expect to further consider each of these exclusions for packaging when we develop our proposals for the 2004 OPPS.

Although we expect to expand packaging of drugs to package payment for more drugs into the APC for the services with which they are billed, we are, nonetheless, requesting comments on alternatives to packaging. One example of an alternative approach is to use different criteria from those we propose in this proposed rule to identify the drugs to package into procedure APCs and the drugs to pay separately. We could package all drugs for which the median cost was less than $500 or alternatively package drugs for which the median cost was less than $100. Another alternative approach would be to create APCs for groups of drugs based on their costs. Under such an approach we could group drugs with costs between $0 and $100 and pay at the mid-point—$50. The next group could consist of drugs with a median cost between $100 and $250 and pay at the mid-point—$175. This approach would be similar to that employed for new technology services. Another approach would be to create separate APCs for each drug. Under this approach we would create a separate APC for each drug (regardless of its median cost) and use its relative weight to calculate a payment rate for the drug. We welcome a full discussion of the alternatives as we determine the best way to ensure that hospitals are paid appropriately for the drugs they administer to the Medicare beneficiaries whom they treat in their outpatient departments.

Table 8 lists drugs and biologicals for which separate payment is currently being made in 2002 with either status indicator ''K'' or ''G'' and whose costs we propose to package in 2003. Drugs that we propose to pay for separately in 2003 are designated in Addendum B by status indicator ''K'' or ''G.''.

TABLE 8.—DRUGS AND BIOLOGICALS SEPARATELY PAYABLE IN CY 2002

HCPCS	Short description
90296	Diphtheria antitoxin
90375	Rabies ig, im/sc
90376	Rabies ig, heat treated
90378	Rsv ig, im, 50mg
90379	Rsv ig, iv
90385	Rh ig, minidose, im
90389	Tetanus ig, im
90393	Vaccina ig, im
90396	Varicella-zoster ig, im
90471	Immunization admin
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
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90665	Lyme disease vaccine, im
90675	Rabies vaccine, im
90676	Rabies vaccine, id
90680	Rotovirus vaccine, oral
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90700	Dtap vaccine, im
90701	Dtp vaccine, im
90702	Dt vaccine < 7, im
90703	Tetanus vaccine, im
90704	Mumps vaccine, sc
90705	Measles vaccine, sc
90706	Rubella vaccine, sc
90707	Mmr vaccine, sc
90708	Measles-rubella vaccine, sc
90710	Mmrv vaccine, sc
90712	Oral poliovirus vaccine
90713	Poliovirus, ipv, sc
90716	Chicken pox vaccine, sc
90717	Yellow fever vaccine, sc
90718	Td vaccine > 7, im
90719	Diphtheria vaccine, im
90720	Dtp/hib vaccine, im
90721	Dtap/hib vaccine, im
90725	Cholera vaccine, injectable
90727	Plague vaccine, im
90733	Meningococcal vaccine, sc
90735	Encephalitis vaccine, sc
90749	Vaccine toxoid
A4642	Satumomab pendetide per dose

TABLE 8.—DRUGS AND BIOLOGICALS SEPARATELY PAYABLE IN CY 2002—Continued

HCPCS	Short description
A9500	Technetium TC 99m sestamibi
A9502	Technetium TC99M tetrofosmin
A9503	Technetium TC 99m medronate
A9504	Technetium tc 99m apcitide
A9505	Thallous chloride TL 201/mci
A9508	Iobenguane sulfate I–131
A9510	Technetium TC99m Disofenin
A9700	Echocardiography Contrast
C1066	IN 111 satumomab pendetide
C1079	CO 57/58 per 0.5 uCi
C1087	I–123 per 100 uCi
C1094	TC99Malbumin aggr, per 1.0 mCi
C1097	TC 99M MEBROFENIN, PER Vial
C1098	TC 99M PENTETATE, PER Vial
C1099	TC 99M PYROPHOSPHATE, PER Via
C1166	CYTARABINE LIPOSOMAL, 10 mg
C1188	I–131 cap, per 1–5 mCi
C1200	TC 99M Sodium Glucoheptonat
C1201	TC 99M SUCCIMER, PER Vial
C1202	TC 99M SULFUR COLLOID, Vial
J2020	Linezolid inj, 200mg
J7525	Tacrolimus inj, per 5 mg
C9007	Baclofen Intrathecal kit-1am
C9008	Baclofen Refill Kit-500mcg
J0706	Caffeine Citrate, inj, 1ml
C9100	Iodinated I–131 Albumin
C9102	51 Na Chromate, 50 mCi
C9103	Na Iothalamate I–125, 10 uCi
J0150	Injection adenosine 6 MG
J0350	Injection anistreplase 30 u
J0640	Leucovorin calcium injection
J0706	Caffeine Citrate, inj, per 5 mg
J1245	Dipyridamole injection
J1260	Dolasetron mesylate
J1325	Epoprostenol injection
J1327	Eptifibatide injection
J1436	Etidronate disodium inj
J1438	Etanercept injection
J1565	RSV-ivig
J1570	Ganciclovir sodium injection
J1620	Gonadorelin hydroch/ 100 mcg
J1626	Granisetron HCl injection
J1670	Tetanus immune globulin inj
J1830	Interferon beta-1b / .25 MG
J2260	Inj milrinone lactate / 5 ML
J2275	Morphine sulfate injection
J2405	Ondansetron hcl injection
J2765	Metoclopramide hcl injection
J2770	Quinupristin/dalfopristin
J2820	Sargramostim injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3010	Fentanyl citrate injeciton
J3280	Thiethylperazine maleate inj
J3365	Urokinase 250,000 IU inj
J7310	Ganciclovir long act implant
J7316	Sodium hyaluronate injection, per 5 mg
J7500	Azathioprine oral 50 mg
J7501	Azathioprine parenteral
J7506	Prednisone oral
J7516	Cyclosporin parenteral 250 mg
J8510	Oral busulfan
J8530	Cyclophosphamide oral 25 MG
J8600	Melphalan oral 2 MG
J8610	Methotrexate oral 2.5 MG
J9000	Doxorubic hcl 10 MG vl chemo
J9020	Asparaginase injection
J9031	Bcg live intravesical vac
J9050	Carmus bischl nitro inj
J9070	Cyclophosphamide 100 MG inj
J9093	Cyclophosphamide lyophilized
J9100	Cytarabine hcl 100 MG inj

TABLE 8.—DRUGS AND BIOLOGICALS SEPARATELY PAYABLE IN CY 2002—Continued

HCPCS	Short description
J9120	Dactinomycin actinomycin d
J9130	Dacarbazine 10 MG inj
J9181	Etoposide 10 MG inj
J9190	Fluorouracil injection
J9212	Interferon alfacon-1
J9213	Interferon alfa-2a inj
J9214	Interferon alfa-2b inj
J9215	Interferon alfa-n3 inj
J9230	Mechlorethamine hcl inj
J9250	Methotrexate sodium inj
J9270	Plicamycin (mithramycin) inj
J9320	Streptozocin injection
J9340	Thiotepa injection
J9360	Vinblastine sulfate inj
J9370	Vincristine sulfate 1 MG inj
Q0163	Diphenhydramine HCl 50 mg
Q0164	Prochlorperazine maleate 5 mg
Q0166	Granisetron HCl 1 mg oral
Q0167	Dronabinol 2.5 mg oral
Q0169	Promethazine HCl 12.5 mg oral
Q0171	Chlorpromazine HCl 10 mg oral
Q0173	Trimethobenzamide HCl 250 mg
Q0174	Thiethylperazine maleate 10 mg
Q0175	Perphenazine 4 mg oral
Q0177	Hydroxyzine pamoate 25 mg
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron mesylate oral
Q2002	Elliotts b solution per ml
Q2003	Aprotinin, 10,000 kiu
Q2004	Bladder calculi irrig sol
Q2007	Ethanolamine oleate 100 mg
Q2008	Fomepizole, 15 mg
Q2009	Fosphenytoin, 50 mg
Q2010	Glatiramer acetate, per dose
Q2013	Pentastarch 10% solution
Q2014	Sermorelin acetate, 0.5 mg
J2940	Somatrem injection
Q2018	Urofollitropin, 75 iu
Q2021	Lepirudin
Q3002	Gallium ga 67
Q3004	Xenon xe 133
Q3005	Technetium tc99m mertiatide
Q3006	Technetium tc99m glucepatate
Q3007	Sodium phosphate p32
Q3009	Technetium tc99m oxidronate
Q3010	Technetium tc99m labeledrbcs

3. Brachytherapy

Section 1833(t)(6) of the Act requires us to establish transitional pass-through payments for devices of brachytherapy. As of August 1, 2000, we established item-specific device codes including codes for brachytherapy seeds, needles, and catheters. Effective April 1, 2001, we established category codes for brachytherapy seeds on a per seed basis (one for each isotope), brachytherapy needles on a per needle basis, and brachytherapy catheters on a per catheter basis. Because initial payment was made for a device in each of these categories in August 2000, we propose that these categories (and the transitional pass-through payments) will be discontinued as of January 1, 2003. Furthermore, as discussed above, we propose that there will be no grace period for billing these category codes.

We received comments, both in writing and at the April 2002 Town Hall meeting, recommending that we continue to make separate payment for brachytherapy seeds. The basis for this recommendation is that the number of brachytherapy seeds implanted per procedure is variable. These commenters stated that the number and type of seeds implanted in a given patient depends on the type of tumor, its size, extent, and biology, and the amount of radioactivity contained in each seed. For example, a given type of cancer may be treated by implanting seeds of different isotopes (for example, iodine or palladium) depending on its biological characteristics. Further, depending on the size of the tumor, the number of implanted seeds that may be required to effectively treat the cancer is quite variable (for example, from 25 to 100 seeds). In addition, implantable seeds may be manufactured with different amounts of radioactivity, and it may be preferable to implant fewer seeds with higher activity in some cases while in other cases it may be preferable to implant a larger number of seeds with lower activity. To further complicate the matter, the HCPCS codes used to report implantation of brachytherapy seeds are not tumor-specific. Instead, they are defined based on the number of sources, that is, the number of seeds or ribbons used in the procedure. This means that the treatment of many different tumors requiring implantation of widely

varying numbers of seeds is described by a single HCPCS code. Therefore, it has been argued that given the costs of seeds and the variety of treatments described by a single HCPCS code, the cost of brachytherapy billed under a single HCPCS code could vary by as much as $3,000.

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

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

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

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

Remote Afterloading High Intensity Brachytherapy.

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

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

Prostate Brachytherapy

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

A number of commenters at the April 5, 2002, Town Hall Meeting and elsewhere have stressed to us their views that brachytherapy seeds should remain unpackaged. The principle argument put forth in favor of this approach is that the number of seeds used is highly variable across patients. We do not find this argument compelling. Payments in the OPPS, as in other prospective payment systems, are based on averages. We expect hospitals, in general, to be able to accommodate variation across patients in resource costs of services paid in a particular payment cell. The degree of variation should be immaterial as long as the payment is appropriate for a typical case, the hospital treats a caseload the resource use of which approximates a typical distribution, and the number of cases treated by a hospital is sufficiently large to overcome peculiarities in resource use that might be observed with a very small number of cases. We believe the service volume at hospitals providing prostate brachytherapy is likely to be large enough for a payment reflecting average use of seeds to be appropriate.

Additionally, appropriate payment for prostate brachytherapy has been of concern to many commenters since implementation of the OPPS because facilities must use multiple HCPCS codes on a single claim to accurately describe the entire procedure. Because we determine APC relative weights using single procedure claims, commenters have argued that payments for prostate brachytherapy are, in part, based on error claims, resulting in underpayment for this important service. We agree that basing the relative weights for APCs reported for prostate brachytherapy services on only the small number of claims related to this service that are single procedure claims may be problematic. To increase the number of claims we could use to develop the proposed 2003 relative payment weights for prostate brachytherapy, we began by identifying all claims billed in 2001 for prostate brachytherapy. That is, we identified all claims that contained a line item for HCPCS code 77778, Interstitial radiation source application; complex, and HCPCS code 55859, Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy. We discovered more than 12,000 claims that met these specifications, suggesting that most of the procedures coded under HCPCS code 77778 were for prostate brachytherapy. Unfortunately, closer analysis of these claims revealed that hospitals do not report prostate brachytherapy using a uniform combination of codes. Of the more than 12,000 claims for prostate brachytherapy that we identified in the 2001 claims data, no single combination of HCPCS codes occurred more than 25 times.

Therefore, in order to facilitate tracking of this service, we propose to establish a G code for hospital use only that will specifically identify prostate brachytherapy. We propose as the descriptor for this G code the following: ''Prostate brachytherapy, including transperineal placement of needles or catheters into the prostate, cystoscopy, and interstitial radiation source application.'' This G code would be used by hospitals instead of HCPCS codes 55859 and 77778 to bill for prostate brachytherapy. Hospitals would continue to use HCPCS codes 55859 and 77778 when reporting services other than prostate brachytherapy. We would also instruct hospitals to continue to

report separately other services provided in conjunction with prostate brachytherapy, such as dosimetry and ultrasound guidance. These additional services would be paid according to the APC payment rate established by our usual methodology.

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

Packaging of Other Device Costs Associated with Brachytherapy

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

D. Criteria for New Device Categories

Section 1833(t)(6)(B)(ii) of the Act, as amended by BIPA, required us to establish criteria by July 1, 2001 that will be used to create additional device categories to be used in determining eligibility of a device for pass-through payments. This provision requires that no medical device be described by more than one category. In addition, the criteria must include a test of whether the average cost of devices that would be included in a category is ''not insignificant'' in relation to the APC payment amount for the associated service.

On November 2, 2001, we published in the **Federal Register** an interim final rule (66 FR 55850) that set forth the criteria for establishing new (that is, additional) categories of medical devices eligible for transitional pass-through payments under the hospital outpatient PPS as required by section 1833(t)(6)(B)(ii) of the Act. The provisions relating to transitional pass-through payments for eligible drugs and biologicals remained unchanged and were not addressed in the November 2001 interim final rule (except for a change relating to contrast agents as provided in section 430 of BIPA). We received several public comments regarding our criteria published in the November 2001 interim final rule. We will respond to these public comments in the final rule for the OPPS for 2003.

In the November 2, 2001 interim final rule, we implemented new § 419.66(c), which establishes the criteria for establishing a new device category. We propose to make a technical correction to § 419.66(c)(1), which establishes one of those criteria. Specifically, we discuss in the November 2, 2001 interim final rule the criterion that a new category must describe devices that demonstrate substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established (that is, previously existing) categories or other available treatments, as described in regulations at new § 419.66(c)(1) (66 FR 55852). Section 1833(t)(6)(B)(ii)(IV) of the Act requires that a new category must include medical devices for which no existing category, or one previously in effect, is appropriate. In the November 2, 2001 IFC, we addressed in the preamble the requirement that no category previously in effect could describe a new category (66 FR 55852), but we did not conform the regulations text to this requirement. Therefore, we propose to correct § 419.66(c)(1) to read as follows:

(1) CMS determines that a device to be included in the category is not described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

E. Payment for Transitional Pass-Through Drugs and Biologicals for Calendar Year 2003

As discussed in the November 13, 2000 interim final rule (65 FR 67809) and the November 30, 2001 final rule (66 FR 59895), we update the payment rates for pass-through drugs on an annual basis. Therefore, as we have done for prior updates, we propose to update the APC rates for drugs that are eligible for pass-through payments in 2003 using the most recent version of the Red Book, the July 2002 version in this case. The updated rates effective January 1, 2003 would remain in effect until we implement the next annual update in 2004, when we would again update the AWPs for any pass-through drugs based on the latest quarterly version of the Red Book. This retains the update of pass-through drug prices on the same calendar year schedule as the other annual OPPS updates.

As described in our final rule of November 30, 2001 (66 FR 59894), in order to establish the applicable beneficiary copayment amount and the pass-through payment amount, we must determine the cost of the pass-through eligible drug or biological that would have been included in the payment rate for its associated APC had the drug or biological been packaged. We used hospital acquisition costs as a proxy for the amount that would have been packaged, based on data from an external survey of hospital drug costs (see the April 7, 2000 final rule (65 FR 18481)). That survey concluded that—

- For drugs available through only one source drugs, the ratio of acquisition cost to AWP equals 0.68;
- For multisource drugs, the ratio of acquisition cost to AWP equals 0.6l;
- For drugs with generic competitors, the ratio is 0.43.

As we stated in our final rule of November 30, 2001 (66 FR 59896), we considered the use of the study-derived ratios of drug costs to AWP to be an interim measure until we could obtain data on hospital costs from claims. We stated that we anticipated having this data to use in setting payment rates for 2003.

As described elsewhere in this preamble, we used 2001 claims data to calculate a median cost per unit of drug for each drug for which we are currently paying separately. We compared the median per unit cost of each drug to the AWP to determine a ratio of acquisition cost to AWP. Using the total units billed for each drug, we then calculated a weighted average for each of the above three categories of drugs. These calculations resulted in the following weighted average ratios:

- For sole-source drugs, the ratio of cost to AWP equals 71.0 percent.
- For multisource drugs, the ratio of cost to AWP equals 68.0 percent.
- For drugs with generic competitors, the ratio of cost to AWP equals 46.0 percent.

We propose to use these percentages for determining the applicable beneficiary copayment amount and the pass-through payment amount for drugs eligible for pass-through payment in 2003.

We propose to use these percentages for determining the applicable beneficiary copayment amount and the pass-through payment amount for most drugs eligible for pass-through payment in 2003. However some drugs may fall into two other classes. The first class includes a drug that is new and for which no cost is yet included in an associated APC. For such a drug, because there is no cost for the drug yet included in an associated APC, the pass-through amount will be 95 percent of the AWP and there would be no copayment. The second class includes a drug that is new and is a substitute for only one drug that is recognized in the OPPS through an unpackaged APC. For drugs in this second class, the pass-through amount would be the difference between 95 percent of the AWP for the pass-through drug and the payment rate for the comparable dose of the associated drug's APC. The copayment would be based on the payment rate of its associated APC. We believe that using this methodology will yield a more accurate payment rate.

We have received questions with respect to our definition of multisource drugs. In determining whether a drug is available from multiple sources, we consider repackagers to be among the sources. This is consistent with the findings of the survey cited above which indicated a lower ratio of acquisition cost to AWP from multiple sources including repackagers.

We note that determining that a drug is eligible for a pass-through payment or assigning a status indicator ''K'' to a drug or biological (indicating that the drugs or biologicals is paid based on a separate APC rate) indicates only the method by which the drug or biological is paid if it is covered by the Medicare program. It does not represent a determination that the drug is covered by the Medicare program. For example, Medicare contractors must determine whether the drug or biological is: (1) reasonable and necessary to treat the beneficiary's conditions; and (2) excluded from payment because it is usually self-administered by the patient.

IV. Wage Index Changes for Calendar Year 2003

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2003 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in this proposed rule. The proposed FY 2003 hospital inpatient wage index published in the May 9, 2002 **Federal Register** (67 FR 31431) is reprinted in this proposed rule as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J—Wage Index for Hospitals That Are Reclassified. We propose to use the final FY 2003 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that we will publish in the final rule implementing the OPPS for CY 2003.

V. Copayment for Calendar Year 2003

Section 1833(t)(8)(C)(ii) of the Act accelerates the reduction of beneficiary copayment amounts, providing that, for services furnished on or after April 1, 2001 and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent of the APC payment rate in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

For 2003, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for 2002 (see the November 30, 2001 final at 66 FR 59888). See Addendum B for proposed national unadjusted copayments for 2003. Our regulations at § 419.41 conform to this provision of the Act.

VI. Conversion Factor Update for Calendar Year 2003

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that for 2003, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The most recent forecast of the hospital market basket increase for FY 2003 is 3.5 percent. To set the proposed OPPS conversion factor for 2003, we increased the 2002 conversion factor of $50.904 (the figure from the March 1, 2002 final rule (67 FR 9556)) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2003 to ensure that the revisions we are proposing to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of .98715 for wage index changes by comparing total payments from our simulation model using the proposed FY 2003 hospital inpatient PPS wage index values to those payments using the current (FY 2002) wage index values.

The increase factor of 3.5 percent for 2003 and the required wage index budget neutrality adjustment of .98715 result in a proposed conversion factor for 2003 of 52.009.

VII. Outlier Policy for Calendar Year 2003

For OPPS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we will calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we propose to continue to set the target for outlier payments at 2.0 percent, as we did for CYs 2001 and 2002. For 2002, the outlier threshold is met when costs of furnishing a service or procedure exceed 3.5 times the APC payment amount, and the current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Based on our simulations for 2003, we propose to set the threshold for 2003 at 2.75 times the APC payment amounts, and the proposed 2003 payment percentage applicable to costs over the threshold at 50 percent.

VIII. Other Policy Decisions and Proposed Changes

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

Background

Currently, facilities code clinic and emergency department visits using the same current procedural terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are five levels of care. While there is only one set of codes for emergency visits, clinic visits are differentiated by new patient, established patient, and consultation visits. CPT codes 99201 through 99205 are used for new patients, CPT codes 99211 through 99215 are used for established patients, and CPT codes 99281 through 99285 for emergency patients.

Physicians determine the proper code for reporting their services by referring to CPT descriptors and our documentation guidelines. The descriptors and guidelines are helpful to physicians because they reference taking a history, performing an examination, and making medical decisions. The lower levels of service (for example, CPT codes 99201, 99211, and 99281) are used for shorter visits and for patients with uncomplicated problems, and the higher levels of service (for example, CPT codes 99205, 99215, and 99285) are used for longer visits and patients with complex problems.

These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services provided by facilities to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Before the implementation of the OPPS, facilities were paid on the basis of charges reduced to costs. In that system, because use of a correct HCPCS code did not influence payment, there was little incentive to correctly report the level of service. In fact, many facilities reported all clinic and emergency visits with the lowest level of service (for example, CPT codes 99211, 99201, and 99281) simply to minimize administrative burden (for example, charge-masters might include only one level of service).

This situation changed with the implementation of the OPPS. The OPPS requires correct reporting of services using HCPCS codes as a prerequisite to payment. For emergency and clinic visits, the OPPS distinguishes three levels of service for payment purposes. These are referred to as ''low-level,'' ''mid-level,'' and ''high-level'' emergency or clinic visits. Low-level clinic and emergency visits include CPT codes for level one and two services (for example, CPT codes 99201, 99211, and 99281), mid-level visits include level three services (for example, CPT codes 99203, 99213, and 99283), and high-level visits include level four and five services (for example, CPT codes 99205, 99215, and 99285). Payment rates for low-level visits are less than for mid-level visits, which are less than rates for high-level visits.

In the April 7, 2000 final rule (65 FR 18434), we stated that to pay hospitals properly, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. We stated in the rule, that if hospitals set up these guidelines and follow them, they would be in compliance with OPPS coding requirements for the visits. Furthermore, we announced that we would be reviewing this issue and planned to set national guidelines for coding clinic and emergency visits in the future. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. We also announced that we would compile these comments and present them to our APC Panel at the January 2002 meeting. We also announced that we planned to propose uniform national facility coding guidelines in the proposed rule for the 2003 OPPS.

During its January 2002 meeting, the APC Panel reviewed written comments, heard oral testimony, discussed the issue, and made recommendations concerning establishment of facility coding guidelines for emergency and clinic visits. Among those who submitted oral and written comments to us and to the Panel were national hospital organizations, national physician organizations, hospital systems, individual hospitals, coding organizations, and consultants.

Discussion

We set forth below, by issue, a summary of the comments we received:

- The need for national coding guidelines.

Except for the American Medical Association (AMA) and one other physician organization, commenters unanimously agreed that national guidelines for facility coding of emergency and clinic visits were required. Furthermore, most commenters requested that we establish these guidelines as soon as possible, but, in any event, not later than January 2003. Among the reasons cited were the following:

+ The need for facilities to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), no later than October 16, 2003 (October 16, 2002 for those entities that do not obtain a one-year extension). Commenters expressed concern that use of CPT E/M codes with different reporting rules when used by facilities (as opposed to use by physicians) would violate HIPAA requirements.

+ The need for facilities to set up effective audit and compliance programs.

+ The need to minimize confusion on the part of coders.

+ The need to minimize inaccurate payments.

+ The need to prevent gaming of the system by facilities.

The AMA recommended that we wait for the CPT Editorial Panel to develop coding guidelines for hospitals to assure that coding guidelines will be minimally burdensome to hospitals.

- The need to establish principles against which facility E/M coding guidelines would be measured. Commenters unanimously agreed that any set of coding guidelines for facilities would have to satisfy a uniform set of basic principles to be acceptable to, and accepted by, hospitals. These include the following:

+ Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, not physician resource use.

+ Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and meet HIPAA requirements.

+ Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

+ Coding guidelines should not facilitate upcoding or gaming.

We would add one other requirement to these principles: The distribution of codes should result in a normal curve. Documentation guidelines should facilitate this result.

- Current use of hospital coding guidelines is inconsistent and much more prevalent in the emergency department.

Several commenters noted that many hospitals have developed their own coding guidelines but that no specific

set of guidelines is in widespread use at the present time. These commenters noted that guidelines have been used much more in the emergency department setting than in the clinic setting. They also noted that only one set of guidelines has undergone any sort of testing. These are the facility coding guidelines for emergency departments, developed and copyrighted by the American College of Emergency Physicians (ACEP). Unfortunately, the testing was not done by protocol, no quantitative data were collected, and only a small number of facilities participated.

- Development of two sets of guidelines: one for emergency department visits and one for clinic visits.

Several commenters noted that the types and intensity of hospital resources used for emergency department visits were significantly different from the types and intensity of resources used for clinic visits. These commenters recommended that we adopt different guidelines for emergency department and clinic visits.

- The need to develop new descriptors and codes for facility emergency and clinic visits.

Commenters unanimously agreed that the current CPT descriptors for E/M services were not only inappropriate for facility coding of emergency and clinic visits but also were confusing and misleading to both facility coders and our reviewers. Commenters stated that patients whose complexity level was low in terms of physician work could frequently require highly intensive and complex facility services (for example, patients with gastroenteritis who require intravenous fluids, patients in motor vehicle accidents who require multiple X-rays, or patients with congestive heart failure or diabetes who require extensive education). In these cases, lack of agreement between physician and hospital coding would be clinically appropriate but could be the source of an investigation given the current code descriptors and hospital reporting guidelines. Commenters were also concerned that internal hospital-specific coding guidelines could vary greatly because the current CPT descriptors exclude any reference to facility services and, therefore, are highly susceptible to individual interpretation. A third concern was HIPAA compliance. Commenters believe that development by individual hospitals of a second set of descriptors that the hospital uses when reporting E/M codes could violate HIPAA requirements. These commenters believe that when HIPAA is first implemented on October 16, 2002 (October 16, 2003 for those entities that obtain a one-year extension), Healthcare Common Procedure Coding System (HCPCS) codes must be used uniformly by all providers. Two sets of descriptors for a single set of codes would require that different providers (that is, physicians and hospitals) use the codes differently. Based on these concerns, all commenters recommended that we develop, on an interim basis, HCPCS codes for emergency and clinic visits with descriptors specific for hospital coding.

- Maintenance of five levels of service.

Although a few commenters were not certain that facilities needed to differentiate among five levels of service, they believe that reducing the number of levels of service, even if clinically appropriate, would cause significant confusion among coders and reviewers. Therefore, they recommended maintaining five levels of service on an interim basis until more data on this issue can be obtained.

- Recommendations concerning adoption of specific guidelines.

Commenters recommended four basic types of guidelines for adoption.

1. Guidelines based on the number or type of staff interventions. Under this model, the level of service reported would be based on the number and/or type of interventions performed by nursing or ancillary staff. In the intervention model, baseline care (including registration, triage, initial nursing assessment, periodic vital signs as appropriate, simple discharge instructions, and exam room set up/clean up) and possibly a single minor intervention (for example, suture removal, rapid strep test, visual acuity) would be reported by the lowest level of service. Higher levels of service would be reported as the number and/or complexity of staff interventions increased.

The most commonly recommended intervention-based guidelines were the facility-coding guidelines developed by ACEP. The ACEP model uses examples of interventions to illustrate appropriate coding. Coders extrapolate from these examples to determine the correct level of service to report. The ACEP model uses the type of intervention rather than the number of interventions to determine the appropriate level of service. This means that the single most complex intervention determines the level of service whether it was the only service provided (in addition to baseline care), whether other similarly complex interventions were also provided, or whether other interventions of less complexity were also provided. The intervention model is based on emergency/clinic resource use, is simple, reflects the care given to the patient, and does not require additional facility documentation. However, we are concerned that the intervention model may provide an incentive to provide unnecessary services and that it is susceptible to upcoding. Furthermore, the ACEP model requires extrapolation from a set of examples that could make it prone to variability across hospitals.

2. Guidelines based on the time staff spent with the patient. Under this model, the level of service would be determined based on the amount of time hospital staff spent with the patient. The underlying assumption is that staff time spent with the patient is an appropriate proxy for total facility resource consumption. In this model, if only baseline care (as described above) were provided a Level 1 service would be reported. Higher levels of service would be reported based on increments of staff time beyond baseline care (for example, Level 2 would be reported for 11 to 20 minutes beyond baseline care, and Level 3 would be reported for 21 to 30 minutes beyond baseline care). This model is simple, it correlates with total facility resource use, and it would provide an objective standard for all hospitals to follow. However, extra, potentially burdensome, documentation (that is, documentation of staff time that is not normally required for clinical care) would be necessary, there would be an incentive to work slowly or use less efficient personnel, and there would be significant potential for upcoding and gaming.

3. Guidelines based on a point system where a certain number of points is assigned to each staff intervention based on the time, intensity, and staff type required for the intervention. In this model, points or weights are assigned to each facility service and/or intervention provided to a patient in the clinic or emergency department. The level of service is determined by the sum of the points for all services/interventions provided. Commenters recommended various approaches to a point system including point systems that assigned points based on the amount of staff time spent with the patient, the number of activities performed during the emergency department or clinic visit, and a combination of patient condition and activities performed. A point system would correlate with facility resource consumption and provide an objective standard. However, a point system could present significant burdens for hospitals in terms of requiring extra, clinically unnecessary, documentation. Point systems are

extremely complex, would probably require dedicated staff to monitor and maintain, and would be susceptible to upcoding and gaming.

4. Guidelines based on patient complexity. Several variations were recommended including assignment of level of service based on ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) diagnosis codes, assignment of level of service based on complexity of medical decision making, or assignment of level of service based on presenting complaint or medical problem. The premise for these systems is that many emergency departments follow established protocols based on patients presenting complaints and diagnoses. Therefore, assigning a level of service based on patient diagnosis should correlate with facility resource consumption. These systems require the use of a coding ''grid,'' which lists more than 100 examples of patient conditions and diagnosis and assigns a level of service to each example. When a patient has a condition that does not appear on the grid, the coder must extrapolate from the grid to the individual patient. These systems are extremely complex, demand significant interpretive work on the part of a coder (who may not have clinical experience), and are subject to variability across hospitals. No clinically unnecessary documentation would be required but, because the system is based on diagnosis, there is a significant potential for upcoding and gaming.

APC Panel Recommendations

The APC Panel reviewed the comments that we received, reviewed background material we prepared, and heard oral testimony. Most commenters recommended that we adopt the ACEP guidelines. However, one organization representing cancer centers stated that the most appropriate proxy for facility resource consumption in cancer care is staff time and asked that we consider basing our guidelines on staff time. Commenters agreed that we needed to address this problem in the proposed rule for CY 2003. They also agreed that to address potential HIPAA compliance issues, we should develop new HCPCS codes for facility visits; and that we should maintain five levels of service for emergency and clinic visits until data are available to show that only three levels of service are required to ensure accurate payments. Commenters also agreed that, for the same level of service, clinic resource consumption should be similar for new, established, and consultation patients. Therefore, we need only create a single set of five codes for clinic visits.

After a thorough discussion, the APC technical panel made the following recommendations:

1. Propose and make final facility coding guidelines for E/M services for calendar year 2003.

2. Create a series of G codes with appropriate descriptors for facility E/M services.

3. Maintain a single set of codes, with five levels of service, for emergency department visits.

4. Develop a single set of codes, with five levels of service, for clinic visits. The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposal

We have reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations. We agree that facility coding guidelines should be implemented as soon as possible. We are particularly concerned that facilities be able to comply with HIPAA requirements. We have worked, and will continue to work, on this issue, with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We note that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we want to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we propose the following (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services: GXXX1—Level 1 Facility Emergency Services, GXXX2—Level 2 Facility Emergency Services, GXXX3—Level 3 Facility Emergency Services, GXXX4—Level 4 Facility Emergency Services, and GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic visits: GXXX6—Level 1 Facility Clinic Services, GXXX7—Level 2 Facility Clinic Services, GXXX8—Level 3 Facility Clinic Services, GXXX9—Level 4 Facility Clinic Services, and GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

With regard to the documentation guidelines, our primary concerns are to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realize that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believe that the potential drawbacks of each of the recommended sets of guidelines outweigh the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We are also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, etc.) as ''interventions'' or ''staff time'' in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC

Panel recommendations, we have also reviewed the current distribution of paid emergency and clinic visit codes in the OPPS. With regard to emergency visits, we have observed that well over 50 percent of the visits are considered ''multiple procedure claims'' because the claim includes services such as diagnostic tests (for example, EKGs, x-rays) or therapeutic interventions (for example, intravenous infusions). The distribution of all emergency services is in a bell-shaped curve with a slight left shift because there are more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also note that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we have observed that more than 50 percent of the services are considered ''single claims'' meaning that they are billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also note that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution is consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, do not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believe that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits is appropriate. As hospitals become more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we will continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We plan to begin the development of uniform guidelines over the next year. If we are ready, we would propose the guidelines for comments in our **Federal Register** document for the calendar year 2004 update. For calendar year 2003, we propose the following new codes:

Emergency Visits

Our data indicate that, in general, hospitals under the OPPS are reporting emergency visits appropriately. We believe that insofar as hospitals have existing guidelines for determining the level of emergency service, those guidelines reflect facility resource consumption. Therefore, we propose that GXXX1—Level 1 Facility Emergency Services be reported when facilities deliver, and document, basic emergency department services. These services include registration, triage, initial nursing assessment, minimal monitoring in the emergency department (for example, one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. We would expect that these services would be delivered to patients who present with minor problems of low acuity.

With regard to GXXX2 through GXXX5, we propose to require that facilities develop internal documentation guidelines based on hospital resource consumption (for example, staff time). These guidelines must be appropriate for the type of services provided in the hospital and must also clearly differentiate the relative resource consumption for each level of service so that a medical reviewer can easily infer the type, complexity, and medical necessity of the services provided and validate the level of service reported. Because there is great variability in available facility resources, staff, and clinical protocols among facilities, we do not believe that it is advisable to require a single set of guidelines for all facilities. Instead, we believe it is appropriate for each facility to develop its own documentation guidelines that take into account the facility's clinical protocols, available facility resources, and staff types. As stated above, we are not proposing any specific requirements with regard to the basis of these guidelines. However, the guidelines must be tied to actual resource consumption in the emergency department such as number and type of staff interventions, staff time, clinical examples, or patient acuity. We also propose to require that facilities have documentation guidelines available for review upon request. The guidelines must emphasize relative resource consumption and must not, to the extent possible, set minimal requirements as a basis for determining the level of service (for example, require 30 minutes of staff time or five staff interventions to bill a Level 3 emergency visit).

If made final, these requirements would be interim. We will work with interested parties to revise these requirements and would propose any revision to these requirements in a future proposed rule.

Clinic Visits

The current distribution of codes for clinic visits may be due to a facility's continued use of pre-OPPS coding policies for clinic visits. We believe that over time facilities will become as experienced differentiating levels of clinic visits as they are at differentiating levels of emergency visits. Therefore, we propose a set of guidelines for clinic visits that parallels the requirements for emergency visits. We propose that GXXX6—Level 1 Facility Clinic Services, be reported when facilities deliver, and document, basic clinic services. These services include registration, triage, initial nursing assessment, minimal monitoring in the clinic (for example, one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. Our proposal for GXXX7 through GXXX10 is the same as for GXXX2 through GXXX5 except that the facility-specific guidelines must be tied to actual resource consumption in the clinic such as number and type of staff intervention, staff time, clinical examples, or patient acuity. The guidelines must also differentiate the relative resource consumption in the clinic for each level of service sufficiently so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided to validate the level of service provided.

This proposal, if made final, would also be interim while we work with interested parties to revise the requirements. Any revision would be proposed in a future proposed rule.

We propose to make final, in the 2003 OPPS final rule, changes in coding for clinic and emergency department visits and requirements related to the development of documentation guidelines for the new codes. However, we propose to implement the new codes and documentation guidelines no earlier than January 1, 2004. This will give hospitals time to develop documentation guidelines for the new codes and prepare their internal billing systems to accommodate the changes. We will continue to work with hospitals throughout CY 2003 as they develop the

documentation guidelines. We solicit comments on this proposal overall as well as the specific components of the proposal.

B. Observation Services

Coding and Billing Instructions

On November 30, 2001, we published a final rule updating changes to the OPPS for 2002. We implemented provisions that allow separate payment for observation services under certain conditions. That is, a hospital may bill for a separate APC payment (APC 0339) for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure when certain criteria are met. The criteria discussed in the November 30, 2001 final rule and as corrected in the March 1, 2002 final rule are also explained in detail in section XI of a Program Memorandum to intermediaries issued on March 28, 2002 (Transmittal A–02–026). Payment for HCPCS code G0244, observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum eight hours, maximum 48 hours, was effective for services furnished on or after April 1, 2002.

Section XI of Transmittal A–02–026 that was issued on March 28, 2002 provides additional billing and coding instructions and requirements that flow from the basic criteria that we implemented in the November 30, 2001 and the March 1, 2002 final rules. Although we do not address them explicitly in the final rules, the additional instructions and requirements in Transmittal A–02–026 were developed to implement the basic observation criteria within the programming logic of the outpatient code editor (OCE), which is used to process claims submitted by hospitals for payment under the OPPS. For example, in the November 30, 2001 final rule, we state that an emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) must be billed in conjunction with each bill for observation services (66 FR 59879). In section XI of Transmittal A–02–026, we state that an Evaluation and Management (E/M) code (referred to, incorrectly, in Transmittal A–02–026 as an ''Emergency Management'' code), for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. That is, unless one of the CPT codes assigned to APCs 0600, 0601, 0602, 0610, 0611, 0612, or 0620 is billed on the day before or the day that the patient is admitted to observation, separate payment for G0244 is not allowed. The codes assigned to these APCs are categorized by CPT as E/M codes. Although we did not include APC 0620, Critical Care, among the APCs that must be billed in order to receive separate payment for observation services, we added it in the program memorandum because critical care is an E/M service which can be furnished in a clinic or an emergency department. Critical care may appropriately precede admission to observation for chest pain, asthma, or congestive heart failure. We clarify in Transmittal A–02–026 that both the associated E/M code and G0244 are paid separately if the observation criteria are met. We also specify that the E/M code associated with observation must be billed on the same claim as the observation service.

Similarly, in the November 30, 2001 and the March 1, 2002 final rules, we require that certain diagnostic tests be performed in order to bill for separate payment for observation services. In Transmittal A–02–026, in section XI.B.2, we list the diagnostic tests that the OCE looks for on a bill for G0244. This list, which amplifies what we published in the November 30, 2001 and March 1, 2002 final rules, is incomplete and should read as follows to reflect the current OCE logic that is applied to claims for G0244:

- For chest pain, at least two sets of cardiac enzymes [either two CPK (82550, 82552, or 82553), or two troponin (84484 or 84512)], *and* two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760, 94761, or 94762);
- For congestive heart failure, a chest x-ray (71010, 71020, or 71030) *and* an electrocardiogram (93005) *and* pulse oximetry (94760, 94761, or 94762).
- Note: Pulse oximetry codes 94760, 94761, and 94762 are treated as packaged services under the OPPS. Although as packaged codes no separate payment is made for these codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

Transmittal A–02–026 also provides specific coding instructions that hospitals must use when billing for observation services that do not meet the criteria for separate payment under APC 0339. In addition, Transmittal A–02–026 addresses the use of modifier ''25 with the E/M code billed with G0244.

Direct Admissions to Observation

Since implementation of the provision for separate payment for observation services under APC 0339, a number of hospitals, hospital associations, and other interested parties have asked if separate payment for observation services would be allowed for a patient with chest pain, asthma, or congestive heart failure who is admitted directly into observation by order of the patient's physician but without having received critical care or E/M services in a hospital clinic or the emergency department on the day before or the day of admission to observation. We have responded during monthly CMS hospital open forum calls that, consistent with the criteria in the November 30, 2001 final rule, effective for services furnished on or after April 1, 2002, separate payment for observation services requires that an admission to observation be made by order of a physician in a hospital clinic or in a hospital emergency department. If a patient is directly admitted to observation but without an associated E/M service (including critical care) shown on the same bill, the hospital should bill observation services using revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (CPT codes 99218, 99219, 99220, 99234, 99235, or 99236).

A related question has arisen in connection with a policy interpretation that was posted as a response to a ''Frequently Asked Question'' (FAQ) on our web site on September 12, 2000. The FAQ follows:

''Q.97: If a patient is admitted from the physician's office to the observation room, will there be no reimbursement?''

''A.97: Since observation is a packaged service, payment cannot be made if it is the only OPPS service on a claim. However, we believe that the ''admission'' of a patient to observation involves a low-level visit billed by the hospital, as well as whatever office visit the physician who arranged for the admission billed. Thus, when a patient arrives for observation arranged for by a physician in the community (that is, ''direct admit to observation''), and is not seen or assessed by a hospital-based physician, the hospital may bill a low-level visit code. This low-level visit code will capture the baseline nursing assessment, the creation of a medical record, the recording and initiation of telephone orders, etc. This visit may be coded only once during the period of observation. The observation charges should be shown in revenue code 762. The number of hours the patient was in

observation status should be shown in the units field. Payment for those services is packaged into the APC for the visit. Other services performed in connection with observation, such as lab, radiology, etc., should be billed for as well * * *''

We have been asked to clarify whether or not the low-level visit code suggested in the FAQ for patients directly admitted for observation services would satisfy the requirement that a line item for a hospital emergency visit, hospital clinic visit, or critical care appear on the same bill as HCPCS code G0244. Our response is that when we established the final criteria effective for services furnished on or after April 1, 2002, we did not contemplate that the low-level visit described in the FAQ would satisfy the requirement for the E/M code that a hospital must bill to show a hospital clinic visit or hospital emergency department visit was performed before observation services for asthma, congestive heart failure, or chest pain to bill and receive payment for G0244 under APC 0339.

In light of these questions, we have reviewed the criteria for separate payment for observation services under APC 0339, and we propose to modify the criteria and coding for observation services furnished on or after January 1, 2003. Specifically, we propose to create two new codes. These additional codes would allow us to collect data on the extent to which patients are directly admitted to hospital observation services without an associated hospital clinic visit or emergency department visit. The proposed codes are as follows:

G0LLL—Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma.

G0MMM—Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

If a hospital directly admits to observation from a physician's office a patient with a diagnosis of congestive heart failure, asthma, or chest pain, we propose to require that G0LLL be billed with G0244. The current requirement that the hospital bill an emergency department visit (APC 0600, 0601, or 0602) or a clinic visit (APC 0610, 0611, or 0612) or a critical care service (APC 0620) in order to receive separate payment for observation services for patients not admitted directly from a physician's office would remain in effect. However, because the initial nursing assessment is part of any observation service, we propose not to make separate payment for G0LLL. Rather, we propose to assign status indicator ''N'' to G0LLL, to designate that charges submitted with G0LLL would be packaged into the costs associated with APC 0339. If G0LLL is billed, we would require that the medical record show that the patient was admitted directly from a physician's office for purposes of evaluating and treating chest pain, asthma, or congestive heart failure.

G0MMM describes the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. We propose to assign G0MMM for payment under APC 0706, New Technology—Level I. We propose to require hospitals to bill G0MMM instead of the low level clinic visit referred to in the FAQ above to describe the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. Separate payment would not be made for observation services billed with G0MMM. Rather, when billing G0MMM, hospitals would be required to use revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (99218, 99219, 99220, 99234, 992335, or 99236). We propose to create G0MMM to establish a separately payable code into which costs for observation care for patients directly admitted for diagnoses other than asthma, chest pain, or congestive heart failure can be packaged and recognized.

We would use billing data for G0LLL and G0MMM in reviewing the provisions for payment of observation services in future updates of the OPPS. We invite comment on the extent to which these codes address the concerns that have been raised in connection with patients who are directly admitted to observation services.

Billing Intravenous Infusions With Observation

Based on questions and concerns raised by hospitals since implementation of payment for APC 0339 effective April 1, 2002, we have also reviewed the current status of billing intravenous infusions with observation. Several hospitals have noted that claims for G0244 when billed with intravenous infusion services reported with HCPCS code Q0084 are denied because of the ''T'' status indicator assigned to HCPCS code Q0084. Our current payment rules for G0244 require that G0244 be denied if a service with status indicator ''T'' is performed the day before, the day of, or the day after observation care. Because patients in observation may require intravenous infusions of fluid, we propose to create code G0EEE, Intravenous infusion during separately payable observation stay, per observation, payable under APC 0340 with status indicator ''X.'' When observation services that otherwise meet the billing requirements for separate payment under APC 0339 include an intravenous infusion administered as part of the observation care, G0EEE would be used to report the infusion service. We include instructions on the use of G0EEE in the program memorandum issued to implement OPPS coding changes for the October 1, 2002 OCE. We solicit comment on the use of this code.

We discuss this and other new Level II HCPCS codes proposed for payment under the OPPS in section II.B.3 of this preamble. We instruct hospitals to use G0EEE only when billing for payment under APC 0339. G0EEE includes placement of the IV access and should not be billed with CPT code 36000.

Annual Update of ICD–9 Diagnosis Codes

To receive payment for G0244, we require hospitals to bill specified ICD–9–CM diagnosis code(s). Because ICD–9–CM codes are updated effective October 1 of each year, we propose to issue by Program Memorandum any changes in the diagnosis codes required for payment of G0244 resulting from the ICD–9–CM annual update.

In the March 1, 2002 final rule (67 FR 9559) and in Transmittal A–02–026 issued on March 28, 2002, we listed the diagnosis codes required in order for separate payment of observation services under APC 0339 to be made for patients with congestive heart failure. We added by program memorandum the following new ICD–9–CM codes to the list of allowed diagnosis codes for separate payment for observation of patients with congestive heart failure, effective for services furnished on or after October 1, 2002:

428.20 unspecified systolic heart failure
428.21 acute systolic heart failure
428.22 chronic systolic heart failure
428.23 acute on chronic systolic heart failure
428.30 unspecified diastolic heart failure
428.31 acute diastolic heart failure
428.32 chronic diastolic heart failure
428.33 acute on chronic diastolic heart failure
428.40 unspecified combined systolic and diastolic heart failure
428.41 acute combined systolic and diastolic heart failure

428.42 chronic combined systolic and diastolic heart failure
428.43 acute on chronic combined systolic and diastolic heart failure

We invite comment on the addition of these diagnosis codes to the criteria for separate payment for observation services under APC 0339.

C. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis

As we state in section II.B.5 of this preamble, the inpatient list specifies those services that are only paid when provided in an inpatient setting. The inpatient list proposed for 2003 is printed as Addendum E. In Addendum B, status indicator C designates a HCPCS code that is on the inpatient list.

Over the past year, some hospitals and hospital associations have asked how a hospital could receive Medicare payment for a procedure on the inpatient list that had to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition who was transferred or died before being admitted as an inpatient. We reviewed within the context of our current policy the cases brought to our attention for which payment under the OPPS was denied because a procedure with status indicator C was on the bill. Based on that review, we propose to clarify our policy regarding Medicare payment when a procedure with status indicator C is performed under certain life-threatening, emergent conditions. We solicit comments on the extent to which the payment policy described below addresses hospitals' concerns. These comments would be most helpful if they are supported by specific examples of cases when hospitals have, in these instances, submitted bills for a procedure with OPPS status indicator C that were not paid.

1. Current Policy

In the April 7, 2000 final rule (65 FR 18451), in response to comments about the appropriate level of payment for patients who die in the emergency department, we set forth the following guidelines for fiscal intermediaries to use in determining how to make payment when a patient dies in the emergency department or is sent directly to surgery and dies there.

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

The OPPS outpatient code editor (OCE) currently has an edit in place that generates a ''line item denial'' for a line on a claim that has a status indicator C. A line item denial means that the claim can be processed for payment but with some line items denied for payment. A line item denial can be appealed under the provisions of section 1869 of the Act. The OCE includes another edit that denies all other line items furnished on the same day as a line item with a status indicator C. The rationale for this edit is that all line items for services furnished on the same date as the procedure with status indicator C would be considered inpatient services and paid under the appropriate DRG.

As part of the definition of line item denial in the program memorandum that we issue quarterly to update the OCE specifications (for example, see Program Memorandum/Intermediaries, Transmittal A–02–052, June 18, 2002, which is available on our website at *http://www.hcfa.gov/pubforms/transmit/A02052.pdf*), we state that a line item denial cannot be resubmitted except for an emergency room visit in which a patient dies during a procedure that is categorized as an inpatient procedure: ''Under such circumstances, the claim can be resubmitted as an inpatient claim.''

In Addendum D of the March 1, 2002 final rule, we designate payment status indicator ''C'' as follows: ''Admit patient; bill as inpatient.''

2. Hospital Concerns

Hospitals have requested clarification regarding billing and payment in certain situations that our current policy does not seem to explicitly address. The following scenarios synthesize cases described by hospitals for which they have encountered problems when billing for a procedure with status indicator C.

Scenario A: A procedure assigned status indicator C under the OPPS is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. The patient dies during surgery or postoperatively before being admitted.

Scenario B: An elective or emergent surgical procedure payable under the OPPS is being performed. Because of sudden, unexpected intra-operative complications, the physician must alter the surgical procedure and perform a procedure with OPPS status indicator C. The patient dies during the operation before he or she is admitted as an inpatient.

Scenario C: A procedure with status indicator C is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. After the procedure, the patient is transferred to another facility for postoperative care.

3. Clarification of Payment Policy

We propose the following policy for fiscal intermediaries and providers to use in determining the appropriate Medicare payment in cases such as those described in the section above.

A procedure assigned status indicator C under the OPPS is never payable under the OPPS. Therefore, for a hospital to receive payment when a procedure with OPPS status indicator C is performed and: (1) the patient dies during or after the procedure, before being admitted, or (2) the patient survives the procedure and is transferred following the procedure, the patient's medical record must contain all of the following information:

- Either orders to admit written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted, the hospital following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient bed, or written orders to admit and transfer the patient to another hospital following the procedure.
- Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C (such as CPT code 61345) was actually performed.
- Documentation that the reported surgical procedure with status indicator C was medically necessary.
- If the patient is admitted and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

Because these services would be paid according to the appropriate DRG or per diem (see below), all services that were furnished before admission that would otherwise be payable under the OPPS would be paid in accordance with the

provisions of section 3610.3 of the Medicare Intermediary Manual (''3-day rule'') and section 415.6 of the Medicare Hospital Manual.

In the case of a patient who dies during performance of a procedure with OPPS status indicator C before being admitted, the hospital would submit a claim for all services provided, including a line item for the status indicator C procedure. The claim would be rejected for payment under the OPPS and returned to the hospital. The hospital would resubmit the claim for payment as an inpatient stay under the appropriate DRG.

In the case of a patient who is admitted and transferred, the transferring hospital would be paid a per diem DRG rate if all the above conditions are met. (We propose to revise section 3610.5 of the Medicare Intermediary Manual accordingly.)

Note that a physician's order to admit a patient to an observation bed following a procedure designated with OPPS status indicator C would not constitute an inpatient admission and, therefore, would not qualify the procedure with status indicator C for payment. In this instance, the only allowable Medicare payment would be for a code payable under APC 0610, 0611, or 0612 if those services were provided. Payment would not be allowed for either the procedure with status indicator C or for any ancillary services furnished on the same date.

4. Orders To Admit

Some hospitals have raised questions about the timing of a physician's order to admit a patient. The requirements for the authenticating physician orders and the standards for medical record keeping fall outside the scope of this proposed rule and OPPS payment policy. The payment guidelines proposed above are to assist hospitals and contractors in determining how to bill and pay for services appropriately under Medicare. The patient's admission status, as documented by the medical records, determines what Medicare payment is appropriate. Medical record keeping and documentation requirements are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State law and State licensing rules and hospital accreditation standards.

D. Status Indicators

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate if a service represented by a HCPCS code is payable under the OPPS or another payment system and also if particular OPPS policies apply to the code. We are providing our proposed status indicator assignments for APCs in Addendum A, HCPCS codes in Addendum B, and definitions of the status indicators in Addendum D.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we need a way to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D defines the meaning of each status indicator for purposes of the OPPS.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

Specifically, in 2003, we propose to use the status indicators in the following manner:

- We use A to indicate services that are paid under some payment method other than OPPS, such as the Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the physician fee schedule. Some but not all of these other payment systems are identified in Addendum D.
- We use ''C'' to indicate inpatient services that are not payable under the OPPS.
- We use ''D'' to indicate a code that was deleted effective with the beginning of the calendar year.
- We use ''E'' to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- We use ''F'' to indicate acquisition of corneal tissue, which is paid at reasonable cost.
- We use ''G'' to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- We use ''H'' to indicate devices that are paid under OPPS transitional pass-through rules.
- We use ''K'' to indicate drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid in separate APCs under the OPPS, but that are not paid under OPPS transitional pass-through rules.
- We use ''N'' to indicate services that are paid under the OPPS for which payment is packaged into another service or APC group.
- We use ''P'' to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- We use ''S'' to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.
- We use ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
- We use ''V'' to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.
- We use ''X'' to indicate ancillary services that are paid under the OPPS.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services. We sometimes change these indicators in the course of a year through Program Memoranda. Moreover, indicators are established for new codes that we establish in the middle of the year, either as a result of a national coverage decision or otherwise. A status indicator, as well as an APC, must be assigned so that payment can be made for the service identified by the new code.

We are proposing the status indicators identified for each HCPCS code and each APC in Addenda A and B and are requesting comments on the appropriateness of the indicators we have assigned.

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

1. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explain the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Effective with implementation of the 2002 OPPS update on April 1, 2002, we deduct from the pass-through payments for those devices an amount that offsets the portion of the otherwise applicable APC payment amount that we determined is associated with the device, as required

by section 1833(t)(6)(D)(ii) of the Act. In the March 1, 2002 final rule, we published the applicable offset amounts for 2002, which we had recalculated to reflect certain device cost assignments that were corrected in the same final rule (67 FR 9557).

For the 2003 OPPS update, we propose to estimate the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data for services furnished between July 1, 2001 through December 31, 2001. We propose to use only the last 6 months of 2001 claims data because bills for pass-through devices submitted during this time period would use only device category codes, allowing a more consistent analysis than would result were we to include pre-July 1 claims that might still show item-specific codes for pass-through devices. Using these claims, we would calculate a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We would then calculate a median cost for every APC with the costs of associated C-codes for device categories that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging by the median APC cost including device packaging would allow us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to the median APC cost, we would determine the applicable offset amount. Table 9 shows the offsets that we propose be applied in 2003 to each APC that contains device costs. APCs were included for offsets if their device costs comprised at least 1 percent of the APC's costs. (However, if any APC's calculated offset had been less than 1 dollar, that APC and offset would not have been included.)

TABLE 9.—PROPOSED OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	APC percent attributed to devices	Device related cost to be subtracted from pass-through payment
0032	Insertion of Central Venous/Arterial Catheter	6.12	$22.73
0046	Open/Percutaneous Treatment Fracture or Dislocation	1.06	16.00
0048	Arthroplasty with Prosthesis	5.78	111.02
0051	Level III Musculoskeletal Procedures Except Hand and Foot	1.24	21.95
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	3.05	67.21
0080	Diagnostic Cardiac Catheterization	4.36	80.82
0081	Non-Coronary Angioplasty or Atherectomy	7.29	86.03
0082	Coronary Atherectomy	47.58	1,866.34
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	20.08	499.51
0085	Level II Electrophysiologic Evaluation	10.22	168.87
0086	Ablate Heart Dysrhythm Focus	20.36	462.74
0087	Cardiac Electrophysiologic Recording/Mapping	15.19	45.90
0088	Thrombectomy	4.08	72.06
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	68.56	3,883.80
0090	Insertion/Replacement of Pacemaker Pulse Generator	64.17	2,574.81
0091	Level II Vascular Ligation	1.75	24.60
0093	Vascular Repair/Fistula Construction	1.63	22.29
0104	Transcatheter Placement of Intracoronary Stents	40.26	1,522.67
0105	Revision/Removal of Pacemakers, AICD, or Vascular	5.79	57.64
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	18.05	274.40
0107	Insertion of Cardioverter-Defibrillator	83.18	7,852.32
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	82.11	9,936.93
0109	Removal of Implanted Devices	1.70	6.79
0115	Cannula/Access Device Procedures	7.22	88.17
0119	Implantation of Devices	13.61	183.19
0122	Level II Tube changes and Repositioning	2.21	4.47
0124	Revision of Implanted Infusion Pump	9.82	119.87
0142	Small Intestine Endoscopy	1.03	4.40
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	2.71	25.69
0152	Percutaneous Abdominal and Biliary Procedures	9.96	32.01
0153	Peritoneal and Abdominal Procedures	1.69	22.84
0154	Hernia/Hydrocele Procedures	2.66	37.33
0167	Level III Urethral Procedures	11.54	162.95
0168	Level II Urethral Procedures	5.20	65.18
0179	Urinary Incontinence Procedures	34.30	1,449.96
0182	Insertion of Penile Prosthesis	42.39	1,847.50
0202	Level VIII Female Reproductive Proc	10.67	216.92
0222	Implantation of Neurological Device	65.75	4,806.58
0223	Implantation of Pain Management Device	11.54	121.84
0225	Implantation of Neurostimulator Electrodes	33.33	770.87
0226	Implantation of Drug Infusion Reservoir	70.33	1,616.75
0227	Implantation of Drug Infusion Device	75.38	5,019.34
0229	Transcatherter Placement of Intravascular Shunts	46.89	1,194.96
0245	Level I Cataract Procedures without IOL Insert	3.24	24.25
0246	Cataract Procedures with IOL Insert	1.20	14.72
0259	Level III ENT Procedures	75.29	11,396.81
0279	Level II Angiography and Venography except Extremity	1.56	6.82
0280	Level III Angiography and Venography except Extremity	5.02	40.49
0281	Venography of Extremity	1.39	3.78

TABLE 9.—PROPOSED OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS—Continued

APC	Description	APC percent attributed to devices	Device related cost to be subtracted from pass-through payment
0297	Level II Therapeutic Radiologic Procedures	1.91	7.75
0656	Transcatheter placement of drug eluting stents	54.15	2668.28
0670	Intravenous and Intracardiac Ultrasound	51.03	392.26
0680	Insertion of Patient Activated Event Recorders	68.48	1,850.24
0681	Knee Arthroplasty	64.57	5,310.69
0684	Prostate Brachytherapy	67.49	3631.89
0686	Level III Skin Repair	4.00	23.51
0687	Revision/Removal of Neurostimulator Electrodes	1.50	15.21
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	22.15	352.28
0693	Level II Breast Reconstruction	1.00	20.44
0981	New Technology—Level XII ($2000—$2500)	13.32	299.70

2. Devices Paid With Multiple Procedures

As explained above, under section 1833(t)(6)(D)(ii) of the Act, the amount of additional payment for a device eligible for pass-through payment is the amount by which the hospital's cost exceeds the portion of the otherwise applicable APC payment amount that the Secretary determines is associated with the device. Thus, for devices eligible for pass-through payment, we reduce the pass-through payment amount by the cost attributable to the device that is already packaged into the APC payment for an associated procedure. For 2002, we developed offset amounts, for 59 APCs (March 1, 2002 final rule, 67 FR 9556 through 9557, Table 1).

In our November 30, 2001 final rule (66 FR 59856), we articulated a policy regarding the calculation of the offsets for device costs already reflected in APCs in cases where the payment for the associated APC is reduced due to the multiple procedure discount. The policy was in response to several commenting parties that recommended that we apply the multiple procedure discount only to the non-device-related portion of the APC payment amount (66 FR 59906).

We agreed with the commenters that the full pass-through offset should not be applied when the APC payment is subject to the multiple procedure discount of 50 percent.

The purpose of the offset is to ensure that the OPPS is not making double payments for any portion of the cost associated with the use of the pass-through item. We stated in the November 30, 2001 rule that the offset should reflect that portion of the cost for the pass-through device actually reflected in the payment that is received for the associated APC. We consequently ruled that the most straightforward methodology for applying this principle is to reduce the amount of the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC. This discounting of the offset is applied in 2002 to bills subject to multiple procedure discounting that also include devices eligible for pass-through payment.

The significant number of device categories that are expiring in 2003 combined with our proposal to package 100 percent of device costs into their associated APCs has prompted us to revisit the current policy of reducing offsets for pass-through devices in instances when multiple procedure discounts are applied to procedures associated with pass-through device categories. In order to determine the impact of multiple procedure discounting on APCs with full packaging of device costs, we reviewed the median costs of all APCs after incorporation of device costs and arrayed them in order of descending median cost. We also determined the contribution (in absolute dollars and as a percentage) of device costs to the median costs of each APC. We did this by examining claims submitted during the last 6 months of 2001 during which only device category codes were used to bill for pass-through devices because those were the only claims where we could specifically identify the contribution of device costs to the cost of each APC.

We then determined which APCs containing devices would be billed together. For example, the APC for insertion of a pacemaker would not be billed with the APC for insertion of neurostimulator electrodes, whereas the APC for coronary stent placement might be billed with the APC for coronary angioplasty. We next determined, based on median cost data, which device containing APCs would be subject to the 50 percent multiple procedure reduction. After identifying these APCs, we applied a 50 percent reduction to arrive at a discounted payment amount. We then reviewed the contribution of device costs to the discounted APC both as a percentage and in absolute dollars to determine if applying the 50 percent reduction would result in underpayment for the service. We determined that the reduced payment was adequate to pay both for the devices incorporated into the APC and for the procedure cost in the context of performing multiple procedures. We obtained the same results even when we overstated device costs in our model by 5 or 10 percent to offset concerns expressed by some manufacturers and physicians that hospital charges for transitional pass-through devices may be understated.

To illustrate this analysis, assume APCs 0104 and 0083 are billed together. The median cost of APC 0104 is $3,960 with 40 percent of the cost attributable to devices. The median cost of APC 0083 is $2,605 with 20 percent of its cost attributable to devices. Under our existing multiple procedure discount payment rules, APC 0104 would be paid at 100 percent, and APC 0083 would be paid at 50 percent. This means that payment for APC 0083 would be $1,302 of which $520 (20 percent of $2,605) is attributable to devices. We believe this total payment accounts for the costs of the devices and the costs of the procedure when it is performed in conjunction with APC 0104.

We note that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps and neurostimulator electrodes) would never be subject to a multiple procedure discount. They have the highest relative weights in the OPPS,

and we would not expect these procedures to be performed during the same operative session with a higher paying procedure with status indicator ''T.'' Therefore, we propose to continue our current policy of multiple procedure discounting. That is, when two or more APCS with status indicator ''T'' are billed together we propose to pay 100 percent for the highest cost APC and 50 percent for all other APCs with status indicator ''T.'' We propose not to adjust these payments to account for device costs in the APCs.

F. Outpatient Billing For Dialysis

Currently, hospitals are unable to bill for dialysis treatments furnished to End-Stage Renal Disease (ESRD) patients on an outpatient basis, unless the hospital also has a certified hospital-based ESRD facility. As a result of this policy, there has been an increase in denials by the PROs for inappropriate hospital admissions.

When ESRD patients come to the hospital for a medical emergency or for problems with their access sites, they typically miss their regularly scheduled dialysis appointments. If the ESRD patient's usual facility is unable to reschedule the dialysis treatment, the beneficiary has to wait until the next scheduled dialysis appointment. CMS is concerned that by maintaining this policy, beneficiaries may be receiving interrupted care because there will be unnecessary lapses in treatment. The ESRD patient should not be prevented from receiving her or his normal dialysis because he or she experienced another unrelated medical situation. Therefore, we propose to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital in specific situations. Payment would be limited to unscheduled dialysis for ESRD patients in exceptional circumstances. Outpatient dialysis for acute patients would not be included in this payment mechanism.

We propose to limit this payment to medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility. Situations that we propose to allow are limited to: (1) dialysis performed following or in connection with a vascular access procedure; (2) dialysis performed following treatment for an unrelated medical emergency. For example, if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we would allow the hospital to provide and bill Medicare for the dialysis treatment; and (3) emergency dialysis—Currently, the only mechanism available for payment in this situation is through an inpatient admission. We will maintain our policy that routine treatments in non-ESRD certified hospitals would not be payable under OPPS.

We believe it is important to make this change in policy for two reasons: (1) to ensure that hospital outpatient departments are paid for providing this much needed service; and (2) to prevent dialysis patients from receiving interrupted care. Non-ESRD certified hospital outpatient facilities would bill Medicare using a new G code, G0GGG, ''Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.'' We propose that this new code will have status indicator ''S'' and be assigned to APC 0170. Payment would be roughly equivalent to the reimbursement rate for acute dialysis. We propose to implement this change effective January 1, 2003. Effective January 1, 2003, this would be the only way for non-ESRD certified hospital outpatient facilities to bill Medicare and be paid for providing outpatient dialysis to ESRD beneficiaries.

CMS will be monitoring the use of this new code to ensure that (1) certified dialysis facilities are not incorrectly using this code; and (2) the same dialysis patient is not repeatedly using this code, which would indicate routine dialysis treatment.

When ESRD patients receive outpatient dialysis in non-ESRD certified hospital outpatient facilities, the patient's home facility would be responsible for obtaining and reviewing the patient's medical records to ensure that appropriate care was provided in the hospital and that modifications are made, if necessary, to the patient's plan of care upon her or his return to the facility. This ensures continuity of care for the patient.

IX. Summary of and Responses to MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) in its March 2002 Report to the Congress: ''Medicare Payment Policy,'' makes a number of recommendations relating to the OPPS. This section provides responses to those recommendations.

Recommendation: For calendar year 2003, the Secretary should increase the payment rates for services covered by the OPPS by the rate of increase in the hospital market basket.

Response: Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor annually. Under section 1833(t)(3)(C)(iv) of the Act, the update is equal to the hospital market basket percentage increase applicable under the hospital inpatient PPS, minus one percentage point for the years 2000 and 2002. The Secretary has the authority under section 1833(t)(3)(C)(iv) of the Act to substitute a market basket that is specific to hospital outpatient services. In the September 8, 1998 proposed rule on the OPPS, we indicated that we were considering the option of developing an outpatient-specific market basket and invited comments on possible sources of data suitable for constructing one (63 FR 47579). We received no comments in response to this invitation, and we therefore announced in the April 7, 2000 final rule that we would update the conversion factor by the hospital inpatient market basket increase, minus one percentage point, for the years 2000, 2001, and 2002 (65 FR 18502). (As required by section 401(c) of the BIPA, we made payment adjustments effective April 1, 2001 under a special payment rule that had the effect of providing a full market basket update in 2001.) For 2003, we propose to increase payment rates by the rate of increase in the hospital market basket.

Recommendation: The Congress should—

- Replace hospital-specific payments for pass-through devices with national rates.
- Give the Secretary authority to consider alternatives to average wholesale price (AWP) when determining payments for pass-through drugs and biologicals.

Response: Regarding the pricing of transitional pass-through devices, we share the Commission's concern that the current methodology provides incentives for hospitals to inflate charges for transitional pass-through devices to increase payments. However, we believe that alternative approaches are not necessarily superior. Further, the salience of this problem should be much less in the future.

At present, the payment for a transitional pass-through device is set, on a claim-by-claim basis, relative to the hospital's charge for that device. The charge is reduced to a measure of cost by application of a hospital-specific cost-to-charge ratio, and a subtraction is made to reflect the portion of device costs already recognized in the payment for the associated procedure APC. This procedure means that a higher charge by a hospital will result in a higher payment from Medicare. The Commission notes that this method embodies an incentive for hospitals, perhaps prompted by manufacturers, to increase charges as a means of

increasing payments. The Commission is concerned that this situation may lead to excessive payments and may bias the charges used to revise, from year to year, relative weights in the OPPS.

In fact, the extent to which hospitals raising their charges on devices is problematic depends on the outcomes. In general, we anticipate that hospital charge structures, on average, reflect their costs; this assumption helps support the use of charge data to revise relative weights in hospital prospective payment systems. Accordingly, whether payments to hospitals for transitional pass-through devices might be considered excessive depends on whether hospitals inflate charges beyond the levels appropriate to recover their costs. Whether their behavior leads to biases in charge data depends on whether they set charges on transitional pass-through devices significantly differently than on other services.

Moving to a fee schedule for transitional pass-through devices would remove the particular incentive problem that the Commission noted, which we agree would be desirable. However, the establishment of appropriate national rates would then become the focus. In the absence of field data on actual costs, we will be inevitably reliant on information that manufacturers provide. At present, manufacturers are asked for information about prices on applications for pass-through status. Anecdotal information suggests this information is not fully reliable as a measure of what hospitals actually pay.

The Commission's report discusses the possibility of CMS setting the rate for a device based on analysis of the manufacturer's costs, including an appropriate rate of return on equity. This approach would confront a number of accounting, legal, and operational difficulties.

- First, it would take some time to complete the analysis for a new product, which could significantly delay establishment of a rate. The rate that would be used in the meantime, or whether billing would be permitted at all, would be open to question.
- Second, it appears that large firms with multiple product lines supply most devices, which would make determining the costs of a particular device difficult. This problem would be compounded when multiple enterprises are involved in bringing a product to market, which is not uncommon in the device industry, where invention and initial development may occur in one firm and final development, manufacturing, and marketing in another.
- Third, the government generally does not have access to manufacturers cost information. While legal authority could be enhanced, manufacturers would face incentives that raise questions about the reliability of information provided, and the need for government accounting and auditing resources would be high.
- Fourth, as the Commission's report notes, an appropriate rate of return on equity would have to be established.
- Fifth, devices are now paid, under BIPA, on the basis of categories. As a result, if a manufacturer brings to market a product that fits the description of a category, hospitals can bill for that manufacturer's product without any change in coding or notification of CMS. Consequently, we do not know what specific devices are actually being billed in these categories, or who manufactures them. Whatever rate might be established on the basis of an initial application for a category would presumably be based on the applicant's costs. Later entrants might have significantly different cost structures, but this information would not come into account unless a more elaborate process was implemented to include it.

Finally, whether a rate set in this fashion would pay less or more than the current method is unclear. The current method is based on actual experience in the field, and it will reflect, though perhaps somewhat tenuously, whatever competitive market pressures exist. Any method that we use aimed at ensuring a more reliable price could yield a price that is too high, since it will not reflect market activity. Whether a rate set by *ex ante* analysis of this sort would produce superior results does not appear obvious.

The Commission's report also mentions the possibility of using competitive bidding to set rates for transitional pass-through devices. While competitive bidding appears attractive as a means of setting a market-related price, it has not proven an easy process for Medicare to implement. Competitive bidding seems best suited for established products with multiple suppliers. However, transitional pass-through devices are by definition new to the market and will frequently have only one manufacturer, at least at the start of the 2 to 3 year transitional pass-through period. Even in those instances in which this technique would be possible, it involves a fair amount of administrative resources and time, and using it to establish a rate that will be used at the most for 3 years does not appear to be an effective use of resources.

Both of the suggestions discussed above reflect procedures that involve relatively high overhead on the part of CMS and of other actors. It is not obvious whether either would produce results that are superior to those derived from the present method. While they would change incentives on hospitals, incentives of manufacturers would still be a source of concern. We agree with the Commission that further investigation would be necessary to determine a feasible alternative to cost-based pass-through payments.

In considering the advantages of various approaches, it is important to keep the size of the problem in mind, especially when contemplating procedures for setting rates that would involve substantial administrative resources. As of July 1, 2002, the OPPS pays for 100 categories of devices. As is explained in section III.C of this preamble, we are proposing that 95 categories will lose pass-through status and be retired as of January 1, 2003.[3] Since the initial categories were established in April 2001, we have added only three categories. While several applications are pending, given the extensiveness of the existing categories, it appears likely that the number of new categories to be established in future years will be small.[4] The likely volume of claims represented by these new categories is of course speculative, but it also does not seem likely to be large relative to the size of the OPPS system. As discussed below, we developed criteria for the establishment of new categories that were specifically intended to limit future pass-through payments to devices that provide a substantial clinical improvement.

Considering that the identified alternatives do not appear to be manifestly superior to the current system but do involve significantly more administrative resources, and given the anticipated small volume of transitional pass-through devices in the future, we think on balance it would be best to let more experience develop with the current system before making significant changes to the current method.

However, we agree that it would be desirable to give the Secretary authority

[3] In accord with the BBRA amendment that established the pass-through payment methodology, items are only eligible for pass-through payments for 2 to 3 years. After expiration of pass-through status, payments for devices described by these categories will be packaged into APC payments for the procedures with which they are used.

[4] If a new device arrives on the market that would have fit in a category formerly in use but subsequently retired, it will not be eligible for pass-through payment.

to use alternatives to AWP when determining payments for pass-through drugs and biologicals. At present, total payment for these items is governed by the general rule (section 1842(o) of the Act) for Medicare pricing of drugs, which requires they be paid at 95 percent of AWP. This rule also covers most drugs delivered ''incident to'' physicians' services in physicians' offices and elsewhere. The Congress is at present considering various changes to the AWP as the basis for Medicare payment for drugs, and if a change is adopted to this standard, it may be an appropriate standard for transitional pass-through drugs and biologicals as well.

Recommendation: The Secretary should do the following:

• Ensure additional payments are made only for new or substantially improved technologies that are expensive in relation to the applicable ambulatory payment classification rate.

• Avoid basing national rates only on reported costs.

• Ensure that the same broad principles guide payments for new technologies in the inpatient and outpatient payment systems.

Response: We agree that additional payments should be limited to items that have the greatest merit and that have high costs not well captured in the existing payment structure. The Commission notes that limiting the number of transitional pass-through items limits the burdens on hospitals and us; reduces the likelihood of exceeding the statutory cap on aggregate pass-through payment, necessitating a uniform reduction in transitional pass-through payments; and limits the redistribution of funds across hospitals that are low versus high users of transitional pass-through items. We agree with these points. On November 2, 2001, we published an interim final rule with comment period in the **Federal Register** (66 FR 55850 to 55857) that set forth criteria we will use to evaluate whether to establish new categories of devices in the future. These criteria include tests of whether a device is new, whether it represents a substantial medical improvement for Medicare beneficiaries, and whether its costs are high relative to the payments that would otherwise be made.

Section 1833(t)(6)(D) of the Act prescribes the method for setting payment for transitional pass-through drugs and devices. The issue of possible alternatives is discussed above.

We agree that the same principles should govern payments for new technologies in the inpatient and outpatient prospective payment systems. Criteria governing extra new technology payments in the IPPS were established in a final rule published in the **Federal Register** (66 FR 46902 to 46925) on September 7, 2001. The criteria have the same general form as those for the OPPS. They differ in some particulars, largely traceable to the difference of the two payment systems. In particular, the IPPS system pays on the basis of an episode of care. As a result, the bundle of payment is generally larger and hospitals are better able to absorb minor cost differences. Considering the impact of new technology on all costs of the episode is also pertinent. Consequently, the criteria for special payment for inpatient new technologies require examination of the net effect on costs of the entire episode (not just the added costs of a new technology), and the relative cost standard we established is somewhat more stringent than for the OPPS. We believe it is premature to judge whether it will make sense to make these criteria even closer in the future, as the Commission's discussion suggests.

X. Summary of Proposed Changes for 2003

A. Changes Required by Statute

We are proposing the following changes to implement statutory requirements:

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

• Recalibrate the relative payment weights of the APCs.

• Update the conversion factor and the wage index.

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

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

B. Additional Changes to OPPS and Payment Suspension Provisions

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

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

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

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

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

• Changes to status indicators for HCPCS codes.

• Changes to our policies governing dialysis for ESRD patients and regarding partial hospitalization.

In addition, we are making changes to payment suspension policies.

C. Changes to the Regulations Text

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

• Amend § 410.43(b) to add clinical social worker services (for the diagnosis and treatment of mental illnesses) that meet the requirements of section 1861(hh)(2) of the Act to the specified professional services that are separately covered and not paid as partial hospitalization services.

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

XI. Summary of Proposed Payment Suspension Provisions

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

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This rule does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XIII. Response to Public Comments

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

XIV. Regulatory Impact Analysis

The regulatory impact analysis for this proposed rule consists of an impact analysis for the OPPS provisions and a regulatory impact statement for the provision for payment suspension for unfiled cost reports.

A. OPPS

1. General

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

We estimate the effects of the provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the proposed rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2003 compared to CY 2002 to be approximately $1.372 billion. Therefore, this proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 to $29 million or less in any 1 year (see 65 FR 69432).

For purposes of the RFA we have determined that approximately 37 percent of hospitals and 98 percent of mental health practitioners would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414) $5.7 billion and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards web site at *http://www.sba.gov/regulations/siccodes/).* Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds (or New England County Metropolitan Area (NECMA)). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this proposed rule has a significant impact on a substantial number of small entities. However, the statute provides for small rural hospitals (of less than 100 beds) to be held harmless by the law and to continue to be paid at cost; therefore this proposed rule has no impact on them.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments. This proposed rule imposes no unfunded mandates on the private sector.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see table 10) shows that payments to governmental hospitals (including State, local and tribal governmental hospitals) would increase by 5 percent under the proposed rule.

2. Changes in this Proposed Rule

We are proposing several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2003 as

we discuss in sections VI and IV, respectively, of this preamble. We are also proposing revisions to the relative APC payment weights based on claims data from January 1, 2001 through December 31, 2001. Finally, we are proposing to remove 95 devices and more than 200 drugs and biologicals from pass-through payment status.

Under this proposed rule, the change to the conversion factor as provided by statute would increase total OPPS payments by 3.5 percent in 2003. The changes to the wage index and to the APC weights (which incorporates the cessation of pass-through payments for many drugs and devices) do not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes do change the distribution of payments within the budget neutral system as shown in Table 10 and described in more detail in this section.

Alternatives Considered

Alternatives to the changes we propose and the reason that we did not choose to propose them are discussed throughout this proposed rule. Below we discuss options we considered when analyzing methodologies to appropriately recognize the costs of former pass-through items. For a more detailed discussion, see section III.C.1 regarding the expiration of pass-through payment for devices and section III.C.2 regarding the expiration of pass-through payment for drugs and biologicals.

Payment for Categories of Devices

We considered establishing separate APCs for categories of devices and paying for them separately. We did not propose this option because we believe that to the extent possible, hospital payment for procedures and visits should include all of the costs required to provide the procedures and visits.

A second option we considered involved (1) packaging some categories of devices into the procedures with which they were billed in 2001 and (2) paying the rest through separate APCs (as discussed in section III.C.). We did not propose this option because we believe that devices are routinely used in the services for which they are needed and therefore are consistently paid at the cost of providing the service. Furthermore, criteria that would provide a basis for some devices to be packaged and for others to be paid separately would have to be developed and approved, thereby further complicating an already complex payment system.

Payment for Drugs and Biologicals

We considered continuing to make separate payment for all drugs and biologicals through separate APCs. We did not propose to pay separately for all drugs through separate APCs because we believe that, to the extent possible, hospital payment for services should include all of the costs of the services. We believe that drugs should be packaged with the services in which they are furnished except when we determine that there is a valid reason to do otherwise. However, we recognize that (unlike the stability that exists with device usage with the applicable procedures) the use of drugs may vary widely depending upon patient and disease characteristics. Therefore, packaging payment for all drugs may, in some cases, provide inadequate payment for the services furnished. Where a hospital has a disproportionate share of patients who need greater amounts of expensive drugs, underpayment for the drugs needed by these patients could result in cessation of needed services. For the first year that we are ceasing transitional pass-through payment for drugs, we decided to proceed cautiously by proposing to pay separately for drugs when the cost per encounter was more than $150 or when special characteristics existed (for example, orphan drugs, blood products).

We also considered packaging the costs of all drugs into the cost of the associated procedures with which they were billed in 2001. We did not package all payment for drugs into the payment for the procedures because, while this packaging is ultimately our goal, we believe, for the reasons indicated above, that we need to proceed cautiously to ensure that we do not inadvertently threaten access to needed care.

Conclusion

It is clear that the changes in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a regulatory impact analysis.

The OPPS rates proposed for CY 2003 would have, overall, a positive effect for every category of hospital with the exception of children's hospitals, which are held harmless under the OPPS. The changes in the OPPS proposed for 2003 would result in an overall 3.5 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments and transitional corridor payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the weights to assure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 10.

The overall projected increase in payments for urban hospitals is slightly lower (2.5 percent) than the average increase for all hospitals (3.5 percent) while the increase for rural hospitals is significantly greater (7.6 percent) than the average increase. Rural hospitals gain 2.3 percent from the wage index change, and also gain 1.6 percent from APC changes. A discussion of the distribution of outlier payments that we project under this proposed rule can be found under section D below. Table 11 presents the outlier distribution that we expect to see under this proposed rule.

3. Limitations of Our Analysis

The distributional impacts represent the projected effects of the proposed policy changes, as well as statutory changes effective for 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

4. Estimated Impacts of This Proposed Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistributive effects of the wage index and APC changes. In some cases, under this proposed rule, hospitals would receive more total payment than in 2002 while in other cases they would receive less total payment than they received in 2002. The impact of this proposed rule would depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital.

Column 4 in Table 10 represents the full impact on each hospital group of all

the changes for 2003. Columns 2 and 3 in the table reflect the independent effects of the proposed change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the proposed 2003 OPPS rates that is summarized in Table 10. For that reason, the total number of hospitals included in Table 10 (4,551) is lower than in previous years. CAHs are excluded from the OPPS.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that would experience a negative impact due to wage index changes are those in Puerto Rico, a decrease of 2.8 percent. Conversely, the urban hospitals are generally negatively affected by wage index changes, with the largest decreases occurring in those with 300–499 beds (−0.7 percent) and those in the Middle Atlantic (−1.3 percent), Pacific (−.09 percent) and Puerto Rico Regions (−1.8 percent). However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals and have a negative effect on urban hospitals in excess of 200 beds. Specifically, urban hospitals with 200–299 beds (−0.5 percent decrease), urban hospitals with 300–499 beds (−2.0 percent decrease) and urban hospitals in excess of 500 beds (a −1.9 percent decrease) all show a decrease attributed to APC recalibration. We believe this occurs as a result of our folding 75 percent of estimated pass-through device costs into APC payments in the 2002 OPPS. Specifically, a comparison of the relative payment weights proposed for 2003, as listed in Addendum A, with the final 2002 relative payment weights in the March 1, 2002 final rule shows a decrease in the weights for certain APCs in 2002 that included a fold-in of 75 percent of estimated pass-through device costs. We relied on cost information supplied by device manufacturers in estimating the device costs to be folded in when calculating the median APC costs for the 2002 OPPS, whereas the proposed 2003 relative payment weights are based on actual hospital charges and utilization under the OPPS as reported by hospitals. We believe this downward tendency in the payment weights for APCs that include device costs, based on actual hospital experience, accounts in part for the lower positive effect of the proposed 2003 rates on urban hospitals and on teaching hospitals, which tend to perform a higher number of procedures involving costly new technology devices, in contrast with an increased positive effect in 2003 on rural and non-teaching hospitals, which tend to furnish a higher volume of clinic and preventive services than procedures associated with expensive new technology devices.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes of fewer than 5000 services are projected to experience a significant increase in payments (8.1 percent). The less favorable impact for the high volume urban hospitals is attributable to both wage index and APC changes. For example, urban hospitals providing more than 42,999 services are projected to gain a combined 1.6 percent due to these changes.

Major teaching hospitals are projected to experience a smaller increase in payments (1.7 percent) than the aggregate for all hospitals (3.5 percent) due to negative impacts of the wage index (−0.5 percent) and recalibration (−1.2 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (2.0 percent) that is smaller than the average for all hospitals. There is little difference in impact among hospitals with that serve low-income patients.

TABLE 10.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of outlier and transitional pass-through payments or of transitional corridor payments.]

	Number of hospitals [1] (1)	New wage index [2] (2)	APC changes)[3] (3)	All CY 2003 changes [4] (4)
ALL HOSPITALS	4,551	0.0	0.0	3.5
NON-TEFRA HOSPITALS	4,002	0.0	−0.1	3.4
URBAN HOSPS	2,429	−0.6	−0.5	2.5
LARGE URBAN (GT 1 MILL.)	1,398	−0.7	−0.1	2.6
OTHER URBAN (LE 1 MILL.)	1,031	−0.4	−0.9	2.2
RURAL HOSPS	1,573	2.3	1.6	7.6
BEDS (URBAN):				
0–99 BEDS	554	−0.3	3.1	6.4
100–199 BEDS	882	−0.6	1.4	4.3
200–299 BEDS	488	−0.6	−0.5	2.3
300–499 BEDS	364	−0.7	−2.0	0.7
500+ BEDS	141	−0.3	−1.9	1.3
BEDS (RURAL):				
0–49 BEDS	754	0.4	2.9	7.0
50–99 BEDS	479	1.5	2.3	7.6
100–149 BEDS	201	2.4	1.5	7.6
150–199 BEDS	73	5.5	0.1	9.5
200+ BEDS	66	3.3	0.0	7.0
VOLUME (URBAN):				
LT 5,000	188	0.9	6.5	10.9
5,000–10,999	305	−0.8	5.1	7.9
11,000–20,999	472	−0.7	2.6	5.5
21,000–42,999	657	−0.8	0.3	3.0
GT 42,999	807	−0.5	−1.4	1.6
VOLUME (RURAL):				
LT 5,000	326	0.2	4.2	8.1
5,000–10,999	446	0.6	4.4	8.7

TABLE 10.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of outlier and transitional pass-through payments or of transitional corridor payments.]

	Number of hospitals [1] (1)	New wage index [2] (2)	APC changes)[3] (3)	All CY 2003 changes [4] (4)
11,000–20,999	373	1.3	2.7	7.7
21,000–42,999	290	1.9	1.4	6.9
GT 42,999	138	4.3	−0.2	7.8
REGION (URBAN):				
NEW ENGLAND	127	−0.6	0.6	3.4
MIDDLE ATLANTIC	372	−1.3	0.2	2.3
SOUTH ATLANTIC	370	−0.2	−0.1	3.2
EAST NORTH CENT.	413	−0.7	−1.4	1.4
EAST SOUTH CENT.	153	−0.6	−1.0	1.9
WEST NORTH CENT.	172	−0.3	−1.6	1.6
WEST SOUTH CENT.	293	0.5	−0.7	3.3
MOUNTAIN	122	−0.4	−1.1	1.9
PACIFIC	368	−0.9	0.6	3.1
PUERTO RICO	39	−1.8	4.7	6.4
REGION (RURAL):				
NEW ENGLAND	40	1.6	1.3	6.5
MIDDLE ATLANTIC	63	2.2	1.3	7.2
SOUTH ATLANTIC	226	2.6	2.1	8.4
EAST NORTH CENT.	213	1.2	−0.2	4.6
EAST SOUTH CENT.	232	2.3	2.6	8.7
WEST NORTH CENT.	271	2.0	0.9	6.6
WEST SOUTH CENT.	278	1.8	3.2	8.8
MOUNTAIN	141	4.1	1.3	9.2
PACIFIC	104	5.6	2.7	12.1
PUERTO RICO	5	−2.8	10.4	11.1
TEACHING STATUS:				
NON-TEACHING	2,935	0.4	1.1	5.0
MINOR	782	−0.4	−1.1	2.0
MAJOR	284	−0.5	−1.2	1.7
DSH PATIENT PERCENT:				
0	11	4.9	10.1	19.4
GT 0–0.10	982	−0.2	−0.4	3.0
0.10–0.16	873	0.7	−0.8	3.4
0.16–0.23	767	−0.6	−0.3	2.6
0.23–0.35	756	−0.2	0.1	3.4
GE 0.35	613	−0.1	2.2	5.8
URBAN IME/DSH:				
IME & DSH	982	−0.7	−1.2	1.6
IME/NO DSH	0	0.0	0.0	0.0
NO IME/DSH	1,441	−0.4	0.7	3.8
NO IME/NO DSH	6	5.4	9.8	19.7
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	610	0.7	2.7	7.1
RRC	167	4.2	0.2	8.2
SCH/EACH	507	1.5	2.7	7.8
MDH	199	0.8	2.1	6.6
SCH AND RRC	75	4.0	0.5	8.2
TYPE OF OWNERSHIP:				
VOLUNTARY	2,440	−0.1	−0.4	3.1
PROPRIETARY	707	−0.6	0.9	3.8
GOVERNMENT	855	0.7	0.7	5.0
SPECIALTY HOSPITALS:				
EYE AND EAR	13	−1.4	11.5	13.7
TRAUMA	153	−0.3	−1.5	1.6
CANCER	10	0.5	−3.9	0.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	166	10.3	2.8	16.9
PSYCH	198	0.1	15.9	20.1
LTC	143	1.3	15.9	20.4
CHILDREN	42	−1.4	−2.8	−0.9

Note: For CY 2003, under the OPPS transitional corridor policy, the following categories of hospitals are held harmless compared to their 1996 payment margin for these services: cancer and children's hospitals and rural hospitals with 100 or fewer beds.

[1] Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.

[2] This column shows the impact of updating the wage index used to calculate payment by applying the proposed FY 2003 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient proposed rule for FY 2003 was published in the FEDERAL REGISTER on May 9, 2002.

[3] This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2001 hospital claims data.

[4] This column shows changes in total payment from CY 2002 to CY 2003, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the proposed CY 2003 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

As stated elsewhere in this preamble, we propose to allocate 2 percent of the estimated 2003 expenditures to outlier payments. In Table 11 below, we provide a distribution by percentage of the total projected outlier payments for the categories of hospitals that we show in the impact table (Table 10).

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2003, that most hospitals will receive outlier payments. It appears that, with the exception of some smaller bed hospitals, all Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA) hospitals can be expected to receive outlier payments. This is because TEFRA hospitals provide an atypical mix of specialty services (which account for less than 1 percent of total OPPS payment before consideration of outliers). A greater percentage of non-TEFRA hospitals are not projected to receive outlier payments.

The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 11.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hosps	Percent of total hosps	Number of hosps with outliers	Percent of total outlier payments
ALL HOSPITALS	4,551	100.00	4,306	100.00
NON-TEFRA HOSPITALS	4,002	88.00	3,987	99.40
URBAN HOSPS	2,429	53.40	2,420	83.20
LARGE URBAN (GT 1 MILL.)	1,398	30.80	1,396	55.20
OTHER URBAN (LE 1 MILL.)	1,031	22.60	1,024	28.00
RURAL HOSPS	1,573	34.60	1,567	16.00
BEDS (URBAN):				
0–99 BEDS	554	12.20	550	6.80
100–199 BEDS	882	19.40	877	18.20
200–299 BEDS	488	10.80	488	16.20
300–499 BEDS	364	8.00	364	21.00
500+ BEDS	141	3.00	141	21.00
BEDS (RURAL):				
0–49 BEDS	754	16.60	751	4.20
50–99 BEDS	479	10.60	477	5.00
100–149 BEDS	201	4.40	200	2.60
150–199 BEDS	73	1.60	73	2.00
200+ BEDS	66	1.40	66	2.40
VOLUME (URBAN):				
LT 5,000	188	4.20	180	1.00
5,000–10,999	310	6.80	309	2.80
11,000–20,999	467	10.20	467	7.00
21,000–42,999	659	14.40	659	15.80
GT 42,999	805	17.60	805	56.60
VOLUME (RURAL):				
LT 5,000	326	7.20	321	1.00
5,000–10,999	447	9.80	446	2.60
11,000–20,999	372	8.20	372	3.80
21,000–42,999	290	6.40	290	4.20
GT 42,999	138	3.00	138	4.40
REGION (URBAN):				
NEW ENGLAND	127	2.80	126	6.20
MIDDLE ATLANTIC	372	8.20	371	22.80
SOUTH ATLANTIC	370	8.20	369	11.00
EAST NORTH CENT.	413	9.00	409	15.60
EAST SOUTH CENT.	153	3.40	152	3.40
WEST NORTH CENT.	172	3.80	172	4.40
WEST SOUTH CENT.	293	6.40	292	8.20
MOUNTAIN	122	2.60	122	3.00
PACIFIC	368	8.00	368	8.60
PUERTO RICO	39	0.80	39	0.20
REGION (RURAL):				
NEW ENGLAND	40	0.80	40	1.00
MIDDLE ATLANTIC	63	1.40	63	1.00
SOUTH ATLANTIC	226	5.00	223	3.00
EAST NORTH CENT.	213	4.60	212	3.00
EAST SOUTH CENT.	232	5.00	232	1.60
WEST NORTH CENT.	271	6.00	270	2.40
WEST SOUTH CENT.	278	6.20	278	1.60
MOUNTAIN	141	3.00	141	1.40
PACIFIC	104	2.20	103	1.20
PUERTO RICO	5	0.20	5	0.00
TEACHING STATUS:				
NON-TEACHING	2,935	64.40	2,920	39.80

TABLE 11.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hosps	Percent of total hosps	Number of hosps with outliers	Percent of total outlier payments
MINOR	782	17.20	782	27.20
MAJOR	284	6.20	284	32.20
DSH PATIENT PERCENT:				
0	11	0.20	10	0.00
GT 0—0.10	982	21.60	978	24.80
0.10—0.16	873	19.20	873	19.40
0.16—0.23	767	16.80	765	17.60
0.23—0.35	756	16.60	753	20.00
GE 0.35	613	13.40	608	17.40
URBAN IME/DSH:				
IME & DSH	982	21.60	982	57.20
IME/NO DSH	0	0.00	0	0.00
NO IME/DSH	1,441	31.60	1,433	26.00
NO IME/NO DSH	6	0.20	5	0.00
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	621	13.60	617	5.20
RRC	167	3.60	166	4.00
SCH/EACH	511	11.20	511	4.40
MDH	199	4.40	198	1.00
SCH AND RRC	75	1.60	75	1.40
TYPE OF OWNERSHIP:				
VOLUNTARY	2,440	53.60	2,435	73.60
PROPRIETARY	707	15.60	702	10.40
GOVERNMENT	855	18.80	850	15.20
SPECIALTY HOSPITALS:				
EYE AND EAR	13	0.20	13	0.20
TRAUMA	153	3.40	153	15.00
CANCER	10	0.20	10	3.80
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	166	3.60	113	0.20
PSYCH	198	4.40	65	0.20
LTC	143	3.20	100	0.20
CHILDREN	42	1.00	41	0.20

5. Estimated Impacts of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which OPPS payments would rise and would decrease for services for which OPPS payments would fall. For example for a mid level office visit (APC 0601), the minimum unadjusted copayment in 2002 was $9.67; under this proposed rule, the minimum unadjusted copayment would be $10.82 because the OPPS payment for the service would increase under this proposed rule. For some services (those services for which a national unadjusted copayment amount is shown in Addendum B), however, the beneficiary copayment is frozen based on historic data and would not change, therefore not presenting any potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. This amount was $812 for 2002, but is not yet determined for 2003. In general, the impact of this proposed rule on beneficiaries would vary based on the service the beneficiary receives and whether the copayment for the service is one that is frozen under the OPPS.

B. Payment Suspension for Unfiled Cost Reports

Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. (A description of each of these requirements is stated above in section XIV.A.1.) We have determined that the proposed payment suspension provision does not have an economic impact on Medicare payments or other payments to providers. We are proposing to allow the Secretary flexibility in payment suspensions, but we are not altering the final payment determination in any way. With the implementation of the various prospective payment systems, the majority of the payment to providers is based on the PPS methodology and not on the cost report. Suspending all payments because the cost report is not timely filed negatively affects providers. Providing the Secretary with flexibility in payment suspension can lessen the financial impact on providers. For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Under the requirement for Unfunded Mandates, this proposed rule will not have an economic effect on State, local, or tribal governments, in the aggregate, or on the private sector.

Anticipated Effects

1. Effects on providers that file cost reports. The majority of providers that file cost reports comply with the timeliness provisions and will be unaffected by this proposed regulation.

In FY 2000, collectively 16 percent of hospitals, skilled nursing facilities, and home health agencies filed late cost reports. Of this 16 percent, 65 percent of those were only 1 day late. Currently, when a provider fails to file an acceptable cost report, the provider is placed on a complete payment suspension. Under this provision, for those providers who do not file timely, an immediate payment suspension less than the total suspension currently required might be imposed if the Secretary deemed it appropriate, which would allow the provider to more easily continue operations while completing and submitting the acceptable cost report.

2. Effects on other providers. The payment suspension provision does not affect other providers.

3. Effects on the Medicare Program. The provision would allow the Secretary to more effectively manage the Medicare program by imposing other than complete payment suspension when it is appropriate to do so. The Medicare program benefits because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients. There are no costs to the Medicare program to doing so, because when the cost report is submitted, the suspended payments are returned to the provider.

4. Effects on Beneficiaries. We have determined that this provision has a potentially positive impact on beneficiaries. Under this proposed provision the Secretary will have the discretion to impose less than 100 percent payment suspension when a provider fails to timely file an acceptable cost report. Doing so will lessen the financial burden on the provider and thereby allow it to provide adequate services to its patient population as it works to complete and file an acceptable cost report.

Alternatives Considered

We considered not revising existing § 405.371(c) to provide that payment suspension could be ''in whole or in part''. However, we did not choose this option because we believe the Secretary should have the discretion to impose partial payment suspensions when circumstances warrant in order to more effectively manage the Medicare program.

Conclusion

In conclusion, we have determined that the proposed payment suspension provision does not have an economic impact on Medicare payments.

Federalism

Since this regulation does not impose any costs on State or local governments, it will not have an effect on State or local governments. State or local governments will have no roles or responsibilities associated with this provision.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

1. The authority citation for subpart C continues to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

2.Section 405.371(c) is revised to read as follows:

§ 405.371 Suspension, offset and recoupment of Medicare payments to providers and suppliers of services.

* * * * *

(c) Suspension of payment in the case of unfiled cost reports. If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the intermediary to be acceptable. In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1.The authority citation continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In 410.43 republish the introductory text of paragraph (b), and add a new paragraph (b)(6) 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:

* * * * *

(6) Clinical social worker services that meet the requirements of section 1861(hh)(2) of the Act.

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

1. The authority citation continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

§ 419.66 [Amended]

2. In § 419.66, paragraph (c)(1) is amended by adding the phrase ''or by any category previously in effect'' after ''categories'' and before ''and'.

Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 31, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 5, 2002.

Tommy G. Thompson,

Secretary.

BILLING CODE 4120–01–P

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0620	Critical Care	S	10.25	$533.09	$150.55	$106.62
0656	Transcatheter Placement of Drug-Eluting Coronary Stents	T	90.90	$4,927.70		$985.54
0657	Placement of Tissue Clips	S	1.38	$71.77		$14.35
0658	Percutaneous Breast Biopsies	T	5.57	$289.69		$57.94

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.43	$22.36	$7.88	$4.47
0002	Fine needle Biopsy/Aspiration	T	0.63	$32.77	$8.52	$6.55
0003	Bone Marrow Biopsy/Aspiration	T	1.24	$64.49	$27.08	$12.90
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow.	T	1.63	$84.77	$22.04	$16.95
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow.	T	3.02	$157.07	$69.11	$31.41
0006	Level I Incision & Drainage	T	1.89	$98.30	$25.56	$19.66
0007	Level II Incision & Drainage	T	9.44	$490.96	$103.10	$98.19
0008	Level III Incision and Drainage	T	16.32	$848.79		$169.76
0009	Nail Procedures	T	0.68	$35.37	$8.34	$7.07
0010	Level I Destruction of Lesion	T	0.70	$36.41	$10.56	$7.28
0011	Level II Destruction of Lesion	T	1.93	$100.38	$27.88	$20.08
0012	Level I Debridement & Destruction	T	0.76	$39.53	$10.67	$7.91
0013	Level II Debridement & Destruction	T	1.10	$57.21	$14.30	$11.44
0015	Level III Debridement & Destruction	T	1.43	$74.37	$18.59	$14.87
0016	Level IV Debridement & Destruction	T	2.57	$133.66	$56.14	$26.73
0017	Level VI Debridement & Destruction	T	16.46	$856.07	$227.84	$171.21
0018	Biopsy of Skin/Puncture of Lesion	T	0.92	$47.85	$15.79	$9.57
0019	Level I Excision/ Biopsy	T	3.94	$204.92	$75.82	$40.98
0020	Level II Excision/ Biopsy	T	7.36	$382.79	$114.84	$76.56
0021	Level III Excision/ Biopsy	T	14.58	$758.29	$227.49	$151.66
0022	Level IV Excision/ Biopsy	T	18.10	$941.36	$367.13	$188.27
0023	Exploration Penetrating Wound	T	2.38	$123.78	$40.37	$24.76
0024	Level I Skin Repair	T	2.00	$104.02	$37.45	$20.80
0025	Level II Skin Repair	T	5.89	$306.33	$116.41	$61.27
0027	Level IV Skin Repair	T	15.73	$818.10	$343.60	$163.62
0028	Level I Breast Surgery	T	17.44	$907.04	$303.74	$181.41
0029	Level II Breast Surgery	T	29.89	$1,554.55	$632.64	$310.91
0030	Level III Breast Surgery	T	40.23	$2,092.32	$763.55	$418.46
0032	Insertion of Central Venous/Arterial Catheter	T	7.14	$371.34		$74.27
0033	Partial Hospitalization	P	4.96	$257.96		$51.59
0035	Placement of Arterial or Central Venous Catheter	T	0.24	$12.48	$3.74	$2.50
0041	Level I Arthroscopy	T	27.58	$1,434.41	$580.06	$286.88
0042	Level II Arthroscopy	T	43.24	$2,248.87	$804.74	$449.77
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.68	$87.38		$17.48
0045	Bone/Joint Manipulation Under Anesthesia	T	13.47	$700.56	$280.22	$140.11
0046	Open/Percutaneous Treatment Fracture or Dislocation.	T	29.03	$1,509.82	$535.76	$301.96
0047	Arthroplasty without Prosthesis	T	29.59	$1,538.95	$537.03	$307.79
0048	Arthroplasty with Prosthesis	T	36.93	$1,920.69	$633.83	$384.14
0049	Level I Musculoskeletal Procedures Except Hand and Foot.	T	19.45	$1,011.58		$202.32
0050	Level II Musculoskeletal Procedures Except Hand and Foot.	T	23.60	$1,227.41		$245.48
0051	Level III Musculoskeletal Procedures Except Hand and Foot.	T	34.03	$1,769.87		$353.97
0052	Level IV Musculoskeletal Procedures Except Hand and Foot.	T	42.37	$2,203.62		$440.72
0053	Level I Hand Musculoskeletal Procedures	T	14.76	$767.65	$253.49	$153.53
0054	Level II Hand Musculoskeletal Procedures	T	23.50	$1,222.21	$472.33	$244.44
0055	Level I Foot Musculoskeletal Procedures	T	18.28	$950.72	$355.34	$190.14
0056	Level II Foot Musculoskeletal Procedures	T	22.94	$1,193.09	$405.81	$238.62
0057	Bunion Procedures	T	23.87	$1,241.45	$496.58	$248.29
0058	Level I Strapping and Cast Application	S	1.09	$56.69	$14.74	$11.34
0060	Manipulation Therapy	S	0.36	$18.72		$3.74

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0068	CPAP Initiation	S	1.59	$82.69	$45.48	$16.54
0069	Thoracoscopy	T	29.51	$1,534.79	$591.64	$306.96
0070	Thoracentesis/Lavage Procedures	T	3.30	$171.63	.....	$34.33
0071	Level I Endoscopy Upper Airway	T	1.01	$52.53	$14.18	$10.51
0072	Level II Endoscopy Upper Airway	T	1.66	$86.33	$37.99	$17.27
0073	Level III Endoscopy Upper Airway	T	3.63	$188.79	$74.14	$37.76
0074	Level IV Endoscopy Upper Airway	T	12.84	$667.80	$295.70	$133.56
0075	Level V Endoscopy Upper Airway	T	20.41	$1,061.50	$445.92	$212.30
0076	Endoscopy Lower Airway	T	9.30	$483.68	$189.92	$96.74
0077	Level I Pulmonary Treatment	S	0.26	$13.52	$7.44	$2.70
0078	Level II Pulmonary Treatment	S	0.68	$35.37	$15.21	$7.07
0079	Ventilation Initiation and Management	S	1.63	$84.77	$16.80	$16.95
0080	Diagnostic Cardiac Catheterization	T	35.64	$1,853.60	$838.92	$370.72
0081	Non-Coronary Angioplasty or Atherectomy	T	22.69	$1,180.08	.....	$236.02
0082	Coronary Atherectomy	T	75.42	$3,922.52	$1,137.53	$784.50
0083	Coronary Angioplasty and Percutaneous Valvuloplasty.	T	47.83	$2,487.59	.....	$497.52
0084	Level I Electrophysiologic Evaluation	S	9.60	$499.29	.....	$99.86
0085	Level II Electrophysiologic Evaluation	T	31.77	$1,652.33	$363.51	$330.47
0086	Ablate Heart Dysrhythm Focus	T	43.70	$2,272.79	$772.75	$454.56
0087	Cardiac Electrophysiologic Recording/Mapping	T	5.81	$302.17	.....	$60.43
0088	Thrombectomy	T	33.96	$1,766.23	$678.68	$353.25
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	108.92	$5,664.82	$1,642.80	$1,132.96
0090	Insertion/Replacement of Pacemaker Pulse Generator.	T	77.15	$4,012.49	$1,444.50	$802.50
0091	Level II Vascular Ligation	T	27.03	$1,405.80	$348.23	$281.16
0092	Level I Vascular Ligation	T	24.97	$1,298.66	$505.37	$259.73
0093	Vascular Repair/Fistula Construction	T	26.29	$1,367.32	$277.34	$273.46
0094	Level I Resuscitation and Cardioversion	S	2.68	$139.38	$47.39	$27.88
0095	Cardiac Rehabilitation	S	0.66	$34.33	$16.73	$6.87
0096	Non-Invasive Vascular Studies	S	1.82	$94.66	$48.15	$18.93
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	0.84	$43.69	$23.80	$8.74
0098	Injection of Sclerosing Solution	T	1.90	$98.82	$20.88	$19.76
0099	Electrocardiograms	S	0.38	$19.76	.....	$3.95
0100	Stress Tests and Continuous ECG	X	1.34	$69.69	$38.33	$13.94
0101	Tilt Table Evaluation	S	4.40	$228.84	$105.27	$45.77
0103	Miscellaneous Vascular Procedures	T	11.26	$585.62	$210.82	$117.12
0104	Transcatheter Placement of Intracoronary Stents	T	72.72	$3,782.09	.....	$756.42
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	19.14	$995.45	$370.40	$199.09
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	29.23	$1,520.22	$410.46	$304.04
0107	Insertion of Cardioverter-Defibrillator	T	181.51	$9,440.15	$2,076.83	$1,888.03
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	232.69	$12,101.97	.....	$2,420.39
0109	Removal of Implanted Devices	T	7.68	$399.43	$131.49	$79.89
0110	Transfusion	S	4.04	$210.12	.....	$42.02
0111	Blood Product Exchange	S	13.60	$707.32	$198.05	$141.46
0112	Apheresis, Photopheresis, and Plasmapheresis	S	39.40	$2,049.15	$612.47	$409.83
0113	Excision Lymphatic System	T	19.75	$1,027.18	.....	$205.44
0114	Thyroid/Lymphadenectomy Procedures	T	37.55	$1,952.94	$507.76	$390.59
0115	Cannula/Access Device Procedures	T	23.48	$1,221.17	$439.62	$244.23
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	0.85	$44.21	.....	$8.84
0117	Chemotherapy Administration by Infusion Only	S	3.87	$201.27	$52.33	$40.25
0118	Chemotherapy Administration by Both Infusion and Other Technique.	S	5.68	$295.41	$72.03	$59.08
0119	Implantation of Devices	T	25.88	$1,345.99	.....	$269.20
0120	Infusion Therapy Except Chemotherapy	T	1.81	$94.14	$25.42	$18.83
0121	Level I Tube changes and Repositioning	T	2.17	$112.86	$45.14	$22.57
0122	Level II Tube changes and Repositioning	T	3.89	$202.32	$46.53	$40.46
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	4.86	$252.76	.....	$50.55
0124	Revision of Implanted Infusion Pump	T	23.47	$1,220.65	.....	$244.13
0125	Refilling of Infusion Pump	T	1.73	$89.98	.....	$18.00
0130	Level I Laparoscopy	T	31.99	$1,663.77	$659.53	$332.75
0131	Level II Laparoscopy	T	42.44	$2,207.26	$1,001.89	$441.45
0132	Level III Laparoscopy	T	57.95	$3,013.92	$1,239.22	$602.78
0140	Esophageal Dilation without Endoscopy	T	5.84	$303.73	$107.24	$60.75

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0141	Upper GI Procedures	T	7.82	$406.71	$150.48	$81.34
0142	Small Intestine Endoscopy	T	8.21	$426.99	$152.78	$85.40
0143	Lower GI Endoscopy	T	8.37	$435.32	$186.06	$87.06
0146	Level I Sigmoidoscopy	T	3.47	$180.47	$64.40	$36.09
0147	Level II Sigmoidoscopy	T	7.30	$379.67	$83.53	$75.93
0148	Level I Anal/Rectal Procedure	T	3.61	$187.75	$67.59	$37.55
0149	Level III Anal/Rectal Procedure	T	16.91	$879.47	$293.06	$175.89
0150	Level IV Anal/Rectal Procedure	T	22.02	$1,145.24	$437.12	$229.05
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	18.23	$948.12	$245.46	$189.62
0152	Percutaneous Abdominal and Biliary Procedures	T	6.18	$321.42	$80.36	$64.28
0153	Peritoneal and Abdominal Procedures	T	25.99	$1,351.71	$540.68	$270.34
0154	Hernia/Hydrocele Procedures	T	26.98	$1,403.20	$491.12	$280.64
0155	Level II Anal/Rectal Procedure	T	10.05	$522.69	$188.17	$104.54
0156	Level II Urinary and Anal Procedures	T	3.10	$161.23	$48.37	$32.25
0157	Colorectal Cancer Screening: Barium Enema	S	2.73	$141.98	$22.19	$28.40
0158	Colorectal Cancer Screening: Colonoscopy	T	7.56	$393.19	.....	$98.30
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.48	$128.98	.....	$32.25
0160	Level I Cystourethroscopy and other Genitourinary Procedures.	T	6.44	$334.94	$105.06	$66.99
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	16.03	$833.70	$249.36	$166.74
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	21.50	$1,118.19	.....	$223.64
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	24.77	$1,288.26	.....	$257.65
0164	Level I Urinary and Anal Procedures	T	1.18	$61.37	$18.41	$12.27
0165	Level III Urinary and Anal Procedures	T	12.62	$656.35	.....	$131.27
0166	Level I Urethral Procedures	T	15.63	$812.90	$218.73	$162.58
0167	Level III Urethral Procedures	T	27.15	$1,412.04	$555.84	$282.41
0168	Level II Urethral Procedures	T	24.10	$1,253.42	$405.60	$250.68
0169	Lithotripsy	T	46.44	$2,415.30	$1,115.69	$483.06
0170	Dialysis	S	4.79	$249.12	.....	$49.82
0179	Urinary Incontinence Procedures	T	81.28	$4,227.29	$1,817.73	$845.46
0180	Circumcision	T	18.95	$985.57	$304.87	$197.11
0181	Penile Procedures	T	29.88	$1,554.03	$621.82	$310.81
0182	Insertion of Penile Prosthesis	T	83.80	$4,358.35	$1,438.26	$871.67
0183	Testes/Epididymis Procedures	T	22.19	$1,154.08	$448.94	$230.82
0184	Prostate Biopsy	T	3.66	$190.35	$95.18	$38.07
0187	Miscellaneous Placement/Repositioning	X	4.19	$217.92	$94.96	$43.58
0188	Level II Female Reproductive Proc	T	1.12	$58.25	$11.95	$11.65
0189	Level III Female Reproductive Proc	T	1.63	$84.77	$18.60	$16.95
0190	Surgical Hysteroscopy	T	20.06	$1,043.30	$424.28	$208.66
0191	Level I Female Reproductive Proc	T	0.22	$11.44	$3.32	$2.29
0192	Level IV Female Reproductive Proc	T	2.94	$152.91	$42.81	$30.58
0193	Level V Female Reproductive Proc	T	14.57	$757.77	$171.13	$151.55
0194	Level VI Female Reproductive Proc	T	18.88	$981.93	$397.84	$196.39
0195	Level VII Female Reproductive Proc	T	24.37	$1,267.46	$483.80	$253.49
0196	Dilation and Curettage	T	16.32	$848.79	$338.23	$169.76
0197	Infertility Procedures	T	1.19	$61.89	$24.76	$12.38
0198	Pregnancy and Neonatal Care Procedures	T	1.33	$69.17	$32.92	$13.83
0199	Vaginal Delivery	T	5.69	$295.93	$72.98	$59.19
0200	Therapeutic Abortion	T	14.49	$753.61	$307.83	$150.72
0201	Spontaneous Abortion	T	15.84	$823.82	$329.65	$164.76
0202	Level VIII Female Reproductive Proc	T	39.09	$2,033.03	$996.18	$406.61
0203	Level IV Nerve Injections	T	10.96	$570.02	$256.51	$114.00
0204	Level I Nerve Injections	T	2.13	$110.78	$42.10	$22.16
0206	Level II Nerve Injections	T	4.89	$254.32	$75.55	$50.86
0207	Level III Nerve Injections	T	5.97	$310.49	$123.69	$62.10
0208	Laminotomies and Laminectomies	T	39.95	$2,077.76	.....	$415.55
0209	Extended EEG Studies and Sleep Studies, Level II	S	12.09	$628.79	$280.58	$125.76
0212	Nervous System Injections	T	3.53	$183.59	$84.45	$36.72
0213	Extended EEG Studies and Sleep Studies, Level I	S	3.38	$175.79	$70.41	$35.16
0214	Electroencephalogram	S	2.37	$123.26	$61.63	$24.65
0215	Level I Nerve and Muscle Tests	S	0.60	$31.21	.....	$6.24
0216	Level III Nerve and Muscle Tests	S	3.06	$159.15	$71.62	$31.83
0218	Level II Nerve and Muscle Tests	S	1.06	$55.13	.....	$11.03
0220	Level I Nerve Procedures	T	16.66	$866.47	.....	$173.29
0221	Level II Nerve Procedures	T	25.35	$1,318.43	$463.62	$263.69

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0222	Implantation of Neurological Device	T	140.56	$7,310.39	.....	$1,462.08
0223	Implantation of Pain Management Device	T	20.30	$1,055.78	.....	$211.16
0224	Implantation of Reservoir/Pump/Shunt	T	39.14	$2,035.63	$453.41	$407.13
0225	Implantation of Neurostimulator Electrodes	T	44.47	$2,312.84	.....	$462.57
0226	Implantation of Drug Infusion Reservoir	T	44.20	$2,298.80	.....	$459.76
0227	Implantation of Drug Infusion Device	T	128.03	$6,658.71	.....	$1,331.74
0228	Creation of Lumbar Subarachnoid Shunt	T	55.05	$2,863.10	$696.46	$572.62
0229	Transcatherter Placement of Intravascular Shunts	T	49.00	$2,548.44	$662.59	$509.69
0230	Level I Eye Tests & Treatments	S	0.78	$40.57	$15.82	$8.11
0231	Level III Eye Tests & Treatments	S	2.24	$116.50	$52.43	$23.30
0232	Level I Anterior Segment Eye Procedures	T	4.91	$255.36	$112.36	$51.07
0233	Level II Anterior Segment Eye Procedures	T	13.43	$698.48	$266.33	$139.70
0234	Level III Anterior Segment Eye Procedures	T	21.45	$1,115.59	$535.48	$223.12
0235	Level I Posterior Segment Eye Procedures	T	5.62	$292.29	$81.84	$58.46
0236	Level II Posterior Segment Eye Procedures	T	20.62	$1,072.43	.....	$214.49
0237	Level III Posterior Segment Eye Procedures	T	35.09	$1,825.00	$818.54	$365.00
0238	Level I Repair and Plastic Eye Procedures	T	3.04	$158.11	$58.96	$31.62
0239	Level II Repair and Plastic Eye Procedures	T	6.91	$359.38	$115.94	$71.88
0240	Level III Repair and Plastic Eye Procedures	T	16.99	$883.63	$315.31	$176.73
0241	Level IV Repair and Plastic Eye Procedures	T	21.89	$1,138.48	$384.47	$227.70
0242	Level V Repair and Plastic Eye Procedures	T	28.87	$1,501.50	$597.36	$300.30
0243	Strabismus/Muscle Procedures	T	20.94	$1,089.07	$431.39	$217.81
0244	Corneal Transplant	T	38.14	$1,983.62	$851.42	$396.72
0245	Level I Cataract Procedures without IOL Insert	T	14.39	$748.41	$251.21	$149.68
0246	Cataract Procedures with IOL Insert	T	23.59	$1,226.89	$495.96	$245.38
0247	Laser Eye Procedures Except Retinal	T	4.97	$258.48	$108.56	$51.70
0248	Laser Retinal Procedures	T	4.44	$230.92	$96.99	$46.18
0249	Level II Cataract Procedures without IOL Insert	T	27.75	$1,443.25	$524.67	$288.65
0250	Nasal Cauterization/Packing	T	1.68	$87.38	$30.58	$17.48
0251	Level I ENT Procedures	T	1.92	$99.86	.....	$19.97
0252	Level II ENT Procedures	T	6.27	$326.10	$114.24	$65.22
0253	Level III ENT Procedures	T	14.79	$769.21	$284.61	$153.84
0254	Level IV ENT Procedures	T	21.89	$1,138.48	$352.93	$227.70
0256	Level V ENT Procedures	T	35.51	$1,846.84	.....	$369.37
0258	Tonsil and Adenoid Procedures	T	21.15	$1,099.99	$437.25	$220.00
0259	Level VI ENT Procedures	T	291.05	$15,137.22	$7,417.24	$3,027.44
0260	Level I Plain Film Except Teeth	X	0.81	$42.13	$23.17	$8.43
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.37	$71.25	$34.15	$14.25
0262	Plain Film of Teeth	X	0.60	$31.21	$10.30	$6.24
0263	Level I Miscellaneous Radiology Procedures	X	1.99	$103.50	$45.54	$20.70
0264	Level II Miscellaneous Radiology Procedures	X	2.75	$143.02	$77.23	$28.60
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.04	$54.09	$29.75	$10.82
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.70	$88.42	$48.63	$17.68
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.58	$134.18	$65.52	$26.84
0268	Ultrasound Guidance Procedures	S	1.48	$76.97	.....	$15.39
0269	Level III Echocardiogram Except Transesophageal	S	3.42	$177.87	$92.49	$35.57
0270	Transesophageal Echocardiogram	S	5.65	$293.85	$146.79	$58.77
0271	Mammography	S	0.69	$35.89	$16.80	$7.18
0272	Level I Fluoroscopy	X	1.38	$71.77	$38.64	$14.35
0274	Myelography	S	3.21	$166.95	$80.14	$33.39
0275	Arthrography	S	3.09	$160.71	$69.09	$32.14
0276	Level I Digestive Radiology	S	1.69	$87.90	$41.72	$17.58
0277	Level II Digestive Radiology	S	2.50	$130.02	$60.47	$26.00
0278	Diagnostic Urography	S	2.65	$137.82	$66.07	$27.56
0279	Level II Angiography and Venography except Extremity.	S	8.41	$437.40	$174.57	$87.48
0280	Level III Angiography and Venography except Extremity.	S	15.51	$806.66	$353.85	$161.33
0281	Venography of Extremity	S	5.23	$272.01	$115.16	$54.40
0282	Miscellaneous Computerized Axial Tomography	S	1.76	$91.54	$44.51	$18.31
0283	Computerized Axial Tomography with Contrast Material.	S	4.75	$247.04	.....	$49.41
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.74	$402.55	$201.02	$80.51
0285	Myocardial Positron Emission Tomography (PET)	S	16.73	$870.11	$374.15	$174.02
0286	Myocardial Scans	S	6.94	$360.94	$198.52	$72.19
0287	Complex Venography	S	7.13	$370.82	$114.51	$74.16
0288	Bone Density:Axial Skeleton	S	1.38	$71.77	.....	$14.35

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0289	Needle Localization for Breast Biopsy	X	1.84	$95.70	$44.80	$19.14
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans.	S	2.16	$112.34	$56.17	$22.47
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans.	S	4.19	$217.92	$108.96	$43.58
0292	Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans.	S	4.53	$235.60	$117.80	$47.12
0294	Level II Therapeutic Nuclear Medicine	S	4.45	$231.44	$127.29	$46.29
0295	Level I Therapeutic Nuclear Medicine	S	3.86	$200.75	$110.41	$40.15
0296	Level I Therapeutic Radiologic Procedures	S	2.12	$110.26	$52.92	$22.05
0297	Level II Therapeutic Radiologic Procedures	S	7.80	$405.67	$172.51	$81.13
0299	Miscellaneous Radiation Treatment	S	6.20	$322.46	.....	$64.49
0300	Level I Radiation Therapy	S	1.53	$79.57	.....	$15.91
0301	Level II Radiation Therapy	S	2.22	$115.46	.....	$23.09
0302	Level III Radiation Therapy	S	10.17	$528.93	$200.99	$105.79
0303	Treatment Device Construction	X	2.93	$152.39	$68.58	$30.48
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.69	$87.90	$41.52	$17.58
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.87	$201.27	$91.38	$40.25
0310	Level III Therapeutic Radiation Treatment Preparation.	X	14.38	$747.89	$339.05	$149.58
0312	Radioelement Applications	S	4.23	$220.00	.....	$44.00
0313	Brachytherapy	S	13.80	$717.72	.....	$143.54
0314	Hyperthermic Therapies	S	4.24	$220.52	$101.77	$44.10
0320	Electroconvulsive Therapy	S	4.46	$231.96	$80.06	$46.39
0321	Biofeedback and Other Training	S	1.27	$66.05	$21.78	$13.21
0322	Brief Individual Psychotherapy	S	1.44	$74.89	$12.40	$14.98
0323	Extended Individual Psychotherapy	S	1.95	$101.42	$21.26	$20.28
0324	Family Psychotherapy	S	2.71	$140.94	.....	$28.19
0325	Group Psychotherapy	S	1.55	$80.61	$18.27	$16.12
0330	Dental Procedures	S	0.64	$33.29	.....	$6.66
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.62	$188.27	$91.27	$37.65
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.69	$295.93	$146.98	$59.19
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.46	$335.98	$151.46	$67.20
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	7.01	$364.58	$176.94	$72.92
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	9.86	$512.81	$240.77	$102.56
0339	Observation	S	7.60	$395.27	.....	$79.05
0340	Minor Ancillary Procedures	X	0.66	$34.33	.....	$6.87
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.16	$8.32	$3.08	$1.66
0342	Level I Pathology	X	0.23	$11.96	$5.88	$2.39
0343	Level II Pathology	X	0.47	$24.44	$13.20	$4.89
0344	Level III Pathology	X	0.66	$34.33	$18.54	$6.87
0345	Level I Transfusion Laboratory Procedures	X	0.19	$9.88	$3.06	$1.98
0346	Level II Transfusion Laboratory Procedures	X	0.42	$21.84	$5.46	$4.37
0347	Level III Transfusion Laboratory Procedures	X	0.98	$50.97	$12.74	$10.19
0348	Fertility Laboratory Procedures	X	0.83	$43.17	.....	$8.63
0352	Level I Injections	X	0.14	$7.28	.....	$1.46
0353	Level II Allergy Injections	X	0.43	$22.36	.....	$4.47
0354	Administration of Influenza/Pneumonia Vaccine	K	0.09	$4.68	.....	.....
0355	Level I Immunizations	K	0.24	$12.48	.....	$2.50
0356	Level II Immunizations	K	0.69	$35.89	.....	$7.18
0359	Level II Injections	X	0.83	$43.17	.....	$8.63
0360	Level I Alimentary Tests	X	1.65	$85.81	$42.91	$17.16
0361	Level II Alimentary Tests	X	3.55	$184.63	$83.23	$36.93
0362	Level III Otorhinolaryngologic Function Tests	X	2.83	$147.19	.....	$29.44
0363	Level I Otorhinolaryngologic Function Tests	X	0.76	$39.53	$14.63	$7.91
0364	Level I Audiometry	X	0.45	$23.40	$9.13	$4.68
0365	Level II Audiometry	X	1.31	$68.13	$20.16	$13.63
0367	Level I Pulmonary Test	X	0.60	$31.21	$15.61	$6.24
0368	Level II Pulmonary Tests	X	0.96	$49.93	$24.97	$9.99
0369	Level III Pulmonary Tests	X	2.39	$124.30	$41.02	$24.86
0370	Allergy Tests	X	0.74	$38.49	$11.16	$7.70
0371	Level I Allergy Injections	X	0.50	$26.00	.....	$5.20
0372	Therapeutic Phlebotomy	X	0.56	$29.13	$10.09	$5.83
0373	Neuropsychological Testing	X	2.37	$123.26	.....	$24.65
0374	Monitoring Psychiatric Drugs	X	1.20	$62.41	.....	$12.48

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0600	Low Level Clinic Visits	V	0.91	$47.33		$9.47
0601	Mid Level Clinic Visits	V	1.04	$54.09		$10.82
0602	High Level Clinic Visits	V	1.57	$81.65		$16.33
0610	Low Level Emergency Visits	V	1.49	$77.49	$19.57	$15.50
0611	Mid Level Emergency Visits	V	2.66	$138.34	$36.47	$27.67
0612	High Level Emergency Visits	V	4.53	$235.60	$54.14	$47.12
0620	Critical Care	S	10.25	$533.09	$150.55	$106.62
0656	Transcatheter Placement of Drug-Eluting Coronary Stents.	T	90.90	$4,927.70		$985.54
0657	Placement of Tissue Clips	S	1.38	$71.77		$14.35
0658	Percutaneous Breast Biopsies	T	5.57	$289.69		$57.94
0659	Hyperbaric Oxygen	S	3.12	$162.27		$32.45
0660	Level II Otorhinolaryngologic Function Tests	X	1.65	$85.81	$31.75	$17.16
0661	Level IV Pathology	X	3.46	$179.95	$98.97	$35.99
0662	CT Angiography	S	5.96	$309.97	$170.48	$61.99
0663	Stereoteactic Radiosurgery	S	63.69	$3,312.45		$662.49
0664	Proton Beam Radiation Therapy	S	11.03	$573.66		$114.73
0665	Bone Density:AppendicularSkeleton	S	0.73	$37.97		$7.59
0666	Myocardial Add-on Scans	S	1.59	$82.69	$45.48	$16.54
0667	Nonmyocardial Positron Emission Tomography (PET)	S	18.68	$971.53		$194.31
0668	Level I Angiography and Venography except Extremity.	S	5.36	$278.77	$122.66	$55.75
0669	Digital Mammography	S	0.95	$49.41		$9.88
0670	Intravenous and Intracardiac Ultrasound	S	14.78	$768.69	$276.73	$153.74
0671	Level II Echocardiogram Except Transesophageal	S	1.68	$87.38	$45.44	$17.48
0672	Level IV Posterior Segment Procedures	T	39.95	$2,077.76	$1,038.88	$415.55
0673	Level IV Anterior Segment Eye Procedures	T	27.47	$1,428.69	$685.77	$285.74
0674	Prostate Cryoablation	T	69.25	$3,601.62		$720.32
0675	Prostatic Thermotherapy	T	51.57	$2,682.10		$536.42
0676	Level II Transcatheter Thrombolysis	T	4.62	$240.28	$64.88	$48.06
0677	Level I Transcatheter Thrombolysis	T	2.80	$145.63		$29.13
0678	External Counterpulsation	T	2.55	$132.62		$26.52
0679	Level II Resuscitation and Cardioversion	S	5.70	$296.45	$100.79	$59.29
0680	Insertion of Patient Activated Event Recorders	S	51.95	$2,701.87		$540.37
0681	Knee Arthroplasty	T	158.14	$8,224.70	$3,289.88	$1,644.94
0682	Level V Debridement & Destruction	T	6.74	$350.54	$161.25	$70.11
0683	Level II Photochemotherapy	S	2.11	$109.74	$39.51	$21.95
0684	Prostate Brachytherapy	T	103.47	$5,381.37		$1,076.27
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow.	T	4.47	$232.48	$102.29	$46.50
0686	Level III Skin Repair	T	11.30	$587.70	$270.34	$117.54
0687	Revision/Removal of Neurostimulator Electrodes	T	19.50	$1,014.18	$466.52	$202.84
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	30.58	$1,590.44	$779.32	$318.09
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.60	$31.21	$12.03	$6.24
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S	0.45	$23.40	$10.63	$4.68
0691	Electronic Analysis of Programmable Shunts/Pumps	S	3.14	$163.31	$89.02	$32.66
0692	Electronic Analysis of Neurostimulator Pulse Generators.	S	0.85	$44.21	$24.32	$8.84
0693	Level II Breast Reconstruction	T	39.30	$2,043.95	$798.17	$408.79
0694	Mohs Surgery	T	3.90	$202.84	$81.14	$40.57
0695	Level VII Debridement & Destruction	T	19.65	$1,021.98	$266.59	$204.40
0697	Level I Echocardiogram Except Transesophageal	S	1.51	$78.53	$40.84	$15.71
0698	Level II Eye Tests & Treatments	S	1.01	$52.53	$20.49	$10.51
0699	Level IV Eye Tests & Treatment	T	2.37	$123.26	$55.47	$24.65
0701	SR 89 chloride, per mCi	K	6.43	$334.42		$66.88
0702	SM 153 lexidronam, 50 mCi	K	15.02	$781.18		$156.24
0706	New Technology - Level I ($0 - $50)	S		$25.00		$5.00
0707	New Technology - Level II ($50 - $100)	S		$75.00		$15.00
0708	New Technology - Level III ($100 - $200)	S		$150.00		$30.00
0709	New Technology - Level IV ($200 - $300)	S		$250.00		$50.00
0710	New Technology - Level V ($300 - $500)	S		$400.00		$80.00
0711	New Technology - Level VI ($500 - $750)	S		$625.00		$125.00
0712	New Technology - Level VII ($750 - $1000)	S		$875.00		$175.00
0713	New Technology - Level VIII ($1000 - $1250)	S		$1,125.00		$225.00
0714	New Technology - Level IX ($1250 - $1500)	S		$1,375.00		$275.00
0715	New Technology - Level X ($1500 - $1750)	S		$1,625.00		$325.00
0716	New Technology - Level XI ($1750 - $2000)	S		$1,875.00		$375.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0717	New Technology - Level XII ($2000 - $2500)	S		$2,250.00		$450.00
0718	New Technology - Level XIII ($2500 - $3000)	S		$2,750.00		$550.00
0719	New Technology-Level XIV ($3000- $3500)	S		$3,250.00		$650.00
0720	New Technology - Level XV ($3500 - $5000)	S		$4,250.00		$850.00
0721	New Technology - Level XVI ($5000 - $6000)	S		$5,500.00		$1,100.00
0726	Dexrazoxane hcl injection, 250 mg	K	2.40	$124.82		$24.96
0728	Filgrastim 300 mcg injection	K	2.24	$116.50		$23.30
0730	Pamidronate disodium , 30 mg	K	3.46	$179.95		$35.99
0732	Mesna injection 200 mg	K	0.55	$28.60		$5.72
0733	Non esrd epoetin alpha inj, 1000 u	K	0.19	$9.88		$1.98
0734	Darbepoetin alfa, 1 mcg	G		$4.74		$.68
0800	Leuprolide acetate, 3.75 mg	K	4.15	$215.84		$43.17
0802	Etoposide oral 50 mg	K	0.54	$28.08		$5.62
0807	Aldesleukin/single use vial	K	6.09	$316.73		$63.35
0810	Goserelin acetate implant 3.6 mg	K	5.94	$308.93		$61.79
0811	Carboplatin injection 50 mg	K	1.58	$82.17		$16.43
0813	Cisplatin 10 mg injection	K	0.47	$24.44		$4.89
0820	Daunorubicin 10 mg	K	2.27	$118.06		$23.61
0821	Daunorubicin citrate liposom 10 mg	K	3.17	$164.87		$32.97
0822	Diethylstilbestrol injection 250 mg	K	2.21	$114.94		$22.99
0823	Docetaxel, 20 mg	K	4.01	$208.56		$41.71
0827	Floxuridine injection 500 mg	K	2.42	$125.86		$25.17
0828	Gemcitabine HCL 200 mg	K	1.49	$77.49		$15.50
0830	Irinotecan injection 20 mg	K	1.86	$96.74		$19.35
0831	Ifosfomide injection 1 gm	K	2.06	$107.14		$21.43
0832	Idarubicin hcl injection 5 mg	K	4.57	$237.68		$47.54
0838	Interferon gamma 1-b inj, 3 million u	K	2.49	$129.50		$25.90
0840	Melphalan hydrochl 50 mg	K	4.09	$212.72		$42.54
0842	Fludarabine phosphate inj 50 mg	K	3.30	$171.63		$34.33
0843	Pegaspargase, singl dose vial	K	2.38	$123.78		$24.76
0844	Pentostatin injection, 10 mg	K	21.32	$1,108.83		$221.77
0849	Rituximab, 100 mg	K	5.71	$296.97		$59.39
0852	Topotecan, 4 mg	K	7.61	$395.79		$79.16
0855	Vinorelbine tartrate, 10 mg	K	1.10	$57.21		$11.44
0856	Porfimer sodium, 75 mg	K	26.35	$1,370.44		$274.09
0857	Bleomycin sulfate injection 15 u	K	3.10	$161.23		$32.25
0858	Cladribine, 1mg	K	0.84	$43.69		$8.74
0861	Leuprolide acetate injection 1 mg	K	0.84	$43.69		$8.74
0862	Mitomycin 5 mg inj	K	1.18	$61.37		$12.27
0863	Paclitaxel injection, 30 mg	K	2.50	$130.02		$26.00
0864	Mitoxantrone hcl, 5 mg	K	3.02	$157.07		$31.41
0884	Rho d immune globulin inj, 1 dose pkg	K	0.70	$36.41		$7.28
0888	Cyclosporine oral 100 mg	K	0.04	$2.08		$.42
0890	Lymphocyte immune globulin 250 mg	K	3.64	$189.31		$37.86
0891	Tacrolimus oral per 1 mg	K	0.02	$1.04		$.21
0900	Alglucerase injection, per 10 u	K	0.53	$27.56		$5.51
0901	Alpha 1 proteinase inhibitor, 10 mg	K	0.02	$1.04		$.21
0902	Botulinum toxin a, per unit	K	0.05	$2.60		$.52
0903	Cytomegalovirus imm IV/vial	K	0.34	$17.68		$3.54
0905	Immune globulin 500 mg	K	0.45	$23.40		$4.68
0909	Interferon beta-1a, 33 mcg	K	2.77	$144.06		$28.81
0916	Injection imiglucerase /unit	K	0.05	$2.60		$.52
0925	Factor viii per iu	K	0.01	$.52		$.10
0926	Factor VIII (porcine) per iu	K	0.02	$1.04		$.21
0927	Factor viii recombinant per iu	K	0.01	$.52		$.10
0928	Factor ix complex per iu	K	0.01	$.52		$.10
0929	Anti-inhibitor per iu	K	0.01	$.52		$.10
0930	Antithrombin iii injection per iu	K	0.01	$.52		$.10
0931	Factor IX non-recombinant, per iu	K	0.01	$.52		$.10
0932	Factor IX recombinant, per iu	K	0.03	$1.56		$.31
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	1.26	$65.53		$13.11
0950	Blood (Whole) For Transfusion	K	1.25	$65.01		$13.00
0952	Cryoprecipitate	K	0.53	$27.56		$5.51
0954	RBC leukocytes reduced	K	1.59	$82.69		$16.54
0955	Plasma, Fresh Frozen	K	0.71	$36.93		$7.39
0956	Plasma Protein Fraction	K	1.94	$100.90		$20.18
0957	Platelet Concentrate	K	0.67	$34.85		$6.97
0958	Platelet Rich Plasma	K	1.12	$58.25		$11.65
0959	Red Blood Cells	K	1.12	$58.25		$11.65

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0960	Washed Red Blood Cells	K	1.42	$73.85		$14.77
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.47	$24.44		$4.89
0963	Albumin (human), 5%, 250 ml	K	2.37	$123.26		$24.65
0964	Albumin (human), 25%, 20 ml	K	0.50	$26.00		$5.20
0965	Albumin (human), 25%, 50ml	K	1.25	$65.01		$13.00
0966	Plasmaprotein fract,5%,250ml	K	9.71	$505.01		$101.00
0970	New Technology - Level I ($0 - $50)	T		$25.00		$5.00
0971	New Technology - Level II ($50 - $100)	T		$75.00		$15.00
0972	New Technology - Level III ($100 - $200)	T		$150.00		$30.00
0973	New Technology - Level IV ($200 - $300)	T		$250.00		$50.00
0974	New Technology - Level V ($300 - $500)	T		$400.00		$80.00
0975	New Technology - Level VI ($500 - $750)	T		$625.00		$125.00
0976	New Technology - Level VII ($750 - $1000)	T		$875.00		$175.00
0977	New Technology - Level VIII ($1000 - $1250)	T		$1,125.00		$225.00
0978	New Technology - Level IX ($1250 - $1500)	T		$1,375.00		$275.00
0979	New Technology - Level X ($1500 - $1750)	T		$1,625.00		$325.00
0980	New Technology - Level XI ($1750 - $2000)	T		$1,875.00		$375.00
0981	New Technology - Level XII ($2000 - $2500)	T		$2,250.00		$450.00
0982	New Technology - Level XIII ($2500 - $3000)	T		$2,750.00		$550.00
0983	New Technology-Level XIV ($3000- $3500)	T		$3,250.00		$650.00
0984	New Technology - Level XV ($3500 - $5000)	T		$4,250.00		$850.00
0985	New Technology - Level XVI ($5000 - $6000)	T		$5,500.00		$1,100.00
1009	Cryoprecip reduced plasma	K	0.66	$34.33		$6.87
1010	Blood, L/R, CMV-neg	K	1.67	$86.86		$17.37
1011	Platelets, HLA-m, L/R, unit	K	6.03	$313.61		$62.72
1013	Platelet concentrate, L/R, unit	K	0.91	$47.33		$9.47
1016	Blood, L/R, froz/deglycerol/washed	K	1.09	$56.69		$11.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	4.78	$248.60		$49.72
1018	Blood, L/R, irradiated	K	1.90	$98.82		$19.76
1019	Platelets, aph/pher, L/R, irradiated, unit	K	6.93	$360.42		$72.08
1058	TC 99M oxidronate, per vial	G		$36.74		$5.26
1059	Cultured chondrocytes implnt	K	43.64	$2,269.67		$453.93
1064	I-131 cap, each add mCi	G		$5.86		$.75
1065	I-131 sol, each add mCi	G		$15.81		$2.03
1084	Denileukin diftitox, 300 MCG	K	13.94	$725.01		$145.00
1086	Temozolomide,oral 5 mg	K	0.05	$2.60		$.52
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.36	$226.76		$45.35
1092	IN 111 Pentetate, per 0.5 mCi	K	4.78	$248.60		$49.72
1095	Technetium TC 99M Depreotide	K	0.25	$13.00		$2.60
1096	TC 99M Exametazime, per dose	K	3.35	$174.23		$34.85
1122	TC 99M arcitumomab, per vial	K	8.33	$433.23		$86.65
1167	Epirubicin hcl, 2 mg	K	0.32	$16.64		$3.33
1178	Busulfan IV, 6 mg	K	0.53	$27.56		$5.51
1203	Verteporfin for injection	K	16.26	$845.67		$169.13
1207	Octreotide acetate depot 1mg	K	1.22	$63.45		$12.69
1305	Apligraf	K	12.47	$648.55		$129.71
1348	I-131 sol, per 1-6 mCi	K	0.19	$9.88		$1.98
1409	Factor viia recombinant, per 1.2 mg	K	13.53	$703.68		$140.74
1604	IN 111 capromab pendetide, per dose	K	5.91	$307.37		$61.47
1605	Abciximab injection, 10 mg	K	5.82	$302.69		$60.54
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.22	$11.44		$2.29
1611	Hylan G-F 20 injection, 16 mg	K	2.43	$126.38		$25.28
1612	Daclizumab, parenteral, 25 mg	K	3.77	$196.07		$39.21
1613	Trastuzumab, 10 mg	K	0.66	$34.33		$6.87
1614	Valrubicin, 200 mg	K	2.04	$106.10		$21.22
1615	Basiliximab, 20 mg	K	9.64	$501.37		$100.27
1618	Vonwillebrandfactrcmplx, per iu	K	0.01	$.52		$.10
1620	Technetium tc99m bicisate	K	2.80	$145.63		$29.13
1625	Indium 111-in pentetreotide	K	4.57	$237.68		$47.54
1628	Chromic phosphate p32	K	1.35	$70.21		$14.04
1716	Brachytx seed, Gold 198	K	0.35	$18.20		$3.64
1718	Brachytx seed, Iodine 125	K	0.64	$33.29		$6.66
1719	Brachytxseed, Non-HDR Ir-192	K	0.57	$29.65		$5.93
1720	Brachytx seed, Palladium 103	K	0.89	$46.29		$9.26
1765	Adhesion barrier	H				
1775	FDG, per dose (4-40 mCi/ml)	G		$475.00		$68.00
1783	Ocular implant, aqueous drainage assist device	H				
1888	Catheter, ablation, non-cardiac, endovascular (implantable.	H				

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2003—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1900	Lead, left ventricular coronary venous system	H				
2618	Probe, cryoablation	H				
7000	Amifostine, 500 mg	K	4.46	$231.96		$46.39
7001	Amphotericin B lipid complex, 50 mg	K	2.05	$106.62		$21.32
7011	Oprelvekin injection, 5 mg	K	2.52	$131.06		$26.21
7024	Corticorelin ovine triflutat	K	4.62	$240.28		$48.06
7025	Digoxin immune FAB (ovine)	K	2.77	$144.06		$28.81
7030	Hemin, per 1 mg	K	0.01	$.52		$.10
7031	Octreotide acetate injection	K	0.90	$46.81		$9.36
7034	Somatropin injection	K	0.78	$40.57		$8.11
7035	Teniposide, 50 mg	K	1.24	$64.49		$12.90
7038	Muromonab-CD3, 5 mg	K	4.43	$230.40		$46.08
7041	Tirofiban hydrochloride 12.5 mg	K	4.82	$250.68		$50.14
7042	Capecitabine, oral, 150 mg	K	0.03	$1.56		$.31
7043	Infliximab injection 10 mg	K	0.74	$38.49		$7.70
7045	Trimetrexate glucoronate	K	1.23	$63.97		$12.79
7046	Doxorubicin hcl liposome inj 10 mg	K	4.54	$236.12		$47.22
7049	Filgrastim 480 mcg injection	K	3.37	$175.27		$35.05
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$773.02
9002	Tenecteplase, 50mg/vial	K	25.46	$1,324.15		$264.83
9003	Palivizumab, per 50mg	K	9.34	$485.76		$97.15
9004	Gemtuzumab ozogamicin inj,5mg	K	1.05	$54.61		$10.92
9005	Reteplase injection	K	10.84	$563.78		$112.76
9009	Baclofen refill kit - per 2000 mcg	K	0.79	$41.09		$8.22
9010	Baclofen refill kit - per 4000 mcg	K	0.95	$49.41		$9.88
9012	Arsenic Trioxide	G		$23.75		$3.40
9015	Mycophenolate mofetil oral 250 mg	G		$2.40		$.34
9016	Echocardiography contrast	G		$118.75		$17.00
9018	Botulinum tox B, per 100 u	G		$8.79		$1.26
9019	Caspofungin acetate, 5 mg	G		$34.20		$4.90
9020	Sirolimus tablet, 1 mg	K	0.05	$2.60		$.52
9104	Anti-thymocycte globulin rabbit	K	1.97	$102.46		$20.49
9105	Hep B imm glob, per 1 ml	K	1.58	$82.17		$16.43
9106	Sirolimus, 1 mg	K	0.05	$2.60		$.52
9108	Thyrotropin alfa, per 1.1 mg	K	8.79	$457.16		$91.43
9109	Tirofliban hcl, per 6.25 mg	K	2.32	$120.66		$24.13
9110	Alemtuzumab, per ml	G		$486.88		$69.70
9111	Inj, bivalirudin, per 250mg vial	G		$397.81		$56.95
9112	Perflutren lipid micro, per 2ml	G		$148.20		$21.22
9113	Inj pantoprazole sodium, vial	G		$22.80		$3.26
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$62.02
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$58.23
9200	Orcel, per 36 cm2	G		$1,135.25		$162.52
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$82.69
9217	Leuprolide acetate suspnsion, 7.5 mg	K	6.30	$327.66		$65.53
9500	Platelets, irradiated	K	0.92	$47.85		$9.57
9501	Platelets, pheresis	K	5.10	$265.25		$53.05
9502	Platelet pheresis irradiated	K	1.99	$103.50		$20.70
9503	Fresh frozen plasma, ea unit	K	0.77	$40.05		$8.01
9504	RBC deglycerolized	K	1.91	$99.34		$19.87
9505	RBC irradiated	K	1.82	$94.66		$18.93
9506	Granulocytes, pheresis	K	0.45	$23.40		$4.68

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0002T	C	Endovas repr abdo ao aneurys					
0003T	S	Cervicography	0706		$25.00		$5.00
0005T	C	Perc cath stent/brain cv art					
0006T	C	Perc cath stent/brain cv art					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0007T	C	Perc cath stent/brain cv art					
0008T	E	Upper gi endoscopy w/suture					
0009T	T	Endometrial cryoablation	0980		$1,875.00		$375.00
00100	N	Anesth, salivary gland					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth, electroshock					
0010T	A	Tb test, gamma interferon					
00120	N	Anesth, ear surgery					
00124	N	Anesth, ear exam					
00126	N	Anesth, tympanotomy					
0012T	T	Osteochondral knee autograft	0041	27.58	$1,434.41	$580.06	$286.88
0013T	T	Osteochondral knee allograft	0041	27.58	$1,434.41	$580.06	$286.88
00140	N	Anesth, procedures on eye					
00142	N	Anesth, lens surgery					
00144	N	Anesth, corneal transplant					
00145	N	Anesth, vitreoretinal surg					
00147	N	Anesth, iridectomy					
00148	N	Anesth, eye exam					
0014T	T	Meniscal transplant, knee	0041	27.58	$1,434.41	$580.06	$286.88
00160	N	Anesth, nose/sinus surgery					
00162	N	Anesth, nose/sinus surgery					
00164	N	Anesth, biopsy of nose					
0016T	E	Thermotx choroid vasc lesion					
00170	N	Anesth, procedure on mouth					
00172	N	Anesth, cleft palate repair					
00174	C	Anesth, pharyngeal surgery					
00176	C	Anesth, pharyngeal surgery					
0017T	E	Photocoagulat macular drusen					
0018T	S	Transcranial magnetic stimul	0215	0.60	$31.21		$6.24
00190	N	Anesth, face/skull bone surg					
00192	C	Anesth, facial bone surgery					
0019T	A	Extracorp shock wave tx, ms					
0020T	A	Extracorp shock wave tx, ft					
00210	N	Anesth, open head surgery					
00212	N	Anesth, skull drainage					
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull repair/fract					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
0021T	C	Fetal oximetry, trnsvag/cerv					
00220	N	Anesth, intrcrn nerve					
00222	N	Anesth, head nerve surgery					
0023T	A	Phenotype drug test, hiv 1					
0024T	C	Transcath cardiac reduction					
0025T	S	Ultrasonic pachymetry	0230	0.78	$40.57	$15.82	$8.11
0026T	A	Measure remnant lipoproteins					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	N	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00537	N	Anesth, cardiac electrophys					
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					
00550	N	Anesth, sternal debridement					
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00563	N	Anesth, heart proc w/pump					
00566	N	Anesth, cabg w/o pump					
00580	C	Anesth heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, sitting procedure					
00620	N	Anesth, spine, cord surgery					
00622	C	Anesth, removal of nerves					
00630	N	Anesth, spine, cord surgery					
00632	C	Anesth, removal of nerves					
00634	C	Anesth for chemonucleolysis					
00635	N	Anesth, lumbar puncture					
00670	C	Anesth, spine, cord surgery					
00700	N	Anesth, abdominal wall surg					
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, upper gi visualize					
00750	N	Anesth, repair of hernia					
00752	N	Anesth, repair of hernia					
00754	N	Anesth, repair of hernia					
00756	N	Anesth, repair of hernia					
00770	N	Anesth, blood vessel repair					
00790	N	Anesth, surg upper abdomen					
00792	C	Anesth, hemorr/excise liver					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
00797	N	Anesth, surgery for obesity					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, low intestine scope					
00820	N	Anesth, abdominal wall surg					
00830	N	Anesth, repair of hernia					
00832	N	Anesth, repair of hernia					
00840	N	Anesth, surg lower abdomen					
00842	N	Anesth, amniocentesis					
00844	C	Anesth, pelvis surgery					
00846	C	Anesth, hysterectomy					
00848	C	Anesth, pelvic organ surg					
00851	N	Anesth, tubal ligation					
00860	N	Anesth, surgery of abdomen					
00862	N	Anesth, kidney/ureter surg					
00864	C	Anesth, removal of bladder					
00865	C	Anesth, removal of prostate					
00866	C	Anesth, removal of adrenal					
00868	C	Anesth, kidney transplant					
00869	N	Anesth, vasectomy					
00870	N	Anesth, bladder stone surg					
00872	N	Anesth kidney stone destruct					
00873	N	Anesth kidney stone destruct					
00880	N	Anesth, abdomen vessel surg					
00882	C	Anesth, major vein ligation					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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, surg on vag/urethal					
00944	C	Anesth, vaginal hysterectomy					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
01112	N	Anesth, bone aspirate/bx					
01120	N	Anesth, pelvis surgery					
01130	N	Anesth, body cast procedure					
01140	C	Anesth, amputation at pelvis					
01150	C	Anesth, pelvic tumor surgery					
01160	N	Anesth, pelvis procedure					
01170	N	Anesth, pelvis surgery					
01180	N	Anesth, pelvis nerve removal					
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, hip arthroplasty					
01215	N	Anesth, revise hip repair					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur surg					
01250	N	Anesth, upper leg surgery					
01260	N	Anesth, upper leg veins surg					
01270	N	Anesth, thigh arteries surg					
01272	C	Anesth, femoral artery surg					
01274	C	Anesth, femoral embolectomy					
01320	N	Anesth, knee area surgery					
01340	N	Anesth, knee area procedure					
01360	N	Anesth, knee area surgery					
01380	N	Anesth, knee joint procedure					
01382	N	Anesth, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, knee arthroplasty					
01404	C	Anesth, amputation at knee					
01420	N	Anesth, knee joint casting					
01430	N	Anesth, knee veins surgery					
01432	N	Anesth, knee vessel surg					
01440	N	Anesth, knee arteries surg					
01442	C	Anesth, knee artery surg					
01444	C	Anesth, knee artery repair					
01462	N	Anesth, lower leg procedure					
01464	N	Anesth, ankle arthroscopy					
01470	N	Anesth, lower leg surgery					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01472	N	Anesth, achilles tendon surg					
01474	N	Anesth, lower leg surgery					
01480	N	Anesth, lower leg bone surg					
01482	N	Anesth, radical leg surgery					
01484	N	Anesth, lower leg revision					
01486	C	Anesth, ankle replacement					
01490	N	Anesth, lower leg casting					
01500	N	Anesth, leg arteries surg					
01502	C	Anesth, lwr leg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein surg					
01610	N	Anesth, surgery of shoulder					
01620	N	Anesth, shoulder procedure					
01622	N	Anesth, shoulder arthroscopy					
01630	N	Anesth, surgery of shoulder					
01632	C	Anesth, surgery of shoulder					
01634	C	Anesth, shoulder joint amput					
01636	C	Anesth, forequarter amput					
01638	C	Anesth, shoulder replacement					
01650	N	Anesth, shoulder artery surg					
01652	C	Anesth, shoulder vessel surg					
01654	C	Anesth, shoulder vessel surg					
01656	C	Anesth, arm-leg vessel surg					
01670	N	Anesth, shoulder vein surg					
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, uppr arm tendon surg					
01714	N	Anesth, uppr arm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, uppr arm procedure					
01732	N	Anesth, elbow arthroscopy					
01740	N	Anesth, upper arm surgery					
01742	N	Anesth, humerus surgery					
01744	N	Anesth, humerus repair					
01756	C	Anesth, radical humerus surg					
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, uppr arm artery surg					
01772	N	Anesth, uppr arm embolectomy					
01780	N	Anesth, upper arm vein surg					
01782	N	Anesth, uppr arm vein repair					
01810	N	Anesth, lower arm surgery					
01820	N	Anesth, lower arm procedure					
01830	N	Anesth, lower arm surgery					
01832	N	Anesth, wrist replacement					
01840	N	Anesth, lwr arm artery surg					
01842	N	Anesth, lwr arm embolectomy					
01844	N	Anesth, vascular shunt surg					
01850	N	Anesth, lower arm vein surg					
01852	N	Anesth, lwr arm vein repair					
01860	N	Anesth, lower arm casting					
01905	N	Anes, spine inject, x-ray/re					
01916	N	Anesth, dx arteriography					
01920	N	Anesth, catheterize heart					
01922	N	Anesth, cat or MRI scan					
01924	N	Anes, ther interven rad, art					
01925	N	Anes, ther interven rad, car					
01926	N	Anes, tx interv rad hrt/cran					
01930	N	Anes, ther interven rad, vei					
01931	N	Anes, ther interven rad, tip					
01932	N	Anes, tx interv rad, th vein					
01933	N	Anes, tx interv rad, cran v					
01951	N	Anesth, burn, less 4 percent					
01952	N	Anesth, burn, 4-9 percent					
01953	N	Anesth, burn, each 9 percent					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01960	N	Anesth, vaginal delivery					
01961	N	Anesth, cs delivery					
01962	N	Anesth, emer hysterectomy					
01963	N	Anesth, cs hysterectomy					
01964	N	Anesth, abortion procedures					
01967	N	Anesth/analg, vag delivery					
01968	N	Anes/analg cs deliver add-on					
01969	N	Anesth/analg cs hyst add-on					
01990	C	Support for organ donor					
01995	N	Regional anesthesia limb					
01996	N	Manage daily drug therapy					
01999	N	Unlisted anesth procedure					
10021	T	Fna w/o image	0002	0.63	$32.77	$8.52	$6.55
10022	T	Fna w/image	0002	0.63	$32.77	$8.52	$6.55
10040	T	Acne surgery	0010	0.70	$36.41	$10.56	$7.28
10060	T	Drainage of skin abscess	0006	1.89	$98.30	$25.56	$19.66
10061	T	Drainage of skin abscess	0006	1.89	$98.30	$25.56	$19.66
10080	T	Drainage of pilonidal cyst	0006	1.89	$98.30	$25.56	$19.66
10081	T	Drainage of pilonidal cyst	0007	9.44	$490.96	$103.10	$98.19
10120	T	Remove foreign body	0006	1.89	$98.30	$25.56	$19.66
10121	T	Remove foreign body	0021	14.58	$758.29	$227.49	$151.66
10140	T	Drainage of hematoma/fluid	0007	9.44	$490.96	$103.10	$98.19
10160	T	Puncture drainage of lesion	0018	0.92	$47.85	$15.79	$9.57
10180	T	Complex drainage, wound	0007	9.44	$490.96	$103.10	$98.19
11000	T	Debride infected skin	0015	1.43	$74.37	$18.59	$14.87
11001	T	Debride infected skin add-on	0013	1.10	$57.21	$14.30	$11.44
11010	T	Debride skin, fx	0022	18.10	$941.36	$367.13	$188.27
11011	T	Debride skin/muscle, fx	0022	18.10	$941.36	$367.13	$188.27
11012	T	Debride skin/muscle/bone, fx	0022	18.10	$941.36	$367.13	$188.27
11040	T	Debride skin, partial	0015	1.43	$74.37	$18.59	$14.87
11041	T	Debride skin, full	0015	1.43	$74.37	$18.59	$14.87
11042	T	Debride skin/tissue	0016	2.57	$133.66	$56.14	$26.73
11043	T	Debride tissue/muscle	0016	2.57	$133.66	$56.14	$26.73
11044	T	Debride tissue/muscle/bone	0682	6.74	$350.54	$161.25	$70.11
11055	T	Trim skin lesion	0012	0.76	$39.53	$10.67	$7.91
11056	T	Trim skin lesions, 2 to 4	0012	0.76	$39.53	$10.67	$7.91
11057	T	Trim skin lesions, over 4	0012	0.76	$39.53	$10.67	$7.91
11100	T	Biopsy of skin lesion	0018	0.92	$47.85	$15.79	$9.57
11101	T	Biopsy, skin add-on	0018	0.92	$47.85	$15.79	$9.57
11200	T	Removal of skin tags	0013	1.10	$57.21	$14.30	$11.44
11201	T	Remove skin tags add-on	0015	1.43	$74.37	$18.59	$14.87
11300	T	Shave skin lesion	0012	0.76	$39.53	$10.67	$7.91
11301	T	Shave skin lesion	0012	0.76	$39.53	$10.67	$7.91
11302	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11303	T	Shave skin lesion	0015	1.43	$74.37	$18.59	$14.87
11305	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11306	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11307	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11308	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11310	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11311	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11312	T	Shave skin lesion	0013	1.10	$57.21	$14.30	$11.44
11313	T	Shave skin lesion	0016	2.57	$133.66	$56.14	$26.73
11400	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11401	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11402	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11403	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11404	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11406	T	Removal of skin lesion	0021	14.58	$758.29	$227.49	$151.66
11420	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11421	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11422	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11423	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11424	T	Removal of skin lesion	0021	14.58	$758.29	$227.49	$151.66
11426	T	Removal of skin lesion	0022	18.10	$941.36	$367.13	$188.27
11440	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11441	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11442	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11443	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11444	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11446	T	Removal of skin lesion	0022	18.10	$941.36	$367.13	$188.27
11450	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11451	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11462	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11463	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11470	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11471	T	Removal, sweat gland lesion	0022	18.10	$941.36	$367.13	$188.27
11600	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11601	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11602	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11603	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11604	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11606	T	Removal of skin lesion	0021	14.58	$758.29	$227.49	$151.66
11620	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11621	T	Removal of skin lesion	0019	3.94	$204.92	$75.82	$40.98
11622	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11623	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11624	T	Removal of skin lesion	0021	14.58	$758.29	$227.49	$151.66
11626	T	Removal of skin lesion	0022	18.10	$941.36	$367.13	$188.27
11640	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11641	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11642	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11643	T	Removal of skin lesion	0020	7.36	$382.79	$114.84	$76.56
11644	T	Removal of skin lesion	0021	14.58	$758.29	$227.49	$151.66
11646	T	Removal of skin lesion	0022	18.10	$941.36	$367.13	$188.27
11719	T	Trim nail(s)	0009	0.68	$35.37	$8.34	$7.07
11720	T	Debride nail, 1-5	0009	0.68	$35.37	$8.34	$7.07
11721	T	Debride nail, 6 or more	0009	0.68	$35.37	$8.34	$7.07
11730	T	Removal of nail plate	0013	1.10	$57.21	$14.30	$11.44
11732	T	Remove nail plate, add-on	0012	0.76	$39.53	$10.67	$7.91
11740	T	Drain blood from under nail	0009	0.68	$35.37	$8.34	$7.07
11750	T	Removal of nail bed	0019	3.94	$204.92	$75.82	$40.98
11752	T	Remove nail bed/finger tip	0022	18.10	$941.36	$367.13	$188.27
11755	T	Biopsy, nail unit	0019	3.94	$204.92	$75.82	$40.98
11760	T	Repair of nail bed	0024	2.00	$104.02	$37.45	$20.80
11762	T	Reconstruction of nail bed	0024	2.00	$104.02	$37.45	$20.80
11765	T	Excision of nail fold, toe	0015	1.43	$74.37	$18.59	$14.87
11770	T	Removal of pilonidal lesion	0022	18.10	$941.36	$367.13	$188.27
11771	T	Removal of pilonidal lesion	0022	18.10	$941.36	$367.13	$188.27
11772	T	Removal of pilonidal lesion	0022	18.10	$941.36	$367.13	$188.27
11900	T	Injection into skin lesions	0012	0.76	$39.53	$10.67	$7.91
11901	T	Added skin lesions injection	0012	0.76	$39.53	$10.67	$7.91
11920	T	Correct skin color defects	0024	2.00	$104.02	$37.45	$20.80
11921	T	Correct skin color defects	0024	2.00	$104.02	$37.45	$20.80
11922	T	Correct skin color defects	0024	2.00	$104.02	$37.45	$20.80
11950	T	Therapy for contour defects	0024	2.00	$104.02	$37.45	$20.80
11951	T	Therapy for contour defects	0024	2.00	$104.02	$37.45	$20.80
11952	T	Therapy for contour defects	0024	2.00	$104.02	$37.45	$20.80
11954	T	Therapy for contour defects	0024	2.00	$104.02	$37.45	$20.80
11960	T	Insert tissue expander(s)	0027	15.73	$818.10	$343.60	$163.62
11970	T	Replace tissue expander	0027	15.73	$818.10	$343.60	$163.62
11971	T	Remove tissue expander(s)	0022	18.10	$941.36	$367.13	$188.27
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	0019	3.94	$204.92	$75.82	$40.98
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
11980	X	Implant hormone pellet(s)	0340	0.66	$34.33	.....	$6.87
11981	X	Insert drug implant device	0340	0.66	$34.33	.....	$6.87
11982	X	Remove drug implant device	0340	0.66	$34.33	.....	$6.87
11983	X	Remove/insert drug implant	0340	0.66	$34.33	.....	$6.87
12001	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12002	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12004	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12005	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12006	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12007	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12011	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12013	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12014	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12015	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12016	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12017	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12018	T	Repair superficial wound(s)	0024	2.00	$104.02	$37.45	$20.80
12020	T	Closure of split wound	0024	2.00	$104.02	$37.45	$20.80
12021	T	Closure of split wound	0024	2.00	$104.02	$37.45	$20.80
12031	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12032	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12034	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12035	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12036	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12037	T	Layer closure of wound(s)	0025	5.89	$306.33	$116.41	$61.27
12041	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12042	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12044	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12045	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12046	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12047	T	Layer closure of wound(s)	0025	5.89	$306.33	$116.41	$61.27
12051	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12052	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12053	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12054	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12055	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12056	T	Layer closure of wound(s)	0024	2.00	$104.02	$37.45	$20.80
12057	T	Layer closure of wound(s)	0025	5.89	$306.33	$116.41	$61.27
13100	T	Repair of wound or lesion	0025	5.89	$306.33	$116.41	$61.27
13101	T	Repair of wound or lesion	0025	5.89	$306.33	$116.41	$61.27
13102	T	Repair wound/lesion add-on	0024	2.00	$104.02	$37.45	$20.80
13120	T	Repair of wound or lesion	0024	2.00	$104.02	$37.45	$20.80
13121	T	Repair of wound or lesion	0024	2.00	$104.02	$37.45	$20.80
13122	T	Repair wound/lesion add-on	0024	2.00	$104.02	$37.45	$20.80
13131	T	Repair of wound or lesion	0024	2.00	$104.02	$37.45	$20.80
13132	T	Repair of wound or lesion	0024	2.00	$104.02	$37.45	$20.80
13133	T	Repair wound/lesion add-on	0024	2.00	$104.02	$37.45	$20.80
13150	T	Repair of wound or lesion	0025	5.89	$306.33	$116.41	$61.27
13151	T	Repair of wound or lesion	0024	2.00	$104.02	$37.45	$20.80
13152	T	Repair of wound or lesion	0025	5.89	$306.33	$116.41	$61.27
13153	T	Repair wound/lesion add-on	0024	2.00	$104.02	$37.45	$20.80
13160	T	Late closure of wound	0027	15.73	$818.10	$343.60	$163.62
14000	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14001	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14020	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14021	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14040	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14041	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14060	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14061	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14300	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
14350	T	Skin tissue rearrangement	0027	15.73	$818.10	$343.60	$163.62
15000	T	Skin graft	0025	5.89	$306.33	$116.41	$61.27
15001	T	Skin graft add-on	0025	5.89	$306.33	$116.41	$61.27
15050	T	Skin pinch graft	0025	5.89	$306.33	$116.41	$61.27
15100	T	Skin split graft	0027	15.73	$818.10	$343.60	$163.62
15101	T	Skin split graft add-on	0027	15.73	$818.10	$343.60	$163.62
15120	T	Skin split graft	0027	15.73	$818.10	$343.60	$163.62
15121	T	Skin split graft add-on	0027	15.73	$818.10	$343.60	$163.62
15200	T	Skin full graft	0027	15.73	$818.10	$343.60	$163.62
15201	T	Skin full graft add-on	0025	5.89	$306.33	$116.41	$61.27
15220	T	Skin full graft	0027	15.73	$818.10	$343.60	$163.62
15221	T	Skin full graft add-on	0025	5.89	$306.33	$116.41	$61.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15240	T	Skin full graft	0027	15.73	$818.10	$343.60	$163.62
15241	T	Skin full graft add-on	0025	5.89	$306.33	$116.41	$61.27
15260	T	Skin full graft	0027	15.73	$818.10	$343.60	$163.62
15261	T	Skin full graft add-on	0025	5.89	$306.33	$116.41	$61.27
15342	T	Cultured skin graft, 25 cm	0025	5.89	$306.33	$116.41	$61.27
15343	T	Culture skn graft addl 25 cm	0024	2.00	$104.02	$37.45	$20.80
15350	T	Skin homograft	0686	11.30	$587.70	$270.34	$117.54
15351	T	Skin homograft add-on	0027	15.73	$818.10	$343.60	$163.62
15400	T	Skin heterograft	0025	5.89	$306.33	$116.41	$61.27
15401	T	Skin heterograft add-on	0025	5.89	$306.33	$116.41	$61.27
15570	T	Form skin pedicle flap	0027	15.73	$818.10	$343.60	$163.62
15572	T	Form skin pedicle flap	0027	15.73	$818.10	$343.60	$163.62
15574	T	Form skin pedicle flap	0027	15.73	$818.10	$343.60	$163.62
15576	T	Form skin pedicle flap	0027	15.73	$818.10	$343.60	$163.62
15600	T	Skin graft	0027	15.73	$818.10	$343.60	$163.62
15610	T	Skin graft	0027	15.73	$818.10	$343.60	$163.62
15620	T	Skin graft	0027	15.73	$818.10	$343.60	$163.62
15630	T	Skin graft	0027	15.73	$818.10	$343.60	$163.62
15650	T	Transfer skin pedicle flap	0027	15.73	$818.10	$343.60	$163.62
15732	T	Muscle-skin graft, head/neck	0027	15.73	$818.10	$343.60	$163.62
15734	T	Muscle-skin graft, trunk	0027	15.73	$818.10	$343.60	$163.62
15736	T	Muscle-skin graft, arm	0027	15.73	$818.10	$343.60	$163.62
15738	T	Muscle-skin graft, leg	0027	15.73	$818.10	$343.60	$163.62
15740	T	Island pedicle flap graft	0027	15.73	$818.10	$343.60	$163.62
15750	T	Neurovascular pedicle graft	0027	15.73	$818.10	$343.60	$163.62
15756	C	Free muscle flap, microvasc	.....	.....	.....	.....	.....
15757	C	Free skin flap, microvasc	.....	.....	.....	.....	.....
15758	C	Free fascial flap, microvasc	.....	.....	.....	.....	.....
15760	T	Composite skin graft	0027	15.73	$818.10	$343.60	$163.62
15770	T	Derma-fat-fascia graft	0027	15.73	$818.10	$343.60	$163.62
15775	T	Hair transplant punch grafts	0025	5.89	$306.33	$116.41	$61.27
15776	T	Hair transplant punch grafts	0025	5.89	$306.33	$116.41	$61.27
15780	T	Abrasion treatment of skin	0022	18.10	$941.36	$367.13	$188.27
15781	T	Abrasion treatment of skin	0022	18.10	$941.36	$367.13	$188.27
15782	T	Abrasion treatment of skin	0022	18.10	$941.36	$367.13	$188.27
15783	T	Abrasion treatment of skin	0016	2.57	$133.66	$56.14	$26.73
15786	T	Abrasion, lesion, single	0013	1.10	$57.21	$14.30	$11.44
15787	T	Abrasion, lesions, add-on	0013	1.10	$57.21	$14.30	$11.44
15788	T	Chemical peel, face, epiderm	0012	0.76	$39.53	$10.67	$7.91
15789	T	Chemical peel, face, dermal	0015	1.43	$74.37	$18.59	$14.87
15792	T	Chemical peel, nonfacial	0012	0.76	$39.53	$10.67	$7.91
15793	T	Chemical peel, nonfacial	0013	1.10	$57.21	$14.30	$11.44
15810	T	Salabrasion	0016	2.57	$133.66	$56.14	$26.73
15811	T	Salabrasion	0016	2.57	$133.66	$56.14	$26.73
15819	T	Plastic surgery, neck	0025	5.89	$306.33	$116.41	$61.27
15820	T	Revision of lower eyelid	0027	15.73	$818.10	$343.60	$163.62
15821	T	Revision of lower eyelid	0027	15.73	$818.10	$343.60	$163.62
15822	T	Revision of upper eyelid	0027	15.73	$818.10	$343.60	$163.62
15823	T	Revision of upper eyelid	0027	15.73	$818.10	$343.60	$163.62
15824	T	Removal of forehead wrinkles	0027	15.73	$818.10	$343.60	$163.62
15825	T	Removal of neck wrinkles	0027	15.73	$818.10	$343.60	$163.62
15826	T	Removal of brow wrinkles	0027	15.73	$818.10	$343.60	$163.62
15828	T	Removal of face wrinkles	0027	15.73	$818.10	$343.60	$163.62
15829	T	Removal of skin wrinkles	0027	15.73	$818.10	$343.60	$163.62
15831	T	Excise excessive skin tissue	0022	18.10	$941.36	$367.13	$188.27
15832	T	Excise excessive skin tissue	0022	18.10	$941.36	$367.13	$188.27
15833	T	Excise excessive skin tissue	0022	18.10	$941.36	$367.13	$188.27
15834	T	Excise excessive skin tissue	0022	18.10	$941.36	$367.13	$188.27
15835	T	Excise excessive skin tissue	0025	5.89	$306.33	$116.41	$61.27
15836	T	Excise excessive skin tissue	0020	7.36	$382.79	$114.84	$76.56
15837	T	Excise excessive skin tissue	0020	7.36	$382.79	$114.84	$76.56
15838	T	Excise excessive skin tissue	0020	7.36	$382.79	$114.84	$76.56
15839	T	Excise excessive skin tissue	0020	7.36	$382.79	$114.84	$76.56
15840	T	Graft for face nerve palsy	0027	15.73	$818.10	$343.60	$163.62
15841	T	Graft for face nerve palsy	0027	15.73	$818.10	$343.60	$163.62
15842	T	Flap for face nerve palsy	0027	15.73	$818.10	$343.60	$163.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15845	T	Skin and muscle repair, face	0027	15.73	$818.10	$343.60	$163.62
15850	T	Removal of sutures	0016	2.57	$133.66	$56.14	$26.73
15851	T	Removal of sutures	0013	1.10	$57.21	$14.30	$11.44
15852	X	Dressing change,not for burn	0340	0.66	$34.33		$6.87
15860	S	Test for blood flow in graft	0706		$25.00		$5.00
15876	T	Suction assisted lipectomy	0027	15.73	$818.10	$343.60	$163.62
15877	T	Suction assisted lipectomy	0027	15.73	$818.10	$343.60	$163.62
15878	T	Suction assisted lipectomy	0027	15.73	$818.10	$343.60	$163.62
15879	T	Suction assisted lipectomy	0027	15.73	$818.10	$343.60	$163.62
15920	T	Removal of tail bone ulcer	0022	18.10	$941.36	$367.13	$188.27
15922	T	Removal of tail bone ulcer	0027	15.73	$818.10	$343.60	$163.62
15931	T	Remove sacrum pressure sore	0022	18.10	$941.36	$367.13	$188.27
15933	T	Remove sacrum pressure sore	0022	18.10	$941.36	$367.13	$188.27
15934	T	Remove sacrum pressure sore	0027	15.73	$818.10	$343.60	$163.62
15935	T	Remove sacrum pressure sore	0027	15.73	$818.10	$343.60	$163.62
15936	T	Remove sacrum pressure sore	0027	15.73	$818.10	$343.60	$163.62
15937	T	Remove sacrum pressure sore	0027	15.73	$818.10	$343.60	$163.62
15940	T	Remove hip pressure sore	0022	18.10	$941.36	$367.13	$188.27
15941	T	Remove hip pressure sore	0022	18.10	$941.36	$367.13	$188.27
15944	T	Remove hip pressure sore	0027	15.73	$818.10	$343.60	$163.62
15945	T	Remove hip pressure sore	0027	15.73	$818.10	$343.60	$163.62
15946	T	Remove hip pressure sore	0027	15.73	$818.10	$343.60	$163.62
15950	T	Remove thigh pressure sore	0022	18.10	$941.36	$367.13	$188.27
15951	T	Remove thigh pressure sore	0022	18.10	$941.36	$367.13	$188.27
15952	T	Remove thigh pressure sore	0027	15.73	$818.10	$343.60	$163.62
15953	T	Remove thigh pressure sore	0027	15.73	$818.10	$343.60	$163.62
15956	T	Remove thigh pressure sore	0027	15.73	$818.10	$343.60	$163.62
15958	T	Remove thigh pressure sore	0027	15.73	$818.10	$343.60	$163.62
15999	T	Removal of pressure sore	0022	18.10	$941.36	$367.13	$188.27
16000	T	Initial treatment of burn(s)	0013	1.10	$57.21	$14.30	$11.44
16010	T	Treatment of burn(s)	0016	2.57	$133.66	$56.14	$26.73
16015	T	Treatment of burn(s)	0017	16.46	$856.07	$227.84	$171.21
16020	T	Treatment of burn(s)	0013	1.10	$57.21	$14.30	$11.44
16025	T	Treatment of burn(s)	0013	1.10	$57.21	$14.30	$11.44
16030	T	Treatment of burn(s)	0015	1.43	$74.37	$18.59	$14.87
16035	C	Incision of burn scab, initi					
16036	C	Incise burn scab, addl incis					
17000	T	Detroy benign/premal lesion	0010	0.70	$36.41	$10.56	$7.28
17003	T	Destroy lesions, 2-14	0010	0.70	$36.41	$10.56	$7.28
17004	T	Destroy lesions, 15 or more	0011	1.93	$100.38	$27.88	$20.08
17106	T	Destruction of skin lesions	0011	1.93	$100.38	$27.88	$20.08
17107	T	Destruction of skin lesions	0011	1.93	$100.38	$27.88	$20.08
17108	T	Destruction of skin lesions	0011	1.93	$100.38	$27.88	$20.08
17110	T	Destruct lesion, 1-14	0010	0.70	$36.41	$10.56	$7.28
17111	T	Destruct lesion, 15 or more	0011	1.93	$100.38	$27.88	$20.08
17250	T	Chemical cautery, tissue	0013	1.10	$57.21	$14.30	$11.44
17260	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17261	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17262	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17263	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17264	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17266	T	Destruction of skin lesions	0016	2.57	$133.66	$56.14	$26.73
17270	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17271	T	Destruction of skin lesions	0012	0.76	$39.53	$10.67	$7.91
17272	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17273	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17274	T	Destruction of skin lesions	0016	2.57	$133.66	$56.14	$26.73
17276	T	Destruction of skin lesions	0016	2.57	$133.66	$56.14	$26.73
17280	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17281	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17282	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17283	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17284	T	Destruction of skin lesions	0016	2.57	$133.66	$56.14	$26.73
17286	T	Destruction of skin lesions	0015	1.43	$74.37	$18.59	$14.87
17304	T	Chemosurgery of skin lesion	0694	3.90	$202.84	$81.14	$40.57
17305	T	2nd stage chemosurgery	0694	3.90	$202.84	$81.14	$40.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17306	T	3rd stage chemosurgery	0694	3.90	$202.84	$81.14	$40.57
17307	T	Followup skin lesion therapy	0694	3.90	$202.84	$81.14	$40.57
17310	T	Extensive skin chemosurgery	0694	3.90	$202.84	$81.14	$40.57
17340	T	Cryotherapy of skin	0012	0.76	$39.53	$10.67	$7.91
17360	T	Skin peel therapy	0012	0.76	$39.53	$10.67	$7.91
17380	T	Hair removal by electrolysis	0012	0.76	$39.53	$10.67	$7.91
17999	T	Skin tissue procedure	0006	1.89	$98.30	$25.56	$19.66
19000	T	Drainage of breast lesion	0004	1.63	$84.77	$22.04	$16.95
19001	T	Drain breast lesion add-on	0004	1.63	$84.77	$22.04	$16.95
19020	T	Incision of breast lesion	0008	16.32	$848.79		$169.76
19030	N	Injection for breast x-ray					
19100	T	Bx breast percut w/o image	0005	3.02	$157.07	$69.11	$31.41
19101	T	Biopsy of breast, open	0028	17.44	$907.04	$303.74	$181.41
19102	T	Bx breast percut w/image	0005	3.02	$157.07	$69.11	$31.41
19103	T	Bx breast percut w/device	0658	5.57	$289.69		$57.94
19110	T	Nipple exploration	0028	17.44	$907.04	$303.74	$181.41
19112	T	Excise breast duct fistula	0028	17.44	$907.04	$303.74	$181.41
19120	T	Removal of breast lesion	0028	17.44	$907.04	$303.74	$181.41
19125	T	Excision, breast lesion	0028	17.44	$907.04	$303.74	$181.41
19126	T	Excision, addl breast lesion	0028	17.44	$907.04	$303.74	$181.41
19140	T	Removal of breast tissue	0028	17.44	$907.04	$303.74	$181.41
19160	T	Removal of breast tissue	0028	17.44	$907.04	$303.74	$181.41
19162	T	Remove breast tissue, nodes	0693	39.30	$2,043.95	$798.17	$408.79
19180	T	Removal of breast	0029	29.89	$1,554.55	$632.64	$310.91
19182	T	Removal of breast	0029	29.89	$1,554.55	$632.64	$310.91
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	T	Removal of breast	0030	40.23	$2,092.32	$763.55	$418.46
19260	T	Removal of chest wall lesion	0021	14.58	$758.29	$227.49	$151.66
19271	C	Revision of chest wall					
19272	C	Extensive chest wall surgery					
19290	N	Place needle wire, breast					
19291	N	Place needle wire, breast					
19295	S	Place breast clip, percut	0657	1.38	$71.77		$14.35
19316	T	Suspension of breast	0029	29.89	$1,554.55	$632.64	$310.91
19318	T	Reduction of large breast	0693	39.30	$2,043.95	$798.17	$408.79
19324	T	Enlarge breast	0693	39.30	$2,043.95	$798.17	$408.79
19325	T	Enlarge breast with implant	0693	39.30	$2,043.95	$798.17	$408.79
19328	T	Removal of breast implant	0029	29.89	$1,554.55	$632.64	$310.91
19330	T	Removal of implant material	0029	29.89	$1,554.55	$632.64	$310.91
19340	T	Immediate breast prosthesis	0030	40.23	$2,092.32	$763.55	$418.46
19342	T	Delayed breast prosthesis	0693	39.30	$2,043.95	$798.17	$408.79
19350	T	Breast reconstruction	0029	29.89	$1,554.55	$632.64	$310.91
19355	T	Correct inverted nipple(s)	0029	29.89	$1,554.55	$632.64	$310.91
19357	T	Breast reconstruction	0693	39.30	$2,043.95	$798.17	$408.79
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0029	29.89	$1,554.55	$632.64	$310.91
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0029	29.89	$1,554.55	$632.64	$310.91
19371	T	Removal of breast capsule	0029	29.89	$1,554.55	$632.64	$310.91
19380	T	Revise breast reconstruction	0030	40.23	$2,092.32	$763.55	$418.46
19396	T	Design custom breast implant	0029	29.89	$1,554.55	$632.64	$310.91
19499	T	Breast surgery procedure	0028	17.44	$907.04	$303.74	$181.41
20000	T	Incision of abscess	0006	1.89	$98.30	$25.56	$19.66
20005	T	Incision of deep abscess	0049	19.45	$1,011.58		$202.32
20100	T	Explore wound, neck	0023	2.38	$123.78	$40.37	$24.76
20101	T	Explore wound, chest	0027	15.73	$818.10	$343.60	$163.62
20102	T	Explore wound, abdomen	0027	15.73	$818.10	$343.60	$163.62
20103	T	Explore wound, extremity	0023	2.38	$123.78	$40.37	$24.76
20150	T	Excise epiphyseal bar	0051	34.03	$1,769.87		$353.97
20200	T	Muscle biopsy	0021	14.58	$758.29	$227.49	$151.66
20205	T	Deep muscle biopsy	0021	14.58	$758.29	$227.49	$151.66
20206	T	Needle biopsy, muscle	0005	3.02	$157.07	$69.11	$31.41

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20220	T	Bone biopsy, trocar/needle	0019	3.94	$204.92	$75.82	$40.98
20225	T	Bone biopsy, trocar/needle	0019	3.94	$204.92	$75.82	$40.98
20240	T	Bone biopsy, excisional	0022	18.10	$941.36	$367.13	$188.27
20245	T	Bone biopsy, excisional	0022	18.10	$941.36	$367.13	$188.27
20250	T	Open bone biopsy	0049	19.45	$1,011.58		$202.32
20251	T	Open bone biopsy	0049	19.45	$1,011.58		$202.32
20500	T	Injection of sinus tract	0251	1.92	$99.86		$19.97
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	3.94	$204.92	$75.82	$40.98
20525	T	Removal of foreign body	0022	18.10	$941.36	$367.13	$188.27
20526	T	Ther injection carpal tunnel	0204	2.13	$110.78	$42.10	$22.16
20550	T	Inject tendon/ligament/cyst	0204	2.13	$110.78	$42.10	$22.16
20551	T	Inject tendon origin/insert	0204	2.13	$110.78	$42.10	$22.16
20552	T	Inject trigger point, 1 or 2	0204	2.13	$110.78	$42.10	$22.16
20553	T	Inject trigger points, > 3	0204	2.13	$110.78	$42.10	$22.16
20600	T	Drain/inject, joint/bursa	0204	2.13	$110.78	$42.10	$22.16
20605	T	Drain/inject, joint/bursa	0204	2.13	$110.78	$42.10	$22.16
20610	T	Drain/inject, joint/bursa	0204	2.13	$110.78	$42.10	$22.16
20615	T	Treatment of bone cyst	0004	1.63	$84.77	$22.04	$16.95
20650	T	Insert and remove bone pin	0049	19.45	$1,011.58		$202.32
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	X	Removal of fixation device	0340	0.66	$34.33		$6.87
20670	T	Removal of support implant	0021	14.58	$758.29	$227.49	$151.66
20680	T	Removal of support implant	0022	18.10	$941.36	$367.13	$188.27
20690	T	Apply bone fixation device	0050	23.60	$1,227.41		$245.48
20692	T	Apply bone fixation device	0050	23.60	$1,227.41		$245.48
20693	T	Adjust bone fixation device	0049	19.45	$1,011.58		$202.32
20694	T	Remove bone fixation device	0049	19.45	$1,011.58		$202.32
20802	C	Replantation, arm, complete					
20805	C	Replant, forearm, complete					
20808	C	Replantation hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation foot, complete					
20900	T	Removal of bone for graft	0050	23.60	$1,227.41		$245.48
20902	T	Removal of bone for graft	0050	23.60	$1,227.41		$245.48
20910	T	Remove cartilage for graft	0027	15.73	$818.10	$343.60	$163.62
20912	T	Remove cartilage for graft	0027	15.73	$818.10	$343.60	$163.62
20920	T	Removal of fascia for graft	0027	15.73	$818.10	$343.60	$163.62
20922	T	Removal of fascia for graft	0027	15.73	$818.10	$343.60	$163.62
20924	T	Removal of tendon for graft	0050	23.60	$1,227.41		$245.48
20926	T	Removal of tissue for graft	0027	15.73	$818.10	$343.60	$163.62
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					
20936	C	Spinal bone autograft					
20937	C	Spinal bone autograft					
20938	C	Spinal bone autograft					
20950	T	Fluid pressure, muscle	0006	1.89	$98.30	$25.56	$19.66
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	19.45	$1,011.58		$202.32
20979	A	Us bone stimulation					
20999	T	Musculoskeletal surgery	0049	19.45	$1,011.58		$202.32

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21010	T	Incision of jaw joint	0254	21.89	$1,138.48	$352.93	$227.70
21015	T	Resection of facial tumor	0253	14.79	$769.21	$284.61	$153.84
21025	T	Excision of bone, lower jaw	0256	35.51	$1,846.84		$369.37
21026	T	Excision of facial bone(s)	0256	35.51	$1,846.84		$369.37
21029	T	Contour of face bone lesion	0256	35.51	$1,846.84		$369.37
21030	T	Removal of face bone lesion	0254	21.89	$1,138.48	$352.93	$227.70
21031	T	Remove exostosis, mandible	0254	21.89	$1,138.48	$352.93	$227.70
21032	T	Remove exostosis, maxilla	0254	21.89	$1,138.48	$352.93	$227.70
21034	T	Removal of face bone lesion	0256	35.51	$1,846.84		$369.37
21040	T	Removal of jaw bone lesion	0254	21.89	$1,138.48	$352.93	$227.70
21041	T	Removal of jaw bone lesion	0256	35.51	$1,846.84		$369.37
21044	T	Removal of jaw bone lesion	0256	35.51	$1,846.84		$369.37
21045	C	Extensive jaw surgery					
21050	T	Removal of jaw joint	0256	35.51	$1,846.84		$369.37
21060	T	Remove jaw joint cartilage	0256	35.51	$1,846.84		$369.37
21070	T	Remove coronoid process	0256	35.51	$1,846.84		$369.37
21076	T	Prepare face/oral prosthesis	0254	21.89	$1,138.48	$352.93	$227.70
21077	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21079	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21080	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21081	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21082	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21083	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21084	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21085	T	Prepare face/oral prosthesis	0253	14.79	$769.21	$284.61	$153.84
21086	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21087	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21088	T	Prepare face/oral prosthesis	0256	35.51	$1,846.84		$369.37
21089	T	Prepare face/oral prosthesis	0253	14.79	$769.21	$284.61	$153.84
21100	T	Maxillofacial fixation	0256	35.51	$1,846.84		$369.37
21110	T	Interdental fixation	0252	6.27	$326.10	$114.24	$65.22
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	21.89	$1,138.48	$352.93	$227.70
21121	T	Reconstruction of chin	0254	21.89	$1,138.48	$352.93	$227.70
21122	T	Reconstruction of chin	0254	21.89	$1,138.48	$352.93	$227.70
21123	T	Reconstruction of chin	0254	21.89	$1,138.48	$352.93	$227.70
21125	T	Augmentation, lower jaw bone	0254	21.89	$1,138.48	$352.93	$227.70
21127	T	Augmentation, lower jaw bone	0256	35.51	$1,846.84		$369.37
21137	T	Reduction of forehead	0254	21.89	$1,138.48	$352.93	$227.70
21138	T	Reduction of forehead	0256	35.51	$1,846.84		$369.37
21139	T	Reduction of forehead	0256	35.51	$1,846.84		$369.37
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	21.89	$1,138.48	$352.93	$227.70
21182	C	Reconstruct cranial bone					
21183	C	Reconstruct cranial bone					
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconst lwr jaw w/o graft					
21194	C	Reconst lwr jaw w/graft					
21195	C	Reconst lwr jaw w/o fixation					
21196	C	Reconst lwr jaw w/fixation					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21198	T	Reconstr lwr jaw segment	0256	35.51	$1,846.84		$369.37
21199	T	Reconstr lwr jaw w/advance	0256	35.51	$1,846.84		$369.37
21206	T	Reconstruct upper jaw bone	0256	35.51	$1,846.84		$369.37
21208	T	Augmentation of facial bones	0256	35.51	$1,846.84		$369.37
21209	T	Reduction of facial bones	0256	35.51	$1,846.84		$369.37
21210	T	Face bone graft	0256	35.51	$1,846.84		$369.37
21215	T	Lower jaw bone graft	0256	35.51	$1,846.84		$369.37
21230	T	Rib cartilage graft	0256	35.51	$1,846.84		$369.37
21235	T	Ear cartilage graft	0254	21.89	$1,138.48	$352.93	$227.70
21240	T	Reconstruction of jaw joint	0256	35.51	$1,846.84		$369.37
21242	T	Reconstruction of jaw joint	0256	35.51	$1,846.84		$369.37
21243	T	Reconstruction of jaw joint	0256	35.51	$1,846.84		$369.37
21244	T	Reconstruction of lower jaw	0256	35.51	$1,846.84		$369.37
21245	T	Reconstruction of jaw	0256	35.51	$1,846.84		$369.37
21246	T	Reconstruction of jaw	0256	35.51	$1,846.84		$369.37
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	35.51	$1,846.84		$369.37
21249	T	Reconstruction of jaw	0256	35.51	$1,846.84		$369.37
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	35.51	$1,846.84		$369.37
21261	T	Revise eye sockets	0256	35.51	$1,846.84		$369.37
21263	T	Revise eye sockets	0256	35.51	$1,846.84		$369.37
21267	T	Revise eye sockets	0256	35.51	$1,846.84		$369.37
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	35.51	$1,846.84		$369.37
21275	T	Revision, orbitofacial bones	0256	35.51	$1,846.84		$369.37
21280	T	Revision of eyelid	0256	35.51	$1,846.84		$369.37
21282	T	Revision of eyelid	0253	14.79	$769.21	$284.61	$153.84
21295	T	Revision of jaw muscle/bone	0252	6.27	$326.10	$114.24	$65.22
21296	T	Revision of jaw muscle/bone	0254	21.89	$1,138.48	$352.93	$227.70
21299	T	Cranio/maxillofacial surgery	0253	14.79	$769.21	$284.61	$153.84
21300	T	Treatment of skull fracture	0253	14.79	$769.21	$284.61	$153.84
21310	X	Treatment of nose fracture	0340	0.66	$34.33		$6.87
21315	X	Treatment of nose fracture	0340	0.66	$34.33		$6.87
21320	X	Treatment of nose fracture	0340	0.66	$34.33		$6.87
21325	T	Treatment of nose fracture	0254	21.89	$1,138.48	$352.93	$227.70
21330	T	Treatment of nose fracture	0254	21.89	$1,138.48	$352.93	$227.70
21335	T	Treatment of nose fracture	0254	21.89	$1,138.48	$352.93	$227.70
21336	T	Treat nasal septal fracture	0046	29.03	$1,509.82	$535.76	$301.96
21337	T	Treat nasal septal fracture	0253	14.79	$769.21	$284.61	$153.84
21338	T	Treat nasoethmoid fracture	0254	21.89	$1,138.48	$352.93	$227.70
21339	T	Treat nasoethmoid fracture	0254	21.89	$1,138.48	$352.93	$227.70
21340	T	Treatment of nose fracture	0256	35.51	$1,846.84		$369.37
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	21.89	$1,138.48	$352.93	$227.70
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	35.51	$1,846.84		$369.37
21356	C	Treat cheek bone fracture					
21360	C	Treat cheek bone fracture					
21365	C	Treat cheek bone fracture					
21366	C	Treat cheek bone fracture					
21385	C	Treat eye socket fracture					
21386	C	Treat eye socket fracture					
21387	C	Treat eye socket fracture					
21390	T	Treat eye socket fracture	0256	35.51	$1,846.84		$369.37
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	6.27	$326.10	$114.24	$65.22
21401	T	Treat eye socket fracture	0253	14.79	$769.21	$284.61	$153.84
21406	T	Treat eye socket fracture	0256	35.51	$1,846.84		$369.37
21407	T	Treat eye socket fracture	0256	35.51	$1,846.84		$369.37
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	21.89	$1,138.48	$352.93	$227.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21422	C	Treat mouth roof fracture					
21423	C	Treat mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Treat craniofacial fracture					
21433	C	Treat craniofacial fracture					
21435	C	Treat craniofacial fracture					
21436	C	Treat craniofacial fracture					
21440	T	Treat dental ridge fracture	0254	21.89	$1,138.48	$352.93	$227.70
21445	T	Treat dental ridge fracture	0254	21.89	$1,138.48	$352.93	$227.70
21450	T	Treat lower jaw fracture	0251	1.92	$99.86		$19.97
21451	T	Treat lower jaw fracture	0252	6.27	$326.10	$114.24	$65.22
21452	T	Treat lower jaw fracture	0253	14.79	$769.21	$284.61	$153.84
21453	T	Treat lower jaw fracture	0256	35.51	$1,846.84		$369.37
21454	T	Treat lower jaw fracture	0254	21.89	$1,138.48	$352.93	$227.70
21461	T	Treat lower jaw fracture	0256	35.51	$1,846.84		$369.37
21462	T	Treat lower jaw fracture	0256	35.51	$1,846.84		$369.37
21465	T	Treat lower jaw fracture	0256	35.51	$1,846.84		$369.37
21470	T	Treat lower jaw fracture	0256	35.51	$1,846.84		$369.37
21480	T	Reset dislocated jaw	0251	1.92	$99.86		$19.97
21485	T	Reset dislocated jaw	0253	14.79	$769.21	$284.61	$153.84
21490	T	Repair dislocated jaw	0256	35.51	$1,846.84		$369.37
21493	T	Treat hyoid bone fracture	0252	6.27	$326.10	$114.24	$65.22
21494	T	Treat hyoid bone fracture	0252	6.27	$326.10	$114.24	$65.22
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	14.79	$769.21	$284.61	$153.84
21499	T	Head surgery procedure	0253	14.79	$769.21	$284.61	$153.84
21501	T	Drain neck/chest lesion	0008	16.32	$848.79		$169.76
21502	T	Drain chest lesion	0049	19.45	$1,011.58		$202.32
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0021	14.58	$758.29	$227.49	$151.66
21555	T	Remove lesion, neck/chest	0022	18.10	$941.36	$367.13	$188.27
21556	T	Remove lesion, neck/chest	0022	18.10	$941.36	$367.13	$188.27
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	23.60	$1,227.41		$245.48
21610	T	Partial removal of rib	0050	23.60	$1,227.41		$245.48
21615	C	Removal of rib					
21616	C	Removal of rib and nerves					
21620	C	Partial removal of sternum					
21627	C	Sternal debridement					
21630	C	Extensive sternum surgery					
21632	C	Extensive sternum surgery					
21700	T	Revision of neck muscle	0049	19.45	$1,011.58		$202.32
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0049	19.45	$1,011.58		$202.32
21725	T	Revision of neck muscle	0006	1.89	$98.30	$25.56	$19.66
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	1.68	$87.38		$17.48
21805	T	Treatment of rib fracture	0046	29.03	$1,509.82	$535.76	$301.96
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0043	1.68	$87.38		$17.48
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	6.27	$326.10	$114.24	$65.22
21920	T	Biopsy soft tissue of back	0020	7.36	$382.79	$114.84	$76.56
21925	T	Biopsy soft tissue of back	0022	18.10	$941.36	$367.13	$188.27
21930	T	Remove lesion, back or flank	0022	18.10	$941.36	$367.13	$188.27
21935	T	Remove tumor, back	0022	18.10	$941.36	$367.13	$188.27
22100	T	Remove part of neck vertebra	0208	39.95	$2,077.76		$415.55
22101	T	Remove part, thorax vertebra	0208	39.95	$2,077.76		$415.55
22102	T	Remove part, lumbar vertebra	0208	39.95	$2,077.76		$415.55
22103	T	Remove extra spine segment	0208	39.95	$2,077.76		$415.55
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.68	$87.38		$17.48
22310	T	Treat spine fracture	0043	1.68	$87.38		$17.48
22315	T	Treat spine fracture	0043	1.68	$87.38		$17.48
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	13.47	$700.56	$280.22	$140.11
22520	T	Percut vertebroplasty thor	0050	23.60	$1,227.41		$245.48
22521	T	Percut vertebroplasty lumb	0050	23.60	$1,227.41		$245.48
22522	T	Percut vertebroplasty addl	0050	23.60	$1,227.41		$245.48
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					
22899	T	Spine surgery procedure	0043	1.68	$87.38		$17.48
22900	T	Remove abdominal wall lesion	0022	18.10	$941.36	$367.13	$188.27
22999	T	Abdomen surgery procedure	0022	18.10	$941.36	$367.13	$188.27
23000	T	Removal of calcium deposits	0021	14.58	$758.29	$227.49	$151.66
23020	T	Release shoulder joint	0051	34.03	$1,769.87		$353.97
23030	T	Drain shoulder lesion	0008	16.32	$848.79		$169.76
23031	T	Drain shoulder bursa	0008	16.32	$848.79		$169.76
23035	T	Drain shoulder bone lesion	0049	19.45	$1,011.58		$202.32
23040	T	Exploratory shoulder surgery	0050	23.60	$1,227.41		$245.48
23044	T	Exploratory shoulder surgery	0050	23.60	$1,227.41		$245.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23065	T	Biopsy shoulder tissues	0021	14.58	$758.29	$227.49	$151.66
23066	T	Biopsy shoulder tissues	0022	18.10	$941.36	$367.13	$188.27
23075	T	Removal of shoulder lesion	0021	14.58	$758.29	$227.49	$151.66
23076	T	Removal of shoulder lesion	0022	18.10	$941.36	$367.13	$188.27
23077	T	Remove tumor of shoulder	0022	18.10	$941.36	$367.13	$188.27
23100	T	Biopsy of shoulder joint	0049	19.45	$1,011.58		$202.32
23101	T	Shoulder joint surgery	0050	23.60	$1,227.41		$245.48
23105	T	Remove shoulder joint lining	0050	23.60	$1,227.41		$245.48
23106	T	Incision of collarbone joint	0050	23.60	$1,227.41		$245.48
23107	T	Explore treat shoulder joint	0050	23.60	$1,227.41		$245.48
23120	T	Partial removal, collar bone	0051	34.03	$1,769.87		$353.97
23125	T	Removal of collar bone	0051	34.03	$1,769.87		$353.97
23130	T	Remove shoulder bone, part	0051	34.03	$1,769.87		$353.97
23140	T	Removal of bone lesion	0049	19.45	$1,011.58		$202.32
23145	T	Removal of bone lesion	0050	23.60	$1,227.41		$245.48
23146	T	Removal of bone lesion	0050	23.60	$1,227.41		$245.48
23150	T	Removal of humerus lesion	0050	23.60	$1,227.41		$245.48
23155	T	Removal of humerus lesion	0050	23.60	$1,227.41		$245.48
23156	T	Removal of humerus lesion	0050	23.60	$1,227.41		$245.48
23170	T	Remove collar bone lesion	0050	23.60	$1,227.41		$245.48
23172	T	Remove shoulder blade lesion	0050	23.60	$1,227.41		$245.48
23174	T	Remove humerus lesion	0050	23.60	$1,227.41		$245.48
23180	T	Remove collar bone lesion	0050	23.60	$1,227.41		$245.48
23182	T	Remove shoulder blade lesion	0050	23.60	$1,227.41		$245.48
23184	T	Remove humerus lesion	0050	23.60	$1,227.41		$245.48
23190	T	Partial removal of scapula	0050	23.60	$1,227.41		$245.48
23195	T	Removal of head of humerus	0050	23.60	$1,227.41		$245.48
23200	C	Removal of collar bone					
23210	C	Removal of shoulder blade					
23220	C	Partial removal of humerus					
23221	C	Partial removal of humerus					
23222	C	Partial removal of humerus					
23330	T	Remove shoulder foreign body	0020	7.36	$382.79	$114.84	$76.56
23331	T	Remove shoulder foreign body	0022	18.10	$941.36	$367.13	$188.27
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	T	Muscle transfer,shoulder/arm	0051	34.03	$1,769.87		$353.97
23397	T	Muscle transfers	0052	42.37	$2,203.62		$440.72
23400	T	Fixation of shoulder blade	0050	23.60	$1,227.41		$245.48
23405	T	Incision of tendon & muscle	0050	23.60	$1,227.41		$245.48
23406	T	Incise tendon(s) & muscle(s)	0050	23.60	$1,227.41		$245.48
23410	T	Repair of tendon(s)	0052	42.37	$2,203.62		$440.72
23412	T	Repair of tendon(s)	0052	42.37	$2,203.62		$440.72
23415	T	Release of shoulder ligament	0051	34.03	$1,769.87		$353.97
23420	T	Repair of shoulder	0052	42.37	$2,203.62		$440.72
23430	T	Repair biceps tendon	0052	42.37	$2,203.62		$440.72
23440	T	Remove/transplant tendon	0052	42.37	$2,203.62		$440.72
23450	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23455	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23460	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23462	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23465	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23466	T	Repair shoulder capsule	0052	42.37	$2,203.62		$440.72
23470	T	Reconstruct shoulder joint	0048	36.93	$1,920.69	$633.83	$384.14
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	34.03	$1,769.87		$353.97
23485	T	Revision of collar bone	0051	34.03	$1,769.87		$353.97
23490	T	Reinforce clavicle	0051	34.03	$1,769.87		$353.97
23491	T	Reinforce shoulder bones	0051	34.03	$1,769.87		$353.97
23500	T	Treat clavicle fracture	0043	1.68	$87.38		$17.48
23505	T	Treat clavicle fracture	0043	1.68	$87.38		$17.48
23515	T	Treat clavicle fracture	0046	29.03	$1,509.82	$535.76	$301.96
23520	T	Treat clavicle dislocation	0043	1.68	$87.38		$17.48
23525	T	Treat clavicle dislocation	0043	1.68	$87.38		$17.48
23530	T	Treat clavicle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
23532	T	Treat clavicle dislocation	0046	29.03	$1,509.82	$535.76	$301.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23540	T	Treat clavicle dislocation	0043	1.68	$87.38		$17.48
23545	T	Treat clavicle dislocation	0043	1.68	$87.38		$17.48
23550	T	Treat clavicle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
23552	T	Treat clavicle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
23570	T	Treat shoulder blade fx	0043	1.68	$87.38		$17.48
23575	T	Treat shoulder blade fx	0043	1.68	$87.38		$17.48
23585	T	Treat scapula fracture	0046	29.03	$1,509.82	$535.76	$301.96
23600	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
23605	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
23615	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
23616	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
23620	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
23625	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
23630	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
23650	T	Treat shoulder dislocation	0043	1.68	$87.38		$17.48
23655	T	Treat shoulder dislocation	0045	13.47	$700.56	$280.22	$140.11
23660	T	Treat shoulder dislocation	0046	29.03	$1,509.82	$535.76	$301.96
23665	T	Treat dislocation/fracture	0043	1.68	$87.38		$17.48
23670	T	Treat dislocation/fracture	0046	29.03	$1,509.82	$535.76	$301.96
23675	T	Treat dislocation/fracture	0043	1.68	$87.38		$17.48
23680	T	Treat dislocation/fracture	0046	29.03	$1,509.82	$535.76	$301.96
23700	T	Fixation of shoulder	0045	13.47	$700.56	$280.22	$140.11
23800	T	Fusion of shoulder joint	0051	34.03	$1,769.87		$353.97
23802	T	Fusion of shoulder joint	0051	34.03	$1,769.87		$353.97
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0025	5.89	$306.33	$116.41	$61.27
23929	T	Shoulder surgery procedure	0043	1.68	$87.38		$17.48
23930	T	Drainage of arm lesion	0008	16.32	$848.79		$169.76
23931	T	Drainage of arm bursa	0006	1.89	$98.30	$25.56	$19.66
23935	T	Drain arm/elbow bone lesion	0049	19.45	$1,011.58		$202.32
24000	T	Exploratory elbow surgery	0050	23.60	$1,227.41		$245.48
24006	T	Release elbow joint	0050	23.60	$1,227.41		$245.48
24065	T	Biopsy arm/elbow soft tissue	0021	14.58	$758.29	$227.49	$151.66
24066	T	Biopsy arm/elbow soft tissue	0021	14.58	$758.29	$227.49	$151.66
24075	T	Remove arm/elbow lesion	0021	14.58	$758.29	$227.49	$151.66
24076	T	Remove arm/elbow lesion	0022	18.10	$941.36	$367.13	$188.27
24077	T	Remove tumor of arm/elbow	0022	18.10	$941.36	$367.13	$188.27
24100	T	Biopsy elbow joint lining	0049	19.45	$1,011.58		$202.32
24101	T	Explore/treat elbow joint	0050	23.60	$1,227.41		$245.48
24102	T	Remove elbow joint lining	0050	23.60	$1,227.41		$245.48
24105	T	Removal of elbow bursa	0049	19.45	$1,011.58		$202.32
24110	T	Remove humerus lesion	0049	19.45	$1,011.58		$202.32
24115	T	Remove/graft bone lesion	0050	23.60	$1,227.41		$245.48
24116	T	Remove/graft bone lesion	0050	23.60	$1,227.41		$245.48
24120	T	Remove elbow lesion	0049	19.45	$1,011.58		$202.32
24125	T	Remove/graft bone lesion	0050	23.60	$1,227.41		$245.48
24126	T	Remove/graft bone lesion	0050	23.60	$1,227.41		$245.48
24130	T	Removal of head of radius	0050	23.60	$1,227.41		$245.48
24134	T	Removal of arm bone lesion	0050	23.60	$1,227.41		$245.48
24136	T	Remove radius bone lesion	0050	23.60	$1,227.41		$245.48
24138	T	Remove elbow bone lesion	0050	23.60	$1,227.41		$245.48
24140	T	Partial removal of arm bone	0050	23.60	$1,227.41		$245.48
24145	T	Partial removal of radius	0050	23.60	$1,227.41		$245.48
24147	T	Partial removal of elbow	0050	23.60	$1,227.41		$245.48
24149	C	Radical resection of elbow					
24150	T	Extensive humerus surgery	0052	42.37	$2,203.62		$440.72
24151	T	Extensive humerus surgery	0052	42.37	$2,203.62		$440.72
24152	T	Extensive radius surgery	0052	42.37	$2,203.62		$440.72
24153	T	Extensive radius surgery	0052	42.37	$2,203.62		$440.72
24155	T	Removal of elbow joint	0051	34.03	$1,769.87		$353.97
24160	T	Remove elbow joint implant	0050	23.60	$1,227.41		$245.48
24164	T	Remove radius head implant	0050	23.60	$1,227.41		$245.48
24200	T	Removal of arm foreign body	0019	3.94	$204.92	$75.82	$40.98
24201	T	Removal of arm foreign body	0021	14.58	$758.29	$227.49	$151.66
24220	N	Injection for elbow x-ray					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24300	T	Manipulate elbow w/anesth	0045	13.47	$700.56	$280.22	$140.11
24301	T	Muscle/tendon transfer	0050	23.60	$1,227.41		$245.48
24305	T	Arm tendon lengthening	0050	23.60	$1,227.41		$245.48
24310	T	Revision of arm tendon	0049	19.45	$1,011.58		$202.32
24320	T	Repair of arm tendon	0051	34.03	$1,769.87		$353.97
24330	T	Revision of arm muscles	0051	34.03	$1,769.87		$353.97
24331	T	Revision of arm muscles	0051	34.03	$1,769.87		$353.97
24332	T	Tenolysis, triceps	0049	19.45	$1,011.58		$202.32
24340	T	Repair of biceps tendon	0051	34.03	$1,769.87		$353.97
24341	T	Repair arm tendon/muscle	0051	34.03	$1,769.87		$353.97
24342	T	Repair of ruptured tendon	0051	34.03	$1,769.87		$353.97
24343	T	Repr elbow lat ligmnt w/tiss	0050	23.60	$1,227.41		$245.48
24344	T	Reconstruct elbow lat ligmnt	0051	34.03	$1,769.87		$353.97
24345	T	Repr elbw med ligmnt w/tiss	0050	23.60	$1,227.41		$245.48
24346	T	Reconstruct elbow med ligmnt	0051	34.03	$1,769.87		$353.97
24350	T	Repair of tennis elbow	0050	23.60	$1,227.41		$245.48
24351	T	Repair of tennis elbow	0050	23.60	$1,227.41		$245.48
24352	T	Repair of tennis elbow	0050	23.60	$1,227.41		$245.48
24354	T	Repair of tennis elbow	0050	23.60	$1,227.41		$245.48
24356	T	Revision of tennis elbow	0050	23.60	$1,227.41		$245.48
24360	T	Reconstruct elbow joint	0047	29.59	$1,538.95	$537.03	$307.79
24361	T	Reconstruct elbow joint	0048	36.93	$1,920.69	$633.83	$384.14
24362	T	Reconstruct elbow joint	0048	36.93	$1,920.69	$633.83	$384.14
24363	T	Replace elbow joint	0048	36.93	$1,920.69	$633.83	$384.14
24365	T	Reconstruct head of radius	0047	29.59	$1,538.95	$537.03	$307.79
24366	T	Reconstruct head of radius	0048	36.93	$1,920.69	$633.83	$384.14
24400	T	Revision of humerus	0050	23.60	$1,227.41		$245.48
24410	T	Revision of humerus	0050	23.60	$1,227.41		$245.48
24420	T	Revision of humerus	0051	34.03	$1,769.87		$353.97
24430	T	Repair of humerus	0051	34.03	$1,769.87		$353.97
24435	T	Repair humerus with graft	0051	34.03	$1,769.87		$353.97
24470	T	Revision of elbow joint	0051	34.03	$1,769.87		$353.97
24495	T	Decompression of forearm	0050	23.60	$1,227.41		$245.48
24498	T	Reinforce humerus	0051	34.03	$1,769.87		$353.97
24500	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24505	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24515	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24516	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24530	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24535	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24538	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24545	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24546	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24560	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24565	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24566	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24575	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24576	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24577	T	Treat humerus fracture	0043	1.68	$87.38		$17.48
24579	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24582	T	Treat humerus fracture	0046	29.03	$1,509.82	$535.76	$301.96
24586	T	Treat elbow fracture	0046	29.03	$1,509.82	$535.76	$301.96
24587	T	Treat elbow fracture	0046	29.03	$1,509.82	$535.76	$301.96
24600	T	Treat elbow dislocation	0043	1.68	$87.38		$17.48
24605	T	Treat elbow dislocation	0045	13.47	$700.56	$280.22	$140.11
24615	T	Treat elbow dislocation	0046	29.03	$1,509.82	$535.76	$301.96
24620	T	Treat elbow fracture	0043	1.68	$87.38		$17.48
24635	T	Treat elbow fracture	0046	29.03	$1,509.82	$535.76	$301.96
24640	T	Treat elbow dislocation	0043	1.68	$87.38		$17.48
24650	T	Treat radius fracture	0043	1.68	$87.38		$17.48
24655	T	Treat radius fracture	0043	1.68	$87.38		$17.48
24665	T	Treat radius fracture	0046	29.03	$1,509.82	$535.76	$301.96
24666	T	Treat radius fracture	0046	29.03	$1,509.82	$535.76	$301.96
24670	T	Treat ulnar fracture	0043	1.68	$87.38		$17.48
24675	T	Treat ulnar fracture	0043	1.68	$87.38		$17.48
24685	T	Treat ulnar fracture	0046	29.03	$1,509.82	$535.76	$301.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24800	T	Fusion of elbow joint	0051	34.03	$1,769.87		$353.97
24802	T	Fusion/graft of elbow joint	0051	34.03	$1,769.87		$353.97
24900	C	Amputation of upper arm					
24920	C	Amputation of upper arm					
24925	T	Amputation follow-up surgery	0049	19.45	$1,011.58		$202.32
24930	C	Amputation follow-up surgery					
24931	C	Amputate upper arm & implant					
24935	T	Revision of amputation	0052	42.37	$2,203.62		$440.72
24940	C	Revision of upper arm					
24999	T	Upper arm/elbow surgery	0043	1.68	$87.38		$17.48
25000	T	Incision of tendon sheath	0049	19.45	$1,011.58		$202.32
25001	T	Incise flexor carpi radialis	0049	19.45	$1,011.58		$202.32
25020	T	Decompress forearm 1 space	0049	19.45	$1,011.58		$202.32
25023	T	Decompress forearm 1 space	0050	23.60	$1,227.41		$245.48
25024	T	Decompress forearm 2 spaces	0050	23.60	$1,227.41		$245.48
25025	T	Decompress forarm 2 spaces	0050	23.60	$1,227.41		$245.48
25028	T	Drainage of forearm lesion	0049	19.45	$1,011.58		$202.32
25031	T	Drainage of forearm bursa	0049	19.45	$1,011.58		$202.32
25035	T	Treat forearm bone lesion	0049	19.45	$1,011.58		$202.32
25040	T	Explore/treat wrist joint	0050	23.60	$1,227.41		$245.48
25065	T	Biopsy forearm soft tissues	0021	14.58	$758.29	$227.49	$151.66
25066	T	Biopsy forearm soft tissues	0022	18.10	$941.36	$367.13	$188.27
25075	T	Remove forearm lesion subcut	0021	14.58	$758.29	$227.49	$151.66
25076	T	Remove forearm lesion deep	0022	18.10	$941.36	$367.13	$188.27
25077	T	Remove tumor, forearm/wrist	0022	18.10	$941.36	$367.13	$188.27
25085	T	Incision of wrist capsule	0049	19.45	$1,011.58		$202.32
25100	T	Biopsy of wrist joint	0049	19.45	$1,011.58		$202.32
25101	T	Explore/treat wrist joint	0050	23.60	$1,227.41		$245.48
25105	T	Remove wrist joint lining	0050	23.60	$1,227.41		$245.48
25107	T	Remove wrist joint cartilage	0050	23.60	$1,227.41		$245.48
25110	T	Remove wrist tendon lesion	0049	19.45	$1,011.58		$202.32
25111	T	Remove wrist tendon lesion	0053	14.76	$767.65	$253.49	$153.53
25112	T	Reremove wrist tendon lesion	0053	14.76	$767.65	$253.49	$153.53
25115	T	Remove wrist/forearm lesion	0049	19.45	$1,011.58		$202.32
25116	T	Remove wrist/forearm lesion	0049	19.45	$1,011.58		$202.32
25118	T	Excise wrist tendon sheath	0050	23.60	$1,227.41		$245.48
25119	T	Partial removal of ulna	0050	23.60	$1,227.41		$245.48
25120	T	Removal of forearm lesion	0050	23.60	$1,227.41		$245.48
25125	T	Remove/graft forearm lesion	0050	23.60	$1,227.41		$245.48
25126	T	Remove/graft forearm lesion	0050	23.60	$1,227.41		$245.48
25130	T	Removal of wrist lesion	0050	23.60	$1,227.41		$245.48
25135	T	Remove & graft wrist lesion	0050	23.60	$1,227.41		$245.48
25136	T	Remove & graft wrist lesion	0050	23.60	$1,227.41		$245.48
25145	T	Remove forearm bone lesion	0050	23.60	$1,227.41		$245.48
25150	T	Partial removal of ulna	0050	23.60	$1,227.41		$245.48
25151	T	Partial removal of radius	0050	23.60	$1,227.41		$245.48
25170	T	Extensive forearm surgery	0052	42.37	$2,203.62		$440.72
25210	T	Removal of wrist bone	0054	23.50	$1,222.21	$472.33	$244.44
25215	T	Removal of wrist bones	0054	23.50	$1,222.21	$472.33	$244.44
25230	T	Partial removal of radius	0050	23.60	$1,227.41		$245.48
25240	T	Partial removal of ulna	0050	23.60	$1,227.41		$245.48
25246	N	Injection for wrist x-ray					
25248	T	Remove forearm foreign body	0049	19.45	$1,011.58		$202.32
25250	T	Removal of wrist prosthesis	0050	23.60	$1,227.41		$245.48
25251	T	Removal of wrist prosthesis	0050	23.60	$1,227.41		$245.48
25259	T	Manipulate wrist w/anesthes	0043	1.68	$87.38		$17.48
25260	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25263	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25265	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25270	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25272	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25274	T	Repair forearm tendon/muscle	0050	23.60	$1,227.41		$245.48
25275	T	Repair forearm tendon sheath	0050	23.60	$1,227.41		$245.48
25280	T	Revise wrist/forearm tendon	0050	23.60	$1,227.41		$245.48
25290	T	Incise wrist/forearm tendon	0050	23.60	$1,227.41		$245.48
25295	T	Release wrist/forearm tendon	0049	19.45	$1,011.58		$202.32

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25300	T	Fusion of tendons at wrist	0050	23.60	$1,227.41		$245.48
25301	T	Fusion of tendons at wrist	0050	23.60	$1,227.41		$245.48
25310	T	Transplant forearm tendon	0051	34.03	$1,769.87		$353.97
25312	T	Transplant forearm tendon	0051	34.03	$1,769.87		$353.97
25315	T	Revise palsy hand tendon(s)	0051	34.03	$1,769.87		$353.97
25316	T	Revise palsy hand tendon(s)	0051	34.03	$1,769.87		$353.97
25320	T	Repair/revise wrist joint	0051	34.03	$1,769.87		$353.97
25332	T	Revise wrist joint	0047	29.59	$1,538.95	$537.03	$307.79
25335	T	Realignment of hand	0051	34.03	$1,769.87		$353.97
25337	T	Reconstruct ulna/radioulnar	0051	34.03	$1,769.87		$353.97
25350	T	Revision of radius	0051	34.03	$1,769.87		$353.97
25355	T	Revision of radius	0051	34.03	$1,769.87		$353.97
25360	T	Revision of ulna	0050	23.60	$1,227.41		$245.48
25365	T	Revise radius & ulna	0050	23.60	$1,227.41		$245.48
25370	T	Revise radius or ulna	0051	34.03	$1,769.87		$353.97
25375	T	Revise radius & ulna	0051	34.03	$1,769.87		$353.97
25390	T	Shorten radius or ulna	0050	23.60	$1,227.41		$245.48
25391	T	Lengthen radius or ulna	0051	34.03	$1,769.87		$353.97
25392	T	Shorten radius & ulna	0050	23.60	$1,227.41		$245.48
25393	T	Lengthen radius & ulna	0051	34.03	$1,769.87		$353.97
25394	T	Repair carpal bone, shorten	0053	14.76	$767.65	$253.49	$153.53
25400	T	Repair radius or ulna	0050	23.60	$1,227.41		$245.48
25405	T	Repair/graft radius or ulna	0050	23.60	$1,227.41		$245.48
25415	T	Repair radius & ulna	0050	23.60	$1,227.41		$245.48
25420	T	Repair/graft radius & ulna	0051	34.03	$1,769.87		$353.97
25425	T	Repair/graft radius or ulna	0051	34.03	$1,769.87		$353.97
25426	T	Repair/graft radius & ulna	0051	34.03	$1,769.87		$353.97
25430	T	Vasc graft into carpal bone	0054	23.50	$1,222.21	$472.33	$244.44
25431	T	Repair nonunion carpal bone	0054	23.50	$1,222.21	$472.33	$244.44
25440	T	Repair/graft wrist bone	0051	34.03	$1,769.87		$353.97
25441	T	Reconstruct wrist joint	0048	36.93	$1,920.69	$633.83	$384.14
25442	T	Reconstruct wrist joint	0048	36.93	$1,920.69	$633.83	$384.14
25443	T	Reconstruct wrist joint	0048	36.93	$1,920.69	$633.83	$384.14
25444	T	Reconstruct wrist joint	0048	36.93	$1,920.69	$633.83	$384.14
25445	T	Reconstruct wrist joint	0048	36.93	$1,920.69	$633.83	$384.14
25446	T	Wrist replacement	0048	36.93	$1,920.69	$633.83	$384.14
25447	T	Repair wrist joint(s)	0047	29.59	$1,538.95	$537.03	$307.79
25449	T	Remove wrist joint implant	0047	29.59	$1,538.95	$537.03	$307.79
25450	T	Revision of wrist joint	0051	34.03	$1,769.87		$353.97
25455	T	Revision of wrist joint	0051	34.03	$1,769.87		$353.97
25490	T	Reinforce radius	0051	34.03	$1,769.87		$353.97
25491	T	Reinforce ulna	0051	34.03	$1,769.87		$353.97
25492	T	Reinforce radius and ulna	0051	34.03	$1,769.87		$353.97
25500	T	Treat fracture of radius	0043	1.68	$87.38		$17.48
25505	T	Treat fracture of radius	0043	1.68	$87.38		$17.48
25515	T	Treat fracture of radius	0046	29.03	$1,509.82	$535.76	$301.96
25520	T	Treat fracture of radius	0043	1.68	$87.38		$17.48
25525	T	Treat fracture of radius	0046	29.03	$1,509.82	$535.76	$301.96
25526	T	Treat fracture of radius	0046	29.03	$1,509.82	$535.76	$301.96
25530	T	Treat fracture of ulna	0043	1.68	$87.38		$17.48
25535	T	Treat fracture of ulna	0043	1.68	$87.38		$17.48
25545	T	Treat fracture of ulna	0046	29.03	$1,509.82	$535.76	$301.96
25560	T	Treat fracture radius & ulna	0043	1.68	$87.38		$17.48
25565	T	Treat fracture radius & ulna	0043	1.68	$87.38		$17.48
25574	T	Treat fracture radius & ulna	0046	29.03	$1,509.82	$535.76	$301.96
25575	T	Treat fracture radius/ulna	0046	29.03	$1,509.82	$535.76	$301.96
25600	T	Treat fracture radius/ulna	0043	1.68	$87.38		$17.48
25605	T	Treat fracture radius/ulna	0043	1.68	$87.38		$17.48
25611	T	Treat fracture radius/ulna	0046	29.03	$1,509.82	$535.76	$301.96
25620	T	Treat fracture radius/ulna	0046	29.03	$1,509.82	$535.76	$301.96
25622	T	Treat wrist bone fracture	0043	1.68	$87.38		$17.48
25624	T	Treat wrist bone fracture	0043	1.68	$87.38		$17.48
25628	T	Treat wrist bone fracture	0046	29.03	$1,509.82	$535.76	$301.96
25630	T	Treat wrist bone fracture	0043	1.68	$87.38		$17.48
25635	T	Treat wrist bone fracture	0043	1.68	$87.38		$17.48
25645	T	Treat wrist bone fracture	0046	29.03	$1,509.82	$535.76	$301.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25650	T	Treat wrist bone fracture	0043	1.68	$87.38		$17.48
25651	T	Pin ulnar styloid fracture	0046	29.03	$1,509.82	$535.76	$301.96
25652	T	Treat fracture ulnar styloid	0046	29.03	$1,509.82	$535.76	$301.96
25660	T	Treat wrist dislocation	0043	1.68	$87.38		$17.48
25670	T	Treat wrist dislocation	0046	29.03	$1,509.82	$535.76	$301.96
25671	T	Pin radioulnar dislocation	0046	29.03	$1,509.82	$535.76	$301.96
25675	T	Treat wrist dislocation	0043	1.68	$87.38		$17.48
25676	T	Treat wrist dislocation	0046	29.03	$1,509.82	$535.76	$301.96
25680	T	Treat wrist fracture	0043	1.68	$87.38		$17.48
25685	T	Treat wrist fracture	0046	29.03	$1,509.82	$535.76	$301.96
25690	T	Treat wrist dislocation	0043	1.68	$87.38		$17.48
25695	T	Treat wrist dislocation	0046	29.03	$1,509.82	$535.76	$301.96
25800	T	Fusion of wrist joint	0051	34.03	$1,769.87		$353.97
25805	T	Fusion/graft of wrist joint	0051	34.03	$1,769.87		$353.97
25810	T	Fusion/graft of wrist joint	0051	34.03	$1,769.87		$353.97
25820	T	Fusion of hand bones	0053	14.76	$767.65	$253.49	$153.53
25825	T	Fuse hand bones with graft	0054	23.50	$1,222.21	$472.33	$244.44
25830	T	Fusion, radioulnar jnt/ulna	0051	34.03	$1,769.87		$353.97
25900	C	Amputation of forearm					
25905	C	Amputation of forearm					
25907	T	Amputation follow-up surgery	0049	19.45	$1,011.58		$202.32
25909	C	Amputation follow-up surgery					
25915	C	Amputation of forearm					
25920	C	Amputate hand at wrist					
25922	T	Amputate hand at wrist	0049	19.45	$1,011.58		$202.32
25924	C	Amputation follow-up surgery					
25927	C	Amputation of hand					
25929	T	Amputation follow-up surgery	0027	15.73	$818.10	$343.60	$163.62
25931	C	Amputation follow-up surgery					
25999	T	Forearm or wrist surgery	0043	1.68	$87.38		$17.48
26010	T	Drainage of finger abscess	0006	1.89	$98.30	$25.56	$19.66
26011	T	Drainage of finger abscess	0007	9.44	$490.96	$103.10	$98.19
26020	T	Drain hand tendon sheath	0053	14.76	$767.65	$253.49	$153.53
26025	T	Drainage of palm bursa	0053	14.76	$767.65	$253.49	$153.53
26030	T	Drainage of palm bursa(s)	0053	14.76	$767.65	$253.49	$153.53
26034	T	Treat hand bone lesion	0053	14.76	$767.65	$253.49	$153.53
26035	T	Decompress fingers/hand	0053	14.76	$767.65	$253.49	$153.53
26037	T	Decompress fingers/hand	0053	14.76	$767.65	$253.49	$153.53
26040	T	Release palm contracture	0054	23.50	$1,222.21	$472.33	$244.44
26045	T	Release palm contracture	0054	23.50	$1,222.21	$472.33	$244.44
26055	T	Incise finger tendon sheath	0053	14.76	$767.65	$253.49	$153.53
26060	T	Incision of finger tendon	0053	14.76	$767.65	$253.49	$153.53
26070	T	Explore/treat hand joint	0053	14.76	$767.65	$253.49	$153.53
26075	T	Explore/treat finger joint	0053	14.76	$767.65	$253.49	$153.53
26080	T	Explore/treat finger joint	0053	14.76	$767.65	$253.49	$153.53
26100	T	Biopsy hand joint lining	0053	14.76	$767.65	$253.49	$153.53
26105	T	Biopsy finger joint lining	0053	14.76	$767.65	$253.49	$153.53
26110	T	Biopsy finger joint lining	0053	14.76	$767.65	$253.49	$153.53
26115	T	Remove hand lesion subcut	0022	18.10	$941.36	$367.13	$188.27
26116	T	Remove hand lesion, deep	0022	18.10	$941.36	$367.13	$188.27
26117	T	Remove tumor, hand/finger	0022	18.10	$941.36	$367.13	$188.27
26121	T	Release palm contracture	0054	23.50	$1,222.21	$472.33	$244.44
26123	T	Release palm contracture	0054	23.50	$1,222.21	$472.33	$244.44
26125	T	Release palm contracture	0054	23.50	$1,222.21	$472.33	$244.44
26130	T	Remove wrist joint lining	0053	14.76	$767.65	$253.49	$153.53
26135	T	Revise finger joint, each	0054	23.50	$1,222.21	$472.33	$244.44
26140	T	Revise finger joint, each	0053	14.76	$767.65	$253.49	$153.53
26145	T	Tendon excision, palm/finger	0053	14.76	$767.65	$253.49	$153.53
26160	T	Remove tendon sheath lesion	0053	14.76	$767.65	$253.49	$153.53
26170	T	Removal of palm tendon, each	0053	14.76	$767.65	$253.49	$153.53
26180	T	Removal of finger tendon	0053	14.76	$767.65	$253.49	$153.53
26185	T	Remove finger bone	0053	14.76	$767.65	$253.49	$153.53
26200	T	Remove hand bone lesion	0053	14.76	$767.65	$253.49	$153.53
26205	T	Remove/graft bone lesion	0054	23.50	$1,222.21	$472.33	$244.44
26210	T	Removal of finger lesion	0053	14.76	$767.65	$253.49	$153.53
26215	T	Remove/graft finger lesion	0053	14.76	$767.65	$253.49	$153.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26230	T	Partial removal of hand bone	0053	14.76	$767.65	$253.49	$153.53
26235	T	Partial removal, finger bone	0053	14.76	$767.65	$253.49	$153.53
26236	T	Partial removal, finger bone	0053	14.76	$767.65	$253.49	$153.53
26250	T	Extensive hand surgery	0053	14.76	$767.65	$253.49	$153.53
26255	T	Extensive hand surgery	0054	23.50	$1,222.21	$472.33	$244.44
26260	T	Extensive finger surgery	0053	14.76	$767.65	$253.49	$153.53
26261	T	Extensive finger surgery	0053	14.76	$767.65	$253.49	$153.53
26262	T	Partial removal of finger	0053	14.76	$767.65	$253.49	$153.53
26320	T	Removal of implant from hand	0021	14.58	$758.29	$227.49	$151.66
26340	T	Manipulate finger w/anesth	0043	1.68	$87.38	.....	$17.48
26350	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26352	T	Repair/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26356	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26357	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26358	T	Repair/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26370	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26372	T	Repair/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26373	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26390	T	Revise hand/finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26392	T	Repair/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26410	T	Repair hand tendon	0053	14.76	$767.65	$253.49	$153.53
26412	T	Repair/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26415	T	Excision, hand/finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26416	T	Graft hand or finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26418	T	Repair finger tendon	0053	14.76	$767.65	$253.49	$153.53
26420	T	Repair/graft finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26426	T	Repair finger/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26428	T	Repair/graft finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26432	T	Repair finger tendon	0053	14.76	$767.65	$253.49	$153.53
26433	T	Repair finger tendon	0053	14.76	$767.65	$253.49	$153.53
26434	T	Repair/graft finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26437	T	Realignment of tendons	0053	14.76	$767.65	$253.49	$153.53
26440	T	Release palm/finger tendon	0053	14.76	$767.65	$253.49	$153.53
26442	T	Release palm & finger tendon	0054	23.50	$1,222.21	$472.33	$244.44
26445	T	Release hand/finger tendon	0053	14.76	$767.65	$253.49	$153.53
26449	T	Release forearm/hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26450	T	Incision of palm tendon	0053	14.76	$767.65	$253.49	$153.53
26455	T	Incision of finger tendon	0053	14.76	$767.65	$253.49	$153.53
26460	T	Incise hand/finger tendon	0053	14.76	$767.65	$253.49	$153.53
26471	T	Fusion of finger tendons	0053	14.76	$767.65	$253.49	$153.53
26474	T	Fusion of finger tendons	0053	14.76	$767.65	$253.49	$153.53
26476	T	Tendon lengthening	0053	14.76	$767.65	$253.49	$153.53
26477	T	Tendon shortening	0053	14.76	$767.65	$253.49	$153.53
26478	T	Lengthening of hand tendon	0053	14.76	$767.65	$253.49	$153.53
26479	T	Shortening of hand tendon	0053	14.76	$767.65	$253.49	$153.53
26480	T	Transplant hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26483	T	Transplant/graft hand tendon	0054	23.50	$1,222.21	$472.33	$244.44
26485	T	Transplant palm tendon	0054	23.50	$1,222.21	$472.33	$244.44
26489	T	Transplant/graft palm tendon	0054	23.50	$1,222.21	$472.33	$244.44
26490	T	Revise thumb tendon	0054	23.50	$1,222.21	$472.33	$244.44
26492	T	Tendon transfer with graft	0054	23.50	$1,222.21	$472.33	$244.44
26494	T	Hand tendon/muscle transfer	0054	23.50	$1,222.21	$472.33	$244.44
26496	T	Revise thumb tendon	0054	23.50	$1,222.21	$472.33	$244.44
26497	T	Finger tendon transfer	0054	23.50	$1,222.21	$472.33	$244.44
26498	T	Finger tendon transfer	0054	23.50	$1,222.21	$472.33	$244.44
26499	T	Revision of finger	0054	23.50	$1,222.21	$472.33	$244.44
26500	T	Hand tendon reconstruction	0053	14.76	$767.65	$253.49	$153.53
26502	T	Hand tendon reconstruction	0054	23.50	$1,222.21	$472.33	$244.44
26504	T	Hand tendon reconstruction	0054	23.50	$1,222.21	$472.33	$244.44
26508	T	Release thumb contracture	0053	14.76	$767.65	$253.49	$153.53
26510	T	Thumb tendon transfer	0054	23.50	$1,222.21	$472.33	$244.44
26516	T	Fusion of knuckle joint	0054	23.50	$1,222.21	$472.33	$244.44
26517	T	Fusion of knuckle joints	0054	23.50	$1,222.21	$472.33	$244.44
26518	T	Fusion of knuckle joints	0054	23.50	$1,222.21	$472.33	$244.44
26520	T	Release knuckle contracture	0053	14.76	$767.65	$253.49	$153.53
26525	T	Release finger contracture	0053	14.76	$767.65	$253.49	$153.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26530	T	Revise knuckle joint	0047	29.59	$1,538.95	$537.03	$307.79
26531	T	Revise knuckle with implant	0048	36.93	$1,920.69	$633.83	$384.14
26535	T	Revise finger joint	0047	29.59	$1,538.95	$537.03	$307.79
26536	T	Revise/implant finger joint	0048	36.93	$1,920.69	$633.83	$384.14
26540	T	Repair hand joint	0053	14.76	$767.65	$253.49	$153.53
26541	T	Repair hand joint with graft	0054	23.50	$1,222.21	$472.33	$244.44
26542	T	Repair hand joint with graft	0053	14.76	$767.65	$253.49	$153.53
26545	T	Reconstruct finger joint	0054	23.50	$1,222.21	$472.33	$244.44
26546	T	Repair nonunion hand	0054	23.50	$1,222.21	$472.33	$244.44
26548	T	Reconstruct finger joint	0054	23.50	$1,222.21	$472.33	$244.44
26550	T	Construct thumb replacement	0054	23.50	$1,222.21	$472.33	$244.44
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	23.50	$1,222.21	$472.33	$244.44
26556	C	Toe joint transfer					
26560	T	Repair of web finger	0053	14.76	$767.65	$253.49	$153.53
26561	T	Repair of web finger	0054	23.50	$1,222.21	$472.33	$244.44
26562	T	Repair of web finger	0054	23.50	$1,222.21	$472.33	$244.44
26565	T	Correct metacarpal flaw	0054	23.50	$1,222.21	$472.33	$244.44
26567	T	Correct finger deformity	0054	23.50	$1,222.21	$472.33	$244.44
26568	T	Lengthen metacarpal/finger	0054	23.50	$1,222.21	$472.33	$244.44
26580	T	Repair hand deformity	0054	23.50	$1,222.21	$472.33	$244.44
26587	T	Reconstruct extra finger	0053	14.76	$767.65	$253.49	$153.53
26590	T	Repair finger deformity	0054	23.50	$1,222.21	$472.33	$244.44
26591	T	Repair muscles of hand	0054	23.50	$1,222.21	$472.33	$244.44
26593	T	Release muscles of hand	0053	14.76	$767.65	$253.49	$153.53
26596	T	Excision constricting tissue	0054	23.50	$1,222.21	$472.33	$244.44
26600	T	Treat metacarpal fracture	0043	1.68	$87.38		$17.48
26605	T	Treat metacarpal fracture	0043	1.68	$87.38		$17.48
26607	T	Treat metacarpal fracture	0043	1.68	$87.38		$17.48
26608	T	Treat metacarpal fracture	0046	29.03	$1,509.82	$535.76	$301.96
26615	T	Treat metacarpal fracture	0046	29.03	$1,509.82	$535.76	$301.96
26641	T	Treat thumb dislocation	0043	1.68	$87.38		$17.48
26645	T	Treat thumb fracture	0043	1.68	$87.38		$17.48
26650	T	Treat thumb fracture	0046	29.03	$1,509.82	$535.76	$301.96
26665	T	Treat thumb fracture	0046	29.03	$1,509.82	$535.76	$301.96
26670	T	Treat hand dislocation	0043	1.68	$87.38		$17.48
26675	T	Treat hand dislocation	0043	1.68	$87.38		$17.48
26676	T	Pin hand dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26685	T	Treat hand dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26686	T	Treat hand dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26700	T	Treat knuckle dislocation	0043	1.68	$87.38		$17.48
26705	T	Treat knuckle dislocation	0043	1.68	$87.38		$17.48
26706	T	Pin knuckle dislocation	0043	1.68	$87.38		$17.48
26715	T	Treat knuckle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26720	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26725	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26727	T	Treat finger fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
26735	T	Treat finger fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
26740	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26742	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26746	T	Treat finger fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
26750	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26755	T	Treat finger fracture, each	0043	1.68	$87.38		$17.48
26756	T	Pin finger fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
26765	T	Treat finger fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
26770	T	Treat finger dislocation	0043	1.68	$87.38		$17.48
26775	T	Treat finger dislocation	0045	13.47	$700.56	$280.22	$140.11
26776	T	Pin finger dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26785	T	Treat finger dislocation	0046	29.03	$1,509.82	$535.76	$301.96
26820	T	Thumb fusion with graft	0054	23.50	$1,222.21	$472.33	$244.44
26841	T	Fusion of thumb	0054	23.50	$1,222.21	$472.33	$244.44
26842	T	Thumb fusion with graft	0054	23.50	$1,222.21	$472.33	$244.44
26843	T	Fusion of hand joint	0054	23.50	$1,222.21	$472.33	$244.44
26844	T	Fusion/graft of hand joint	0054	23.50	$1,222.21	$472.33	$244.44

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26850	T	Fusion of knuckle	0054	23.50	$1,222.21	$472.33	$244.44
26852	T	Fusion of knuckle with graft	0054	23.50	$1,222.21	$472.33	$244.44
26860	T	Fusion of finger joint	0054	23.50	$1,222.21	$472.33	$244.44
26861	T	Fusion of finger jnt, add-on	0054	23.50	$1,222.21	$472.33	$244.44
26862	T	Fusion/graft of finger joint	0054	23.50	$1,222.21	$472.33	$244.44
26863	T	Fuse/graft added joint	0054	23.50	$1,222.21	$472.33	$244.44
26910	T	Amputate metacarpal bone	0054	23.50	$1,222.21	$472.33	$244.44
26951	T	Amputation of finger/thumb	0053	14.76	$767.65	$253.49	$153.53
26952	T	Amputation of finger/thumb	0053	14.76	$767.65	$253.49	$153.53
26989	T	Hand/finger surgery	0043	1.68	$87.38		$17.48
26990	T	Drainage of pelvis lesion	0049	19.45	$1,011.58		$202.32
26991	T	Drainage of pelvis bursa	0049	19.45	$1,011.58		$202.32
26992	C	Drainage of bone lesion					
27000	T	Incision of hip tendon	0049	19.45	$1,011.58		$202.32
27001	T	Incision of hip tendon	0050	23.60	$1,227.41		$245.48
27003	T	Incision of hip tendon	0050	23.60	$1,227.41		$245.48
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	34.03	$1,769.87		$353.97
27035	T	Denervation of hip joint	0052	42.37	$2,203.62		$440.72
27036	C	Excision of hip joint/muscle					
27040	T	Biopsy of soft tissues	0021	14.58	$758.29	$227.49	$151.66
27041	T	Biopsy of soft tissues	0022	18.10	$941.36	$367.13	$188.27
27047	T	Remove hip/pelvis lesion	0022	18.10	$941.36	$367.13	$188.27
27048	T	Remove hip/pelvis lesion	0022	18.10	$941.36	$367.13	$188.27
27049	T	Remove tumor, hip/pelvis	0022	18.10	$941.36	$367.13	$188.27
27050	T	Biopsy of sacroiliac joint	0049	19.45	$1,011.58		$202.32
27052	T	Biopsy of hip joint	0049	19.45	$1,011.58		$202.32
27054	C	Removal of hip joint lining					
27060	T	Removal of ischial bursa	0049	19.45	$1,011.58		$202.32
27062	T	Remove femur lesion/bursa	0049	19.45	$1,011.58		$202.32
27065	T	Removal of hip bone lesion	0049	19.45	$1,011.58		$202.32
27066	T	Removal of hip bone lesion	0050	23.60	$1,227.41		$245.48
27067	T	Remove/graft hip bone lesion	0050	23.60	$1,227.41		$245.48
27070	C	Partial removal of hip bone					
27071	C	Partial removal of hip bone					
27075	C	Extensive hip surgery					
27076	C	Extensive hip surgery					
27077	C	Extensive hip surgery					
27078	C	Extensive hip surgery					
27079	C	Extensive hip surgery					
27080	T	Removal of tail bone	0050	23.60	$1,227.41		$245.48
27086	T	Remove hip foreign body	0020	7.36	$382.79	$114.84	$76.56
27087	T	Remove hip foreign body	0049	19.45	$1,011.58		$202.32
27090	C	Removal of hip prosthesis					
27091	C	Removal of hip prosthesis					
27093	N	Injection for hip x-ray					
27095	N	Injection for hip x-ray					
27096	N	Inject sacroiliac joint					
27097	T	Revision of hip tendon	0050	23.60	$1,227.41		$245.48
27098	T	Transfer tendon to pelvis	0050	23.60	$1,227.41		$245.48
27100	T	Transfer of abdominal muscle	0051	34.03	$1,769.87		$353.97
27105	T	Transfer of spinal muscle	0051	34.03	$1,769.87		$353.97
27110	T	Transfer of iliopsoas muscle	0051	34.03	$1,769.87		$353.97
27111	T	Transfer of iliopsoas muscle	0051	34.03	$1,769.87		$353.97
27120	C	Reconstruction of hip socket					
27122	C	Reconstruction of hip socket					
27125	C	Partial hip replacement					
27130	C	Total hip arthroplasty					
27132	C	Total hip arthroplasty					
27134	C	Revise hip joint replacement					
27137	C	Revise hip joint replacement					
27138	C	Revise hip joint replacement					
27140	C	Transplant femur ridge					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27146	C	Incision of hip bone					
27147	C	Revision of hip bone					
27151	C	Incision of hip bones					
27156	C	Revision of hip bones					
27158	C	Revision of pelvis					
27161	C	Incision of neck of femur					
27165	C	Incision/fixation of femur					
27170	C	Repair/graft femur head/neck					
27175	C	Treat slipped epiphysis					
27176	C	Treat slipped epiphysis					
27177	C	Treat slipped epiphysis					
27178	C	Treat slipped epiphysis					
27179	C	Revise head/neck of femur					
27181	C	Treat slipped epiphysis					
27185	C	Revision of femur epiphysis					
27187	C	Reinforce hip bones					
27193	T	Treat pelvic ring fracture	0043	1.68	$87.38		$17.48
27194	T	Treat pelvic ring fracture	0045	13.47	$700.56	$280.22	$140.11
27200	T	Treat tail bone fracture	0043	1.68	$87.38		$17.48
27202	T	Treat tail bone fracture	0046	29.03	$1,509.82	$535.76	$301.96
27215	C	Treat pelvic fracture(s)					
27216	T	Treat pelvic ring fracture	0050	23.60	$1,227.41		$245.48
27217	C	Treat pelvic ring fracture					
27218	C	Treat pelvic ring fracture					
27220	T	Treat hip socket fracture	0043	1.68	$87.38		$17.48
27222	C	Treat hip socket fracture					
27226	C	Treat hip wall fracture					
27227	C	Treat hip fracture(s)					
27228	C	Treat hip fracture(s)					
27230	T	Treat thigh fracture	0043	1.68	$87.38		$17.48
27232	C	Treat thigh fracture					
27235	T	Treat thigh fracture	0050	23.60	$1,227.41		$245.48
27236	C	Treat thigh fracture					
27238	T	Treat thigh fracture	0043	1.68	$87.38		$17.48
27240	C	Treat thigh fracture					
27244	C	Treat thigh fracture					
27245	C	Treat thigh fracture					
27246	T	Treat thigh fracture	0043	1.68	$87.38		$17.48
27248	C	Treat thigh fracture					
27250	T	Treat hip dislocation	0043	1.68	$87.38		$17.48
27252	T	Treat hip dislocation	0045	13.47	$700.56	$280.22	$140.11
27253	C	Treat hip dislocation					
27254	C	Treat hip dislocation					
27256	T	Treat hip dislocation	0043	1.68	$87.38		$17.48
27257	T	Treat hip dislocation	0045	13.47	$700.56	$280.22	$140.11
27258	C	Treat hip dislocation					
27259	C	Treat hip dislocation					
27265	T	Treat hip dislocation	0043	1.68	$87.38		$17.48
27266	T	Treat hip dislocation	0045	13.47	$700.56	$280.22	$140.11
27275	T	Manipulation of hip joint	0045	13.47	$700.56	$280.22	$140.11
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	1.68	$87.38		$17.48
27301	T	Drain thigh/knee lesion	0008	16.32	$848.79		$169.76
27303	C	Drainage of bone lesion					
27305	T	Incise thigh tendon & fascia	0049	19.45	$1,011.58		$202.32
27306	T	Incision of thigh tendon	0049	19.45	$1,011.58		$202.32
27307	T	Incision of thigh tendons	0049	19.45	$1,011.58		$202.32
27310	T	Exploration of knee joint	0050	23.60	$1,227.41		$245.48
27315	T	Partial removal, thigh nerve	0220	16.66	$866.47		$173.29
27320	T	Partial removal, thigh nerve	0220	16.66	$866.47		$173.29
27323	T	Biopsy, thigh soft tissues	0021	14.58	$758.29	$227.49	$151.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27324	T	Biopsy, thigh soft tissues	0022	18.10	$941.36	$367.13	$188.27
27327	T	Removal of thigh lesion	0022	18.10	$941.36	$367.13	$188.27
27328	T	Removal of thigh lesion	0022	18.10	$941.36	$367.13	$188.27
27329	T	Remove tumor, thigh/knee	0022	18.10	$941.36	$367.13	$188.27
27330	T	Biopsy, knee joint lining	0050	23.60	$1,227.41		$245.48
27331	T	Explore/treat knee joint	0050	23.60	$1,227.41		$245.48
27332	T	Removal of knee cartilage	0050	23.60	$1,227.41		$245.48
27333	T	Removal of knee cartilage	0050	23.60	$1,227.41		$245.48
27334	T	Remove knee joint lining	0050	23.60	$1,227.41		$245.48
27335	T	Remove knee joint lining	0050	23.60	$1,227.41		$245.48
27340	T	Removal of kneecap bursa	0049	19.45	$1,011.58		$202.32
27345	T	Removal of knee cyst	0049	19.45	$1,011.58		$202.32
27347	T	Remove knee cyst	0049	19.45	$1,011.58		$202.32
27350	T	Removal of kneecap	0050	23.60	$1,227.41		$245.48
27355	T	Remove femur lesion	0050	23.60	$1,227.41		$245.48
27356	T	Remove femur lesion/graft	0050	23.60	$1,227.41		$245.48
27357	T	Remove femur lesion/graft	0050	23.60	$1,227.41		$245.48
27358	T	Remove femur lesion/fixation	0050	23.60	$1,227.41		$245.48
27360	T	Partial removal, leg bone(s)	0050	23.60	$1,227.41		$245.48
27365	C	Extensive leg surgery					
27370	N	Injection for knee x-ray					
27372	T	Removal of foreign body	0022	18.10	$941.36	$367.13	$188.27
27380	T	Repair of kneecap tendon	0049	19.45	$1,011.58		$202.32
27381	T	Repair/graft kneecap tendon	0049	19.45	$1,011.58		$202.32
27385	T	Repair of thigh muscle	0049	19.45	$1,011.58		$202.32
27386	T	Repair/graft of thigh muscle	0049	19.45	$1,011.58		$202.32
27390	T	Incision of thigh tendon	0049	19.45	$1,011.58		$202.32
27391	T	Incision of thigh tendons	0049	19.45	$1,011.58		$202.32
27392	T	Incision of thigh tendons	0049	19.45	$1,011.58		$202.32
27393	T	Lengthening of thigh tendon	0050	23.60	$1,227.41		$245.48
27394	T	Lengthening of thigh tendons	0050	23.60	$1,227.41		$245.48
27395	T	Lengthening of thigh tendons	0051	34.03	$1,769.87		$353.97
27396	T	Transplant of thigh tendon	0050	23.60	$1,227.41		$245.48
27397	T	Transplants of thigh tendons	0051	34.03	$1,769.87		$353.97
27400	T	Revise thigh muscles/tendons	0051	34.03	$1,769.87		$353.97
27403	T	Repair of knee cartilage	0050	23.60	$1,227.41		$245.48
27405	T	Repair of knee ligament	0051	34.03	$1,769.87		$353.97
27407	T	Repair of knee ligament	0051	34.03	$1,769.87		$353.97
27409	T	Repair of knee ligaments	0051	34.03	$1,769.87		$353.97
27418	T	Repair degenerated kneecap	0051	34.03	$1,769.87		$353.97
27420	T	Revision of unstable kneecap	0051	34.03	$1,769.87		$353.97
27422	T	Revision of unstable kneecap	0051	34.03	$1,769.87		$353.97
27424	T	Revision/removal of kneecap	0051	34.03	$1,769.87		$353.97
27425	T	Lateral retinacular release	0050	23.60	$1,227.41		$245.48
27427	T	Reconstruction, knee	0052	42.37	$2,203.62		$440.72
27428	T	Reconstruction, knee	0052	42.37	$2,203.62		$440.72
27429	T	Reconstruction, knee	0052	42.37	$2,203.62		$440.72
27430	T	Revision of thigh muscles	0051	34.03	$1,769.87		$353.97
27435	T	Incision of knee joint	0051	34.03	$1,769.87		$353.97
27437	T	Revise kneecap	0047	29.59	$1,538.95	$537.03	$307.79
27438	T	Revise kneecap with implant	0048	36.93	$1,920.69	$633.83	$384.14
27440	T	Revision of knee joint	0047	29.59	$1,538.95	$537.03	$307.79
27441	T	Revision of knee joint	0047	29.59	$1,538.95	$537.03	$307.79
27442	T	Revision of knee joint	0047	29.59	$1,538.95	$537.03	$307.79
27443	T	Revision of knee joint	0047	29.59	$1,538.95	$537.03	$307.79
27445	C	Revision of knee joint					
27446	T	Revision of knee joint	0681	158.14	$8,224.70	$3,289.88	$1,644.94
27447	C	Total knee arthroplasty					
27448	C	Incision of thigh					
27450	C	Incision of thigh					
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					
27457	C	Realignment of knee					
27465	C	Shortening of thigh bone					
27466	C	Lengthening of thigh bone					
27468	C	Shorten/lengthen thighs					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	19.45	$1,011.58		$202.32
27497	T	Decompression of thigh/knee	0049	19.45	$1,011.58		$202.32
27498	T	Decompression of thigh/knee	0049	19.45	$1,011.58		$202.32
27499	T	Decompression of thigh/knee	0049	19.45	$1,011.58		$202.32
27500	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27501	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27502	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27503	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27506	C	Treatment of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27509	T	Treatment of thigh fracture	0046	29.03	$1,509.82	$535.76	$301.96
27510	T	Treatment of thigh fracture	0043	1.68	$87.38		$17.48
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Treatment of thigh fracture					
27516	T	Treat thigh fx growth plate	0043	1.68	$87.38		$17.48
27517	T	Treat thigh fx growth plate	0043	1.68	$87.38		$17.48
27519	C	Treat thigh fx growth plate					
27520	T	Treat kneecap fracture	0043	1.68	$87.38		$17.48
27524	T	Treat kneecap fracture	0046	29.03	$1,509.82	$535.76	$301.96
27530	T	Treat knee fracture	0043	1.68	$87.38		$17.48
27532	T	Treat knee fracture	0043	1.68	$87.38		$17.48
27535	C	Treat knee fracture					
27536	C	Treat knee fracture					
27538	T	Treat knee fracture(s)	0043	1.68	$87.38		$17.48
27540	C	Treat knee fracture					
27550	T	Treat knee dislocation	0043	1.68	$87.38		$17.48
27552	T	Treat knee dislocation	0045	13.47	$700.56	$280.22	$140.11
27556	C	Treat knee dislocation					
27557	C	Treat knee dislocation					
27558	C	Treat knee dislocation					
27560	T	Treat kneecap dislocation	0043	1.68	$87.38		$17.48
27562	T	Treat kneecap dislocation	0045	13.47	$700.56	$280.22	$140.11
27566	T	Treat kneecap dislocation	0046	29.03	$1,509.82	$535.76	$301.96
27570	T	Fixation of knee joint	0045	13.47	$700.56	$280.22	$140.11
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	19.45	$1,011.58		$202.32
27596	C	Amputation follow-up surgery					
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	0043	1.68	$87.38		$17.48
27600	T	Decompression of lower leg	0049	19.45	$1,011.58		$202.32
27601	T	Decompression of lower leg	0049	19.45	$1,011.58		$202.32
27602	T	Decompression of lower leg	0049	19.45	$1,011.58		$202.32
27603	T	Drain lower leg lesion	0008	16.32	$848.79		$169.76
27604	T	Drain lower leg bursa	0049	19.45	$1,011.58		$202.32
27605	T	Incision of achilles tendon	0055	18.28	$950.72	$355.34	$190.14
27606	T	Incision of achilles tendon	0049	19.45	$1,011.58		$202.32
27607	T	Treat lower leg bone lesion	0049	19.45	$1,011.58		$202.32
27610	T	Explore/treat ankle joint	0050	23.60	$1,227.41		$245.48
27612	T	Exploration of ankle joint	0050	23.60	$1,227.41		$245.48
27613	T	Biopsy lower leg soft tissue	0020	7.36	$382.79	$114.84	$76.56
27614	T	Biopsy lower leg soft tissue	0022	18.10	$941.36	$367.13	$188.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27615	T	Remove tumor, lower leg	0046	29.03	$1,509.82	$535.76	$301.96
27618	T	Remove lower leg lesion	0021	14.58	$758.29	$227.49	$151.66
27619	T	Remove lower leg lesion	0022	18.10	$941.36	$367.13	$188.27
27620	T	Explore/treat ankle joint	0050	23.60	$1,227.41		$245.48
27625	T	Remove ankle joint lining	0050	23.60	$1,227.41		$245.48
27626	T	Remove ankle joint lining	0050	23.60	$1,227.41		$245.48
27630	T	Removal of tendon lesion	0049	19.45	$1,011.58		$202.32
27635	T	Remove lower leg bone lesion	0050	23.60	$1,227.41		$245.48
27637	T	Remove/graft leg bone lesion	0050	23.60	$1,227.41		$245.48
27638	T	Remove/graft leg bone lesion	0050	23.60	$1,227.41		$245.48
27640	T	Partial removal of tibia	0051	34.03	$1,769.87		$353.97
27641	T	Partial removal of fibula	0050	23.60	$1,227.41		$245.48
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	0051	34.03	$1,769.87		$353.97
27648	N	Injection for ankle x-ray					
27650	T	Repair achilles tendon	0051	34.03	$1,769.87		$353.97
27652	T	Repair/graft achilles tendon	0051	34.03	$1,769.87		$353.97
27654	T	Repair of achilles tendon	0051	34.03	$1,769.87		$353.97
27656	T	Repair leg fascia defect	0049	19.45	$1,011.58		$202.32
27658	T	Repair of leg tendon, each	0049	19.45	$1,011.58		$202.32
27659	T	Repair of leg tendon, each	0049	19.45	$1,011.58		$202.32
27664	T	Repair of leg tendon, each	0049	19.45	$1,011.58		$202.32
27665	T	Repair of leg tendon, each	0050	23.60	$1,227.41		$245.48
27675	T	Repair lower leg tendons	0049	19.45	$1,011.58		$202.32
27676	T	Repair lower leg tendons	0050	23.60	$1,227.41		$245.48
27680	T	Release of lower leg tendon	0050	23.60	$1,227.41		$245.48
27681	T	Release of lower leg tendons	0050	23.60	$1,227.41		$245.48
27685	T	Revision of lower leg tendon	0050	23.60	$1,227.41		$245.48
27686	T	Revise lower leg tendons	0050	23.60	$1,227.41		$245.48
27687	T	Revision of calf tendon	0050	23.60	$1,227.41		$245.48
27690	T	Revise lower leg tendon	0051	34.03	$1,769.87		$353.97
27691	T	Revise lower leg tendon	0051	34.03	$1,769.87		$353.97
27692	T	Revise additional leg tendon	0051	34.03	$1,769.87		$353.97
27695	T	Repair of ankle ligament	0050	23.60	$1,227.41		$245.48
27696	T	Repair of ankle ligaments	0050	23.60	$1,227.41		$245.48
27698	T	Repair of ankle ligament	0050	23.60	$1,227.41		$245.48
27700	T	Revision of ankle joint	0047	29.59	$1,538.95	$537.03	$307.79
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	0049	19.45	$1,011.58		$202.32
27705	T	Incision of tibia	0051	34.03	$1,769.87		$353.97
27707	T	Incision of fibula	0049	19.45	$1,011.58		$202.32
27709	T	Incision of tibia & fibula	0050	23.60	$1,227.41		$245.48
27712	C	Realignment of lower leg					
27715	C	Revision of lower leg					
27720	C	Repair of tibia					
27722	C	Repair/graft of tibia					
27724	C	Repair/graft of tibia					
27725	C	Repair of lower leg					
27727	C	Repair of lower leg					
27730	T	Repair of tibia epiphysis	0050	23.60	$1,227.41		$245.48
27732	T	Repair of fibula epiphysis	0050	23.60	$1,227.41		$245.48
27734	T	Repair lower leg epiphyses	0050	23.60	$1,227.41		$245.48
27740	T	Repair of leg epiphyses	0050	23.60	$1,227.41		$245.48
27742	T	Repair of leg epiphyses	0051	34.03	$1,769.87		$353.97
27745	T	Reinforce tibia	0051	34.03	$1,769.87		$353.97
27750	T	Treatment of tibia fracture	0043	1.68	$87.38		$17.48
27752	T	Treatment of tibia fracture	0043	1.68	$87.38		$17.48
27756	T	Treatment of tibia fracture	0046	29.03	$1,509.82	$535.76	$301.96
27758	T	Treatment of tibia fracture	0046	29.03	$1,509.82	$535.76	$301.96
27759	T	Treatment of tibia fracture	0046	29.03	$1,509.82	$535.76	$301.96
27760	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27762	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27766	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
27780	T	Treatment of fibula fracture	0043	1.68	$87.38		$17.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27781	T	Treatment of fibula fracture	0043	1.68	$87.38		$17.48
27784	T	Treatment of fibula fracture	0046	29.03	$1,509.82	$535.76	$301.96
27786	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27788	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27792	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
27808	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27810	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27814	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
27816	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27818	T	Treatment of ankle fracture	0043	1.68	$87.38		$17.48
27822	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
27823	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
27824	T	Treat lower leg fracture	0043	1.68	$87.38		$17.48
27825	T	Treat lower leg fracture	0043	1.68	$87.38		$17.48
27826	T	Treat lower leg fracture	0046	29.03	$1,509.82	$535.76	$301.96
27827	T	Treat lower leg fracture	0046	29.03	$1,509.82	$535.76	$301.96
27828	T	Treat lower leg fracture	0046	29.03	$1,509.82	$535.76	$301.96
27829	T	Treat lower leg joint	0046	29.03	$1,509.82	$535.76	$301.96
27830	T	Treat lower leg dislocation	0043	1.68	$87.38		$17.48
27831	T	Treat lower leg dislocation	0043	1.68	$87.38		$17.48
27832	T	Treat lower leg dislocation	0046	29.03	$1,509.82	$535.76	$301.96
27840	T	Treat ankle dislocation	0043	1.68	$87.38		$17.48
27842	T	Treat ankle dislocation	0045	13.47	$700.56	$280.22	$140.11
27846	T	Treat ankle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
27848	T	Treat ankle dislocation	0046	29.03	$1,509.82	$535.76	$301.96
27860	T	Fixation of ankle joint	0045	13.47	$700.56	$280.22	$140.11
27870	T	Fusion of ankle joint	0051	34.03	$1,769.87		$353.97
27871	T	Fusion of tibiofibular joint	0051	34.03	$1,769.87		$353.97
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	19.45	$1,011.58		$202.32
27886	C	Amputation follow-up surgery					
27888	C	Amputation of foot at ankle					
27889	T	Amputation of foot at ankle	0050	23.60	$1,227.41		$245.48
27892	T	Decompression of leg	0049	19.45	$1,011.58		$202.32
27893	T	Decompression of leg	0049	19.45	$1,011.58		$202.32
27894	T	Decompression of leg	0049	19.45	$1,011.58		$202.32
27899	T	Leg/ankle surgery procedure	0043	1.68	$87.38		$17.48
28001	T	Drainage of bursa of foot	0008	16.32	$848.79		$169.76
28002	T	Treatment of foot infection	0049	19.45	$1,011.58		$202.32
28003	T	Treatment of foot infection	0049	19.45	$1,011.58		$202.32
28005	T	Treat foot bone lesion	0055	18.28	$950.72	$355.34	$190.14
28008	T	Incision of foot fascia	0055	18.28	$950.72	$355.34	$190.14
28010	T	Incision of toe tendon	0055	18.28	$950.72	$355.34	$190.14
28011	T	Incision of toe tendons	0055	18.28	$950.72	$355.34	$190.14
28020	T	Exploration of foot joint	0055	18.28	$950.72	$355.34	$190.14
28022	T	Exploration of foot joint	0055	18.28	$950.72	$355.34	$190.14
28024	T	Exploration of toe joint	0055	18.28	$950.72	$355.34	$190.14
28030	T	Removal of foot nerve	0220	16.66	$866.47		$173.29
28035	T	Decompression of tibia nerve	0220	16.66	$866.47		$173.29
28043	T	Excision of foot lesion	0021	14.58	$758.29	$227.49	$151.66
28045	T	Excision of foot lesion	0055	18.28	$950.72	$355.34	$190.14
28046	T	Resection of tumor, foot	0055	18.28	$950.72	$355.34	$190.14
28050	T	Biopsy of foot joint lining	0055	18.28	$950.72	$355.34	$190.14
28052	T	Biopsy of foot joint lining	0055	18.28	$950.72	$355.34	$190.14
28054	T	Biopsy of toe joint lining	0055	18.28	$950.72	$355.34	$190.14
28060	T	Partial removal, foot fascia	0056	22.94	$1,193.09	$405.81	$238.62
28062	T	Removal of foot fascia	0056	22.94	$1,193.09	$405.81	$238.62
28070	T	Removal of foot joint lining	0056	22.94	$1,193.09	$405.81	$238.62
28072	T	Removal of foot joint lining	0056	22.94	$1,193.09	$405.81	$238.62
28080	T	Removal of foot lesion	0055	18.28	$950.72	$355.34	$190.14
28086	T	Excise foot tendon sheath	0055	18.28	$950.72	$355.34	$190.14
28088	T	Excise foot tendon sheath	0055	18.28	$950.72	$355.34	$190.14
28090	T	Removal of foot lesion	0055	18.28	$950.72	$355.34	$190.14
28092	T	Removal of toe lesions	0055	18.28	$950.72	$355.34	$190.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28100	T	Removal of ankle/heel lesion	0055	18.28	$950.72	$355.34	$190.14
28102	T	Remove/graft foot lesion	0056	22.94	$1,193.09	$405.81	$238.62
28103	T	Remove/graft foot lesion	0056	22.94	$1,193.09	$405.81	$238.62
28104	T	Removal of foot lesion	0055	18.28	$950.72	$355.34	$190.14
28106	T	Remove/graft foot lesion	0056	22.94	$1,193.09	$405.81	$238.62
28107	T	Remove/graft foot lesion	0056	22.94	$1,193.09	$405.81	$238.62
28108	T	Removal of toe lesions	0055	18.28	$950.72	$355.34	$190.14
28110	T	Part removal of metatarsal	0056	22.94	$1,193.09	$405.81	$238.62
28111	T	Part removal of metatarsal	0055	18.28	$950.72	$355.34	$190.14
28112	T	Part removal of metatarsal	0055	18.28	$950.72	$355.34	$190.14
28113	T	Part removal of metatarsal	0055	18.28	$950.72	$355.34	$190.14
28114	T	Removal of metatarsal heads	0055	18.28	$950.72	$355.34	$190.14
28116	T	Revision of foot	0055	18.28	$950.72	$355.34	$190.14
28118	T	Removal of heel bone	0055	18.28	$950.72	$355.34	$190.14
28119	T	Removal of heel spur	0055	18.28	$950.72	$355.34	$190.14
28120	T	Part removal of ankle/heel	0055	18.28	$950.72	$355.34	$190.14
28122	T	Partial removal of foot bone	0055	18.28	$950.72	$355.34	$190.14
28124	T	Partial removal of toe	0055	18.28	$950.72	$355.34	$190.14
28126	T	Partial removal of toe	0055	18.28	$950.72	$355.34	$190.14
28130	T	Removal of ankle bone	0055	18.28	$950.72	$355.34	$190.14
28140	T	Removal of metatarsal	0055	18.28	$950.72	$355.34	$190.14
28150	T	Removal of toe	0055	18.28	$950.72	$355.34	$190.14
28153	T	Partial removal of toe	0055	18.28	$950.72	$355.34	$190.14
28160	T	Partial removal of toe	0055	18.28	$950.72	$355.34	$190.14
28171	T	Extensive foot surgery	0055	18.28	$950.72	$355.34	$190.14
28173	T	Extensive foot surgery	0055	18.28	$950.72	$355.34	$190.14
28175	T	Extensive foot surgery	0055	18.28	$950.72	$355.34	$190.14
28190	T	Removal of foot foreign body	0019	3.94	$204.92	$75.82	$40.98
28192	T	Removal of foot foreign body	0021	14.58	$758.29	$227.49	$151.66
28193	T	Removal of foot foreign body	0021	14.58	$758.29	$227.49	$151.66
28200	T	Repair of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28202	T	Repair/graft of foot tendon	0056	22.94	$1,193.09	$405.81	$238.62
28208	T	Repair of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28210	T	Repair/graft of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28220	T	Release of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28222	T	Release of foot tendons	0055	18.28	$950.72	$355.34	$190.14
28225	T	Release of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28226	T	Release of foot tendons	0055	18.28	$950.72	$355.34	$190.14
28230	T	Incision of foot tendon(s)	0055	18.28	$950.72	$355.34	$190.14
28232	T	Incision of toe tendon	0055	18.28	$950.72	$355.34	$190.14
28234	T	Incision of foot tendon	0055	18.28	$950.72	$355.34	$190.14
28238	T	Revision of foot tendon	0056	22.94	$1,193.09	$405.81	$238.62
28240	T	Release of big toe	0055	18.28	$950.72	$355.34	$190.14
28250	T	Revision of foot fascia	0056	22.94	$1,193.09	$405.81	$238.62
28260	T	Release of midfoot joint	0056	22.94	$1,193.09	$405.81	$238.62
28261	T	Revision of foot tendon	0056	22.94	$1,193.09	$405.81	$238.62
28262	T	Revision of foot and ankle	0056	22.94	$1,193.09	$405.81	$238.62
28264	T	Release of midfoot joint	0056	22.94	$1,193.09	$405.81	$238.62
28270	T	Release of foot contracture	0055	18.28	$950.72	$355.34	$190.14
28272	T	Release of toe joint, each	0055	18.28	$950.72	$355.34	$190.14
28280	T	Fusion of toes	0055	18.28	$950.72	$355.34	$190.14
28285	T	Repair of hammertoe	0055	18.28	$950.72	$355.34	$190.14
28286	T	Repair of hammertoe	0055	18.28	$950.72	$355.34	$190.14
28288	T	Partial removal of foot bone	0056	22.94	$1,193.09	$405.81	$238.62
28289	T	Repair hallux rigidus	0056	22.94	$1,193.09	$405.81	$238.62
28290	T	Correction of bunion	0056	22.94	$1,193.09	$405.81	$238.62
28292	T	Correction of bunion	0057	23.87	$1,241.45	$496.58	$248.29
28293	T	Correction of bunion	0057	23.87	$1,241.45	$496.58	$248.29
28294	T	Correction of bunion	0056	22.94	$1,193.09	$405.81	$238.62
28296	T	Correction of bunion	0056	22.94	$1,193.09	$405.81	$238.62
28297	T	Correction of bunion	0057	23.87	$1,241.45	$496.58	$248.29
28298	T	Correction of bunion	0056	22.94	$1,193.09	$405.81	$238.62
28299	T	Correction of bunion	0057	23.87	$1,241.45	$496.58	$248.29
28300	T	Incision of heel bone	0056	22.94	$1,193.09	$405.81	$238.62
28302	T	Incision of ankle bone	0056	22.94	$1,193.09	$405.81	$238.62
28304	T	Incision of midfoot bones	0056	22.94	$1,193.09	$405.81	$238.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28305	T	Incise/graft midfoot bones	0056	22.94	$1,193.09	$405.81	$238.62
28306	T	Incision of metatarsal	0056	22.94	$1,193.09	$405.81	$238.62
28307	T	Incision of metatarsal	0056	22.94	$1,193.09	$405.81	$238.62
28308	T	Incision of metatarsal	0056	22.94	$1,193.09	$405.81	$238.62
28309	T	Incision of metatarsals	0056	22.94	$1,193.09	$405.81	$238.62
28310	T	Revision of big toe	0055	18.28	$950.72	$355.34	$190.14
28312	T	Revision of toe	0055	18.28	$950.72	$355.34	$190.14
28313	T	Repair deformity of toe	0055	18.28	$950.72	$355.34	$190.14
28315	T	Removal of sesamoid bone	0055	18.28	$950.72	$355.34	$190.14
28320	T	Repair of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28322	T	Repair of metatarsals	0056	22.94	$1,193.09	$405.81	$238.62
28340	T	Resect enlarged toe tissue	0055	18.28	$950.72	$355.34	$190.14
28341	T	Resect enlarged toe	0055	18.28	$950.72	$355.34	$190.14
28344	T	Repair extra toe(s)	0056	22.94	$1,193.09	$405.81	$238.62
28345	T	Repair webbed toe(s)	0056	22.94	$1,193.09	$405.81	$238.62
28360	T	Reconstruct cleft foot	0056	22.94	$1,193.09	$405.81	$238.62
28400	T	Treatment of heel fracture	0043	1.68	$87.38	.....	$17.48
28405	T	Treatment of heel fracture	0043	1.68	$87.38	.....	$17.48
28406	T	Treatment of heel fracture	0046	29.03	$1,509.82	$535.76	$301.96
28415	T	Treat heel fracture	0046	29.03	$1,509.82	$535.76	$301.96
28420	T	Treat/graft heel fracture	0046	29.03	$1,509.82	$535.76	$301.96
28430	T	Treatment of ankle fracture	0043	1.68	$87.38	.....	$17.48
28435	T	Treatment of ankle fracture	0043	1.68	$87.38	.....	$17.48
28436	T	Treatment of ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
28445	T	Treat ankle fracture	0046	29.03	$1,509.82	$535.76	$301.96
28450	T	Treat midfoot fracture, each	0043	1.68	$87.38	.....	$17.48
28455	T	Treat midfoot fracture, each	0043	1.68	$87.38	.....	$17.48
28456	T	Treat midfoot fracture	0046	29.03	$1,509.82	$535.76	$301.96
28465	T	Treat midfoot fracture, each	0046	29.03	$1,509.82	$535.76	$301.96
28470	T	Treat metatarsal fracture	0043	1.68	$87.38	.....	$17.48
28475	T	Treat metatarsal fracture	0043	1.68	$87.38	.....	$17.48
28476	T	Treat metatarsal fracture	0046	29.03	$1,509.82	$535.76	$301.96
28485	T	Treat metatarsal fracture	0046	29.03	$1,509.82	$535.76	$301.96
28490	T	Treat big toe fracture	0043	1.68	$87.38	.....	$17.48
28495	T	Treat big toe fracture	0043	1.68	$87.38	.....	$17.48
28496	T	Treat big toe fracture	0046	29.03	$1,509.82	$535.76	$301.96
28505	T	Treat big toe fracture	0046	29.03	$1,509.82	$535.76	$301.96
28510	T	Treatment of toe fracture	0043	1.68	$87.38	.....	$17.48
28515	T	Treatment of toe fracture	0043	1.68	$87.38	.....	$17.48
28525	T	Treat toe fracture	0046	29.03	$1,509.82	$535.76	$301.96
28530	T	Treat sesamoid bone fracture	0043	1.68	$87.38	.....	$17.48
28531	T	Treat sesamoid bone fracture	0046	29.03	$1,509.82	$535.76	$301.96
28540	T	Treat foot dislocation	0043	1.68	$87.38	.....	$17.48
28545	T	Treat foot dislocation	0045	13.47	$700.56	$280.22	$140.11
28546	T	Treat foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28555	T	Repair foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28570	T	Treat foot dislocation	0043	1.68	$87.38	.....	$17.48
28575	T	Treat foot dislocation	0043	1.68	$87.38	.....	$17.48
28576	T	Treat foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28585	T	Repair foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28600	T	Treat foot dislocation	0043	1.68	$87.38	.....	$17.48
28605	T	Treat foot dislocation	0043	1.68	$87.38	.....	$17.48
28606	T	Treat foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28615	T	Repair foot dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28630	T	Treat toe dislocation	0043	1.68	$87.38	.....	$17.48
28635	T	Treat toe dislocation	0045	13.47	$700.56	$280.22	$140.11
28636	T	Treat toe dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28645	T	Repair toe dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28660	T	Treat toe dislocation	0043	1.68	$87.38	.....	$17.48
28665	T	Treat toe dislocation	0045	13.47	$700.56	$280.22	$140.11
28666	T	Treat toe dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28675	T	Repair of toe dislocation	0046	29.03	$1,509.82	$535.76	$301.96
28705	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28715	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28725	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28730	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28735	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28737	T	Revision of foot bones	0055	18.28	$950.72	$355.34	$190.14
28740	T	Fusion of foot bones	0056	22.94	$1,193.09	$405.81	$238.62
28750	T	Fusion of big toe joint	0055	18.28	$950.72	$355.34	$190.14
28755	T	Fusion of big toe joint	0055	18.28	$950.72	$355.34	$190.14
28760	T	Fusion of big toe joint	0056	22.94	$1,193.09	$405.81	$238.62
28800	C	Amputation of midfoot	.....	.....	.....	.....	.....
28805	C	Amputation thru metatarsal	.....	.....	.....	.....	.....
28810	T	Amputation toe & metatarsal	0055	18.28	$950.72	$355.34	$190.14
28820	T	Amputation of toe	0055	18.28	$950.72	$355.34	$190.14
28825	T	Partial amputation of toe	0055	18.28	$950.72	$355.34	$190.14
28899	T	Foot/toes surgery procedure	0043	1.68	$87.38	.....	$17.48
29000	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29010	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29015	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29020	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29025	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29035	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29040	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29044	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29046	S	Application of body cast	0058	1.09	$56.69	$14.74	$11.34
29049	S	Application of figure eight	0058	1.09	$56.69	$14.74	$11.34
29055	S	Application of shoulder cast	0058	1.09	$56.69	$14.74	$11.34
29058	S	Application of shoulder cast	0058	1.09	$56.69	$14.74	$11.34
29065	S	Application of long arm cast	0058	1.09	$56.69	$14.74	$11.34
29075	S	Application of forearm cast	0058	1.09	$56.69	$14.74	$11.34
29085	S	Apply hand/wrist cast	0058	1.09	$56.69	$14.74	$11.34
29086	S	Apply finger cast	0058	1.09	$56.69	$14.74	$11.34
29105	S	Apply long arm splint	0058	1.09	$56.69	$14.74	$11.34
29125	S	Apply forearm splint	0058	1.09	$56.69	$14.74	$11.34
29126	S	Apply forearm splint	0058	1.09	$56.69	$14.74	$11.34
29130	S	Application of finger splint	0058	1.09	$56.69	$14.74	$11.34
29131	S	Application of finger splint	0058	1.09	$56.69	$14.74	$11.34
29200	S	Strapping of chest	0058	1.09	$56.69	$14.74	$11.34
29220	S	Strapping of low back	0058	1.09	$56.69	$14.74	$11.34
29240	S	Strapping of shoulder	0058	1.09	$56.69	$14.74	$11.34
29260	S	Strapping of elbow or wrist	0058	1.09	$56.69	$14.74	$11.34
29280	S	Strapping of hand or finger	0058	1.09	$56.69	$14.74	$11.34
29305	S	Application of hip cast	0058	1.09	$56.69	$14.74	$11.34
29325	S	Application of hip casts	0058	1.09	$56.69	$14.74	$11.34
29345	S	Application of long leg cast	0058	1.09	$56.69	$14.74	$11.34
29355	S	Application of long leg cast	0058	1.09	$56.69	$14.74	$11.34
29358	S	Apply long leg cast brace	0058	1.09	$56.69	$14.74	$11.34
29365	S	Application of long leg cast	0058	1.09	$56.69	$14.74	$11.34
29405	S	Apply short leg cast	0058	1.09	$56.69	$14.74	$11.34
29425	S	Apply short leg cast	0058	1.09	$56.69	$14.74	$11.34
29435	S	Apply short leg cast	0058	1.09	$56.69	$14.74	$11.34
29440	S	Addition of walker to cast	0058	1.09	$56.69	$14.74	$11.34
29445	S	Apply rigid leg cast	0058	1.09	$56.69	$14.74	$11.34
29450	S	Application of leg cast	0058	1.09	$56.69	$14.74	$11.34
29505	S	Application, long leg splint	0058	1.09	$56.69	$14.74	$11.34
29515	S	Application lower leg splint	0058	1.09	$56.69	$14.74	$11.34
29520	S	Strapping of hip	0058	1.09	$56.69	$14.74	$11.34
29530	S	Strapping of knee	0058	1.09	$56.69	$14.74	$11.34
29540	S	Strapping of ankle	0058	1.09	$56.69	$14.74	$11.34
29550	S	Strapping of toes	0058	1.09	$56.69	$14.74	$11.34
29580	S	Application of paste boot	0058	1.09	$56.69	$14.74	$11.34
29590	S	Application of foot splint	0058	1.09	$56.69	$14.74	$11.34
29700	S	Removal/revision of cast	0058	1.09	$56.69	$14.74	$11.34
29705	S	Removal/revision of cast	0058	1.09	$56.69	$14.74	$11.34
29710	S	Removal/revision of cast	0058	1.09	$56.69	$14.74	$11.34
29715	S	Removal/revision of cast	0058	1.09	$56.69	$14.74	$11.34
29720	S	Repair of body cast	0058	1.09	$56.69	$14.74	$11.34
29730	S	Windowing of cast	0058	1.09	$56.69	$14.74	$11.34
29740	S	Wedging of cast	0058	1.09	$56.69	$14.74	$11.34
29750	S	Wedging of clubfoot cast	0058	1.09	$56.69	$14.74	$11.34

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29799	S	Casting/strapping procedure	0058	1.09	$56.69	$14.74	$11.34
29800	T	Jaw arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29804	T	Jaw arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29805	T	Shoulder arthroscopy, dx	0041	27.58	$1,434.41	$580.06	$286.88
29806	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29807	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29819	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29820	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29821	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29822	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29823	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29824	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29825	T	Shoulder arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29826	T	Shoulder arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29830	T	Elbow arthroscopy	0041	27.58	$1,434.41	$580.06	$286.88
29834	T	Elbow arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29835	T	Elbow arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29836	T	Elbow arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29837	T	Elbow arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29838	T	Elbow arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29840	T	Wrist arthroscopy	0041	27.58	$1,434.41	$580.06	$286.88
29843	T	Wrist arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29844	T	Wrist arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29845	T	Wrist arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29846	T	Wrist arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29847	T	Wrist arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29848	T	Wrist endoscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29850	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29851	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29855	T	Tibial arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29856	T	Tibial arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29860	T	Hip arthroscopy, dx	0041	27.58	$1,434.41	$580.06	$286.88
29861	T	Hip arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29862	T	Hip arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29863	T	Hip arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29870	T	Knee arthroscopy, dx	0041	27.58	$1,434.41	$580.06	$286.88
29871	T	Knee arthroscopy/drainage	0041	27.58	$1,434.41	$580.06	$286.88
29874	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29875	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29876	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29877	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29879	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29880	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29881	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29882	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29883	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29884	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29885	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29886	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29887	T	Knee arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29888	T	Knee arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29889	T	Knee arthroscopy/surgery	0042	43.24	$2,248.87	$804.74	$449.77
29891	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29892	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29893	T	Scope, plantar fasciotomy	0055	18.28	$950.72	$355.34	$190.14
29894	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29895	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29897	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29898	T	Ankle arthroscopy/surgery	0041	27.58	$1,434.41	$580.06	$286.88
29900	T	Mcp joint arthroscopy, dx	0053	14.76	$767.65	$253.49	$153.53
29901	T	Mcp joint arthroscopy, surg	0053	14.76	$767.65	$253.49	$153.53
29902	T	Mcp joint arthroscopy, surg	0053	14.76	$767.65	$253.49	$153.53
29999	T	Arthroscopy of joint	0041	27.58	$1,434.41	$580.06	$286.88
30000	T	Drainage of nose lesion	0251	1.92	$99.86	.....	$19.97
30020	T	Drainage of nose lesion	0251	1.92	$99.86	.....	$19.97
30100	T	Intranasal biopsy	0252	6.27	$326.10	$114.24	$65.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30110	T	Removal of nose polyp(s)	0253	14.79	$769.21	$284.61	$153.84
30115	T	Removal of nose polyp(s)	0253	14.79	$769.21	$284.61	$153.84
30117	T	Removal of intranasal lesion	0253	14.79	$769.21	$284.61	$153.84
30118	T	Removal of intranasal lesion	0254	21.89	$1,138.48	$352.93	$227.70
30120	T	Revision of nose	0253	14.79	$769.21	$284.61	$153.84
30124	T	Removal of nose lesion	0252	6.27	$326.10	$114.24	$65.22
30125	T	Removal of nose lesion	0256	35.51	$1,846.84		$369.37
30130	T	Removal of turbinate bones	0253	14.79	$769.21	$284.61	$153.84
30140	T	Removal of turbinate bones	0254	21.89	$1,138.48	$352.93	$227.70
30150	T	Partial removal of nose	0256	35.51	$1,846.84		$369.37
30160	T	Removal of nose	0256	35.51	$1,846.84		$369.37
30200	T	Injection treatment of nose	0253	14.79	$769.21	$284.61	$153.84
30210	T	Nasal sinus therapy	0252	6.27	$326.10	$114.24	$65.22
30220	T	Insert nasal septal button	0252	6.27	$326.10	$114.24	$65.22
30300	X	Remove nasal foreign body	0340	0.66	$34.33		$6.87
30310	T	Remove nasal foreign body	0253	14.79	$769.21	$284.61	$153.84
30320	T	Remove nasal foreign body	0253	14.79	$769.21	$284.61	$153.84
30400	T	Reconstruction of nose	0256	35.51	$1,846.84		$369.37
30410	T	Reconstruction of nose	0256	35.51	$1,846.84		$369.37
30420	T	Reconstruction of nose	0256	35.51	$1,846.84		$369.37
30430	T	Revision of nose	0254	21.89	$1,138.48	$352.93	$227.70
30435	T	Revision of nose	0256	35.51	$1,846.84		$369.37
30450	T	Revision of nose	0256	35.51	$1,846.84		$369.37
30460	T	Revision of nose	0256	35.51	$1,846.84		$369.37
30462	T	Revision of nose	0256	35.51	$1,846.84		$369.37
30465	T	Repair nasal stenosis	0256	35.51	$1,846.84		$369.37
30520	T	Repair of nasal septum	0254	21.89	$1,138.48	$352.93	$227.70
30540	T	Repair nasal defect	0256	35.51	$1,846.84		$369.37
30545	T	Repair nasal defect	0256	35.51	$1,846.84		$369.37
30560	T	Release of nasal adhesions	0251	1.92	$99.86		$19.97
30580	T	Repair upper jaw fistula	0256	35.51	$1,846.84		$369.37
30600	T	Repair mouth/nose fistula	0256	35.51	$1,846.84		$369.37
30620	T	Intranasal reconstruction	0256	35.51	$1,846.84		$369.37
30630	T	Repair nasal septum defect	0254	21.89	$1,138.48	$352.93	$227.70
30801	T	Cauterization, inner nose	0252	6.27	$326.10	$114.24	$65.22
30802	T	Cauterization, inner nose	0253	14.79	$769.21	$284.61	$153.84
30901	T	Control of nosebleed	0250	1.68	$87.38	$30.58	$17.48
30903	T	Control of nosebleed	0250	1.68	$87.38	$30.58	$17.48
30905	T	Control of nosebleed	0250	1.68	$87.38	$30.58	$17.48
30906	T	Repeat control of nosebleed	0250	1.68	$87.38	$30.58	$17.48
30915	T	Ligation, nasal sinus artery	0091	27.03	$1,405.80	$348.23	$281.16
30920	T	Ligation, upper jaw artery	0092	24.97	$1,298.66	$505.37	$259.73
30930	T	Therapy, fracture of nose	0253	14.79	$769.21	$284.61	$153.84
30999	T	Nasal surgery procedure	0251	1.92	$99.86		$19.97
31000	T	Irrigation, maxillary sinus	0251	1.92	$99.86		$19.97
31002	T	Irrigation, sphenoid sinus	0252	6.27	$326.10	$114.24	$65.22
31020	T	Exploration, maxillary sinus	0254	21.89	$1,138.48	$352.93	$227.70
31030	T	Exploration, maxillary sinus	0256	35.51	$1,846.84		$369.37
31032	T	Explore sinus,remove polyps	0256	35.51	$1,846.84		$369.37
31040	T	Exploration behind upper jaw	0254	21.89	$1,138.48	$352.93	$227.70
31050	T	Exploration, sphenoid sinus	0256	35.51	$1,846.84		$369.37
31051	T	Sphenoid sinus surgery	0256	35.51	$1,846.84		$369.37
31070	T	Exploration of frontal sinus	0254	21.89	$1,138.48	$352.93	$227.70
31075	T	Exploration of frontal sinus	0256	35.51	$1,846.84		$369.37
31080	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31081	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31084	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31085	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31086	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31087	T	Removal of frontal sinus	0256	35.51	$1,846.84		$369.37
31090	T	Exploration of sinuses	0256	35.51	$1,846.84		$369.37
31200	T	Removal of ethmoid sinus	0256	35.51	$1,846.84		$369.37
31201	T	Removal of ethmoid sinus	0256	35.51	$1,846.84		$369.37
31205	T	Removal of ethmoid sinus	0256	35.51	$1,846.84		$369.37
31225	C	Removal of upper jaw					
31230	C	Removal of upper jaw					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31231	T	Nasal endoscopy, dx	0071	1.01	$52.53	$14.18	$10.51
31233	T	Nasal/sinus endoscopy, dx	0072	1.66	$86.33	$37.99	$17.27
31235	T	Nasal/sinus endoscopy, dx	0074	12.84	$667.80	$295.70	$133.56
31237	T	Nasal/sinus endoscopy, surg	0075	20.41	$1,061.50	$445.92	$212.30
31238	T	Nasal/sinus endoscopy, surg	0074	12.84	$667.80	$295.70	$133.56
31239	T	Nasal/sinus endoscopy, surg	0075	20.41	$1,061.50	$445.92	$212.30
31240	T	Nasal/sinus endoscopy, surg	0074	12.84	$667.80	$295.70	$133.56
31254	T	Revision of ethmoid sinus	0075	20.41	$1,061.50	$445.92	$212.30
31255	T	Removal of ethmoid sinus	0075	20.41	$1,061.50	$445.92	$212.30
31256	T	Exploration maxillary sinus	0075	20.41	$1,061.50	$445.92	$212.30
31267	T	Endoscopy, maxillary sinus	0075	20.41	$1,061.50	$445.92	$212.30
31276	T	Sinus endoscopy, surgical	0075	20.41	$1,061.50	$445.92	$212.30
31287	T	Nasal/sinus endoscopy, surg	0075	20.41	$1,061.50	$445.92	$212.30
31288	T	Nasal/sinus endoscopy, surg	0075	20.41	$1,061.50	$445.92	$212.30
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	6.27	$326.10	$114.24	$65.22
31300	T	Removal of larynx lesion	0256	35.51	$1,846.84		$369.37
31320	T	Diagnostic incision, larynx	0256	35.51	$1,846.84		$369.37
31360	C	Removal of larynx					
31365	C	Removal of larynx					
31367	C	Partial removal of larynx					
31368	C	Partial removal of larynx					
31370	C	Partial removal of larynx					
31375	C	Partial removal of larynx					
31380	C	Partial removal of larynx					
31382	C	Partial removal of larynx					
31390	C	Removal of larynx & pharynx					
31395	C	Reconstruct larynx & pharynx					
31400	T	Revision of larynx	0256	35.51	$1,846.84		$369.37
31420	T	Removal of epiglottis	0256	35.51	$1,846.84		$369.37
31500	S	Insert emergency airway	0094	2.68	$139.38	$47.39	$27.88
31502	T	Change of windpipe airway	0121	2.17	$112.86	$45.14	$22.57
31505	T	Diagnostic laryngoscopy	0072	1.66	$86.33	$37.99	$17.27
31510	T	Laryngoscopy with biopsy	0074	12.84	$667.80	$295.70	$133.56
31511	T	Remove foreign body, larynx	0072	1.66	$86.33	$37.99	$17.27
31512	T	Removal of larynx lesion	0074	12.84	$667.80	$295.70	$133.56
31513	T	Injection into vocal cord	0072	1.66	$86.33	$37.99	$17.27
31515	T	Laryngoscopy for aspiration	0074	12.84	$667.80	$295.70	$133.56
31520	T	Diagnostic laryngoscopy	0072	1.66	$86.33	$37.99	$17.27
31525	T	Diagnostic laryngoscopy	0074	12.84	$667.80	$295.70	$133.56
31526	T	Diagnostic laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31527	T	Laryngoscopy for treatment	0075	20.41	$1,061.50	$445.92	$212.30
31528	T	Laryngoscopy and dilation	0074	12.84	$667.80	$295.70	$133.56
31529	T	Laryngoscopy and dilation	0074	12.84	$667.80	$295.70	$133.56
31530	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31531	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31535	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31536	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31540	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31541	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31560	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31561	T	Operative laryngoscopy	0075	20.41	$1,061.50	$445.92	$212.30
31570	T	Laryngoscopy with injection	0074	12.84	$667.80	$295.70	$133.56
31571	T	Laryngoscopy with injection	0075	20.41	$1,061.50	$445.92	$212.30
31575	T	Diagnostic laryngoscopy	0071	1.01	$52.53	$14.18	$10.51
31576	T	Laryngoscopy with biopsy	0075	20.41	$1,061.50	$445.92	$212.30
31577	T	Remove foreign body, larynx	0073	3.63	$188.79	$74.14	$37.76
31578	T	Removal of larynx lesion	0075	20.41	$1,061.50	$445.92	$212.30
31579	T	Diagnostic laryngoscopy	0073	3.63	$188.79	$74.14	$37.76
31580	T	Revision of larynx	0256	35.51	$1,846.84		$369.37
31582	T	Revision of larynx	0256	35.51	$1,846.84		$369.37
31584	C	Treat larynx fracture					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31585	T	Treat larynx fracture	0253	14.79	$769.21	$284.61	$153.84
31586	T	Treat larynx fracture	0256	35.51	$1,846.84		$369.37
31587	C	Revision of larynx					
31588	T	Revision of larynx	0256	35.51	$1,846.84		$369.37
31590	T	Reinnervate larynx	0256	35.51	$1,846.84		$369.37
31595	T	Larynx nerve surgery	0256	35.51	$1,846.84		$369.37
31599	T	Larynx surgery procedure	0254	21.89	$1,138.48	$352.93	$227.70
31600	T	Incision of windpipe	0254	21.89	$1,138.48	$352.93	$227.70
31601	T	Incision of windpipe	0254	21.89	$1,138.48	$352.93	$227.70
31603	T	Incision of windpipe	0252	6.27	$326.10	$114.24	$65.22
31605	T	Incision of windpipe	0253	14.79	$769.21	$284.61	$153.84
31610	T	Incision of windpipe	0254	21.89	$1,138.48	$352.93	$227.70
31611	T	Surgery/speech prosthesis	0254	21.89	$1,138.48	$352.93	$227.70
31612	T	Puncture/clear windpipe	0254	21.89	$1,138.48	$352.93	$227.70
31613	T	Repair windpipe opening	0254	21.89	$1,138.48	$352.93	$227.70
31614	T	Repair windpipe opening	0256	35.51	$1,846.84		$369.37
31615	T	Visualization of windpipe	0076	9.30	$483.68	$189.92	$96.74
31622	T	Dx bronchoscope/wash	0076	9.30	$483.68	$189.92	$96.74
31623	T	Dx bronchoscope/brush	0076	9.30	$483.68	$189.92	$96.74
31624	T	Dx bronchoscope/lavage	0076	9.30	$483.68	$189.92	$96.74
31625	T	Bronchoscopy with biopsy	0076	9.30	$483.68	$189.92	$96.74
31628	T	Bronchoscopy with biopsy	0076	9.30	$483.68	$189.92	$96.74
31629	T	Bronchoscopy with biopsy	0076	9.30	$483.68	$189.92	$96.74
31630	T	Bronchoscopy with repair	0076	9.30	$483.68	$189.92	$96.74
31631	T	Bronchoscopy with dilation	0076	9.30	$483.68	$189.92	$96.74
31635	T	Remove foreign body, airway	0076	9.30	$483.68	$189.92	$96.74
31640	T	Bronchoscopy & remove lesion	0076	9.30	$483.68	$189.92	$96.74
31641	T	Bronchoscopy, treat blockage	0076	9.30	$483.68	$189.92	$96.74
31643	T	Diag bronchoscope/catheter	0076	9.30	$483.68	$189.92	$96.74
31645	T	Bronchoscopy, clear airways	0076	9.30	$483.68	$189.92	$96.74
31646	T	Bronchoscopy, reclear airway	0076	9.30	$483.68	$189.92	$96.74
31656	T	Bronchoscopy, inj for xray	0076	9.30	$483.68	$189.92	$96.74
31700	T	Insertion of airway catheter	0072	1.66	$86.33	$37.99	$17.27
31708	N	Instill airway contrast dye					
31710	N	Insertion of airway catheter					
31715	N	Injection for bronchus x-ray					
31717	T	Bronchial brush biopsy	0073	3.63	$188.79	$74.14	$37.76
31720	T	Clearance of airways	0072	1.66	$86.33	$37.99	$17.27
31725	C	Clearance of airways					
31730	T	Intro, windpipe wire/tube	0073	3.63	$188.79	$74.14	$37.76
31750	T	Repair of windpipe	0256	35.51	$1,846.84		$369.37
31755	T	Repair of windpipe	0256	35.51	$1,846.84		$369.37
31760	C	Repair of windpipe					
31766	C	Reconstruction of windpipe					
31770	C	Repair/graft of bronchus					
31775	C	Reconstruct bronchus					
31780	C	Reconstruct windpipe					
31781	C	Reconstruct windpipe					
31785	T	Remove windpipe lesion	0254	21.89	$1,138.48	$352.93	$227.70
31786	C	Remove windpipe lesion					
31800	C	Repair of windpipe injury					
31805	C	Repair of windpipe injury					
31820	T	Closure of windpipe lesion	0253	14.79	$769.21	$284.61	$153.84
31825	T	Repair of windpipe defect	0254	21.89	$1,138.48	$352.93	$227.70
31830	T	Revise windpipe scar	0254	21.89	$1,138.48	$352.93	$227.70
31899	T	Airways surgical procedure	0076	9.30	$483.68	$189.92	$96.74
32000	T	Drainage of chest	0070	3.30	$171.63		$34.33
32002	T	Treatment of collapsed lung	0070	3.30	$171.63		$34.33
32005	T	Treat lung lining chemically	0070	3.30	$171.63		$34.33
32020	T	Insertion of chest tube	0070	3.30	$171.63		$34.33
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32124	C	Explore chest free adhesions					
32140	C	Removal of lung lesion(s)					
32141	C	Remove/treat lung lesions					
32150	C	Removal of lung lesion(s)					
32151	C	Remove lung foreign body					
32160	C	Open chest heart massage					
32200	C	Drain, open, lung lesion					
32201	T	Drain, percut, lung lesion	0070	3.30	$171.63		$34.33
32215	C	Treat chest lining					
32220	C	Release of lung					
32225	C	Partial release of lung					
32310	C	Removal of chest lining					
32320	C	Free/remove chest lining					
32400	T	Needle biopsy chest lining	0005	3.02	$157.07	$69.11	$31.41
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	0685	4.47	$232.48	$102.29	$46.50
32420	T	Puncture/clear lung	0070	3.30	$171.63		$34.33
32440	C	Removal of lung					
32442	C	Sleeve pneumonectomy					
32445	C	Removal of lung					
32480	C	Partial removal of lung					
32482	C	Bilobectomy					
32484	C	Segmentectomy					
32486	C	Sleeve lobectomy					
32488	C	Completion pneumonectomy					
32491	C	Lung volume reduction					
32500	C	Partial removal of lung					
32501	C	Repair bronchus add-on					
32520	C	Remove lung & revise chest					
32522	C	Remove lung & revise chest					
32525	C	Remove lung & revise chest					
32540	C	Removal of lung lesion					
32601	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
32602	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
32603	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
32604	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
32605	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
32606	T	Thoracoscopy, diagnostic	0069	29.51	$1,534.79	$591.64	$306.96
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32940	C	Revision of lung					
32960	T	Therapeutic pneumothorax	0070	3.30	$171.63		$34.33
32997	C	Total lung lavage					
32999	T	Chest surgery procedure	0070	3.30	$171.63		$34.33
33010	T	Drainage of heart sac	0070	3.30	$171.63		$34.33
33011	T	Repeat drainage of heart sac	0070	3.30	$171.63		$34.33
33015	C	Incision of heart sac					
33020	C	Incision of heart sac					
33025	C	Incision of heart sac					
33030	C	Partial removal of heart sac					
33031	C	Partial removal of heart sac					
33050	C	Removal of heart sac lesion					
33120	C	Removal of heart lesion					
33130	C	Removal of heart lesion					
33140	C	Heart revascularize (tmr)					
33141	C	Heart tmr w/other procedure					
33200	C	Insertion of heart pacemaker					
33201	C	Insertion of heart pacemaker					
33206	T	Insertion of heart pacemaker	0089	108.92	$5,664.82	$1,642.80	$1,132.96
33207	T	Insertion of heart pacemaker	0089	108.92	$5,664.82	$1,642.80	$1,132.96
33208	T	Insertion of heart pacemaker	0089	108.92	$5,664.82	$1,642.80	$1,132.96
33210	T	Insertion of heart electrode	0106	29.23	$1,520.22	$410.46	$304.04
33211	T	Insertion of heart electrode	0106	29.23	$1,520.22	$410.46	$304.04
33212	T	Insertion of pulse generator	0090	77.15	$4,012.49	$1,444.50	$802.50
33213	T	Insertion of pulse generator	0090	77.15	$4,012.49	$1,444.50	$802.50
33214	T	Upgrade of pacemaker system	0089	108.92	$5,664.82	$1,642.80	$1,132.96
33216	T	Revise eltrd pacing-defib	0106	29.23	$1,520.22	$410.46	$304.04
33217	T	Revise eltrd pacing-defib	0106	29.23	$1,520.22	$410.46	$304.04
33218	T	Revise eltrd pacing-defib	0106	29.23	$1,520.22	$410.46	$304.04
33220	T	Revise eltrd pacing-defib	0106	29.23	$1,520.22	$410.46	$304.04
33222	T	Revise pocket, pacemaker	0027	15.73	$818.10	$343.60	$163.62
33223	T	Revise pocket, pacing-defib	0027	15.73	$818.10	$343.60	$163.62
33233	T	Removal of pacemaker system	0105	19.14	$995.45	$370.40	$199.09
33234	T	Removal of pacemaker system	0105	19.14	$995.45	$370.40	$199.09
33235	T	Removal pacemaker electrode	0105	19.14	$995.45	$370.40	$199.09
33236	C	Remove electrode/thoracotomy					
33237	C	Remove electrode/thoracotomy					
33238	C	Remove electrode/thoracotomy					
33240	T	Insert pulse generator	0107	181.51	$9,440.15	$2,076.83	$1,888.03
33241	T	Remove pulse generator	0105	19.14	$995.45	$370.40	$199.09
33243	C	Remove eltrd/thoracotomy					
33244	T	Remove eltrd, transven	0105	19.14	$995.45	$370.40	$199.09
33245	C	Insert epic eltrd pace-defib					
33246	C	Insert epic eltrd/generator					
33249	T	Eltrd/insert pace-defib	0108	232.69	$12,101.97		$2,420.39
33250	C	Ablate heart dysrhythm focus					
33251	C	Ablate heart dysrhythm focus					
33253	C	Reconstruct atria					
33261	C	Ablate heart dysrhythm focus					
33282	S	Implant pat-active ht record	0680	51.95	$2,701.87		$540.37
33284	T	Remove pat-active ht record	0109	7.68	$399.43	$131.49	$79.89
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33406	C	Replacement of aortic valve					
33410	C	Replacement of aortic valve					
33411	C	Replacement of aortic valve					
33412	C	Replacement of aortic valve					
33413	C	Replacement of aortic valve					
33414	C	Repair of aortic valve					
33415	C	Revision, subvalvular tissue					
33416	C	Revise ventricle muscle					
33417	C	Repair of aortic valve					
33420	C	Revision of mitral valve					
33422	C	Revision of mitral valve					
33425	C	Repair of mitral valve					
33426	C	Repair of mitral valve					
33427	C	Repair of mitral valve					
33430	C	Replacement of mitral valve					
33460	C	Revision of tricuspid valve					
33463	C	Valvuloplasty, tricuspid					
33464	C	Valvuloplasty, tricuspid					
33465	C	Replace tricuspid valve					
33468	C	Revision of tricuspid valve					
33470	C	Revision of pulmonary valve					
33471	C	Valvotomy, pulmonary valve					
33472	C	Revision of pulmonary valve					
33474	C	Revision of pulmonary valve					
33475	C	Replacement, pulmonary valve					
33476	C	Revision of heart chamber					
33478	C	Revision of heart chamber					
33496	C	Repair, prosth valve clot					
33500	C	Repair heart vessel fistula					
33501	C	Repair heart vessel fistula					
33502	C	Coronary artery correction					
33503	C	Coronary artery graft					
33504	C	Coronary artery graft					
33505	C	Repair artery w/tunnel					
33506	C	Repair artery, translocation					
33510	C	CABG, vein, single					
33511	C	CABG, vein, two					
33512	C	CABG, vein, three					
33513	C	CABG, vein, four					
33514	C	CABG, vein, five					
33516	C	Cabg, vein, six or more					
33517	C	CABG, artery-vein, single					
33518	C	CABG, artery-vein, two					
33519	C	CABG, artery-vein, three					
33521	C	CABG, artery-vein, four					
33522	C	CABG, artery-vein, five					
33523	C	Cabg, art-vein, six or more					
33530	C	Coronary artery, bypass/reop					
33533	C	CABG, arterial, single					
33534	C	CABG, arterial, two					
33535	C	CABG, arterial, three					
33536	C	Cabg, arterial, four or more					
33542	C	Removal of heart lesion					
33545	C	Repair of heart damage					
33572	C	Open coronary endarterectomy					
33600	C	Closure of valve					
33602	C	Closure of valve					
33606	C	Anastomosis/artery-aorta					
33608	C	Repair anomaly w/conduit					
33610	C	Repair by enlargement					
33611	C	Repair double ventricle					
33612	C	Repair double ventricle					
33615	C	Repair, modified fontan					
33617	C	Repair single ventricle					
33619	C	Repair single ventricle					
33641	C	Repair heart septum defect					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33645	C	Revision of heart veins					
33647	C	Repair heart septum defects					
33660	C	Repair of heart defects					
33665	C	Repair of heart defects					
33670	C	Repair of heart chambers					
33681	C	Repair heart septum defect					
33684	C	Repair heart septum defect					
33688	C	Repair heart septum defect					
33690	C	Reinforce pulmonary artery					
33692	C	Repair of heart defects					
33694	C	Repair of heart defects					
33697	C	Repair of heart defects					
33702	C	Repair of heart defects					
33710	C	Repair of heart defects					
33720	C	Repair of heart defect					
33722	C	Repair of heart defect					
33730	C	Repair heart-vein defect(s)					
33732	C	Repair heart-vein defect					
33735	C	Revision of heart chamber					
33736	C	Revision of heart chamber					
33737	C	Revision of heart chamber					
33750	C	Major vessel shunt					
33755	C	Major vessel shunt					
33762	C	Major vessel shunt					
33764	C	Major vessel shunt & graft					
33766	C	Major vessel shunt					
33767	C	Major vessel shunt					
33770	C	Repair great vessels defect					
33771	C	Repair great vessels defect					
33774	C	Repair great vessels defect					
33775	C	Repair great vessels defect					
33776	C	Repair great vessels defect					
33777	C	Repair great vessels defect					
33778	C	Repair great vessels defect					
33779	C	Repair great vessels defect					
33780	C	Repair great vessels defect					
33781	C	Repair great vessels defect					
33786	C	Repair arterial trunk					
33788	C	Revision of pulmonary artery					
33800	C	Aortic suspension					
33802	C	Repair vessel defect					
33803	C	Repair vessel defect					
33813	C	Repair septal defect					
33814	C	Repair septal defect					
33820	C	Revise major vessel					
33822	C	Revise major vessel					
33824	C	Revise major vessel					
33840	C	Remove aorta constriction					
33845	C	Remove aorta constriction					
33851	C	Remove aorta constriction					
33852	C	Repair septal defect					
33853	C	Repair septal defect					
33860	C	Ascending aortic graft					
33861	C	Ascending aortic graft					
33863	C	Ascending aortic graft					
33870	C	Transverse aortic arch graft					
33875	C	Thoracic aortic graft					
33877	C	Thoracoabdominal graft					
33910	C	Remove lung artery emboli					
33915	C	Remove lung artery emboli					
33916	C	Surgery of great vessel					
33917	C	Repair pulmonary artery					
33918	C	Repair pulmonary atresia					
33919	C	Repair pulmonary atresia					
33920	C	Repair pulmonary atresia					
33922	C	Transect pulmonary artery					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33924	C	Remove pulmonary shunt					
33930	C	Removal of donor heart/lung					
33935	C	Transplantation, heart/lung					
33940	C	Removal of donor heart					
33945	C	Transplantation of heart					
33960	C	External circulation assist					
33961	C	External circulation assist					
33967	C	Insert ia percut device					
33968	C	Remove aortic assist device					
33970	C	Aortic circulation assist					
33971	C	Aortic circulation assist					
33973	C	Insert balloon device					
33974	C	Remove intra-aortic balloon					
33975	C	Implant ventricular device					
33976	C	Implant ventricular device					
33977	C	Remove ventricular device					
33978	C	Remove ventricular device					
33979	C	Insert intracorporeal device					
33980	C	Remove intracorporeal device					
33999	T	Cardiac surgery procedure	0070	3.30	$171.63		$34.33
34001	C	Removal of artery clot					
34051	C	Removal of artery clot					
34101	T	Removal of artery clot	0088	33.96	$1,766.23	$678.68	$353.25
34111	T	Removal of arm artery clot	0088	33.96	$1,766.23	$678.68	$353.25
34151	C	Removal of artery clot					
34201	T	Removal of artery clot	0088	33.96	$1,766.23	$678.68	$353.25
34203	T	Removal of leg artery clot	0088	33.96	$1,766.23	$678.68	$353.25
34401	C	Removal of vein clot					
34421	T	Removal of vein clot	0088	33.96	$1,766.23	$678.68	$353.25
34451	C	Removal of vein clot					
34471	T	Removal of vein clot	0088	33.96	$1,766.23	$678.68	$353.25
34490	T	Removal of vein clot	0088	33.96	$1,766.23	$678.68	$353.25
34501	T	Repair valve, femoral vein	0088	33.96	$1,766.23	$678.68	$353.25
34502	C	Reconstruct vena cava					
34510	T	Transposition of vein valve	0088	33.96	$1,766.23	$678.68	$353.25
34520	T	Cross-over vein graft	0088	33.96	$1,766.23	$678.68	$353.25
34530	T	Leg vein fusion	0088	33.96	$1,766.23	$678.68	$353.25
34800	C	Endovasc abdo repair w/tube					
34802	C	Endovasc abdo repr w/device					
34804	C	Endovasc abdo repr w/device					
34808	C	Endovasc abdo occlud device					
34812	C	Xpose for endoprosth, aortic					
34813	C	Xpose for endoprosth, femorl					
34820	C	Xpose for endoprosth, iliac					
34825	C	Endovasc extend prosth, init					
34826	C	Endovasc exten prosth, addl					
34830	C	Open aortic tube prosth repr					
34831	C	Open aortoiliac prosth repr					
34832	C	Open aortofemor prosth repr					
35001	C	Repair defect of artery					
35002	C	Repair artery rupture, neck					
35005	C	Repair defect of artery					
35011	T	Repair defect of artery	0093	26.29	$1,367.32	$277.34	$273.46
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35122	C	Repair artery rupture, belly					
35131	C	Repair defect of artery					
35132	C	Repair artery rupture, groin					
35141	C	Repair defect of artery					
35142	C	Repair artery rupture, thigh					
35151	C	Repair defect of artery					
35152	C	Repair artery rupture, knee					
35161	C	Repair defect of artery					
35162	C	Repair artery rupture					
35180	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35182	C	Repair blood vessel lesion					
35184	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35188	T	Repair blood vessel lesion	0088	33.96	$1,766.23	$678.68	$353.25
35189	C	Repair blood vessel lesion					
35190	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35201	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35206	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35207	T	Repair blood vessel lesion	0088	33.96	$1,766.23	$678.68	$353.25
35211	C	Repair blood vessel lesion					
35216	C	Repair blood vessel lesion					
35221	C	Repair blood vessel lesion					
35226	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35231	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35236	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35241	C	Repair blood vessel lesion					
35246	C	Repair blood vessel lesion					
35251	C	Repair blood vessel lesion					
35256	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35261	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35266	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	T	Repair blood vessel lesion	0093	26.29	$1,367.32	$277.34	$273.46
35301	C	Rechanneling of artery					
35311	C	Rechanneling of artery					
35321	T	Rechanneling of artery	0093	26.29	$1,367.32	$277.34	$273.46
35331	C	Rechanneling of artery					
35341	C	Rechanneling of artery					
35351	C	Rechanneling of artery					
35355	C	Rechanneling of artery					
35361	C	Rechanneling of artery					
35363	C	Rechanneling of artery					
35371	C	Rechanneling of artery					
35372	C	Rechanneling of artery					
35381	C	Rechanneling of artery					
35390	C	Reoperation, carotid add-on					
35400	C	Angioscopy					
35450	C	Repair arterial blockage					
35452	C	Repair arterial blockage					
35454	C	Repair arterial blockage					
35456	C	Repair arterial blockage					
35458	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35459	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35460	T	Repair venous blockage	0081	22.69	$1,180.08		$236.02
35470	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35471	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35472	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35473	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35474	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35475	T	Repair arterial blockage	0081	22.69	$1,180.08		$236.02
35476	T	Repair venous blockage	0081	22.69	$1,180.08		$236.02
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35484	T	Atherectomy, open	0081	22.69	$1,180.08		$236.02
35485	T	Atherectomy, open	0081	22.69	$1,180.08		$236.02
35490	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35491	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35492	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35493	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35494	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35495	T	Atherectomy, percutaneous	0081	22.69	$1,180.08		$236.02
35500	T	Harvest vein for bypass	0081	22.69	$1,180.08		$236.02
35501	C	Artery bypass graft					
35506	C	Artery bypass graft					
35507	C	Artery bypass graft					
35508	C	Artery bypass graft					
35509	C	Artery bypass graft					
35511	C	Artery bypass graft					
35515	C	Artery bypass graft					
35516	C	Artery bypass graft					
35518	C	Artery bypass graft					
35521	C	Artery bypass graft					
35526	C	Artery bypass graft					
35531	C	Artery bypass graft					
35533	C	Artery bypass graft					
35536	C	Artery bypass graft					
35541	C	Artery bypass graft					
35546	C	Artery bypass graft					
35548	C	Artery bypass graft					
35549	C	Artery bypass graft					
35551	C	Artery bypass graft					
35556	C	Artery bypass graft					
35558	C	Artery bypass graft					
35560	C	Artery bypass graft					
35563	C	Artery bypass graft					
35565	C	Artery bypass graft					
35566	C	Artery bypass graft					
35571	C	Artery bypass graft					
35582	C	Vein bypass graft					
35583	C	Vein bypass graft					
35585	C	Vein bypass graft					
35587	C	Vein bypass graft					
35600	C	Harvest artery for cabg					
35601	C	Artery bypass graft					
35606	C	Artery bypass graft					
35612	C	Artery bypass graft					
35616	C	Artery bypass graft					
35621	C	Artery bypass graft					
35623	C	Bypass graft, not vein					
35626	C	Artery bypass graft					
35631	C	Artery bypass graft					
35636	C	Artery bypass graft					
35641	C	Artery bypass graft					
35642	C	Artery bypass graft					
35645	C	Artery bypass graft					
35646	C	Artery bypass graft					
35647	C	Artery bypass graft					
35650	C	Artery bypass graft					
35651	C	Artery bypass graft					
35654	C	Artery bypass graft					
35656	C	Artery bypass graft					
35661	C	Artery bypass graft					
35663	C	Artery bypass graft					
35665	C	Artery bypass graft					
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 B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35685	T	Bypass graft patency/patch	0093	26.29	$1,367.32	$277.34	$273.46
35686	T	Bypass graft/av fist patency	0093	26.29	$1,367.32	$277.34	$273.46
35691	C	Arterial transposition					
35693	C	Arterial transposition					
35694	C	Arterial transposition					
35695	C	Arterial transposition					
35700	C	Reoperation, bypass graft					
35701	C	Exploration, carotid artery					
35721	C	Exploration, femoral artery					
35741	C	Exploration popliteal artery					
35761	T	Exploration of artery/vein	0115	23.48	$1,221.17	$439.62	$244.23
35800	C	Explore neck vessels					
35820	C	Explore chest vessels					
35840	C	Explore abdominal vessels					
35860	T	Explore limb vessels	0093	26.29	$1,367.32	$277.34	$273.46
35870	C	Repair vessel graft defect					
35875	T	Removal of clot in graft	0088	33.96	$1,766.23	$678.68	$353.25
35876	T	Removal of clot in graft	0088	33.96	$1,766.23	$678.68	$353.25
35879	T	Revise graft w/vein	0088	33.96	$1,766.23	$678.68	$353.25
35881	T	Revise graft w/vein	0088	33.96	$1,766.23	$678.68	$353.25
35901	C	Excision, graft, neck					
35903	T	Excision, graft, extremity	0115	23.48	$1,221.17	$439.62	$244.23
35905	C	Excision, graft, thorax					
35907	C	Excision, graft, abdomen					
36000	N	Place needle in vein					
36002	S	Pseudoaneurysm injection trt	0267	2.58	$134.18	$65.52	$26.84
36005	N	Injection ext venography					
36010	N	Place catheter in vein					
36011	N	Place catheter in vein					
36012	N	Place catheter in vein					
36013	N	Place catheter in artery					
36014	N	Place catheter in artery					
36015	N	Place catheter in artery					
36100	N	Establish access to artery					
36120	N	Establish access to artery					
36140	N	Establish access to artery					
36145	N	Artery to vein shunt					
36160	N	Establish access to aorta					
36200	N	Place catheter in aorta					
36215	N	Place catheter in artery					
36216	N	Place catheter in artery					
36217	N	Place catheter in artery					
36218	N	Place catheter in artery					
36245	N	Place catheter in artery					
36246	N	Place catheter in artery					
36247	N	Place catheter in artery					
36248	N	Place catheter in artery					
36260	T	Insertion of infusion pump	0119	25.88	$1,345.99		$269.20
36261	T	Revision of infusion pump	0124	23.47	$1,220.65		$244.13
36262	T	Removal of infusion pump	0109	7.68	$399.43	$131.49	$79.89
36299	N	Vessel injection procedure					
36400	N	Drawing blood					
36405	N	Drawing blood					
36406	N	Drawing blood					
36410	N	Drawing blood					
36415	E	Drawing blood					
36420	T	Establish access to vein	0035	0.24	$12.48	$3.74	$2.50
36425	T	Establish access to vein	0035	0.24	$12.48	$3.74	$2.50
36430	S	Blood transfusion service	0110	4.04	$210.12		$42.02
36440	S	Blood transfusion service	0110	4.04	$210.12		$42.02
36450	S	Exchange transfusion service	0110	4.04	$210.12		$42.02
36455	S	Exchange transfusion service	0110	4.04	$210.12		$42.02
36460	S	Transfusion service, fetal	0110	4.04	$210.12		$42.02
36468	T	Injection(s), spider veins	0098	1.90	$98.82	$20.88	$19.76
36469	T	Injection(s), spider veins	0098	1.90	$98.82	$20.88	$19.76
36470	T	Injection therapy of vein	0098	1.90	$98.82	$20.88	$19.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36471	T	Injection therapy of veins	0098	1.90	$98.82	$20.88	$19.76
36481	N	Insertion of catheter, vein					
36488	T	Insertion of catheter, vein	0032	7.14	$371.34		$74.27
36489	T	Insertion of catheter, vein	0032	7.14	$371.34		$74.27
36490	T	Insertion of catheter, vein	0032	7.14	$371.34		$74.27
36491	T	Insertion of catheter, vein	0032	7.14	$371.34		$74.27
36493	X	Repositioning of cvc	0187	4.19	$217.92	$94.96	$43.58
36500	N	Insertion of catheter, vein					
36510	C	Insertion of catheter, vein					
36520	S	Plasma and/or cell exchange	0111	13.60	$707.32	$198.05	$141.46
36521	S	Apheresis w/ adsorp/reinfuse	0112	39.40	$2,049.15	$612.47	$409.83
36522	S	Photopheresis	0112	39.40	$2,049.15	$612.47	$409.83
36530	T	Insertion of infusion pump	0119	25.88	$1,345.99		$269.20
36531	T	Revision of infusion pump	0124	23.47	$1,220.65		$244.13
36532	T	Removal of infusion pump	0109	7.68	$399.43	$131.49	$79.89
36533	T	Insertion of access device	0115	23.48	$1,221.17	$439.62	$244.23
36534	T	Revision of access device	0109	7.68	$399.43	$131.49	$79.89
36535	T	Removal of access device	0109	7.68	$399.43	$131.49	$79.89
36540	N	Collect blood venous device					
36550	T	Declot vascular device	0677	2.80	$145.63		$29.13
36600	N	Withdrawal of arterial blood					
36620	N	Insertion catheter, artery					
36625	N	Insertion catheter, artery					
36640	T	Insertion catheter, artery	0032	7.14	$371.34		$74.27
36660	C	Insertion catheter, artery					
36680	T	Insert needle, bone cavity	0120	1.81	$94.14	$25.42	$18.83
36800	T	Insertion of cannula	0115	23.48	$1,221.17	$439.62	$244.23
36810	T	Insertion of cannula	0115	23.48	$1,221.17	$439.62	$244.23
36815	T	Insertion of cannula	0115	23.48	$1,221.17	$439.62	$244.23
36819	T	Av fusion/uppr arm vein	0088	33.96	$1,766.23	$678.68	$353.25
36820	T	Av fusion/forearm vein	0088	33.96	$1,766.23	$678.68	$353.25
36821	T	Av fusion direct any site	0088	33.96	$1,766.23	$678.68	$353.25
36822	C	Insertion of cannula(s)					
36823	C	Insertion of cannula(s)					
36825	T	Artery-vein graft	0088	33.96	$1,766.23	$678.68	$353.25
36830	T	Artery-vein graft	0088	33.96	$1,766.23	$678.68	$353.25
36831	T	Open thrombect av fistula	0088	33.96	$1,766.23	$678.68	$353.25
36832	T	Av fistula revision, open	0088	33.96	$1,766.23	$678.68	$353.25
36833	T	Av fistula revision	0088	33.96	$1,766.23	$678.68	$353.25
36834	T	Repair A-V aneurysm	0088	33.96	$1,766.23	$678.68	$353.25
36835	T	Artery to vein shunt	0115	23.48	$1,221.17	$439.62	$244.23
36860	T	External cannula declotting	0103	11.26	$585.62	$210.82	$117.12
36861	T	Cannula declotting	0115	23.48	$1,221.17	$439.62	$244.23
36870	T	Percut thrombect av fistula	0093	26.29	$1,367.32	$277.34	$273.46
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	T	Transcatheter biopsy	0685	4.47	$232.48	$102.29	$46.50
37201	T	Transcatheter therapy infuse	0676	4.62	$240.28	$64.88	$48.06
37202	T	Transcatheter therapy infuse	0677	2.80	$145.63		$29.13
37203	T	Transcatheter retrieval	0103	11.26	$585.62	$210.82	$117.12
37204	T	Transcatheter occlusion	0115	23.48	$1,221.17	$439.62	$244.23
37205	T	Transcatheter stent	0229	49.00	$2,548.44	$662.59	$509.69
37206	T	Transcatheter stent add-on	0229	49.00	$2,548.44	$662.59	$509.69
37207	T	Transcatheter stent	0229	49.00	$2,548.44	$662.59	$509.69
37208	T	Transcatheter stent add-on	0229	49.00	$2,548.44	$662.59	$509.69
37209	T	Exchange arterial catheter	0103	11.26	$585.62	$210.82	$117.12
37250	S	Iv us first vessel add-on	0670	14.78	$768.69	$276.73	$153.74
37251	S	Iv us each add vessel add-on	0670	14.78	$768.69	$276.73	$153.74
37565	T	Ligation of neck vein	0093	26.29	$1,367.32	$277.34	$273.46
37600	T	Ligation of neck artery	0093	26.29	$1,367.32	$277.34	$273.46
37605	T	Ligation of neck artery	0091	27.03	$1,405.80	$348.23	$281.16
37606	T	Ligation of neck artery	0091	27.03	$1,405.80	$348.23	$281.16

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37607	T	Ligation of a-v fistula	0092	24.97	$1,298.66	$505.37	$259.73
37609	T	Temporal artery procedure	0021	14.58	$758.29	$227.49	$151.66
37615	T	Ligation of neck artery	0091	27.03	$1,405.80	$348.23	$281.16
37616	C	Ligation of chest artery					
37617	C	Ligation of abdomen artery					
37618	C	Ligation of extremity artery					
37620	T	Revision of major vein	0091	27.03	$1,405.80	$348.23	$281.16
37650	T	Revision of major vein	0091	27.03	$1,405.80	$348.23	$281.16
37660	C	Revision of major vein					
37700	T	Revise leg vein	0091	27.03	$1,405.80	$348.23	$281.16
37720	T	Removal of leg vein	0092	24.97	$1,298.66	$505.37	$259.73
37730	T	Removal of leg veins	0092	24.97	$1,298.66	$505.37	$259.73
37735	T	Removal of leg veins/lesion	0092	24.97	$1,298.66	$505.37	$259.73
37760	T	Revision of leg veins	0091	27.03	$1,405.80	$348.23	$281.16
37780	T	Revision of leg vein	0091	27.03	$1,405.80	$348.23	$281.16
37785	T	Revise secondary varicosity	0091	27.03	$1,405.80	$348.23	$281.16
37788	C	Revascularization, penis					
37790	T	Penile venous occlusion	0181	29.88	$1,554.03	$621.82	$310.81
37799	T	Vascular surgery procedure	0035	0.24	$12.48	$3.74	$2.50
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	42.44	$2,207.26	$1,001.89	$441.45
38129	T	Laparoscope proc, spleen	0130	31.99	$1,663.77	$659.53	$332.75
38200	N	Injection for spleen x-ray					
38220	T	Bone marrow aspiration	0003	1.24	$64.49	$27.08	$12.90
38221	T	Bone marrow biopsy	0003	1.24	$64.49	$27.08	$12.90
38230	S	Bone marrow collection	0123	4.86	$252.76		$50.55
38231	S	Stem cell collection	0111	13.60	$707.32	$198.05	$141.46
38240	S	Bone marrow/stem transplant	0123	4.86	$252.76		$50.55
38241	S	Bone marrow/stem transplant	0123	4.86	$252.76		$50.55
38300	T	Drainage, lymph node lesion	0008	16.32	$848.79		$169.76
38305	T	Drainage, lymph node lesion	0008	16.32	$848.79		$169.76
38308	T	Incision of lymph channels	0113	19.75	$1,027.18		$205.44
38380	C	Thoracic duct procedure					
38381	C	Thoracic duct procedure					
38382	C	Thoracic duct procedure					
38500	T	Biopsy/removal, lymph nodes	0113	19.75	$1,027.18		$205.44
38505	T	Needle biopsy, lymph nodes	0005	3.02	$157.07	$69.11	$31.41
38510	T	Biopsy/removal, lymph nodes	0113	19.75	$1,027.18		$205.44
38520	T	Biopsy/removal, lymph nodes	0113	19.75	$1,027.18		$205.44
38525	T	Biopsy/removal, lymph nodes	0113	19.75	$1,027.18		$205.44
38530	T	Biopsy/removal, lymph nodes	0113	19.75	$1,027.18		$205.44
38542	T	Explore deep node(s), neck	0114	37.55	$1,952.94	$507.76	$390.59
38550	T	Removal, neck/armpit lesion	0113	19.75	$1,027.18		$205.44
38555	T	Removal, neck/armpit lesion	0113	19.75	$1,027.18		$205.44
38562	C	Removal, pelvic lymph nodes					
38564	C	Removal, abdomen lymph nodes					
38570	T	Laparoscopy, lymph node biop	0131	42.44	$2,207.26	$1,001.89	$441.45
38571	T	Laparoscopy, lymphadenectomy	0132	57.95	$3,013.92	$1,239.22	$602.78
38572	T	Laparoscopy, lymphadenectomy	0131	42.44	$2,207.26	$1,001.89	$441.45
38589	T	Laparoscope proc, lymphatic	0130	31.99	$1,663.77	$659.53	$332.75
38700	T	Removal of lymph nodes, neck	0113	19.75	$1,027.18		$205.44
38720	T	Removal of lymph nodes, neck	0113	19.75	$1,027.18		$205.44
38724	C	Removal of lymph nodes, neck					
38740	T	Remove armpit lymph nodes	0114	37.55	$1,952.94	$507.76	$390.59
38745	T	Remove armpit lymph nodes	0114	37.55	$1,952.94	$507.76	$390.59
38746	C	Remove thoracic lymph nodes					
38747	C	Remove abdominal lymph nodes					
38760	T	Remove groin lymph nodes	0113	19.75	$1,027.18		$205.44
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38794	N	Access thoracic lymph duct					
38999	S	Blood/lymph system procedure	0110	4.04	$210.12		$42.02
39000	C	Exploration of chest					
39010	C	Exploration of chest					
39200	C	Removal chest lesion					
39220	C	Removal chest lesion					
39400	T	Visualization of chest	0069	29.51	$1,534.79	$591.64	$306.96
39499	C	Chest procedure					
39501	C	Repair diaphragm laceration					
39502	C	Repair paraesophageal hernia					
39503	C	Repair of diaphragm hernia					
39520	C	Repair of diaphragm hernia					
39530	C	Repair of diaphragm hernia					
39531	C	Repair of diaphragm hernia					
39540	C	Repair of diaphragm hernia					
39541	C	Repair of diaphragm hernia					
39545	C	Revision of diaphragm					
39560	C	Resect diaphragm, simple					
39561	C	Resect diaphragm, complex					
39599	C	Diaphragm surgery procedure					
40490	T	Biopsy of lip	0251	1.92	$99.86		$19.97
40500	T	Partial excision of lip	0253	14.79	$769.21	$284.61	$153.84
40510	T	Partial excision of lip	0254	21.89	$1,138.48	$352.93	$227.70
40520	T	Partial excision of lip	0253	14.79	$769.21	$284.61	$153.84
40525	T	Reconstruct lip with flap	0254	21.89	$1,138.48	$352.93	$227.70
40527	T	Reconstruct lip with flap	0254	21.89	$1,138.48	$352.93	$227.70
40530	T	Partial removal of lip	0254	21.89	$1,138.48	$352.93	$227.70
40650	T	Repair lip	0252	6.27	$326.10	$114.24	$65.22
40652	T	Repair lip	0252	6.27	$326.10	$114.24	$65.22
40654	T	Repair lip	0252	6.27	$326.10	$114.24	$65.22
40700	T	Repair cleft lip/nasal	0256	35.51	$1,846.84		$369.37
40701	T	Repair cleft lip/nasal	0256	35.51	$1,846.84		$369.37
40702	T	Repair cleft lip/nasal	0256	35.51	$1,846.84		$369.37
40720	T	Repair cleft lip/nasal	0256	35.51	$1,846.84		$369.37
40761	T	Repair cleft lip/nasal	0256	35.51	$1,846.84		$369.37
40799	T	Lip surgery procedure	0253	14.79	$769.21	$284.61	$153.84
40800	T	Drainage of mouth lesion	0251	1.92	$99.86		$19.97
40801	T	Drainage of mouth lesion	0252	6.27	$326.10	$114.24	$65.22
40804	X	Removal, foreign body, mouth	0340	0.66	$34.33		$6.87
40805	T	Removal, foreign body, mouth	0252	6.27	$326.10	$114.24	$65.22
40806	T	Incision of lip fold	0251	1.92	$99.86		$19.97
40808	T	Biopsy of mouth lesion	0251	1.92	$99.86		$19.97
40810	T	Excision of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
40812	T	Excise/repair mouth lesion	0253	14.79	$769.21	$284.61	$153.84
40814	T	Excise/repair mouth lesion	0253	14.79	$769.21	$284.61	$153.84
40816	T	Excision of mouth lesion	0254	21.89	$1,138.48	$352.93	$227.70
40818	T	Excise oral mucosa for graft	0251	1.92	$99.86		$19.97
40819	T	Excise lip or cheek fold	0252	6.27	$326.10	$114.24	$65.22
40820	T	Treatment of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
40830	T	Repair mouth laceration	0251	1.92	$99.86		$19.97
40831	T	Repair mouth laceration	0252	6.27	$326.10	$114.24	$65.22
40840	T	Reconstruction of mouth	0254	21.89	$1,138.48	$352.93	$227.70
40842	T	Reconstruction of mouth	0254	21.89	$1,138.48	$352.93	$227.70
40843	T	Reconstruction of mouth	0254	21.89	$1,138.48	$352.93	$227.70
40844	T	Reconstruction of mouth	0256	35.51	$1,846.84		$369.37
40845	T	Reconstruction of mouth	0256	35.51	$1,846.84		$369.37
40899	T	Mouth surgery procedure	0252	6.27	$326.10	$114.24	$65.22
41000	T	Drainage of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
41005	T	Drainage of mouth lesion	0251	1.92	$99.86		$19.97
41006	T	Drainage of mouth lesion	0254	21.89	$1,138.48	$352.93	$227.70
41007	T	Drainage of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
41008	T	Drainage of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
41009	T	Drainage of mouth lesion	0251	1.92	$99.86		$19.97
41010	T	Incision of tongue fold	0253	14.79	$769.21	$284.61	$153.84
41015	T	Drainage of mouth lesion	0251	1.92	$99.86		$19.97
41016	T	Drainage of mouth lesion	0252	6.27	$326.10	$114.24	$65.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41017	T	Drainage of mouth lesion	0252	6.27	$326.10	$114.24	$65.22
41018	T	Drainage of mouth lesion	0252	6.27	$326.10	$114.24	$65.22
41100	T	Biopsy of tongue	0252	6.27	$326.10	$114.24	$65.22
41105	T	Biopsy of tongue	0253	14.79	$769.21	$284.61	$153.84
41108	T	Biopsy of floor of mouth	0252	6.27	$326.10	$114.24	$65.22
41110	T	Excision of tongue lesion	0253	14.79	$769.21	$284.61	$153.84
41112	T	Excision of tongue lesion	0253	14.79	$769.21	$284.61	$153.84
41113	T	Excision of tongue lesion	0253	14.79	$769.21	$284.61	$153.84
41114	T	Excision of tongue lesion	0254	21.89	$1,138.48	$352.93	$227.70
41115	T	Excision of tongue fold	0252	6.27	$326.10	$114.24	$65.22
41116	T	Excision of mouth lesion	0253	14.79	$769.21	$284.61	$153.84
41120	T	Partial removal of tongue	0254	21.89	$1,138.48	$352.93	$227.70
41130	C	Partial removal of tongue	.....	.....	.....	.....	.....
41135	C	Tongue and neck surgery	.....	.....	.....	.....	.....
41140	C	Removal of tongue	.....	.....	.....	.....	.....
41145	C	Tongue removal, neck surgery	.....	.....	.....	.....	.....
41150	C	Tongue, mouth, jaw surgery	.....	.....	.....	.....	.....
41153	C	Tongue, mouth, neck surgery	.....	.....	.....	.....	.....
41155	C	Tongue, jaw, & neck surgery	.....	.....	.....	.....	.....
41250	T	Repair tongue laceration	0251	1.92	$99.86	.....	$19.97
41251	T	Repair tongue laceration	0252	6.27	$326.10	$114.24	$65.22
41252	T	Repair tongue laceration	0252	6.27	$326.10	$114.24	$65.22
41500	T	Fixation of tongue	0254	21.89	$1,138.48	$352.93	$227.70
41510	T	Tongue to lip surgery	0253	14.79	$769.21	$284.61	$153.84
41520	T	Reconstruction, tongue fold	0252	6.27	$326.10	$114.24	$65.22
41599	T	Tongue and mouth surgery	0251	1.92	$99.86	.....	$19.97
41800	T	Drainage of gum lesion	0251	1.92	$99.86	.....	$19.97
41805	T	Removal foreign body, gum	0254	21.89	$1,138.48	$352.93	$227.70
41806	T	Removal foreign body,jawbone	0253	14.79	$769.21	$284.61	$153.84
41820	T	Excision, gum, each quadrant	0252	6.27	$326.10	$114.24	$65.22
41821	T	Excision of gum flap	0252	6.27	$326.10	$114.24	$65.22
41822	T	Excision of gum lesion	0253	14.79	$769.21	$284.61	$153.84
41823	T	Excision of gum lesion	0254	21.89	$1,138.48	$352.93	$227.70
41825	T	Excision of gum lesion	0253	14.79	$769.21	$284.61	$153.84
41826	T	Excision of gum lesion	0253	14.79	$769.21	$284.61	$153.84
41827	T	Excision of gum lesion	0254	21.89	$1,138.48	$352.93	$227.70
41828	T	Excision of gum lesion	0253	14.79	$769.21	$284.61	$153.84
41830	T	Removal of gum tissue	0253	14.79	$769.21	$284.61	$153.84
41850	T	Treatment of gum lesion	0253	14.79	$769.21	$284.61	$153.84
41870	T	Gum graft	0254	21.89	$1,138.48	$352.93	$227.70
41872	T	Repair gum	0253	14.79	$769.21	$284.61	$153.84
41874	T	Repair tooth socket	0254	21.89	$1,138.48	$352.93	$227.70
41899	T	Dental surgery procedure	0253	14.79	$769.21	$284.61	$153.84
42000	T	Drainage mouth roof lesion	0251	1.92	$99.86	.....	$19.97
42100	T	Biopsy roof of mouth	0252	6.27	$326.10	$114.24	$65.22
42104	T	Excision lesion, mouth roof	0253	14.79	$769.21	$284.61	$153.84
42106	T	Excision lesion, mouth roof	0253	14.79	$769.21	$284.61	$153.84
42107	T	Excision lesion, mouth roof	0254	21.89	$1,138.48	$352.93	$227.70
42120	T	Remove palate/lesion	0256	35.51	$1,846.84	.....	$369.37
42140	T	Excision of uvula	0252	6.27	$326.10	$114.24	$65.22
42145	T	Repair palate, pharynx/uvula	0254	21.89	$1,138.48	$352.93	$227.70
42160	T	Treatment mouth roof lesion	0253	14.79	$769.21	$284.61	$153.84
42180	T	Repair palate	0251	1.92	$99.86	.....	$19.97
42182	T	Repair palate	0256	35.51	$1,846.84	.....	$369.37
42200	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42205	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42210	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42215	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42220	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42225	T	Reconstruct cleft palate	0256	35.51	$1,846.84	.....	$369.37
42226	T	Lengthening of palate	0256	35.51	$1,846.84	.....	$369.37
42227	T	Lengthening of palate	0256	35.51	$1,846.84	.....	$369.37
42235	T	Repair palate	0253	14.79	$769.21	$284.61	$153.84
42260	T	Repair nose to lip fistula	0254	21.89	$1,138.48	$352.93	$227.70
42280	T	Preparation, palate mold	0251	1.92	$99.86	.....	$19.97
42281	T	Insertion, palate prosthesis	0253	14.79	$769.21	$284.61	$153.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42299	T	Palate/uvula surgery	0251	1.92	$99.86	.....	$19.97
42300	T	Drainage of salivary gland	0253	14.79	$769.21	$284.61	$153.84
42305	T	Drainage of salivary gland	0253	14.79	$769.21	$284.61	$153.84
42310	T	Drainage of salivary gland	0251	1.92	$99.86	.....	$19.97
42320	T	Drainage of salivary gland	0251	1.92	$99.86	.....	$19.97
42325	T	Create salivary cyst drain	0251	1.92	$99.86	.....	$19.97
42326	T	Create salivary cyst drain	0252	6.27	$326.10	$114.24	$65.22
42330	T	Removal of salivary stone	0253	14.79	$769.21	$284.61	$153.84
42335	T	Removal of salivary stone	0253	14.79	$769.21	$284.61	$153.84
42340	T	Removal of salivary stone	0253	14.79	$769.21	$284.61	$153.84
42400	T	Biopsy of salivary gland	0004	1.63	$84.77	$22.04	$16.95
42405	T	Biopsy of salivary gland	0253	14.79	$769.21	$284.61	$153.84
42408	T	Excision of salivary cyst	0253	14.79	$769.21	$284.61	$153.84
42409	T	Drainage of salivary cyst	0253	14.79	$769.21	$284.61	$153.84
42410	T	Excise parotid gland/lesion	0256	35.51	$1,846.84	.....	$369.37
42415	T	Excise parotid gland/lesion	0256	35.51	$1,846.84	.....	$369.37
42420	T	Excise parotid gland/lesion	0256	35.51	$1,846.84	.....	$369.37
42425	T	Excise parotid gland/lesion	0256	35.51	$1,846.84	.....	$369.37
42426	C	Excise parotid gland/lesion	.....	.....	.....	.....	.....
42440	T	Excise submaxillary gland	0256	35.51	$1,846.84	.....	$369.37
42450	T	Excise sublingual gland	0254	21.89	$1,138.48	$352.93	$227.70
42500	T	Repair salivary duct	0254	21.89	$1,138.48	$352.93	$227.70
42505	T	Repair salivary duct	0256	35.51	$1,846.84	.....	$369.37
42507	T	Parotid duct diversion	0256	35.51	$1,846.84	.....	$369.37
42508	T	Parotid duct diversion	0256	35.51	$1,846.84	.....	$369.37
42509	T	Parotid duct diversion	0256	35.51	$1,846.84	.....	$369.37
42510	T	Parotid duct diversion	0256	35.51	$1,846.84	.....	$369.37
42550	N	Injection for salivary x-ray	.....	.....	.....	.....	.....
42600	T	Closure of salivary fistula	0253	14.79	$769.21	$284.61	$153.84
42650	T	Dilation of salivary duct	0252	6.27	$326.10	$114.24	$65.22
42660	T	Dilation of salivary duct	0252	6.27	$326.10	$114.24	$65.22
42665	T	Ligation of salivary duct	0254	21.89	$1,138.48	$352.93	$227.70
42699	T	Salivary surgery procedure	0253	14.79	$769.21	$284.61	$153.84
42700	T	Drainage of tonsil abscess	0251	1.92	$99.86	.....	$19.97
42720	T	Drainage of throat abscess	0253	14.79	$769.21	$284.61	$153.84
42725	T	Drainage of throat abscess	0256	35.51	$1,846.84	.....	$369.37
42800	T	Biopsy of throat	0252	6.27	$326.10	$114.24	$65.22
42802	T	Biopsy of throat	0253	14.79	$769.21	$284.61	$153.84
42804	T	Biopsy of upper nose/throat	0253	14.79	$769.21	$284.61	$153.84
42806	T	Biopsy of upper nose/throat	0254	21.89	$1,138.48	$352.93	$227.70
42808	T	Excise pharynx lesion	0253	14.79	$769.21	$284.61	$153.84
42809	X	Remove pharynx foreign body	0340	0.66	$34.33	.....	$6.87
42810	T	Excision of neck cyst	0254	21.89	$1,138.48	$352.93	$227.70
42815	T	Excision of neck cyst	0256	35.51	$1,846.84	.....	$369.37
42820	T	Remove tonsils and adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42821	T	Remove tonsils and adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42825	T	Removal of tonsils	0258	21.15	$1,099.99	$437.25	$220.00
42826	T	Removal of tonsils	0258	21.15	$1,099.99	$437.25	$220.00
42830	T	Removal of adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42831	T	Removal of adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42835	T	Removal of adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42836	T	Removal of adenoids	0258	21.15	$1,099.99	$437.25	$220.00
42842	T	Extensive surgery of throat	0254	21.89	$1,138.48	$352.93	$227.70
42844	T	Extensive surgery of throat	0256	35.51	$1,846.84	.....	$369.37
42845	C	Extensive surgery of throat	.....	.....	.....	.....	.....
42860	T	Excision of tonsil tags	0258	21.15	$1,099.99	$437.25	$220.00
42870	T	Excision of lingual tonsil	0258	21.15	$1,099.99	$437.25	$220.00
42890	T	Partial removal of pharynx	0256	35.51	$1,846.84	.....	$369.37
42892	T	Revision of pharyngeal walls	0256	35.51	$1,846.84	.....	$369.37
42894	C	Revision of pharyngeal walls	.....	.....	.....	.....	.....
42900	T	Repair throat wound	0252	6.27	$326.10	$114.24	$65.22
42950	T	Reconstruction of throat	0254	21.89	$1,138.48	$352.93	$227.70
42953	C	Repair throat, esophagus	.....	.....	.....	.....	.....
42955	T	Surgical opening of throat	0254	21.89	$1,138.48	$352.93	$227.70
42960	T	Control throat bleeding	0250	1.68	$87.38	$30.58	$17.48
42961	C	Control throat bleeding	.....	.....	.....	.....	.....

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42962	T	Control throat bleeding	0256	35.51	$1,846.84		$369.37
42970	T	Control nose/throat bleeding	0250	1.68	$87.38	$30.58	$17.48
42971	C	Control nose/throat bleeding					
42972	T	Control nose/throat bleeding	0253	14.79	$769.21	$284.61	$153.84
42999	T	Throat surgery procedure	0252	6.27	$326.10	$114.24	$65.22
43020	T	Incision of esophagus	0252	6.27	$326.10	$114.24	$65.22
43030	T	Throat muscle surgery	0253	14.79	$769.21	$284.61	$153.84
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	T	Removal of esophagus pouch	0254	21.89	$1,138.48	$352.93	$227.70
43135	C	Removal of esophagus pouch					
43200	T	Esophagus endoscopy	0141	7.82	$406.71	$150.48	$81.34
43202	T	Esophagus endoscopy, biopsy	0141	7.82	$406.71	$150.48	$81.34
43204	T	Esophagus endoscopy & inject	0141	7.82	$406.71	$150.48	$81.34
43205	T	Esophagus endoscopy/ligation	0141	7.82	$406.71	$150.48	$81.34
43215	T	Esophagus endoscopy	0141	7.82	$406.71	$150.48	$81.34
43216	T	Esophagus endoscopy/lesion	0141	7.82	$406.71	$150.48	$81.34
43217	T	Esophagus endoscopy	0141	7.82	$406.71	$150.48	$81.34
43219	T	Esophagus endoscopy	0141	7.82	$406.71	$150.48	$81.34
43220	T	Esoph endoscopy, dilation	0141	7.82	$406.71	$150.48	$81.34
43226	T	Esoph endoscopy, dilation	0141	7.82	$406.71	$150.48	$81.34
43227	T	Esoph endoscopy, repair	0141	7.82	$406.71	$150.48	$81.34
43228	T	Esoph endoscopy, ablation	0141	7.82	$406.71	$150.48	$81.34
43231	T	Esoph endoscopy w/us exam	0141	7.82	$406.71	$150.48	$81.34
43232	T	Esoph endoscopy w/us fn bx	0141	7.82	$406.71	$150.48	$81.34
43234	T	Upper GI endoscopy, exam	0141	7.82	$406.71	$150.48	$81.34
43235	T	Uppr gi endoscopy, diagnosis	0141	7.82	$406.71	$150.48	$81.34
43239	T	Upper GI endoscopy, biopsy	0141	7.82	$406.71	$150.48	$81.34
43240	T	Esoph endoscope w/drain cyst	0141	7.82	$406.71	$150.48	$81.34
43241	T	Upper GI endoscopy with tube	0141	7.82	$406.71	$150.48	$81.34
43242	T	Uppr gi endoscopy w/us fn bx	0141	7.82	$406.71	$150.48	$81.34
43243	T	Upper gi endoscopy & inject	0141	7.82	$406.71	$150.48	$81.34
43244	T	Upper GI endoscopy/ligation	0141	7.82	$406.71	$150.48	$81.34
43245	T	Operative upper GI endoscopy	0141	7.82	$406.71	$150.48	$81.34
43246	T	Place gastrostomy tube	0141	7.82	$406.71	$150.48	$81.34
43247	T	Operative upper GI endoscopy	0141	7.82	$406.71	$150.48	$81.34
43248	T	Uppr gi endoscopy/guide wire	0141	7.82	$406.71	$150.48	$81.34
43249	T	Esoph endoscopy, dilation	0141	7.82	$406.71	$150.48	$81.34
43250	T	Upper GI endoscopy/tumor	0141	7.82	$406.71	$150.48	$81.34
43251	T	Operative upper GI endoscopy	0141	7.82	$406.71	$150.48	$81.34
43255	T	Operative upper GI endoscopy	0141	7.82	$406.71	$150.48	$81.34
43256	T	Uppr gi endoscopy w stent	0141	7.82	$406.71	$150.48	$81.34
43258	T	Operative upper GI endoscopy	0141	7.82	$406.71	$150.48	$81.34
43259	T	Endoscopic ultrasound exam	0141	7.82	$406.71	$150.48	$81.34
43260	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43261	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43262	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43263	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43264	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43265	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43267	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43268	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43269	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43271	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43272	T	Endo cholangiopancreatograph	0151	18.23	$948.12	$245.46	$189.62
43280	T	Laparoscopy, fundoplasty	0132	57.95	$3,013.92	$1,239.22	$602.78
43289	T	Laparoscope proc, esoph	0130	31.99	$1,663.77	$659.53	$332.75
43300	C	Repair of esophagus					
43305	C	Repair esophagus and fistula					
43310	C	Repair of esophagus					
43312	C	Repair esophagus and fistula					
43313	C	Esophagoplasty congential					
43314	C	Tracheo-esophagoplasty cong					
43320	C	Fuse esophagus & stomach					
43324	C	Revise esophagus & stomach					
43325	C	Revise esophagus & stomach					
43326	C	Revise esophagus & stomach					
43330	C	Repair of esophagus					
43331	C	Repair of esophagus					
43340	C	Fuse esophagus & intestine					
43341	C	Fuse esophagus & intestine					
43350	C	Surgical opening, esophagus					
43351	C	Surgical opening, esophagus					
43352	C	Surgical opening, esophagus					
43360	C	Gastrointestinal repair					
43361	C	Gastrointestinal repair					
43400	C	Ligate esophagus veins					
43401	C	Esophagus surgery for veins					
43405	C	Ligate/staple esophagus					
43410	C	Repair esophagus wound					
43415	C	Repair esophagus wound					
43420	C	Repair esophagus opening					
43425	C	Repair esophagus opening					
43450	T	Dilate esophagus	0140	5.84	$303.73	$107.24	$60.75
43453	T	Dilate esophagus	0140	5.84	$303.73	$107.24	$60.75
43456	T	Dilate esophagus	0140	5.84	$303.73	$107.24	$60.75
43458	T	Dilate esophagus	0140	5.84	$303.73	$107.24	$60.75
43460	C	Pressure treatment esophagus					
43496	C	Free jejunum flap, microvasc					
43499	T	Esophagus surgery procedure	0141	7.82	$406.71	$150.48	$81.34
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	7.82	$406.71	$150.48	$81.34
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	57.95	$3,013.92	$1,239.22	$602.78
43652	T	Laparoscopy, vagus nerve	0132	57.95	$3,013.92	$1,239.22	$602.78
43653	T	Laparoscopy, gastrostomy	0131	42.44	$2,207.26	$1,001.89	$441.45
43659	T	Laparoscope proc, stom	0130	31.99	$1,663.77	$659.53	$332.75
43750	T	Place gastrostomy tube	0141	7.82	$406.71	$150.48	$81.34
43752	E	Nasal/orogastric w/stent					
43760	T	Change gastrostomy tube	0121	2.17	$112.86	$45.14	$22.57
43761	T	Reposition gastrostomy tube	0121	2.17	$112.86	$45.14	$22.57
43800	C	Reconstruction of pylorus					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	7.82	$406.71	$150.48	$81.34
43831	T	Place gastrostomy tube	0141	7.82	$406.71	$150.48	$81.34
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	0141	7.82	$406.71	$150.48	$81.34
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	0141	7.82	$406.71	$150.48	$81.34
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle cath bowel					
44020	C	Explore small intestine					
44021	C	Decompress small bowel					
44025	C	Incision of large bowel					
44050	C	Reduce bowel obstruction					
44055	C	Correct malrotation of bowel					
44100	T	Biopsy of bowel	0141	7.82	$406.71	$150.48	$81.34
44110	C	Excise intestine lesion(s)					
44111	C	Excision of bowel lesion(s)					
44120	C	Removal of small intestine					
44121	C	Removal of small intestine					
44125	C	Removal of small intestine					
44126	C	Enterectomy w/taper, cong					
44127	C	Enterectomy w/o taper, cong					
44128	C	Enterectomy cong, add-on					
44130	C	Bowel to bowel fusion					
44132	C	Enterectomy, cadaver donor					
44133	C	Enterectomy, live donor					
44135	C	Intestine transplnt, cadaver					
44136	C	Intestine transplant, live					
44139	C	Mobilization of colon					
44140	C	Partial removal of colon					
44141	C	Partial removal of colon					
44143	C	Partial removal of colon					
44144	C	Partial removal of colon					
44145	C	Partial removal of colon					
44146	C	Partial removal of colon					
44147	C	Partial removal of colon					
44150	C	Removal of colon					
44151	C	Removal of colon/ileostomy					
44152	C	Removal of colon/ileostomy					
44153	C	Removal of colon/ileostomy					
44155	C	Removal of colon/ileostomy					
44156	C	Removal of colon/ileostomy					
44160	C	Removal of colon					
44200	T	Laparoscopy, enterolysis	0131	42.44	$2,207.26	$1,001.89	$441.45
44201	T	Laparoscopy, jejunostomy	0131	42.44	$2,207.26	$1,001.89	$441.45
44202	C	Lap resect s/intestine singl					
44203	C	Lap resect s/intestine, addl					
44204	C	Laparo partial colectomy					
44205	C	Lap colectomy part w/ileum					
44209	T	Laparoscope proc, intestine	0130	31.99	$1,663.77	$659.53	$332.75
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	0027	15.73	$818.10	$343.60	$163.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	0027	15.73	$818.10	$343.60	$163.62
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44361	T	Small bowel endoscopy/biopsy	0142	8.21	$426.99	$152.78	$85.40
44363	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44364	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44365	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44366	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44369	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44370	T	Small bowel endoscopy/stent	0142	8.21	$426.99	$152.78	$85.40
44372	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44373	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44376	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44377	T	Small bowel endoscopy/biopsy	0142	8.21	$426.99	$152.78	$85.40
44378	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44379	T	S bowel endoscope w/stent	0142	8.21	$426.99	$152.78	$85.40
44380	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44382	T	Small bowel endoscopy	0142	8.21	$426.99	$152.78	$85.40
44383	T	Ileoscopy w/stent	0142	8.21	$426.99	$152.78	$85.40
44385	T	Endoscopy of bowel pouch	0143	8.37	$435.32	$186.06	$87.06
44386	T	Endoscopy, bowel pouch/biop	0143	8.37	$435.32	$186.06	$87.06
44388	T	Colon endoscopy	0143	8.37	$435.32	$186.06	$87.06
44389	T	Colonoscopy with biopsy	0143	8.37	$435.32	$186.06	$87.06
44390	T	Colonoscopy for foreign body	0143	8.37	$435.32	$186.06	$87.06
44391	T	Colonoscopy for bleeding	0143	8.37	$435.32	$186.06	$87.06
44392	T	Colonoscopy & polypectomy	0143	8.37	$435.32	$186.06	$87.06
44393	T	Colonoscopy, lesion removal	0143	8.37	$435.32	$186.06	$87.06
44394	T	Colonoscopy w/snare	0143	8.37	$435.32	$186.06	$87.06
44397	T	Colonoscopy w stent	0143	8.37	$435.32	$186.06	$87.06
44500	T	Intro, gastrointestinal tube	0121	2.17	$112.86	$45.14	$22.57
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	8.21	$426.99	$152.78	$85.40
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	31.99	$1,663.77	$659.53	$332.75
44979	T	Laparoscope proc, app	0130	31.99	$1,663.77	$659.53	$332.75
45000	T	Drainage of pelvic abscess	0149	16.91	$879.47	$293.06	$175.89
45005	T	Drainage of rectal abscess	0148	3.61	$187.75	$67.59	$37.55
45020	T	Drainage of rectal abscess	0149	16.91	$879.47	$293.06	$175.89
45100	T	Biopsy of rectum	0149	16.91	$879.47	$293.06	$175.89
45108	T	Removal of anorectal lesion	0150	22.02	$1,145.24	$437.12	$229.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45110	C	Removal of rectum					
45111	C	Partial removal of rectum					
45112	C	Removal of rectum					
45113	C	Partial proctectomy					
45114	C	Partial removal of rectum					
45116	C	Partial removal of rectum					
45119	C	Remove rectum w/reservoir					
45120	C	Removal of rectum					
45121	C	Removal of rectum and colon					
45123	C	Partial proctectomy					
45126	C	Pelvic exenteration					
45130	C	Excision of rectal prolapse					
45135	C	Excision of rectal prolapse					
45136	C	Excise ileoanal reservoir					
45150	T	Excision of rectal stricture	0150	22.02	$1,145.24	$437.12	$229.05
45160	T	Excision of rectal lesion	0150	22.02	$1,145.24	$437.12	$229.05
45170	T	Excision of rectal lesion	0150	22.02	$1,145.24	$437.12	$229.05
45190	T	Destruction, rectal tumor	0150	22.02	$1,145.24	$437.12	$229.05
45300	T	Proctosigmoidoscopy dx	0146	3.47	$180.47	$64.40	$36.09
45303	T	Proctosigmoidoscopy dilate	0146	3.47	$180.47	$64.40	$36.09
45305	T	Protosigmoidoscopy w/bx	0146	3.47	$180.47	$64.40	$36.09
45307	T	Protosigmoidoscopy fb	0146	3.47	$180.47	$64.40	$36.09
45308	T	Protosigmoidoscopy removal	0147	7.30	$379.67	$83.53	$75.93
45309	T	Protosigmoidoscopy removal	0147	7.30	$379.67	$83.53	$75.93
45315	T	Protosigmoidoscopy removal	0147	7.30	$379.67	$83.53	$75.93
45317	T	Protosigmoidoscopy bleed	0146	3.47	$180.47	$64.40	$36.09
45320	T	Protosigmoidoscopy ablate	0147	7.30	$379.67	$83.53	$75.93
45321	T	Protosigmoidoscopy volvul	0147	7.30	$379.67	$83.53	$75.93
45327	T	Proctosigmoidoscopy w/stent	0147	7.30	$379.67	$83.53	$75.93
45330	T	Diagnostic sigmoidoscopy	0146	3.47	$180.47	$64.40	$36.09
45331	T	Sigmoidoscopy and biopsy	0146	3.47	$180.47	$64.40	$36.09
45332	T	Sigmoidoscopy w/fb removal	0146	3.47	$180.47	$64.40	$36.09
45333	T	Sigmoidoscopy & polypectomy	0147	7.30	$379.67	$83.53	$75.93
45334	T	Sigmoidoscopy for bleeding	0147	7.30	$379.67	$83.53	$75.93
45337	T	Sigmoidoscopy & decompress	0147	7.30	$379.67	$83.53	$75.93
45338	T	Sigmoidoscpy w/tumr remove	0147	7.30	$379.67	$83.53	$75.93
45339	T	Sigmoidoscopy w/ablate tumr	0147	7.30	$379.67	$83.53	$75.93
45341	T	Sigmoidoscopy w/ultrasound	0147	7.30	$379.67	$83.53	$75.93
45342	T	Sigmoidoscopy w/us guide bx	0147	7.30	$379.67	$83.53	$75.93
45345	T	Sigmodoscopy w/stent	0147	7.30	$379.67	$83.53	$75.93
45355	T	Surgical colonoscopy	0143	8.37	$435.32	$186.06	$87.06
45378	T	Diagnostic colonoscopy	0143	8.37	$435.32	$186.06	$87.06
45379	T	Colonoscopy w/fb removal	0143	8.37	$435.32	$186.06	$87.06
45380	T	Colonoscopy and biopsy	0143	8.37	$435.32	$186.06	$87.06
45382	T	Colonoscopy/control bleeding	0143	8.37	$435.32	$186.06	$87.06
45383	T	Lesion removal colonoscopy	0143	8.37	$435.32	$186.06	$87.06
45384	T	Lesion remove colonoscopy	0143	8.37	$435.32	$186.06	$87.06
45385	T	Lesion removal colonoscopy	0143	8.37	$435.32	$186.06	$87.06
45387	T	Colonoscopy w/stent	0143	8.37	$435.32	$186.06	$87.06
45500	T	Repair of rectum	0150	22.02	$1,145.24	$437.12	$229.05
45505	T	Repair of rectum	0150	22.02	$1,145.24	$437.12	$229.05
45520	T	Treatment of rectal prolapse	0098	1.90	$98.82	$20.88	$19.76
45540	C	Correct rectal prolapse					
45541	C	Correct rectal prolapse					
45550	C	Repair rectum/remove sigmoid					
45560	T	Repair of rectocele	0150	22.02	$1,145.24	$437.12	$229.05
45562	C	Exploration/repair of rectum					
45563	C	Exploration/repair of rectum					
45800	C	Repair rect/bladder fistula					
45805	C	Repair fistula w/colostomy					
45820	C	Repair rectourethral fistula					
45825	C	Repair fistula w/colostomy					
45900	T	Reduction of rectal prolapse	0148	3.61	$187.75	$67.59	$37.55
45905	T	Dilation of anal sphincter	0149	16.91	$879.47	$293.06	$175.89
45910	T	Dilation of rectal narrowing	0149	16.91	$879.47	$293.06	$175.89
45915	T	Remove rectal obstruction	0148	3.61	$187.75	$67.59	$37.55

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45999	T	Rectum surgery procedure	0148	3.61	$187.75	$67.59	$37.55
46020	T	Placement of seton	0148	3.61	$187.75	$67.59	$37.55
46030	T	Removal of rectal marker	0148	3.61	$187.75	$67.59	$37.55
46040	T	Incision of rectal abscess	0155	10.05	$522.69	$188.17	$104.54
46045	T	Incision of rectal abscess	0150	22.02	$1,145.24	$437.12	$229.05
46050	T	Incision of anal abscess	0155	10.05	$522.69	$188.17	$104.54
46060	T	Incision of rectal abscess	0150	22.02	$1,145.24	$437.12	$229.05
46070	T	Incision of anal septum	0155	10.05	$522.69	$188.17	$104.54
46080	T	Incision of anal sphincter	0149	16.91	$879.47	$293.06	$175.89
46083	T	Incise external hemorrhoid	0148	3.61	$187.75	$67.59	$37.55
46200	T	Removal of anal fissure	0150	22.02	$1,145.24	$437.12	$229.05
46210	T	Removal of anal crypt	0149	16.91	$879.47	$293.06	$175.89
46211	T	Removal of anal crypts	0150	22.02	$1,145.24	$437.12	$229.05
46220	T	Removal of anal tab	0149	16.91	$879.47	$293.06	$175.89
46221	T	Ligation of hemorrhoid(s)	0148	3.61	$187.75	$67.59	$37.55
46230	T	Removal of anal tabs	0149	16.91	$879.47	$293.06	$175.89
46250	T	Hemorrhoidectomy	0150	22.02	$1,145.24	$437.12	$229.05
46255	T	Hemorrhoidectomy	0150	22.02	$1,145.24	$437.12	$229.05
46257	T	Remove hemorrhoids & fissure	0150	22.02	$1,145.24	$437.12	$229.05
46258	T	Remove hemorrhoids & fistula	0150	22.02	$1,145.24	$437.12	$229.05
46260	T	Hemorrhoidectomy	0150	22.02	$1,145.24	$437.12	$229.05
46261	T	Remove hemorrhoids & fissure	0150	22.02	$1,145.24	$437.12	$229.05
46262	T	Remove hemorrhoids & fistula	0150	22.02	$1,145.24	$437.12	$229.05
46270	T	Removal of anal fistula	0150	22.02	$1,145.24	$437.12	$229.05
46275	T	Removal of anal fistula	0150	22.02	$1,145.24	$437.12	$229.05
46280	T	Removal of anal fistula	0150	22.02	$1,145.24	$437.12	$229.05
46285	T	Removal of anal fistula	0150	22.02	$1,145.24	$437.12	$229.05
46288	T	Repair anal fistula	0150	22.02	$1,145.24	$437.12	$229.05
46320	T	Removal of hemorrhoid clot	0148	3.61	$187.75	$67.59	$37.55
46500	T	Injection into hemorrhoid(s)	0155	10.05	$522.69	$188.17	$104.54
46600	X	Diagnostic anoscopy	0340	0.66	$34.33	.....	$6.87
46604	T	Anoscopy and dilation	0147	7.30	$379.67	$83.53	$75.93
46606	T	Anoscopy and biopsy	0147	7.30	$379.67	$83.53	$75.93
46608	T	Anoscopy/ remove for body	0147	7.30	$379.67	$83.53	$75.93
46610	T	Anoscopy/remove lesion	0147	7.30	$379.67	$83.53	$75.93
46611	T	Anoscopy	0147	7.30	$379.67	$83.53	$75.93
46612	T	Anoscopy/ remove lesions	0147	7.30	$379.67	$83.53	$75.93
46614	T	Anoscopy/control bleeding	0147	7.30	$379.67	$83.53	$75.93
46615	T	Anoscopy	0147	7.30	$379.67	$83.53	$75.93
46700	T	Repair of anal stricture	0150	22.02	$1,145.24	$437.12	$229.05
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	22.02	$1,145.24	$437.12	$229.05
46751	C	Repair of anal sphincter	.....	.....	.....	.....	.....
46753	T	Reconstruction of anus	0150	22.02	$1,145.24	$437.12	$229.05
46754	T	Removal of suture from anus	0149	16.91	$879.47	$293.06	$175.89
46760	T	Repair of anal sphincter	0150	22.02	$1,145.24	$437.12	$229.05
46761	T	Repair of anal sphincter	0150	22.02	$1,145.24	$437.12	$229.05
46762	T	Implant artificial sphincter	0150	22.02	$1,145.24	$437.12	$229.05
46900	T	Destruction, anal lesion(s)	0016	2.57	$133.66	$56.14	$26.73
46910	T	Destruction, anal lesion(s)	0017	16.46	$856.07	$227.84	$171.21
46916	T	Cryosurgery, anal lesion(s)	0013	1.10	$57.21	$14.30	$11.44
46917	T	Laser surgery, anal lesions	0695	19.65	$1,021.98	$266.59	$204.40
46922	T	Excision of anal lesion(s)	0695	19.65	$1,021.98	$266.59	$204.40
46924	T	Destruction, anal lesion(s)	0695	19.65	$1,021.98	$266.59	$204.40
46934	T	Destruction of hemorrhoids	0155	10.05	$522.69	$188.17	$104.54
46935	T	Destruction of hemorrhoids	0155	10.05	$522.69	$188.17	$104.54
46936	T	Destruction of hemorrhoids	0149	16.91	$879.47	$293.06	$175.89

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46937	T	Cryotherapy of rectal lesion	0149	16.91	$879.47	$293.06	$175.89
46938	T	Cryotherapy of rectal lesion	0150	22.02	$1,145.24	$437.12	$229.05
46940	T	Treatment of anal fissure	0149	16.91	$879.47	$293.06	$175.89
46942	T	Treatment of anal fissure	0148	3.61	$187.75	$67.59	$37.55
46945	T	Ligation of hemorrhoids	0155	10.05	$522.69	$188.17	$104.54
46946	T	Ligation of hemorrhoids	0155	10.05	$522.69	$188.17	$104.54
46999	T	Anus surgery procedure	0148	3.61	$187.75	$67.59	$37.55
47000	T	Needle biopsy of liver	0685	4.47	$232.48	$102.29	$46.50
47001	N	Needle biopsy, liver add-on					
47010	C	Open drainage, liver lesion					
47011	T	Percut drain, liver lesion	0005	3.02	$157.07	$69.11	$31.41
47015	C	Inject/aspirate liver cyst					
47100	C	Wedge biopsy of liver					
47120	C	Partial removal of liver					
47122	C	Extensive removal of liver					
47125	C	Partial removal of liver					
47130	C	Partial removal of liver					
47133	C	Removal of donor liver					
47134	C	Partial removal, donor liver					
47135	C	Transplantation of liver					
47136	C	Transplantation of liver					
47300	C	Surgery for liver lesion					
47350	C	Repair liver wound					
47360	C	Repair liver wound					
47361	C	Repair liver wound					
47362	C	Repair liver wound					
47370	T	Laparo ablate liver tumor rf	0130	31.99	$1,663.77	$659.53	$332.75
47371	T	Laparo ablate liver cryosug	0130	31.99	$1,663.77	$659.53	$332.75
47379	T	Laparoscope procedure, liver	0130	31.99	$1,663.77	$659.53	$332.75
47380	C	Open ablate liver tumor rf					
47381	C	Open ablate liver tumor cryo					
47382	T	Percut ablate liver rf	0980		$1,875.00		$375.00
47399	T	Liver surgery procedure	0005	3.02	$157.07	$69.11	$31.41
47400	C	Incision of liver duct					
47420	C	Incision of bile duct					
47425	C	Incision of bile duct					
47460	C	Incise bile duct sphincter					
47480	C	Incision of gallbladder					
47490	T	Incision of gallbladder	0152	6.18	$321.42	$80.36	$64.28
47500	N	Injection for liver x-rays					
47505	N	Injection for liver x-rays					
47510	T	Insert catheter, bile duct	0152	6.18	$321.42	$80.36	$64.28
47511	T	Insert bile duct drain	0152	6.18	$321.42	$80.36	$64.28
47525	T	Change bile duct catheter	0122	3.89	$202.32	$46.53	$40.46
47530	T	Revise/reinsert bile tube	0121	2.17	$112.86	$45.14	$22.57
47550	C	Bile duct endoscopy add-on					
47552	T	Biliary endoscopy thru skin	0152	6.18	$321.42	$80.36	$64.28
47553	T	Biliary endoscopy thru skin	0152	6.18	$321.42	$80.36	$64.28
47554	T	Biliary endoscopy thru skin	0152	6.18	$321.42	$80.36	$64.28
47555	T	Biliary endoscopy thru skin	0152	6.18	$321.42	$80.36	$64.28
47556	T	Biliary endoscopy thru skin	0152	6.18	$321.42	$80.36	$64.28
47560	T	Laparoscopy w/cholangio	0130	31.99	$1,663.77	$659.53	$332.75
47561	T	Laparo w/cholangio/biopsy	0130	31.99	$1,663.77	$659.53	$332.75
47562	T	Laparoscopic cholecystectomy	0131	42.44	$2,207.26	$1,001.89	$441.45
47563	T	Laparo cholecystectomy/graph	0131	42.44	$2,207.26	$1,001.89	$441.45
47564	T	Laparo cholecystectomy/explr	0131	42.44	$2,207.26	$1,001.89	$441.45
47570	C	Laparo cholecystoenterostomy					
47579	T	Laparoscope proc, biliary	0130	31.99	$1,663.77	$659.53	$332.75
47600	C	Removal of gallbladder					
47605	C	Removal of gallbladder					
47610	C	Removal of gallbladder					
47612	C	Removal of gallbladder					
47620	C	Removal of gallbladder					
47630	T	Remove bile duct stone	0152	6.18	$321.42	$80.36	$64.28
47700	C	Exploration of bile ducts					
47701	C	Bile duct revision					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47711	C	Excision of bile duct tumor					
47712	C	Excision of bile duct tumor					
47715	C	Excision of bile duct cyst					
47716	C	Fusion of bile duct cyst					
47720	C	Fuse gallbladder & bowel					
47721	C	Fuse upper gi structures					
47740	C	Fuse gallbladder & bowel					
47741	C	Fuse gallbladder & bowel					
47760	C	Fuse bile ducts and bowel					
47765	C	Fuse liver ducts & bowel					
47780	C	Fuse bile ducts and bowel					
47785	C	Fuse bile ducts and bowel					
47800	C	Reconstruction of bile ducts					
47801	C	Placement, bile duct support					
47802	C	Fuse liver duct & intestine					
47900	C	Suture bile duct injury					
47999	T	Bile tract surgery procedure	0152	6.18	$321.42	$80.36	$64.28
48000	C	Drainage of abdomen					
48001	C	Placement of drain, pancreas					
48005	C	Resect/debride pancreas					
48020	C	Removal of pancreatic stone					
48100	C	Biopsy of pancreas, open					
48102	T	Needle biopsy, pancreas	0685	4.47	$232.48	$102.29	$46.50
48120	C	Removal of pancreas lesion					
48140	C	Partial removal of pancreas					
48145	C	Partial removal of pancreas					
48146	C	Pancreatectomy					
48148	C	Removal of pancreatic duct					
48150	C	Partial removal of pancreas					
48152	C	Pancreatectomy					
48153	C	Pancreatectomy					
48154	C	Pancreatectomy					
48155	C	Removal of pancreas					
48160	E	Pancreas removal/transplant					
48180	C	Fuse pancreas and bowel					
48400	C	Injection, intraop add-on					
48500	C	Surgery of pancreatic cyst					
48510	C	Drain pancreatic pseudocyst					
48511	T	Drain pancreatic pseudocyst	0005	3.02	$157.07	$69.11	$31.41
48520	C	Fuse pancreas cyst and bowel					
48540	C	Fuse pancreas cyst and bowel					
48545	C	Pancreatorrhaphy					
48547	C	Duodenal exclusion					
48550	E	Donor pancreatectomy					
48554	E	Transpl allograft pancreas					
48556	C	Removal, allograft pancreas					
48999	T	Pancreas surgery procedure	0005	3.02	$157.07	$69.11	$31.41
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	3.30	$171.63		$34.33
49081	T	Removal of abdominal fluid	0070	3.30	$171.63		$34.33
49085	T	Remove abdomen foreign body	0153	25.99	$1,351.71	$540.68	$270.34
49180	T	Biopsy, abdominal mass	0685	4.47	$232.48	$102.29	$46.50
49200	T	Removal of abdominal lesion	0130	31.99	$1,663.77	$659.53	$332.75
49201	C	Removal of abdominal lesion					
49215	C	Excise sacral spine tumor					
49220	C	Multiple surgery, abdomen					
49250	T	Excision of umbilicus	0153	25.99	$1,351.71	$540.68	$270.34

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49255	C	Removal of omentum					
49320	T	Diag laparo separate proc	0130	31.99	$1,663.77	$659.53	$332.75
49321	T	Laparoscopy, biopsy	0130	31.99	$1,663.77	$659.53	$332.75
49322	T	Laparoscopy, aspiration	0130	31.99	$1,663.77	$659.53	$332.75
49323	T	Laparo drain lymphocele	0130	31.99	$1,663.77	$659.53	$332.75
49329	T	Laparo proc, abdm/per/oment	0130	31.99	$1,663.77	$659.53	$332.75
49400	N	Air injection into abdomen					
49420	T	Insert abdominal drain	0153	25.99	$1,351.71	$540.68	$270.34
49421	T	Insert abdominal drain	0153	25.99	$1,351.71	$540.68	$270.34
49422	T	Remove perm cannula/catheter	0105	19.14	$995.45	$370.40	$199.09
49423	T	Exchange drainage catheter	0152	6.18	$321.42	$80.36	$64.28
49424	N	Assess cyst, contrast inject					
49425	C	Insert abdomen-venous drain					
49426	T	Revise abdomen-venous shunt	0153	25.99	$1,351.71	$540.68	$270.34
49427	N	Injection, abdominal shunt					
49428	C	Ligation of shunt					
49429	T	Removal of shunt	0105	19.14	$995.45	$370.40	$199.09
49491	T	Repairing hern premie reduc	0154	26.98	$1,403.20	$491.12	$280.64
49492	T	Rpr ing hern premie, blocked	0154	26.98	$1,403.20	$491.12	$280.64
49495	T	Rpr ing hernia baby, reduc	0154	26.98	$1,403.20	$491.12	$280.64
49496	T	Rpr ing hernia baby, blocked	0154	26.98	$1,403.20	$491.12	$280.64
49500	T	Rpr ing hernia, init, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49501	T	Rpr ing hernia, init blocked	0154	26.98	$1,403.20	$491.12	$280.64
49505	T	Rpr i/hern init reduc>5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49507	T	Rpr i/hern init block>5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49520	T	Rerepair ing hernia, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49521	T	Rerepair ing hernia, blocked	0154	26.98	$1,403.20	$491.12	$280.64
49525	T	Repair ing hernia, sliding	0154	26.98	$1,403.20	$491.12	$280.64
49540	T	Repair lumbar hernia	0154	26.98	$1,403.20	$491.12	$280.64
49550	T	Rpr fem hernia, init, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49553	T	Rpr fem hernia, init blocked	0154	26.98	$1,403.20	$491.12	$280.64
49555	T	Rerepair fem hernia, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49557	T	Rerepair fem hernia, blocked	0154	26.98	$1,403.20	$491.12	$280.64
49560	T	Rpr ventral hern init, reduc	0154	26.98	$1,403.20	$491.12	$280.64
49561	T	Rpr ventral hern init, block	0154	26.98	$1,403.20	$491.12	$280.64
49565	T	Rerepair ventrl hern, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49566	T	Rerepair ventrl hern, block	0154	26.98	$1,403.20	$491.12	$280.64
49568	T	Hernia repair w/mesh	0154	26.98	$1,403.20	$491.12	$280.64
49570	T	Rpr epigastric hern, reduce	0154	26.98	$1,403.20	$491.12	$280.64
49572	T	Rpr epigastric hern, blocked	0154	26.98	$1,403.20	$491.12	$280.64
49580	T	Rpr umbil hern, reduc <5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49582	T	Rpr umbil hern, block < 5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49585	T	Rpr umbil hern, reduc > 5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49587	T	Rpr umbil hern, block > 5 yr	0154	26.98	$1,403.20	$491.12	$280.64
49590	T	Repair spigelian hernia	0154	26.98	$1,403.20	$491.12	$280.64
49600	T	Repair umbilical lesion	0154	26.98	$1,403.20	$491.12	$280.64
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49650	T	Laparo hernia repair initial	0131	42.44	$2,207.26	$1,001.89	$441.45
49651	T	Laparo hernia repair recur	0131	42.44	$2,207.26	$1,001.89	$441.45
49659	T	Laparo proc, hernia repair	0131	42.44	$2,207.26	$1,001.89	$441.45
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	0153	25.99	$1,351.71	$540.68	$270.34
50010	C	Exploration of kidney					
50020	C	Renal abscess, open drain					
50021	T	Renal abscess, percut drain	0005	3.02	$157.07	$69.11	$31.41
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50080	T	Removal of kidney stone	0163	24.77	$1,288.26		$257.65
50081	T	Removal of kidney stone	0163	24.77	$1,288.26		$257.65
50100	C	Revise kidney blood vessels					
50120	C	Exploration of kidney					
50125	C	Explore and drain kidney					
50130	C	Removal of kidney stone					
50135	C	Exploration of kidney					
50200	T	Biopsy of kidney	0685	4.47	$232.48	$102.29	$46.50
50205	C	Biopsy of kidney					
50220	C	Remove kidney, open					
50225	C	Removal kidney open, complex					
50230	C	Removal kidney open, radical					
50234	C	Removal of kidney & ureter					
50236	C	Removal of kidney & ureter					
50240	C	Partial removal of kidney					
50280	C	Removal of kidney lesion					
50290	C	Removal of kidney lesion					
50300	C	Removal of donor kidney					
50320	C	Removal of donor kidney					
50340	C	Removal of kidney					
50360	C	Transplantation of kidney					
50365	C	Transplantation of kidney					
50370	C	Remove transplanted kidney					
50380	C	Reimplantation of kidney					
50390	T	Drainage of kidney lesion	0685	4.47	$232.48	$102.29	$46.50
50392	T	Insert kidney drain	0161	16.03	$833.70	$249.36	$166.74
50393	T	Insert ureteral tube	0161	16.03	$833.70	$249.36	$166.74
50394	N	Injection for kidney x-ray					
50395	T	Create passage to kidney	0161	16.03	$833.70	$249.36	$166.74
50396	T	Measure kidney pressure	0164	1.18	$61.37	$18.41	$12.27
50398	T	Change kidney tube	0122	3.89	$202.32	$46.53	$40.46
50400	C	Revision of kidney/ureter					
50405	C	Revision of kidney/ureter					
50500	C	Repair of kidney wound					
50520	C	Close kidney-skin fistula					
50525	C	Repair renal-abdomen fistula					
50526	C	Repair renal-abdomen fistula					
50540	C	Revision of horseshoe kidney					
50541	T	Laparo ablate renal cyst	0130	31.99	$1,663.77	$659.53	$332.75
50544	T	Laparoscopy, pyeloplasty	0130	31.99	$1,663.77	$659.53	$332.75
50545	C	Laparo radical nephrectomy					
50546	C	Laparoscopic nephrectomy					
50547	C	Laparo removal donor kidney					
50548	C	Laparo remove k/ureter					
50549	T	Laparoscope proc, renal	0130	31.99	$1,663.77	$659.53	$332.75
50551	T	Kidney endoscopy	0160	6.44	$334.94	$105.06	$66.99
50553	T	Kidney endoscopy	0161	16.03	$833.70	$249.36	$166.74
50555	T	Kidney endoscopy & biopsy	0160	6.44	$334.94	$105.06	$66.99
50557	T	Kidney endoscopy & treatment	0162	21.50	$1,118.19		$223.64
50559	T	Renal endoscopy/radiotracer	0160	6.44	$334.94	$105.06	$66.99
50561	T	Kidney endoscopy & treatment	0161	16.03	$833.70	$249.36	$166.74
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					
50590	T	Fragmenting of kidney stone	0169	46.44	$2,415.30	$1,115.69	$483.06
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50684	N	Injection for ureter x-ray					
50686	T	Measure ureter pressure	0164	1.18	$61.37	$18.41	$12.27
50688	T	Change of ureter tube	0121	2.17	$112.86	$45.14	$22.57
50690	N	Injection for ureter x-ray					
50700	C	Revision of ureter					
50715	C	Release of ureter					
50722	C	Release of ureter					
50725	C	Release/revise ureter					
50727	C	Revise ureter					
50728	C	Revise ureter					
50740	C	Fusion of ureter & kidney					
50750	C	Fusion of ureter & kidney					
50760	C	Fusion of ureters					
50770	C	Splicing of ureters					
50780	C	Reimplant ureter in bladder					
50782	C	Reimplant ureter in bladder					
50783	C	Reimplant ureter in bladder					
50785	C	Reimplant ureter in bladder					
50800	C	Implant ureter in bowel					
50810	C	Fusion of ureter & bowel					
50815	C	Urine shunt to intestine					
50820	C	Construct bowel bladder					
50825	C	Construct bowel bladder					
50830	C	Revise urine flow					
50840	C	Replace ureter by bowel					
50845	C	Appendico-vesicostomy					
50860	C	Transplant ureter to skin					
50900	C	Repair of ureter					
50920	C	Closure ureter/skin fistula					
50930	C	Closure ureter/bowel fistula					
50940	C	Release of ureter					
50945	T	Laparoscopy ureterolithotomy	0131	42.44	$2,207.26	$1,001.89	$441.45
50947	T	Laparo new ureter/bladder	0131	42.44	$2,207.26	$1,001.89	$441.45
50948	T	Laparo new ureter/bladder	0131	42.44	$2,207.26	$1,001.89	$441.45
50949	T	Laparoscope proc, ureter	0130	31.99	$1,663.77	$659.53	$332.75
50951	T	Endoscopy of ureter	0160	6.44	$334.94	$105.06	$66.99
50953	T	Endoscopy of ureter	0160	6.44	$334.94	$105.06	$66.99
50955	T	Ureter endoscopy & biopsy	0161	16.03	$833.70	$249.36	$166.74
50957	T	Ureter endoscopy & treatment	0161	16.03	$833.70	$249.36	$166.74
50959	T	Ureter endoscopy & tracer	0161	16.03	$833.70	$249.36	$166.74
50961	T	Ureter endoscopy & treatment	0161	16.03	$833.70	$249.36	$166.74
50970	T	Ureter endoscopy	0160	6.44	$334.94	$105.06	$66.99
50972	T	Ureter endoscopy & catheter	0160	6.44	$334.94	$105.06	$66.99
50974	T	Ureter endoscopy & biopsy	0161	16.03	$833.70	$249.36	$166.74
50976	T	Ureter endoscopy & treatment	0161	16.03	$833.70	$249.36	$166.74
50978	T	Ureter endoscopy & tracer	0161	16.03	$833.70	$249.36	$166.74
50980	T	Ureter endoscopy & treatment	0161	16.03	$833.70	$249.36	$166.74
51000	T	Drainage of bladder	0165	12.62	$656.35		$131.27
51005	T	Drainage of bladder	0164	1.18	$61.37	$18.41	$12.27
51010	T	Drainage of bladder	0165	12.62	$656.35		$131.27
51020	T	Incise & treat bladder	0162	21.50	$1,118.19		$223.64
51030	T	Incise & treat bladder	0162	21.50	$1,118.19		$223.64
51040	T	Incise & drain bladder	0162	21.50	$1,118.19		$223.64
51045	T	Incise bladder/drain ureter	0160	6.44	$334.94	$105.06	$66.99
51050	T	Removal of bladder stone	0162	21.50	$1,118.19		$223.64
51060	C	Removal of ureter stone					
51065	T	Remove ureter calculus	0162	21.50	$1,118.19		$223.64
51080	T	Drainage of bladder abscess	0007	9.44	$490.96	$103.10	$98.19
51500	T	Removal of bladder cyst	0154	26.98	$1,403.20	$491.12	$280.64
51520	T	Removal of bladder lesion	0162	21.50	$1,118.19		$223.64
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)					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51570	C	Removal of bladder					
51575	C	Removal of bladder & nodes					
51580	C	Remove bladder/revise tract					
51585	C	Removal of bladder & nodes					
51590	C	Remove bladder/revise tract					
51595	C	Remove bladder/revise tract					
51596	C	Remove bladder/create pouch					
51597	C	Removal of pelvic structures					
51600	N	Injection for bladder x-ray					
51605	N	Preparation for bladder xray					
51610	N	Injection for bladder x-ray					
51700	T	Irrigation of bladder	0164	1.18	$61.37	$18.41	$12.27
51705	T	Change of bladder tube	0121	2.17	$112.86	$45.14	$22.57
51710	T	Change of bladder tube	0121	2.17	$112.86	$45.14	$22.57
51715	T	Endoscopic injection/implant	0167	27.15	$1,412.04	$555.84	$282.41
51720	T	Treatment of bladder lesion	0156	3.10	$161.23	$48.37	$32.25
51725	T	Simple cystometrogram	0156	3.10	$161.23	$48.37	$32.25
51726	T	Complex cystometrogram	0156	3.10	$161.23	$48.37	$32.25
51736	T	Urine flow measurement	0164	1.18	$61.37	$18.41	$12.27
51741	T	Electro-uroflowmetry, first	0164	1.18	$61.37	$18.41	$12.27
51772	T	Urethra pressure profile	0164	1.18	$61.37	$18.41	$12.27
51784	T	Anal/urinary muscle study	0164	1.18	$61.37	$18.41	$12.27
51785	T	Anal/urinary muscle study	0164	1.18	$61.37	$18.41	$12.27
51792	T	Urinary reflex study	0164	1.18	$61.37	$18.41	$12.27
51795	T	Urine voiding pressure study	0164	1.18	$61.37	$18.41	$12.27
51797	T	Intraabdominal pressure test	0164	1.18	$61.37	$18.41	$12.27
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	21.50	$1,118.19		$223.64
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	42.44	$2,207.26	$1,001.89	$441.45
51992	T	Laparo sling operation	0132	57.95	$3,013.92	$1,239.22	$602.78
52000	T	Cystoscopy	0160	6.44	$334.94	$105.06	$66.99
52001	T	Cystoscopy, removal of clots	0160	6.44	$334.94	$105.06	$66.99
52005	T	Cystoscopy & ureter catheter	0161	16.03	$833.70	$249.36	$166.74
52007	T	Cystoscopy and biopsy	0161	16.03	$833.70	$249.36	$166.74
52010	T	Cystoscopy & duct catheter	0160	6.44	$334.94	$105.06	$66.99
52204	T	Cystoscopy	0161	16.03	$833.70	$249.36	$166.74
52214	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52224	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52234	T	Cystoscopy and treatment	0163	24.77	$1,288.26		$257.65
52235	T	Cystoscopy and treatment	0163	24.77	$1,288.26		$257.65
52240	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52250	T	Cystoscopy and radiotracer	0162	21.50	$1,118.19		$223.64
52260	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52265	T	Cystoscopy and treatment	0160	6.44	$334.94	$105.06	$66.99
52270	T	Cystoscopy & revise urethra	0161	16.03	$833.70	$249.36	$166.74
52275	T	Cystoscopy & revise urethra	0161	16.03	$833.70	$249.36	$166.74
52276	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52277	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52281	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52282	T	Cystoscopy, implant stent	0163	24.77	$1,288.26		$257.65
52283	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52285	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52290	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52300	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52301	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52305	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52310	T	Cystoscopy and treatment	0160	6.44	$334.94	$105.06	$66.99
52315	T	Cystoscopy and treatment	0161	16.03	$833.70	$249.36	$166.74
52317	T	Remove bladder stone	0162	21.50	$1,118.19		$223.64
52318	T	Remove bladder stone	0162	21.50	$1,118.19		$223.64
52320	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52325	T	Cystoscopy, stone removal	0162	21.50	$1,118.19		$223.64
52327	T	Cystoscopy, inject material	0162	21.50	$1,118.19		$223.64
52330	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52332	T	Cystoscopy and treatment	0162	21.50	$1,118.19		$223.64
52334	T	Create passage to kidney	0162	21.50	$1,118.19		$223.64
52341	T	Cysto w/ureter stricture tx	0162	21.50	$1,118.19		$223.64
52342	T	Cysto w/up stricture tx	0162	21.50	$1,118.19		$223.64
52343	T	Cysto w/renal stricture tx	0162	21.50	$1,118.19		$223.64
52344	T	Cysto/uretero, stone remove	0162	21.50	$1,118.19		$223.64
52345	T	Cysto/uretero w/up stricture	0162	21.50	$1,118.19		$223.64
52346	T	Cystouretero w/renal strict	0162	21.50	$1,118.19		$223.64
52347	T	Cystoscopy, resect ducts	0160	6.44	$334.94	$105.06	$66.99
52351	T	Cystouretro & or pyeloscope	0160	6.44	$334.94	$105.06	$66.99
52352	T	Cystouretro w/stone remove	0162	21.50	$1,118.19		$223.64
52353	T	Cystouretero w/lithotripsy	0163	24.77	$1,288.26		$257.65
52354	T	Cystouretero w/biopsy	0162	21.50	$1,118.19		$223.64
52355	T	Cystouretero w/excise tumor	0162	21.50	$1,118.19		$223.64
52400	T	Cystouretero w/congen repr	0162	21.50	$1,118.19		$223.64
52450	T	Incision of prostate	0162	21.50	$1,118.19		$223.64
52500	T	Revision of bladder neck	0162	21.50	$1,118.19		$223.64
52510	T	Dilation prostatic urethra	0161	16.03	$833.70	$249.36	$166.74
52601	T	Prostatectomy (TURP)	0163	24.77	$1,288.26		$257.65
52606	T	Control postop bleeding	0162	21.50	$1,118.19		$223.64
52612	T	Prostatectomy, first stage	0163	24.77	$1,288.26		$257.65
52614	T	Prostatectomy, second stage	0163	24.77	$1,288.26		$257.65
52620	T	Remove residual prostate	0163	24.77	$1,288.26		$257.65
52630	T	Remove prostate regrowth	0163	24.77	$1,288.26		$257.65
52640	T	Relieve bladder contracture	0162	21.50	$1,118.19		$223.64
52647	T	Laser surgery of prostate	0163	24.77	$1,288.26		$257.65
52648	T	Laser surgery of prostate	0163	24.77	$1,288.26		$257.65
52700	T	Drainage of prostate abscess	0162	21.50	$1,118.19		$223.64
53000	T	Incision of urethra	0166	15.63	$812.90	$218.73	$162.58
53010	T	Incision of urethra	0166	15.63	$812.90	$218.73	$162.58
53020	T	Incision of urethra	0166	15.63	$812.90	$218.73	$162.58
53025	T	Incision of urethra	0166	15.63	$812.90	$218.73	$162.58
53040	T	Drainage of urethra abscess	0166	15.63	$812.90	$218.73	$162.58
53060	T	Drainage of urethra abscess	0166	15.63	$812.90	$218.73	$162.58
53080	T	Drainage of urinary leakage	0166	15.63	$812.90	$218.73	$162.58
53085	C	Drainage of urinary leakage					
53200	T	Biopsy of urethra	0166	15.63	$812.90	$218.73	$162.58
53210	T	Removal of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53215	T	Removal of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53220	T	Treatment of urethra lesion	0168	24.10	$1,253.42	$405.60	$250.68
53230	T	Removal of urethra lesion	0168	24.10	$1,253.42	$405.60	$250.68
53235	T	Removal of urethra lesion	0168	24.10	$1,253.42	$405.60	$250.68
53240	T	Surgery for urethra pouch	0168	24.10	$1,253.42	$405.60	$250.68
53250	T	Removal of urethra gland	0166	15.63	$812.90	$218.73	$162.58
53260	T	Treatment of urethra lesion	0166	15.63	$812.90	$218.73	$162.58
53265	T	Treatment of urethra lesion	0166	15.63	$812.90	$218.73	$162.58
53270	T	Removal of urethra gland	0167	27.15	$1,412.04	$555.84	$282.41
53275	T	Repair of urethra defect	0166	15.63	$812.90	$218.73	$162.58
53400	T	Revise urethra, stage 1	0168	24.10	$1,253.42	$405.60	$250.68
53405	T	Revise urethra, stage 2	0168	24.10	$1,253.42	$405.60	$250.68
53410	T	Reconstruction of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53415	C	Reconstruction of urethra					
53420	T	Reconstruct urethra, stage 1	0168	24.10	$1,253.42	$405.60	$250.68
53425	T	Reconstruct urethra, stage 2	0168	24.10	$1,253.42	$405.60	$250.68
53430	T	Reconstruction of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53431	T	Reconstruct urethra/bladder	0168	24.10	$1,253.42	$405.60	$250.68

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53440	T	Correct bladder function	0179	81.28	$4,227.29	$1,817.73	$845.46
53442	T	Remove perineal prosthesis	0166	15.63	$812.90	$218.73	$162.58
53444	T	Insert tandem cuff	0179	81.28	$4,227.29	$1,817.73	$845.46
53445	T	Insert uro/ves nck sphincter	0179	81.28	$4,227.29	$1,817.73	$845.46
53446	T	Remove uro sphincter	0168	24.10	$1,253.42	$405.60	$250.68
53447	T	Remove/replace ur sphincter	0179	81.28	$4,227.29	$1,817.73	$845.46
53448	C	Remov/replc ur sphinctr comp					
53449	T	Repair uro sphincter	0168	24.10	$1,253.42	$405.60	$250.68
53450	T	Revision of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53460	T	Revision of urethra	0168	24.10	$1,253.42	$405.60	$250.68
53502	T	Repair of urethra injury	0166	15.63	$812.90	$218.73	$162.58
53505	T	Repair of urethra injury	0167	27.15	$1,412.04	$555.84	$282.41
53510	T	Repair of urethra injury	0166	15.63	$812.90	$218.73	$162.58
53515	T	Repair of urethra injury	0168	24.10	$1,253.42	$405.60	$250.68
53520	T	Repair of urethra defect	0168	24.10	$1,253.42	$405.60	$250.68
53600	T	Dilate urethra stricture	0156	3.10	$161.23	$48.37	$32.25
53601	T	Dilate urethra stricture	0164	1.18	$61.37	$18.41	$12.27
53605	T	Dilate urethra stricture	0161	16.03	$833.70	$249.36	$166.74
53620	T	Dilate urethra stricture	0165	12.62	$656.35		$131.27
53621	T	Dilate urethra stricture	0164	1.18	$61.37	$18.41	$12.27
53660	T	Dilation of urethra	0164	1.18	$61.37	$18.41	$12.27
53661	T	Dilation of urethra	0164	1.18	$61.37	$18.41	$12.27
53665	T	Dilation of urethra	0166	15.63	$812.90	$218.73	$162.58
53670	N	Insert urinary catheter					
53675	T	Insert urinary catheter	0164	1.18	$61.37	$18.41	$12.27
53850	T	Prostatic microwave thermotx	0675	51.57	$2,682.10		$536.42
53852	T	Prostatic rf thermotx	0675	51.57	$2,682.10		$536.42
53853	T	Prostatic water thermother	0977		$1,125.00		$225.00
53899	T	Urology surgery procedure	0164	1.18	$61.37	$18.41	$12.27
54000	T	Slitting of prepuce	0166	15.63	$812.90	$218.73	$162.58
54001	T	Slitting of prepuce	0166	15.63	$812.90	$218.73	$162.58
54015	T	Drain penis lesion	0007	9.44	$490.96	$103.10	$98.19
54050	T	Destruction, penis lesion(s)	0013	1.10	$57.21	$14.30	$11.44
54055	T	Destruction, penis lesion(s)	0017	16.46	$856.07	$227.84	$171.21
54056	T	Cryosurgery, penis lesion(s)	0012	0.76	$39.53	$10.67	$7.91
54057	T	Laser surg, penis lesion(s)	0017	16.46	$856.07	$227.84	$171.21
54060	T	Excision of penis lesion(s)	0017	16.46	$856.07	$227.84	$171.21
54065	T	Destruction, penis lesion(s)	0695	19.65	$1,021.98	$266.59	$204.40
54100	T	Biopsy of penis	0021	14.58	$758.29	$227.49	$151.66
54105	T	Biopsy of penis	0022	18.10	$941.36	$367.13	$188.27
54110	T	Treatment of penis lesion	0181	29.88	$1,554.03	$621.82	$310.81
54111	T	Treat penis lesion, graft	0181	29.88	$1,554.03	$621.82	$310.81
54112	T	Treat penis lesion, graft	0181	29.88	$1,554.03	$621.82	$310.81
54115	T	Treatment of penis lesion	0008	16.32	$848.79		$169.76
54120	T	Partial removal of penis	0181	29.88	$1,554.03	$621.82	$310.81
54125	C	Removal of penis					
54130	C	Remove penis & nodes					
54135	C	Remove penis & nodes					
54150	T	Circumcision	0180	18.95	$985.57	$304.87	$197.11
54152	T	Circumcision	0180	18.95	$985.57	$304.87	$197.11
54160	T	Circumcision	0180	18.95	$985.57	$304.87	$197.11
54161	T	Circumcision	0180	18.95	$985.57	$304.87	$197.11
54162	T	Lysis penil circumcis lesion	0180	18.95	$985.57	$304.87	$197.11
54163	T	Repair of circumcision	0180	18.95	$985.57	$304.87	$197.11
54164	T	Frenulotomy of penis	0180	18.95	$985.57	$304.87	$197.11
54200	T	Treatment of penis lesion	0156	3.10	$161.23	$48.37	$32.25
54205	T	Treatment of penis lesion	0181	29.88	$1,554.03	$621.82	$310.81
54220	T	Treatment of penis lesion	0156	3.10	$161.23	$48.37	$32.25
54230	N	Prepare penis study					
54231	T	Dynamic cavernosometry	0165	12.62	$656.35		$131.27
54235	T	Penile injection	0164	1.18	$61.37	$18.41	$12.27
54240	T	Penis study	0164	1.18	$61.37	$18.41	$12.27
54250	T	Penis study	0165	12.62	$656.35		$131.27
54300	T	Revision of penis	0181	29.88	$1,554.03	$621.82	$310.81
54304	T	Revision of penis	0181	29.88	$1,554.03	$621.82	$310.81
54308	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54312	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54316	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54318	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54322	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54324	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54326	T	Reconstruction of urethra	0181	29.88	$1,554.03	$621.82	$310.81
54328	T	Revise penis/urethra	0181	29.88	$1,554.03	$621.82	$310.81
54332	C	Revise penis/urethra					
54336	C	Revise penis/urethra					
54340	T	Secondary urethral surgery	0181	29.88	$1,554.03	$621.82	$310.81
54344	T	Secondary urethral surgery	0181	29.88	$1,554.03	$621.82	$310.81
54348	T	Secondary urethral surgery	0181	29.88	$1,554.03	$621.82	$310.81
54352	T	Reconstruct urethra/penis	0181	29.88	$1,554.03	$621.82	$310.81
54360	T	Penis plastic surgery	0181	29.88	$1,554.03	$621.82	$310.81
54380	T	Repair penis	0181	29.88	$1,554.03	$621.82	$310.81
54385	T	Repair penis	0181	29.88	$1,554.03	$621.82	$310.81
54390	C	Repair penis and bladder					
54400	T	Insert semi-rigid prosthesis	0182	83.80	$4,358.35	$1,438.26	$871.67
54401	T	Insert self-contd prosthesis	0182	83.80	$4,358.35	$1,438.26	$871.67
54405	T	Insert multi-comp penis pros	0182	83.80	$4,358.35	$1,438.26	$871.67
54406	T	Remove multi-comp penis pros	0181	29.88	$1,554.03	$621.82	$310.81
54408	T	Repair multi-comp penis pros	0181	29.88	$1,554.03	$621.82	$310.81
54410	T	Remove/replace penis prosth	0182	83.80	$4,358.35	$1,438.26	$871.67
54411	C	Remv/replc penis pros, comp					
54415	T	Remove self-contd penis pros	0181	29.88	$1,554.03	$621.82	$310.81
54416	T	Remv/repl penis contain pros	0182	83.80	$4,358.35	$1,438.26	$871.67
54417	C	Remv/replc penis pros, compl					
54420	T	Revision of penis	0181	29.88	$1,554.03	$621.82	$310.81
54430	C	Revision of penis					
54435	T	Revision of penis	0181	29.88	$1,554.03	$621.82	$310.81
54440	T	Repair of penis	0181	29.88	$1,554.03	$621.82	$310.81
54450	T	Preputial stretching	0156	3.10	$161.23	$48.37	$32.25
54500	T	Biopsy of testis	0005	3.02	$157.07	$69.11	$31.41
54505	T	Biopsy of testis	0183	22.19	$1,154.08	$448.94	$230.82
54512	T	Excise lesion testis	0183	22.19	$1,154.08	$448.94	$230.82
54520	T	Removal of testis	0183	22.19	$1,154.08	$448.94	$230.82
54522	T	Orchiectomy, partial	0183	22.19	$1,154.08	$448.94	$230.82
54530	T	Removal of testis	0154	26.98	$1,403.20	$491.12	$280.64
54535	C	Extensive testis surgery					
54550	T	Exploration for testis	0154	26.98	$1,403.20	$491.12	$280.64
54560	C	Exploration for testis					
54600	T	Reduce testis torsion	0183	22.19	$1,154.08	$448.94	$230.82
54620	T	Suspension of testis	0183	22.19	$1,154.08	$448.94	$230.82
54640	T	Suspension of testis	0154	26.98	$1,403.20	$491.12	$280.64
54650	C	Orchiopexy (Fowler-Stephens)					
54660	T	Revision of testis	0183	22.19	$1,154.08	$448.94	$230.82
54670	T	Repair testis injury	0183	22.19	$1,154.08	$448.94	$230.82
54680	T	Relocation of testis(es)	0183	22.19	$1,154.08	$448.94	$230.82
54690	T	Laparoscopy, orchiectomy	0131	42.44	$2,207.26	$1,001.89	$441.45
54692	T	Laparoscopy, orchiopexy	0132	57.95	$3,013.92	$1,239.22	$602.78
54699	T	Laparoscope proc, testis	0130	31.99	$1,663.77	$659.53	$332.75
54700	T	Drainage of scrotum	0183	22.19	$1,154.08	$448.94	$230.82
54800	T	Biopsy of epididymis	0004	1.63	$84.77	$22.04	$16.95
54820	T	Exploration of epididymis	0183	22.19	$1,154.08	$448.94	$230.82
54830	T	Remove epididymis lesion	0183	22.19	$1,154.08	$448.94	$230.82
54840	T	Remove epididymis lesion	0183	22.19	$1,154.08	$448.94	$230.82
54860	T	Removal of epididymis	0183	22.19	$1,154.08	$448.94	$230.82
54861	T	Removal of epididymis	0183	22.19	$1,154.08	$448.94	$230.82
54900	T	Fusion of spermatic ducts	0183	22.19	$1,154.08	$448.94	$230.82
54901	T	Fusion of spermatic ducts	0183	22.19	$1,154.08	$448.94	$230.82
55000	T	Drainage of hydrocele	0004	1.63	$84.77	$22.04	$16.95
55040	T	Removal of hydrocele	0154	26.98	$1,403.20	$491.12	$280.64
55041	T	Removal of hydroceles	0154	26.98	$1,403.20	$491.12	$280.64
55060	T	Repair of hydrocele	0183	22.19	$1,154.08	$448.94	$230.82
55100	T	Drainage of scrotum abscess	0007	9.44	$490.96	$103.10	$98.19
55110	T	Explore scrotum	0183	22.19	$1,154.08	$448.94	$230.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55120	T	Removal of scrotum lesion	0183	22.19	$1,154.08	$448.94	$230.82
55150	T	Removal of scrotum	0183	22.19	$1,154.08	$448.94	$230.82
55175	T	Revision of scrotum	0183	22.19	$1,154.08	$448.94	$230.82
55180	T	Revision of scrotum	0183	22.19	$1,154.08	$448.94	$230.82
55200	T	Incision of sperm duct	0183	22.19	$1,154.08	$448.94	$230.82
55250	T	Removal of sperm duct(s)	0183	22.19	$1,154.08	$448.94	$230.82
55300	N	Prepare, sperm duct x-ray					
55400	T	Repair of sperm duct	0183	22.19	$1,154.08	$448.94	$230.82
55450	T	Ligation of sperm duct	0183	22.19	$1,154.08	$448.94	$230.82
55500	T	Removal of hydrocele	0183	22.19	$1,154.08	$448.94	$230.82
55520	T	Removal of sperm cord lesion	0183	22.19	$1,154.08	$448.94	$230.82
55530	T	Revise spermatic cord veins	0183	22.19	$1,154.08	$448.94	$230.82
55535	T	Revise spermatic cord veins	0154	26.98	$1,403.20	$491.12	$280.64
55540	T	Revise hernia & sperm veins	0154	26.98	$1,403.20	$491.12	$280.64
55550	T	Laparo ligate spermatic vein	0131	42.44	$2,207.26	$1,001.89	$441.45
55559	T	Laparo proc, spermatic cord	0130	31.99	$1,663.77	$659.53	$332.75
55600	C	Incise sperm duct pouch					
55605	C	Incise sperm duct pouch					
55650	C	Remove sperm duct pouch					
55680	T	Remove sperm pouch lesion	0183	22.19	$1,154.08	$448.94	$230.82
55700	T	Biopsy of prostate	0184	3.66	$190.35	$95.18	$38.07
55705	T	Biopsy of prostate	0184	3.66	$190.35	$95.18	$38.07
55720	T	Drainage of prostate abscess	0162	21.50	$1,118.19		$223.64
55725	T	Drainage of prostate abscess	0162	21.50	$1,118.19		$223.64
55801	C	Removal of prostate					
55810	C	Extensive prostate surgery					
55812	C	Extensive prostate surgery					
55815	C	Extensive prostate surgery					
55821	C	Removal of prostate					
55831	C	Removal of prostate					
55840	C	Extensive prostate surgery					
55842	C	Extensive prostate surgery					
55845	C	Extensive prostate surgery					
55859	T	Percut/needle insert, pros	0163	24.77	$1,288.26		$257.65
55860	T	Surgical exposure, prostate	0165	12.62	$656.35		$131.27
55862	C	Extensive prostate surgery					
55865	C	Extensive prostate surgery					
55870	T	Electroejaculation	0197	1.19	$61.89	$24.76	$12.38
55873	T	Cryoablate prostate	0674	69.25	$3,601.62		$720.32
55899	T	Genital surgery procedure	0164	1.18	$61.37	$18.41	$12.27
55970	E	Sex transformation, M to F					
55980	E	Sex transformation, F to M					
56405	T	I & D of vulva/perineum	0192	2.94	$152.91	$42.81	$30.58
56420	T	Drainage of gland abscess	0192	2.94	$152.91	$42.81	$30.58
56440	T	Surgery for vulva lesion	0194	18.88	$981.93	$397.84	$196.39
56441	T	Lysis of labial lesion(s)	0193	14.57	$757.77	$171.13	$151.55
56501	T	Destroy, vulva lesions, simp	0017	16.46	$856.07	$227.84	$171.21
56515	T	Destroy vulva lesion/s compl	0695	19.65	$1,021.98	$266.59	$204.40
56605	T	Biopsy of vulva/perineum	0019	3.94	$204.92	$75.82	$40.98
56606	T	Biopsy of vulva/perineum	0019	3.94	$204.92	$75.82	$40.98
56620	T	Partial removal of vulva	0195	24.37	$1,267.46	$483.80	$253.49
56625	T	Complete removal of vulva	0195	24.37	$1,267.46	$483.80	$253.49
56630	C	Extensive vulva surgery					
56631	C	Extensive vulva surgery					
56632	C	Extensive vulva surgery					
56633	C	Extensive vulva surgery					
56634	C	Extensive vulva surgery					
56637	C	Extensive vulva surgery					
56640	C	Extensive vulva surgery					
56700	T	Partial removal of hymen	0194	18.88	$981.93	$397.84	$196.39
56720	T	Incision of hymen	0193	14.57	$757.77	$171.13	$151.55
56740	T	Remove vagina gland lesion	0194	18.88	$981.93	$397.84	$196.39
56800	T	Repair of vagina	0194	18.88	$981.93	$397.84	$196.39
56805	T	Repair clitoris	0194	18.88	$981.93	$397.84	$196.39
56810	T	Repair of perineum	0194	18.88	$981.93	$397.84	$196.39
57000	T	Exploration of vagina	0194	18.88	$981.93	$397.84	$196.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57010	T	Drainage of pelvic abscess	0194	18.88	$981.93	$397.84	$196.39
57020	T	Drainage of pelvic fluid	0192	2.94	$152.91	$42.81	$30.58
57022	T	I & d vaginal hematoma, pp	0007	9.44	$490.96	$103.10	$98.19
57023	T	I & d vag hematoma, non-ob	0007	9.44	$490.96	$103.10	$98.19
57061	T	Destroy vag lesions, simple	0194	18.88	$981.93	$397.84	$196.39
57065	T	Destroy vag lesions, complex	0194	18.88	$981.93	$397.84	$196.39
57100	T	Biopsy of vagina	0192	2.94	$152.91	$42.81	$30.58
57105	T	Biopsy of vagina	0194	18.88	$981.93	$397.84	$196.39
57106	T	Remove vagina wall, partial	0194	18.88	$981.93	$397.84	$196.39
57107	T	Remove vagina tissue, part	0195	24.37	$1,267.46	$483.80	$253.49
57109	T	Vaginectomy partial w/nodes	0202	39.09	$2,033.03	$996.18	$406.61
57110	C	Remove vagina wall, complete					
57111	C	Remove vagina tissue, compl					
57112	C	Vaginectomy w/nodes, compl					
57120	T	Closure of vagina	0194	18.88	$981.93	$397.84	$196.39
57130	T	Remove vagina lesion	0194	18.88	$981.93	$397.84	$196.39
57135	T	Remove vagina lesion	0194	18.88	$981.93	$397.84	$196.39
57150	T	Treat vagina infection	0191	0.22	$11.44	$3.32	$2.29
57155	T	Insert uteri tandems/ovoids	0192	2.94	$152.91	$42.81	$30.58
57160	T	Insert pessary/other device	0188	1.12	$58.25	$11.95	$11.65
57170	T	Fitting of diaphragm/cap	0191	0.22	$11.44	$3.32	$2.29
57180	T	Treat vaginal bleeding	0192	2.94	$152.91	$42.81	$30.58
57200	T	Repair of vagina	0194	18.88	$981.93	$397.84	$196.39
57210	T	Repair vagina/perineum	0194	18.88	$981.93	$397.84	$196.39
57220	T	Revision of urethra	0195	24.37	$1,267.46	$483.80	$253.49
57230	T	Repair of urethral lesion	0194	18.88	$981.93	$397.84	$196.39
57240	T	Repair bladder & vagina	0195	24.37	$1,267.46	$483.80	$253.49
57250	T	Repair rectum & vagina	0195	24.37	$1,267.46	$483.80	$253.49
57260	T	Repair of vagina	0195	24.37	$1,267.46	$483.80	$253.49
57265	T	Extensive repair of vagina	0195	24.37	$1,267.46	$483.80	$253.49
57268	T	Repair of bowel bulge	0195	24.37	$1,267.46	$483.80	$253.49
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	0195	24.37	$1,267.46	$483.80	$253.49
57287	T	Revise/remove sling repair	0202	39.09	$2,033.03	$996.18	$406.61
57288	T	Repair bladder defect	0202	39.09	$2,033.03	$996.18	$406.61
57289	T	Repair bladder & vagina	0195	24.37	$1,267.46	$483.80	$253.49
57291	T	Construction of vagina	0195	24.37	$1,267.46	$483.80	$253.49
57292	C	Construct vagina with graft					
57300	T	Repair rectum-vagina fistula	0195	24.37	$1,267.46	$483.80	$253.49
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	T	Repair urethrovaginal lesion	0195	24.37	$1,267.46	$483.80	$253.49
57311	C	Repair urethrovaginal lesion					
57320	T	Repair bladder-vagina lesion	0195	24.37	$1,267.46	$483.80	$253.49
57330	T	Repair bladder-vagina lesion	0195	24.37	$1,267.46	$483.80	$253.49
57335	C	Repair vagina					
57400	T	Dilation of vagina	0194	18.88	$981.93	$397.84	$196.39
57410	T	Pelvic examination	0194	18.88	$981.93	$397.84	$196.39
57415	T	Remove vaginal foreign body	0194	18.88	$981.93	$397.84	$196.39
57452	T	Examination of vagina	0189	1.63	$84.77	$18.60	$16.95
57454	T	Vagina examination & biopsy	0192	2.94	$152.91	$42.81	$30.58
57460	T	Cervix excision	0193	14.57	$757.77	$171.13	$151.55
57500	T	Biopsy of cervix	0192	2.94	$152.91	$42.81	$30.58
57505	T	Endocervical curettage	0192	2.94	$152.91	$42.81	$30.58
57510	T	Cauterization of cervix	0193	14.57	$757.77	$171.13	$151.55
57511	T	Cryocautery of cervix	0189	1.63	$84.77	$18.60	$16.95
57513	T	Laser surgery of cervix	0193	14.57	$757.77	$171.13	$151.55
57520	T	Conization of cervix	0194	18.88	$981.93	$397.84	$196.39
57522	T	Conization of cervix	0195	24.37	$1,267.46	$483.80	$253.49
57530	T	Removal of cervix	0195	24.37	$1,267.46	$483.80	$253.49
57531	C	Removal of cervix, radical					
57540	C	Removal of residual cervix					
57545	C	Remove cervix/repair pelvis					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57550	T	Removal of residual cervix	0195	24.37	$1,267.46	$483.80	$253.49
57555	T	Remove cervix/repair vagina	0195	24.37	$1,267.46	$483.80	$253.49
57556	T	Remove cervix, repair bowel	0195	24.37	$1,267.46	$483.80	$253.49
57700	T	Revision of cervix	0194	18.88	$981.93	$397.84	$196.39
57720	T	Revision of cervix	0194	18.88	$981.93	$397.84	$196.39
57800	T	Dilation of cervical canal	0192	2.94	$152.91	$42.81	$30.58
57820	T	D & c of residual cervix	0196	16.32	$848.79	$338.23	$169.76
58100	T	Biopsy of uterus lining	0188	1.12	$58.25	$11.95	$11.65
58120	T	Dilation and curettage	0196	16.32	$848.79	$338.23	$169.76
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	0195	24.37	$1,267.46	$483.80	$253.49
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	0189	1.63	$84.77	$18.60	$16.95
58321	T	Artificial insemination	0197	1.19	$61.89	$24.76	$12.38
58322	T	Artificial insemination	0197	1.19	$61.89	$24.76	$12.38
58323	T	Sperm washing	0197	1.19	$61.89	$24.76	$12.38
58340	N	Catheter for hysterography					
58345	T	Reopen fallopian tube	0194	18.88	$981.93	$397.84	$196.39
58346	T	Insert heyman uteri capsule	0192	2.94	$152.91	$42.81	$30.58
58350	T	Reopen fallopian tube	0194	18.88	$981.93	$397.84	$196.39
58353	T	Endometr ablate, thermal	0193	14.57	$757.77	$171.13	$151.55
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	57.95	$3,013.92	$1,239.22	$602.78
58551	T	Laparoscopy, remove myoma	0131	42.44	$2,207.26	$1,001.89	$441.45
58555	T	Hysteroscopy, dx, sep proc	0194	18.88	$981.93	$397.84	$196.39
58558	T	Hysteroscopy, biopsy	0190	20.06	$1,043.30	$424.28	$208.66
58559	T	Hysteroscopy, lysis	0190	20.06	$1,043.30	$424.28	$208.66
58560	T	Hysteroscopy, resect septum	0190	20.06	$1,043.30	$424.28	$208.66
58561	T	Hysteroscopy, remove myoma	0190	20.06	$1,043.30	$424.28	$208.66
58562	T	Hysteroscopy, remove fb	0190	20.06	$1,043.30	$424.28	$208.66
58563	T	Hysteroscopy, ablation	0190	20.06	$1,043.30	$424.28	$208.66
58578	T	Laparo proc, uterus	0190	20.06	$1,043.30	$424.28	$208.66
58579	T	Hysteroscope procedure	0190	20.06	$1,043.30	$424.28	$208.66
58600	T	Division of fallopian tube	0194	18.88	$981.93	$397.84	$196.39
58605	C	Division of fallopian tube					
58611	C	Ligate oviduct(s) add-on					
58615	T	Occlude fallopian tube(s)	0194	18.88	$981.93	$397.84	$196.39
58660	T	Laparoscopy, lysis	0131	42.44	$2,207.26	$1,001.89	$441.45
58661	T	Laparoscopy, remove adnexa	0131	42.44	$2,207.26	$1,001.89	$441.45
58662	T	Laparoscopy, excise lesions	0131	42.44	$2,207.26	$1,001.89	$441.45
58670	T	Laparoscopy, tubal cautery	0131	42.44	$2,207.26	$1,001.89	$441.45
58671	T	Laparoscopy, tubal block	0131	42.44	$2,207.26	$1,001.89	$441.45
58672	T	Laparoscopy, fimbrioplasty	0131	42.44	$2,207.26	$1,001.89	$441.45
58673	T	Laparoscopy, salpingostomy	0131	42.44	$2,207.26	$1,001.89	$441.45
58679	T	Laparo proc, oviduct-ovary	0130	31.99	$1,663.77	$659.53	$332.75
58700	C	Removal of fallopian tube					
58720	C	Removal of ovary/tube(s)					
58740	C	Revise fallopian tube(s)					
58750	C	Repair oviduct					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58752	C	Revise ovarian tube(s)					
58760	C	Remove tubal obstruction					
58770	C	Create new tubal opening					
58800	T	Drainage of ovarian cyst(s)	0195	24.37	$1,267.46	$483.80	$253.49
58805	C	Drainage of ovarian cyst(s)					
58820	T	Drain ovary abscess, open	0195	24.37	$1,267.46	$483.80	$253.49
58822	C	Drain ovary abscess, percut					
58823	T	Drain pelvic abscess, percut	0193	14.57	$757.77	$171.13	$151.55
58825	C	Transposition, ovary(s)					
58900	T	Biopsy of ovary(s)	0195	24.37	$1,267.46	$483.80	$253.49
58920	T	Partial removal of ovary(s)	0202	39.09	$2,033.03	$996.18	$406.61
58925	T	Removal of ovarian cyst(s)	0202	39.09	$2,033.03	$996.18	$406.61
58940	C	Removal of ovary(s)					
58943	C	Removal of ovary(s)					
58950	C	Resect ovarian malignancy					
58951	C	Resect ovarian malignancy					
58952	C	Resect ovarian malignancy					
58953	C	Tah, rad dissect for debulk					
58954	C	Tah rad debulk/lymph remove					
58960	C	Exploration of abdomen					
58970	T	Retrieval of oocyte	0194	18.88	$981.93	$397.84	$196.39
58974	T	Transfer of embryo	0197	1.19	$61.89	$24.76	$12.38
58976	T	Transfer of embryo	0197	1.19	$61.89	$24.76	$12.38
58999	T	Genital surgery procedure	0191	0.22	$11.44	$3.32	$2.29
59000	T	Amniocentesis, diagnostic	0198	1.33	$69.17	$32.92	$13.83
59001	T	Amniocentesis, therapeutic	0198	1.33	$69.17	$32.92	$13.83
59012	T	Fetal cord puncture,prenatal	0198	1.33	$69.17	$32.92	$13.83
59015	T	Chorion biopsy	0198	1.33	$69.17	$32.92	$13.83
59020	T	Fetal contract stress test	0198	1.33	$69.17	$32.92	$13.83
59025	T	Fetal non-stress test	0198	1.33	$69.17	$32.92	$13.83
59030	T	Fetal scalp blood sample	0198	1.33	$69.17	$32.92	$13.83
59050	E	Fetal monitor w/report					
59051	E	Fetal monitor/interpret only					
59100	C	Remove uterus lesion					
59120	C	Treat ectopic pregnancy					
59121	C	Treat ectopic pregnancy					
59130	C	Treat ectopic pregnancy					
59135	C	Treat ectopic pregnancy					
59136	C	Treat ectopic pregnancy					
59140	C	Treat ectopic pregnancy					
59150	T	Treat ectopic pregnancy	0131	42.44	$2,207.26	$1,001.89	$441.45
59151	T	Treat ectopic pregnancy	0131	42.44	$2,207.26	$1,001.89	$441.45
59160	T	D & c after delivery	0196	16.32	$848.79	$338.23	$169.76
59200	T	Insert cervical dilator	0189	1.63	$84.77	$18.60	$16.95
59300	T	Episiotomy or vaginal repair	0193	14.57	$757.77	$171.13	$151.55
59320	T	Revision of cervix	0194	18.88	$981.93	$397.84	$196.39
59325	C	Revision of cervix					
59350	C	Repair of uterus					
59400	E	Obstetrical care					
59409	T	Obstetrical care	0199	5.69	$295.93	$72.98	$59.19
59410	E	Obstetrical care					
59412	T	Antepartum manipulation	0199	5.69	$295.93	$72.98	$59.19
59414	T	Deliver placenta	0199	5.69	$295.93	$72.98	$59.19
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	5.69	$295.93	$72.98	$59.19
59614	E	Vbac care after delivery					
59618	E	Attempted vbac delivery					
59620	C	Attempted vbac delivery only					
59622	E	Attempted vbac after care					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59812	T	Treatment of miscarriage	0201	15.84	$823.82	$329.65	$164.76
59820	T	Care of miscarriage	0201	15.84	$823.82	$329.65	$164.76
59821	T	Treatment of miscarriage	0201	15.84	$823.82	$329.65	$164.76
59830	C	Treat uterus infection					
59840	T	Abortion	0200	14.49	$753.61	$307.83	$150.72
59841	T	Abortion	0200	14.49	$753.61	$307.83	$150.72
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	T	Abortion (mpr)	0198	1.33	$69.17	$32.92	$13.83
59870	T	Evacuate mole of uterus	0201	15.84	$823.82	$329.65	$164.76
59871	T	Remove cerclage suture	0194	18.88	$981.93	$397.84	$196.39
59898	T	Laparo proc, ob care/deliver	0130	31.99	$1,663.77	$659.53	$332.75
59899	T	Maternity care procedure	0198	1.33	$69.17	$32.92	$13.83
60000	T	Drain thyroid/tongue cyst	0252	6.27	$326.10	$114.24	$65.22
60001	T	Aspirate/inject thyriod cyst	0004	1.63	$84.77	$22.04	$16.95
60100	T	Biopsy of thyroid	0004	1.63	$84.77	$22.04	$16.95
60200	T	Remove thyroid lesion	0114	37.55	$1,952.94	$507.76	$390.59
60210	T	Partial thyroid excision	0114	37.55	$1,952.94	$507.76	$390.59
60212	T	Parital thyroid excision	0114	37.55	$1,952.94	$507.76	$390.59
60220	T	Partial removal of thyroid	0114	37.55	$1,952.94	$507.76	$390.59
60225	T	Partial removal of thyroid	0114	37.55	$1,952.94	$507.76	$390.59
60240	T	Removal of thyroid	0114	37.55	$1,952.94	$507.76	$390.59
60252	T	Removal of thyroid	0256	35.51	$1,846.84		$369.37
60254	C	Extensive thyroid surgery					
60260	T	Repeat thyroid surgery	0256	35.51	$1,846.84		$369.37
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	0114	37.55	$1,952.94	$507.76	$390.59
60281	T	Remove thyroid duct lesion	0114	37.55	$1,952.94	$507.76	$390.59
60500	T	Explore parathyroid glands	0256	35.51	$1,846.84		$369.37
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	T	Autotransplant parathyroid	0022	18.10	$941.36	$367.13	$188.27
60520	C	Removal of thymus gland					
60521	C	Removal of thymus gland					
60522	C	Removal of thymus gland					
60540	C	Explore adrenal gland					
60545	C	Explore adrenal gland					
60600	C	Remove carotid body lesion					
60605	C	Remove carotid body lesion					
60650	C	Laparoscopy adrenalectomy					
60659	T	Laparo proc, endocrine	0130	31.99	$1,663.77	$659.53	$332.75
60699	T	Endocrine surgery procedure	0114	37.55	$1,952.94	$507.76	$390.59
61000	T	Remove cranial cavity fluid	0212	3.53	$183.59	$84.45	$36.72
61001	T	Remove cranial cavity fluid	0212	3.53	$183.59	$84.45	$36.72
61020	T	Remove brain cavity fluid	0212	3.53	$183.59	$84.45	$36.72
61026	T	Injection into brain canal	0212	3.53	$183.59	$84.45	$36.72
61050	T	Remove brain canal fluid	0212	3.53	$183.59	$84.45	$36.72
61055	T	Injection into brain canal	0212	3.53	$183.59	$84.45	$36.72
61070	T	Brain canal shunt procedure	0212	3.53	$183.59	$84.45	$36.72
61105	C	Twist drill hole					
61107	C	Drill skull for implantation					
61108	C	Drill skull for drainage					
61120	C	Burr hole for puncture					
61140	C	Pierce skull for biopsy					
61150	C	Pierce skull for drainage					
61151	C	Pierce skull for drainage					
61154	C	Pierce skull & remove clot					
61156	C	Pierce skull for drainage					
61210	C	Pierce skull, implant device					
61215	T	Insert brain-fluid device	0224	39.14	$2,035.63	$453.41	$407.13
61250	C	Pierce skull & explore					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	35.51	$1,846.84		$369.37
61332	C	Explore/biopsy eye socket					
61333	C	Explore orbit/remove lesion					
61334	C	Explore orbit/remove object					
61340	C	Relieve cranial pressure					
61343	C	Incise skull (press relief)					
61345	C	Relieve cranial pressure					
61440	C	Incise skull for surgery					
61450	C	Incise skull for surgery					
61458	C	Incise skull for brain wound					
61460	C	Incise skull for surgery					
61470	C	Incise skull for surgery					
61480	C	Incise skull for surgery					
61490	C	Incise skull for surgery					
61500	C	Removal of skull lesion					
61501	C	Remove infected skull bone					
61510	C	Removal of brain lesion					
61512	C	Remove brain lining lesion					
61514	C	Removal of brain abscess					
61516	C	Removal of brain lesion					
61518	C	Removal of brain lesion					
61519	C	Remove brain lining lesion					
61520	C	Removal of brain lesion					
61521	C	Removal of brain lesion					
61522	C	Removal of brain abscess					
61524	C	Removal of brain lesion					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	T	Occlusion/embolization cath	0081	22.69	$1,180.08		$236.02
61680	C	Intracranial vessel surgery					
61682	C	Intracranial vessel surgery					
61684	C	Intracranial vessel surgery					
61686	C	Intracranial vessel surgery					
61690	C	Intracranial vessel surgery					
61692	C	Intracranial vessel surgery					
61697	C	Brain aneurysm repr, complx					
61698	C	Brain aneurysm repr, complx					
61700	C	Brain aneurysm repr , simple					
61702	C	Inner skull vessel surgery					
61703	C	Clamp neck artery					
61705	C	Revise circulation to head					
61708	C	Revise circulation to head					
61710	C	Revise circulation to head					
61711	C	Fusion of skull arteries					
61720	C	Incise skull/brain surgery					
61735	C	Incise skull/brain surgery					
61750	C	Incise skull/brain biopsy					
61751	C	Brain biopsy w/ ct/mr guide					
61760	C	Implant brain electrodes					
61770	C	Incise skull for treatment					
61790	T	Treat trigeminal nerve	0220	16.66	$866.47		$173.29
61791	T	Treat trigeminal tract	0204	2.13	$110.78	$42.10	$22.16
61793	E	Focus radiation beam					
61795	S	Brain surgery using computer	0302	10.17	$528.93	$200.99	$105.79
61850	C	Implant neuroelectrodes					
61860	C	Implant neuroelectrodes					
61862	C	Implant neurostimul, subcort					
61870	C	Implant neuroelectrodes					
61875	C	Implant neuroelectrodes					
61880	T	Revise/remove neuroelectrode	0687	19.50	$1,014.18	$466.52	$202.84
61885	T	Implant neurostim one array	0222	140.56	$7,310.39		$1,462.08
61886	T	Implant neurostim arrays	0222	140.56	$7,310.39		$1,462.08
61888	T	Revise/remove neuroreceiver	0688	30.58	$1,590.44	$779.32	$318.09
62000	C	Treat skull fracture					
62005	C	Treat skull fracture					
62010	C	Treatment of head injury					
62100	C	Repair brain fluid leakage					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	2.17	$112.86	$45.14	$22.57
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	2.17	$112.86	$45.14	$22.57
62230	T	Replace/revise brain shunt	0224	39.14	$2,035.63	$453.41	$407.13
62252	S	Csf shunt reprogram	0691	3.14	$163.31	$89.02	$32.66
62256	C	Remove brain cavity shunt					
62258	C	Replace brain cavity shunt					
62263	T	Lysis epidural adhesions	0203	10.96	$570.02	$256.51	$114.00
62268	T	Drain spinal cord cyst	0212	3.53	$183.59	$84.45	$36.72
62269	T	Needle biopsy, spinal cord	0005	3.02	$157.07	$69.11	$31.41
62270	T	Spinal fluid tap, diagnostic	0206	4.89	$254.32	$75.55	$50.86
62272	T	Drain cerebro spinal fluid	0206	4.89	$254.32	$75.55	$50.86
62273	T	Treat epidural spine lesion	0206	4.89	$254.32	$75.55	$50.86
62280	T	Treat spinal cord lesion	0207	5.97	$310.49	$123.69	$62.10
62281	T	Treat spinal cord lesion	0207	5.97	$310.49	$123.69	$62.10
62282	T	Treat spinal canal lesion	0207	5.97	$310.49	$123.69	$62.10
62284	N	Injection for myelogram					
62287	T	Percutaneous diskectomy	0220	16.66	$866.47		$173.29
62290	N	Inject for spine disk x-ray					
62291	N	Inject for spine disk x-ray					
62292	T	Injection into disk lesion	0212	3.53	$183.59	$84.45	$36.72
62294	T	Injection into spinal artery	0212	3.53	$183.59	$84.45	$36.72
62310	T	Inject spine c/t	0206	4.89	$254.32	$75.55	$50.86
62311	T	Inject spine l/s (cd)	0206	4.89	$254.32	$75.55	$50.86
62318	T	Inject spine w/cath, c/t	0206	4.89	$254.32	$75.55	$50.86
62319	T	Inject spine w/cath l/s (cd)	0206	4.89	$254.32	$75.55	$50.86
62350	T	Implant spinal canal cath	0223	20.30	$1,055.78		$211.16
62351	T	Implant spinal canal cath	0208	39.95	$2,077.76		$415.55
62355	T	Remove spinal canal catheter	0203	10.96	$570.02	$256.51	$114.00
62360	T	Insert spine infusion device	0226	44.20	$2,298.80		$459.76
62361	T	Implant spine infusion pump	0227	128.03	$6,658.71		$1,331.74
62362	T	Implant spine infusion pump	0227	128.03	$6,658.71		$1,331.74
62365	T	Remove spine infusion device	0203	10.96	$570.02	$256.51	$114.00
62367	S	Analyze spine infusion pump	0691	3.14	$163.31	$89.02	$32.66
62368	S	Analyze spine infusion pump	0691	3.14	$163.31	$89.02	$32.66
63001	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63003	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63005	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63011	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63012	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63015	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63016	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63017	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63020	T	Neck spine disk surgery	0208	39.95	$2,077.76		$415.55
63030	T	Low back disk surgery	0208	39.95	$2,077.76		$415.55
63035	T	Spinal disk surgery add-on	0208	39.95	$2,077.76		$415.55
63040	T	Laminotomy, single cervical	0208	39.95	$2,077.76		$415.55
63042	T	Laminotomy, single lumbar	0208	39.95	$2,077.76		$415.55

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63043	C	Laminotomy, addl cervical					
63044	C	Laminotomy, addl lumbar					
63045	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63046	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63047	T	Removal of spinal lamina	0208	39.95	$2,077.76		$415.55
63048	T	Remove spinal lamina add-on	0208	39.95	$2,077.76		$415.55
63055	T	Decompress spinal cord	0208	39.95	$2,077.76		$415.55
63056	T	Decompress spinal cord	0208	39.95	$2,077.76		$415.55
63057	T	Decompress spine cord add-on	0208	39.95	$2,077.76		$415.55
63064	T	Decompress spinal cord	0208	39.95	$2,077.76		$415.55
63066	T	Decompress spine cord add-on	0208	39.95	$2,077.76		$415.55
63075	C	Neck spine disk surgery					
63076	C	Neck spine disk surgery					
63077	C	Spine disk surgery, thorax					
63078	C	Spine disk surgery, thorax					
63081	C	Removal of vertebral body					
63082	C	Remove vertebral body add-on					
63085	C	Removal of vertebral body					
63086	C	Remove vertebral body add-on					
63087	C	Removal of vertebral body					
63088	C	Remove vertebral body add-on					
63090	C	Removal of vertebral body					
63091	C	Remove vertebral body add-on					
63170	C	Incise spinal cord tract(s)					
63172	C	Drainage of spinal cyst					
63173	C	Drainage of spinal cyst					
63180	C	Revise spinal cord ligaments					
63182	C	Revise spinal cord ligaments					
63185	C	Incise spinal column/nerves					
63190	C	Incise spinal column/nerves					
63191	C	Incise spinal column/nerves					
63194	C	Incise spinal column & cord					
63195	C	Incise spinal column & cord					
63196	C	Incise spinal column & cord					
63197	C	Incise spinal column & cord					
63198	C	Incise spinal column & cord					
63199	C	Incise spinal column & cord					
63200	C	Release of spinal cord					
63250	C	Revise spinal cord vessels					
63251	C	Revise spinal cord vessels					
63252	C	Revise spinal cord vessels					
63265	C	Excise intraspinal lesion					
63266	C	Excise intraspinal lesion					
63267	C	Excise intraspinal lesion					
63268	C	Excise intraspinal lesion					
63270	C	Excise intraspinal lesion					
63271	C	Excise intraspinal lesion					
63272	C	Excise intraspinal lesion					
63273	C	Excise intraspinal lesion					
63275	C	Biopsy/excise spinal tumor					
63276	C	Biopsy/excise spinal tumor					
63277	C	Biopsy/excise spinal tumor					
63278	C	Biopsy/excise spinal tumor					
63280	C	Biopsy/excise spinal tumor					
63281	C	Biopsy/excise spinal tumor					
63282	C	Biopsy/excise spinal tumor					
63283	C	Biopsy/excise spinal tumor					
63285	C	Biopsy/excise spinal tumor					
63286	C	Biopsy/excise spinal tumor					
63287	C	Biopsy/excise spinal tumor					
63290	C	Biopsy/excise spinal tumor					
63300	C	Removal of vertebral body					
63301	C	Removal of vertebral body					
63302	C	Removal of vertebral body					
63303	C	Removal of vertebral body					
63304	C	Removal of vertebral body					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	16.66	$866.47		$173.29
63610	T	Stimulation of spinal cord	0220	16.66	$866.47		$173.29
63615	T	Remove lesion of spinal cord	0220	16.66	$866.47		$173.29
63650	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
63655	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
63660	T	Revise/remove neuroelectrode	0687	19.50	$1,014.18	$466.52	$202.84
63685	T	Implant neuroreceiver	0222	140.56	$7,310.39		$1,462.08
63688	T	Revise/remove neuroreceiver	0688	30.58	$1,590.44	$779.32	$318.09
63700	C	Repair of spinal herniation					
63702	C	Repair of spinal herniation					
63704	C	Repair of spinal herniation					
63706	C	Repair of spinal herniation					
63707	C	Repair spinal fluid leakage					
63709	C	Repair spinal fluid leakage					
63710	C	Graft repair of spine defect					
63740	C	Install spinal shunt					
63741	T	Install spinal shunt	0228	55.05	$2,863.10	$696.46	$572.62
63744	T	Revision of spinal shunt	0228	55.05	$2,863.10	$696.46	$572.62
63746	T	Removal of spinal shunt	0109	7.68	$399.43	$131.49	$79.89
64400	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64402	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64405	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64408	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64410	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64412	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64413	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64415	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64417	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64418	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64420	T	Injection for nerve block	0207	5.97	$310.49	$123.69	$62.10
64421	T	Injection for nerve block	0207	5.97	$310.49	$123.69	$62.10
64425	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64430	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64435	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64445	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64450	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64470	T	Inj paravertebral c/t	0207	5.97	$310.49	$123.69	$62.10
64472	T	Inj paravertebral c/t add-on	0207	5.97	$310.49	$123.69	$62.10
64475	T	Inj paravertebral l/s	0207	5.97	$310.49	$123.69	$62.10
64476	T	Inj paravertebral l/s add-on	0207	5.97	$310.49	$123.69	$62.10
64479	T	Inj foramen epidural c/t	0207	5.97	$310.49	$123.69	$62.10
64480	T	Inj foramen epidural add-on	0207	5.97	$310.49	$123.69	$62.10
64483	T	Inj foramen epidural l/s	0207	5.97	$310.49	$123.69	$62.10
64484	T	Inj foramen epidural add-on	0207	5.97	$310.49	$123.69	$62.10
64505	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64508	T	Injection for nerve block	0204	2.13	$110.78	$42.10	$22.16
64510	T	Injection for nerve block	0207	5.97	$310.49	$123.69	$62.10
64520	T	Injection for nerve block	0207	5.97	$310.49	$123.69	$62.10
64530	T	Injection for nerve block	0207	5.97	$310.49	$123.69	$62.10
64550	A	Apply neurostimulator					
64553	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64555	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64560	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64561	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64565	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64573	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64575	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64577	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64580	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64581	T	Implant neuroelectrodes	0225	44.47	$2,312.84		$462.57
64585	T	Revise/remove neuroelectrode	0687	19.50	$1,014.18	$466.52	$202.84
64590	T	Implant neuroreceiver	0222	140.56	$7,310.39		$1,462.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64595	T	Revise/remove neuroreceiver	0688	30.58	$1,590.44	$779.32	$318.09
64600	T	Injection treatment of nerve	0203	10.96	$570.02	$256.51	$114.00
64605	T	Injection treatment of nerve	0203	10.96	$570.02	$256.51	$114.00
64610	T	Injection treatment of nerve	0203	10.96	$570.02	$256.51	$114.00
64612	T	Destroy nerve, face muscle	0204	2.13	$110.78	$42.10	$22.16
64613	T	Destroy nerve, spine muscle	0204	2.13	$110.78	$42.10	$22.16
64614	T	Destroy nerve, extrem musc	0204	2.13	$110.78	$42.10	$22.16
64620	T	Injection treatment of nerve	0203	10.96	$570.02	$256.51	$114.00
64622	T	Destr paravertebrl nerve l/s	0203	10.96	$570.02	$256.51	$114.00
64623	T	Destr paravertebral n add-on	0203	10.96	$570.02	$256.51	$114.00
64626	T	Destr paravertebrl nerve c/t	0203	10.96	$570.02	$256.51	$114.00
64627	T	Destr paravertebral n add-on	0203	10.96	$570.02	$256.51	$114.00
64630	T	Injection treatment of nerve	0207	5.97	$310.49	$123.69	$62.10
64640	T	Injection treatment of nerve	0207	5.97	$310.49	$123.69	$62.10
64680	T	Injection treatment of nerve	0203	10.96	$570.02	$256.51	$114.00
64702	T	Revise finger/toe nerve	0220	16.66	$866.47		$173.29
64704	T	Revise hand/foot nerve	0220	16.66	$866.47		$173.29
64708	T	Revise arm/leg nerve	0220	16.66	$866.47		$173.29
64712	T	Revision of sciatic nerve	0220	16.66	$866.47		$173.29
64713	T	Revision of arm nerve(s)	0220	16.66	$866.47		$173.29
64714	T	Revise low back nerve(s)	0220	16.66	$866.47		$173.29
64716	T	Revision of cranial nerve	0220	16.66	$866.47		$173.29
64718	T	Revise ulnar nerve at elbow	0220	16.66	$866.47		$173.29
64719	T	Revise ulnar nerve at wrist	0220	16.66	$866.47		$173.29
64721	T	Carpal tunnel surgery	0220	16.66	$866.47		$173.29
64722	T	Relieve pressure on nerve(s)	0220	16.66	$866.47		$173.29
64726	T	Release foot/toe nerve	0220	16.66	$866.47		$173.29
64727	T	Internal nerve revision	0220	16.66	$866.47		$173.29
64732	T	Incision of brow nerve	0220	16.66	$866.47		$173.29
64734	T	Incision of cheek nerve	0220	16.66	$866.47		$173.29
64736	T	Incision of chin nerve	0220	16.66	$866.47		$173.29
64738	T	Incision of jaw nerve	0220	16.66	$866.47		$173.29
64740	T	Incision of tongue nerve	0220	16.66	$866.47		$173.29
64742	T	Incision of facial nerve	0220	16.66	$866.47		$173.29
64744	T	Incise nerve, back of head	0220	16.66	$866.47		$173.29
64746	T	Incise diaphragm nerve	0220	16.66	$866.47		$173.29
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	16.66	$866.47		$173.29
64763	C	Incise hip/thigh nerve					
64766	C	Incise hip/thigh nerve					
64771	T	Sever cranial nerve	0220	16.66	$866.47		$173.29
64772	T	Incision of spinal nerve	0220	16.66	$866.47		$173.29
64774	T	Remove skin nerve lesion	0220	16.66	$866.47		$173.29
64776	T	Remove digit nerve lesion	0220	16.66	$866.47		$173.29
64778	T	Digit nerve surgery add-on	0220	16.66	$866.47		$173.29
64782	T	Remove limb nerve lesion	0220	16.66	$866.47		$173.29
64783	T	Limb nerve surgery add-on	0220	16.66	$866.47		$173.29
64784	T	Remove nerve lesion	0220	16.66	$866.47		$173.29
64786	T	Remove sciatic nerve lesion	0221	25.35	$1,318.43	$463.62	$263.69
64787	T	Implant nerve end	0220	16.66	$866.47		$173.29
64788	T	Remove skin nerve lesion	0220	16.66	$866.47		$173.29
64790	T	Removal of nerve lesion	0220	16.66	$866.47		$173.29
64792	T	Removal of nerve lesion	0221	25.35	$1,318.43	$463.62	$263.69
64795	T	Biopsy of nerve	0220	16.66	$866.47		$173.29
64802	T	Remove sympathetic nerves	0220	16.66	$866.47		$173.29
64804	C	Remove sympathetic nerves					
64809	C	Remove sympathetic nerves					
64818	C	Remove sympathetic nerves					
64820	T	Remove sympathetic nerves	0220	16.66	$866.47		$173.29
64821	T	Remove sympathetic nerves	0054	23.50	$1,222.21	$472.33	$244.44
64822	T	Remove sympathetic nerves	0054	23.50	$1,222.21	$472.33	$244.44
64823	T	Remove sympathetic nerves	0054	23.50	$1,222.21	$472.33	$244.44
64831	T	Repair of digit nerve	0221	25.35	$1,318.43	$463.62	$263.69
64832	T	Repair nerve add-on	0221	25.35	$1,318.43	$463.62	$263.69

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64834	T	Repair of hand or foot nerve	0221	25.35	$1,318.43	$463.62	$263.69
64835	T	Repair of hand or foot nerve	0221	25.35	$1,318.43	$463.62	$263.69
64836	T	Repair of hand or foot nerve	0221	25.35	$1,318.43	$463.62	$263.69
64837	T	Repair nerve add-on	0221	25.35	$1,318.43	$463.62	$263.69
64840	T	Repair of leg nerve	0221	25.35	$1,318.43	$463.62	$263.69
64856	T	Repair/transpose nerve	0221	25.35	$1,318.43	$463.62	$263.69
64857	T	Repair arm/leg nerve	0221	25.35	$1,318.43	$463.62	$263.69
64858	T	Repair sciatic nerve	0221	25.35	$1,318.43	$463.62	$263.69
64859	T	Nerve surgery	0221	25.35	$1,318.43	$463.62	$263.69
64861	T	Repair of arm nerves	0221	25.35	$1,318.43	$463.62	$263.69
64862	T	Repair of low back nerves	0221	25.35	$1,318.43	$463.62	$263.69
64864	T	Repair of facial nerve	0221	25.35	$1,318.43	$463.62	$263.69
64865	T	Repair of facial nerve	0221	25.35	$1,318.43	$463.62	$263.69
64866	C	Fusion of facial/other nerve					
64868	C	Fusion of facial/other nerve					
64870	T	Fusion of facial/other nerve	0221	25.35	$1,318.43	$463.62	$263.69
64872	T	Subsequent repair of nerve	0221	25.35	$1,318.43	$463.62	$263.69
64874	T	Repair & revise nerve add-on	0221	25.35	$1,318.43	$463.62	$263.69
64876	T	Repair nerve/shorten bone	0221	25.35	$1,318.43	$463.62	$263.69
64885	T	Nerve graft, head or neck	0221	25.35	$1,318.43	$463.62	$263.69
64886	T	Nerve graft, head or neck	0221	25.35	$1,318.43	$463.62	$263.69
64890	T	Nerve graft, hand or foot	0221	25.35	$1,318.43	$463.62	$263.69
64891	T	Nerve graft, hand or foot	0221	25.35	$1,318.43	$463.62	$263.69
64892	T	Nerve graft, arm or leg	0221	25.35	$1,318.43	$463.62	$263.69
64893	T	Nerve graft, arm or leg	0221	25.35	$1,318.43	$463.62	$263.69
64895	T	Nerve graft, hand or foot	0221	25.35	$1,318.43	$463.62	$263.69
64896	T	Nerve graft, hand or foot	0221	25.35	$1,318.43	$463.62	$263.69
64897	T	Nerve graft, arm or leg	0221	25.35	$1,318.43	$463.62	$263.69
64898	T	Nerve graft, arm or leg	0221	25.35	$1,318.43	$463.62	$263.69
64901	T	Nerve graft add-on	0221	25.35	$1,318.43	$463.62	$263.69
64902	T	Nerve graft add-on	0221	25.35	$1,318.43	$463.62	$263.69
64905	T	Nerve pedicle transfer	0221	25.35	$1,318.43	$463.62	$263.69
64907	T	Nerve pedicle transfer	0221	25.35	$1,318.43	$463.62	$263.69
64999	T	Nervous system surgery	0204	2.13	$110.78	$42.10	$22.16
65091	T	Revise eye	0242	28.87	$1,501.50	$597.36	$300.30
65093	T	Revise eye with implant	0241	21.89	$1,138.48	$384.47	$227.70
65101	T	Removal of eye	0242	28.87	$1,501.50	$597.36	$300.30
65103	T	Remove eye/insert implant	0242	28.87	$1,501.50	$597.36	$300.30
65105	T	Remove eye/attach implant	0242	28.87	$1,501.50	$597.36	$300.30
65110	T	Removal of eye	0242	28.87	$1,501.50	$597.36	$300.30
65112	T	Remove eye/revise socket	0242	28.87	$1,501.50	$597.36	$300.30
65114	T	Remove eye/revise socket	0242	28.87	$1,501.50	$597.36	$300.30
65125	T	Revise ocular implant	0240	16.99	$883.63	$315.31	$176.73
65130	T	Insert ocular implant	0241	21.89	$1,138.48	$384.47	$227.70
65135	T	Insert ocular implant	0241	21.89	$1,138.48	$384.47	$227.70
65140	T	Attach ocular implant	0242	28.87	$1,501.50	$597.36	$300.30
65150	T	Revise ocular implant	0241	21.89	$1,138.48	$384.47	$227.70
65155	T	Reinsert ocular implant	0242	28.87	$1,501.50	$597.36	$300.30
65175	T	Removal of ocular implant	0240	16.99	$883.63	$315.31	$176.73
65205	S	Remove foreign body from eye	0698	1.01	$52.53	$20.49	$10.51
65210	S	Remove foreign body from eye	0231	2.24	$116.50	$52.43	$23.30
65220	S	Remove foreign body from eye	0231	2.24	$116.50	$52.43	$23.30
65222	S	Remove foreign body from eye	0231	2.24	$116.50	$52.43	$23.30
65235	T	Remove foreign body from eye	0233	13.43	$698.48	$266.33	$139.70
65260	T	Remove foreign body from eye	0236	20.62	$1,072.43		$214.49
65265	T	Remove foreign body from eye	0236	20.62	$1,072.43		$214.49
65270	T	Repair of eye wound	0240	16.99	$883.63	$315.31	$176.73
65272	T	Repair of eye wound	0233	13.43	$698.48	$266.33	$139.70
65273	C	Repair of eye wound					
65275	T	Repair of eye wound	0233	13.43	$698.48	$266.33	$139.70
65280	T	Repair of eye wound	0234	21.45	$1,115.59	$535.48	$223.12
65285	T	Repair of eye wound	0234	21.45	$1,115.59	$535.48	$223.12
65286	T	Repair of eye wound	0233	13.43	$698.48	$266.33	$139.70
65290	T	Repair of eye socket wound	0243	20.94	$1,089.07	$431.39	$217.81
65400	T	Removal of eye lesion	0233	13.43	$698.48	$266.33	$139.70
65410	T	Biopsy of cornea	0233	13.43	$698.48	$266.33	$139.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65420	T	Removal of eye lesion	0233	13.43	$698.48	$266.33	$139.70
65426	T	Removal of eye lesion	0234	21.45	$1,115.59	$535.48	$223.12
65430	S	Corneal smear	0230	0.78	$40.57	$15.82	$8.11
65435	T	Curette/treat cornea	0239	6.91	$359.38	$115.94	$71.88
65436	T	Curette/treat cornea	0233	13.43	$698.48	$266.33	$139.70
65450	S	Treatment of corneal lesion	0231	2.24	$116.50	$52.43	$23.30
65600	T	Revision of cornea	0240	16.99	$883.63	$315.31	$176.73
65710	T	Corneal transplant	0244	38.14	$1,983.62	$851.42	$396.72
65730	T	Corneal transplant	0244	38.14	$1,983.62	$851.42	$396.72
65750	T	Corneal transplant	0244	38.14	$1,983.62	$851.42	$396.72
65755	T	Corneal transplant	0244	38.14	$1,983.62	$851.42	$396.72
65760	E	Revision of cornea					
65765	E	Revision of cornea					
65767	E	Corneal tissue transplant					
65770	T	Revise cornea with implant	0244	38.14	$1,983.62	$851.42	$396.72
65771	E	Radial keratotomy					
65772	T	Correction of astigmatism	0233	13.43	$698.48	$266.33	$139.70
65775	T	Correction of astigmatism	0233	13.43	$698.48	$266.33	$139.70
65800	T	Drainage of eye	0233	13.43	$698.48	$266.33	$139.70
65805	T	Drainage of eye	0233	13.43	$698.48	$266.33	$139.70
65810	T	Drainage of eye	0234	21.45	$1,115.59	$535.48	$223.12
65815	T	Drainage of eye	0234	21.45	$1,115.59	$535.48	$223.12
65820	T	Relieve inner eye pressure	0232	4.91	$255.36	$112.36	$51.07
65850	T	Incision of eye	0234	21.45	$1,115.59	$535.48	$223.12
65855	T	Laser surgery of eye	0247	4.97	$258.48	$108.56	$51.70
65860	T	Incise inner eye adhesions	0247	4.97	$258.48	$108.56	$51.70
65865	T	Incise inner eye adhesions	0233	13.43	$698.48	$266.33	$139.70
65870	T	Incise inner eye adhesions	0234	21.45	$1,115.59	$535.48	$223.12
65875	T	Incise inner eye adhesions	0234	21.45	$1,115.59	$535.48	$223.12
65880	T	Incise inner eye adhesions	0233	13.43	$698.48	$266.33	$139.70
65900	T	Remove eye lesion	0233	13.43	$698.48	$266.33	$139.70
65920	T	Remove implant of eye	0233	13.43	$698.48	$266.33	$139.70
65930	T	Remove blood clot from eye	0234	21.45	$1,115.59	$535.48	$223.12
66020	T	Injection treatment of eye	0233	13.43	$698.48	$266.33	$139.70
66030	T	Injection treatment of eye	0233	13.43	$698.48	$266.33	$139.70
66130	T	Remove eye lesion	0234	21.45	$1,115.59	$535.48	$223.12
66150	T	Glaucoma surgery	0233	13.43	$698.48	$266.33	$139.70
66155	T	Glaucoma surgery	0234	21.45	$1,115.59	$535.48	$223.12
66160	T	Glaucoma surgery	0234	21.45	$1,115.59	$535.48	$223.12
66165	T	Glaucoma surgery	0234	21.45	$1,115.59	$535.48	$223.12
66170	T	Glaucoma surgery	0234	21.45	$1,115.59	$535.48	$223.12
66172	T	Incision of eye	0673	27.47	$1,428.69	$685.77	$285.74
66180	T	Implant eye shunt	0673	27.47	$1,428.69	$685.77	$285.74
66185	T	Revise eye shunt	0673	27.47	$1,428.69	$685.77	$285.74
66220	T	Repair eye lesion	0236	20.62	$1,072.43		$214.49
66225	T	Repair/graft eye lesion	0673	27.47	$1,428.69	$685.77	$285.74
66250	T	Follow-up surgery of eye	0233	13.43	$698.48	$266.33	$139.70
66500	T	Incision of iris	0232	4.91	$255.36	$112.36	$51.07
66505	T	Incision of iris	0232	4.91	$255.36	$112.36	$51.07
66600	T	Remove iris and lesion	0233	13.43	$698.48	$266.33	$139.70
66605	T	Removal of iris	0234	21.45	$1,115.59	$535.48	$223.12
66625	T	Removal of iris	0233	13.43	$698.48	$266.33	$139.70
66630	T	Removal of iris	0233	13.43	$698.48	$266.33	$139.70
66635	T	Removal of iris	0234	21.45	$1,115.59	$535.48	$223.12
66680	T	Repair iris & ciliary body	0234	21.45	$1,115.59	$535.48	$223.12
66682	T	Repair iris & ciliary body	0234	21.45	$1,115.59	$535.48	$223.12
66700	T	Destruction, ciliary body	0233	13.43	$698.48	$266.33	$139.70
66710	T	Destruction, ciliary body	0233	13.43	$698.48	$266.33	$139.70
66720	T	Destruction, ciliary body	0233	13.43	$698.48	$266.33	$139.70
66740	T	Destruction, ciliary body	0233	13.43	$698.48	$266.33	$139.70
66761	T	Revision of iris	0247	4.97	$258.48	$108.56	$51.70
66762	T	Revision of iris	0247	4.97	$258.48	$108.56	$51.70
66770	T	Removal of inner eye lesion	0247	4.97	$258.48	$108.56	$51.70
66820	T	Incision, secondary cataract	0232	4.91	$255.36	$112.36	$51.07
66821	T	After cataract laser surgery	0247	4.97	$258.48	$108.56	$51.70
66825	T	Reposition intraocular lens	0234	21.45	$1,115.59	$535.48	$223.12

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66830	T	Removal of lens lesion	0232	4.91	$255.36	$112.36	$51.07
66840	T	Removal of lens material	0245	14.39	$748.41	$251.21	$149.68
66850	T	Removal of lens material	0249	27.75	$1,443.25	$524.67	$288.65
66852	T	Removal of lens material	0249	27.75	$1,443.25	$524.67	$288.65
66920	T	Extraction of lens	0249	27.75	$1,443.25	$524.67	$288.65
66930	T	Extraction of lens	0249	27.75	$1,443.25	$524.67	$288.65
66940	T	Extraction of lens	0245	14.39	$748.41	$251.21	$149.68
66982	T	Cataract surgery, complex	0246	23.59	$1,226.89	$495.96	$245.38
66983	T	Cataract surg w/iol, 1 stage	0246	23.59	$1,226.89	$495.96	$245.38
66984	T	Cataract surg w/iol, i stage	0246	23.59	$1,226.89	$495.96	$245.38
66985	T	Insert lens prosthesis	0246	23.59	$1,226.89	$495.96	$245.38
66986	T	Exchange lens prosthesis	0246	23.59	$1,226.89	$495.96	$245.38
66999	T	Eye surgery procedure	0232	4.91	$255.36	$112.36	$51.07
67005	T	Partial removal of eye fluid	0237	35.09	$1,825.00	$818.54	$365.00
67010	T	Partial removal of eye fluid	0237	35.09	$1,825.00	$818.54	$365.00
67015	T	Release of eye fluid	0237	35.09	$1,825.00	$818.54	$365.00
67025	T	Replace eye fluid	0236	20.62	$1,072.43	.....	$214.49
67027	T	Implant eye drug system	0237	35.09	$1,825.00	$818.54	$365.00
67028	T	Injection eye drug	0235	5.62	$292.29	$81.84	$58.46
67030	T	Incise inner eye strands	0236	20.62	$1,072.43	.....	$214.49
67031	T	Laser surgery, eye strands	0247	4.97	$258.48	$108.56	$51.70
67036	T	Removal of inner eye fluid	0237	35.09	$1,825.00	$818.54	$365.00
67038	T	Strip retinal membrane	0237	35.09	$1,825.00	$818.54	$365.00
67039	T	Laser treatment of retina	0237	35.09	$1,825.00	$818.54	$365.00
67040	T	Laser treatment of retina	0672	39.95	$2,077.76	$1,038.88	$415.55
67101	T	Repair detached retina	0235	5.62	$292.29	$81.84	$58.46
67105	T	Repair detached retina	0248	4.44	$230.92	$96.99	$46.18
67107	T	Repair detached retina	0672	39.95	$2,077.76	$1,038.88	$415.55
67108	T	Repair detached retina	0672	39.95	$2,077.76	$1,038.88	$415.55
67110	T	Repair detached retina	0235	5.62	$292.29	$81.84	$58.46
67112	T	Rerepair detached retina	0672	39.95	$2,077.76	$1,038.88	$415.55
67115	T	Release encircling material	0236	20.62	$1,072.43	.....	$214.49
67120	T	Remove eye implant material	0236	20.62	$1,072.43	.....	$214.49
67121	T	Remove eye implant material	0237	35.09	$1,825.00	$818.54	$365.00
67141	T	Treatment of retina	0235	5.62	$292.29	$81.84	$58.46
67145	T	Treatment of retina	0248	4.44	$230.92	$96.99	$46.18
67208	T	Treatment of retinal lesion	0235	5.62	$292.29	$81.84	$58.46
67210	T	Treatment of retinal lesion	0248	4.44	$230.92	$96.99	$46.18
67218	T	Treatment of retinal lesion	0236	20.62	$1,072.43	.....	$214.49
67220	T	Treatment of choroid lesion	0235	5.62	$292.29	$81.84	$58.46
67221	T	Ocular photodynamic ther	0235	5.62	$292.29	$81.84	$58.46
67225	T	Eye photodynamic ther add-on	0235	5.62	$292.29	$81.84	$58.46
67227	T	Treatment of retinal lesion	0235	5.62	$292.29	$81.84	$58.46
67228	T	Treatment of retinal lesion	0248	4.44	$230.92	$96.99	$46.18
67250	T	Reinforce eye wall	0240	16.99	$883.63	$315.31	$176.73
67255	T	Reinforce/graft eye wall	0237	35.09	$1,825.00	$818.54	$365.00
67299	T	Eye surgery procedure	0235	5.62	$292.29	$81.84	$58.46
67311	T	Revise eye muscle	0243	20.94	$1,089.07	$431.39	$217.81
67312	T	Revise two eye muscles	0243	20.94	$1,089.07	$431.39	$217.81
67314	T	Revise eye muscle	0243	20.94	$1,089.07	$431.39	$217.81
67316	T	Revise two eye muscles	0243	20.94	$1,089.07	$431.39	$217.81
67318	T	Revise eye muscle(s)	0243	20.94	$1,089.07	$431.39	$217.81
67320	T	Revise eye muscle(s) add-on	0243	20.94	$1,089.07	$431.39	$217.81
67331	T	Eye surgery follow-up add-on	0243	20.94	$1,089.07	$431.39	$217.81
67332	T	Rerevise eye muscles add-on	0243	20.94	$1,089.07	$431.39	$217.81
67334	T	Revise eye muscle w/suture	0243	20.94	$1,089.07	$431.39	$217.81
67335	T	Eye suture during surgery	0243	20.94	$1,089.07	$431.39	$217.81
67340	T	Revise eye muscle add-on	0243	20.94	$1,089.07	$431.39	$217.81
67343	T	Release eye tissue	0243	20.94	$1,089.07	$431.39	$217.81
67345	T	Destroy nerve of eye muscle	0238	3.04	$158.11	$58.96	$31.62
67350	T	Biopsy eye muscle	0699	2.37	$123.26	$55.47	$24.65
67399	T	Eye muscle surgery procedure	0243	20.94	$1,089.07	$431.39	$217.81
67400	T	Explore/biopsy eye socket	0241	21.89	$1,138.48	$384.47	$227.70
67405	T	Explore/drain eye socket	0241	21.89	$1,138.48	$384.47	$227.70
67412	T	Explore/treat eye socket	0241	21.89	$1,138.48	$384.47	$227.70
67413	T	Explore/treat eye socket	0241	21.89	$1,138.48	$384.47	$227.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67414	T	Explr/decompress eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67415	T	Aspiration, orbital contents	0239	6.91	$359.38	$115.94	$71.88
67420	T	Explore/treat eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67430	T	Explore/treat eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67440	T	Explore/drain eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67445	T	Explr/decompress eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67450	T	Explore/biopsy eye socket	0242	28.87	$1,501.50	$597.36	$300.30
67500	S	Inject/treat eye socket	0231	2.24	$116.50	$52.43	$23.30
67505	T	Inject/treat eye socket	0238	3.04	$158.11	$58.96	$31.62
67515	T	Inject/treat eye socket	0239	6.91	$359.38	$115.94	$71.88
67550	T	Insert eye socket implant	0242	28.87	$1,501.50	$597.36	$300.30
67560	T	Revise eye socket implant	0241	21.89	$1,138.48	$384.47	$227.70
67570	T	Decompress optic nerve	0242	28.87	$1,501.50	$597.36	$300.30
67599	T	Orbit surgery procedure	0239	6.91	$359.38	$115.94	$71.88
67700	T	Drainage of eyelid abscess	0238	3.04	$158.11	$58.96	$31.62
67710	T	Incision of eyelid	0239	6.91	$359.38	$115.94	$71.88
67715	T	Incision of eyelid fold	0240	16.99	$883.63	$315.31	$176.73
67800	T	Remove eyelid lesion	0238	3.04	$158.11	$58.96	$31.62
67801	T	Remove eyelid lesions	0239	6.91	$359.38	$115.94	$71.88
67805	T	Remove eyelid lesions	0238	3.04	$158.11	$58.96	$31.62
67808	T	Remove eyelid lesion(s)	0240	16.99	$883.63	$315.31	$176.73
67810	T	Biopsy of eyelid	0238	3.04	$158.11	$58.96	$31.62
67820	S	Revise eyelashes	0230	0.78	$40.57	$15.82	$8.11
67825	T	Revise eyelashes	0238	3.04	$158.11	$58.96	$31.62
67830	T	Revise eyelashes	0239	6.91	$359.38	$115.94	$71.88
67835	T	Revise eyelashes	0240	16.99	$883.63	$315.31	$176.73
67840	T	Remove eyelid lesion	0239	6.91	$359.38	$115.94	$71.88
67850	T	Treat eyelid lesion	0239	6.91	$359.38	$115.94	$71.88
67875	T	Closure of eyelid by suture	0239	6.91	$359.38	$115.94	$71.88
67880	T	Revision of eyelid	0233	13.43	$698.48	$266.33	$139.70
67882	T	Revision of eyelid	0240	16.99	$883.63	$315.31	$176.73
67900	T	Repair brow defect	0240	16.99	$883.63	$315.31	$176.73
67901	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67902	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67903	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67904	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67906	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67908	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67909	T	Revise eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67911	T	Revise eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67914	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67915	T	Repair eyelid defect	0239	6.91	$359.38	$115.94	$71.88
67916	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67917	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67921	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67922	T	Repair eyelid defect	0239	6.91	$359.38	$115.94	$71.88
67923	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67924	T	Repair eyelid defect	0240	16.99	$883.63	$315.31	$176.73
67930	T	Repair eyelid wound	0240	16.99	$883.63	$315.31	$176.73
67935	T	Repair eyelid wound	0240	16.99	$883.63	$315.31	$176.73
67938	S	Remove eyelid foreign body	0698	1.01	$52.53	$20.49	$10.51
67950	T	Revision of eyelid	0240	16.99	$883.63	$315.31	$176.73
67961	T	Revision of eyelid	0240	16.99	$883.63	$315.31	$176.73
67966	T	Revision of eyelid	0240	16.99	$883.63	$315.31	$176.73
67971	T	Reconstruction of eyelid	0241	21.89	$1,138.48	$384.47	$227.70
67973	T	Reconstruction of eyelid	0241	21.89	$1,138.48	$384.47	$227.70
67974	T	Reconstruction of eyelid	0241	21.89	$1,138.48	$384.47	$227.70
67975	T	Reconstruction of eyelid	0240	16.99	$883.63	$315.31	$176.73
67999	T	Revision of eyelid	0240	16.99	$883.63	$315.31	$176.73
68020	T	Incise/drain eyelid lining	0240	16.99	$883.63	$315.31	$176.73
68040	S	Treatment of eyelid lesions	0698	1.01	$52.53	$20.49	$10.51
68100	T	Biopsy of eyelid lining	0232	4.91	$255.36	$112.36	$51.07
68110	T	Remove eyelid lining lesion	0699	2.37	$123.26	$55.47	$24.65
68115	T	Remove eyelid lining lesion	0239	6.91	$359.38	$115.94	$71.88
68130	T	Remove eyelid lining lesion	0233	13.43	$698.48	$266.33	$139.70
68135	T	Remove eyelid lining lesion	0239	6.91	$359.38	$115.94	$71.88

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68200	S	Treat eyelid by injection	0698	1.01	$52.53	$20.49	$10.51
68320	T	Revise/graft eyelid lining	0240	16.99	$883.63	$315.31	$176.73
68325	T	Revise/graft eyelid lining	0242	28.87	$1,501.50	$597.36	$300.30
68326	T	Revise/graft eyelid lining	0241	21.89	$1,138.48	$384.47	$227.70
68328	T	Revise/graft eyelid lining	0241	21.89	$1,138.48	$384.47	$227.70
68330	T	Revise eyelid lining	0233	13.43	$698.48	$266.33	$139.70
68335	T	Revise/graft eyelid lining	0241	21.89	$1,138.48	$384.47	$227.70
68340	T	Separate eyelid adhesions	0240	16.99	$883.63	$315.31	$176.73
68360	T	Revise eyelid lining	0234	21.45	$1,115.59	$535.48	$223.12
68362	T	Revise eyelid lining	0234	21.45	$1,115.59	$535.48	$223.12
68399	T	Eyelid lining surgery	0239	6.91	$359.38	$115.94	$71.88
68400	T	Incise/drain tear gland	0238	3.04	$158.11	$58.96	$31.62
68420	T	Incise/drain tear sac	0240	16.99	$883.63	$315.31	$176.73
68440	T	Incise tear duct opening	0238	3.04	$158.11	$58.96	$31.62
68500	T	Removal of tear gland	0241	21.89	$1,138.48	$384.47	$227.70
68505	T	Partial removal, tear gland	0241	21.89	$1,138.48	$384.47	$227.70
68510	T	Biopsy of tear gland	0240	16.99	$883.63	$315.31	$176.73
68520	T	Removal of tear sac	0241	21.89	$1,138.48	$384.47	$227.70
68525	T	Biopsy of tear sac	0240	16.99	$883.63	$315.31	$176.73
68530	T	Clearance of tear duct	0240	16.99	$883.63	$315.31	$176.73
68540	T	Remove tear gland lesion	0241	21.89	$1,138.48	$384.47	$227.70
68550	T	Remove tear gland lesion	0242	28.87	$1,501.50	$597.36	$300.30
68700	T	Repair tear ducts	0241	21.89	$1,138.48	$384.47	$227.70
68705	T	Revise tear duct opening	0238	3.04	$158.11	$58.96	$31.62
68720	T	Create tear sac drain	0242	28.87	$1,501.50	$597.36	$300.30
68745	T	Create tear duct drain	0241	21.89	$1,138.48	$384.47	$227.70
68750	T	Create tear duct drain	0242	28.87	$1,501.50	$597.36	$300.30
68760	S	Close tear duct opening	0698	1.01	$52.53	$20.49	$10.51
68761	S	Close tear duct opening	0231	2.24	$116.50	$52.43	$23.30
68770	T	Close tear system fistula	0240	16.99	$883.63	$315.31	$176.73
68801	S	Dilate tear duct opening	0231	2.24	$116.50	$52.43	$23.30
68810	T	Probe nasolacrimal duct	0699	2.37	$123.26	$55.47	$24.65
68811	T	Probe nasolacrimal duct	0240	16.99	$883.63	$315.31	$176.73
68815	T	Probe nasolacrimal duct	0240	16.99	$883.63	$315.31	$176.73
68840	T	Explore/irrigate tear ducts	0699	2.37	$123.26	$55.47	$24.65
68850	N	Injection for tear sac x-ray					
68899	T	Tear duct system surgery	0699	2.37	$123.26	$55.47	$24.65
69000	T	Drain external ear lesion	0006	1.89	$98.30	$25.56	$19.66
69005	T	Drain external ear lesion	0007	9.44	$490.96	$103.10	$98.19
69020	T	Drain outer ear canal lesion	0006	1.89	$98.30	$25.56	$19.66
69090	E	Pierce earlobes					
69100	T	Biopsy of external ear	0019	3.94	$204.92	$75.82	$40.98
69105	T	Biopsy of external ear canal	0253	14.79	$769.21	$284.61	$153.84
69110	T	Remove external ear, partial	0021	14.58	$758.29	$227.49	$151.66
69120	T	Removal of external ear	0254	21.89	$1,138.48	$352.93	$227.70
69140	T	Remove ear canal lesion(s)	0254	21.89	$1,138.48	$352.93	$227.70
69145	T	Remove ear canal lesion(s)	0021	14.58	$758.29	$227.49	$151.66
69150	T	Extensive ear canal surgery	0252	6.27	$326.10	$114.24	$65.22
69155	C	Extensive ear/neck surgery					
69200	X	Clear outer ear canal	0340	0.66	$34.33		$6.87
69205	T	Clear outer ear canal	0022	18.10	$941.36	$367.13	$188.27
69210	X	Remove impacted ear wax	0340	0.66	$34.33		$6.87
69220	T	Clean out mastoid cavity	0012	0.76	$39.53	$10.67	$7.91
69222	T	Clean out mastoid cavity	0253	14.79	$769.21	$284.61	$153.84
69300	T	Revise external ear	0254	21.89	$1,138.48	$352.93	$227.70
69310	T	Rebuild outer ear canal	0256	35.51	$1,846.84		$369.37
69320	T	Rebuild outer ear canal	0256	35.51	$1,846.84		$369.37
69399	T	Outer ear surgery procedure	0251	1.92	$99.86		$19.97
69400	T	Inflate middle ear canal	0251	1.92	$99.86		$19.97
69401	T	Inflate middle ear canal	0251	1.92	$99.86		$19.97
69405	T	Catheterize middle ear canal	0252	6.27	$326.10	$114.24	$65.22
69410	T	Inset middle ear (baffle)	0252	6.27	$326.10	$114.24	$65.22
69420	T	Incision of eardrum	0251	1.92	$99.86		$19.97
69421	T	Incision of eardrum	0253	14.79	$769.21	$284.61	$153.84
69424	T	Remove ventilating tube	0252	6.27	$326.10	$114.24	$65.22
69433	T	Create eardrum opening	0252	6.27	$326.10	$114.24	$65.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69436	T	Create eardrum opening	0253	14.79	$769.21	$284.61	$153.84
69440	T	Exploration of middle ear	0254	21.89	$1,138.48	$352.93	$227.70
69450	T	Eardrum revision	0256	35.51	$1,846.84		$369.37
69501	T	Mastoidectomy	0256	35.51	$1,846.84		$369.37
69502	T	Mastoidectomy	0254	21.89	$1,138.48	$352.93	$227.70
69505	T	Remove mastoid structures	0256	35.51	$1,846.84		$369.37
69511	T	Extensive mastoid surgery	0256	35.51	$1,846.84		$369.37
69530	T	Extensive mastoid surgery	0256	35.51	$1,846.84		$369.37
69535	C	Remove part of temporal bone					
69540	T	Remove ear lesion	0253	14.79	$769.21	$284.61	$153.84
69550	T	Remove ear lesion	0256	35.51	$1,846.84		$369.37
69552	T	Remove ear lesion	0256	35.51	$1,846.84		$369.37
69554	C	Remove ear lesion					
69601	T	Mastoid surgery revision	0256	35.51	$1,846.84		$369.37
69602	T	Mastoid surgery revision	0256	35.51	$1,846.84		$369.37
69603	T	Mastoid surgery revision	0256	35.51	$1,846.84		$369.37
69604	T	Mastoid surgery revision	0256	35.51	$1,846.84		$369.37
69605	T	Mastoid surgery revision	0256	35.51	$1,846.84		$369.37
69610	T	Repair of eardrum	0254	21.89	$1,138.48	$352.93	$227.70
69620	T	Repair of eardrum	0254	21.89	$1,138.48	$352.93	$227.70
69631	T	Repair eardrum structures	0256	35.51	$1,846.84		$369.37
69632	T	Rebuild eardrum structures	0256	35.51	$1,846.84		$369.37
69633	T	Rebuild eardrum structures	0256	35.51	$1,846.84		$369.37
69635	T	Repair eardrum structures	0256	35.51	$1,846.84		$369.37
69636	T	Rebuild eardrum structures	0256	35.51	$1,846.84		$369.37
69637	T	Rebuild eardrum structures	0256	35.51	$1,846.84		$369.37
69641	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69642	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69643	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69644	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69645	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69646	T	Revise middle ear & mastoid	0256	35.51	$1,846.84		$369.37
69650	T	Release middle ear bone	0254	21.89	$1,138.48	$352.93	$227.70
69660	T	Revise middle ear bone	0256	35.51	$1,846.84		$369.37
69661	T	Revise middle ear bone	0256	35.51	$1,846.84		$369.37
69662	T	Revise middle ear bone	0256	35.51	$1,846.84		$369.37
69666	T	Repair middle ear structures	0256	35.51	$1,846.84		$369.37
69667	T	Repair middle ear structures	0256	35.51	$1,846.84		$369.37
69670	T	Remove mastoid air cells	0256	35.51	$1,846.84		$369.37
69676	T	Remove middle ear nerve	0256	35.51	$1,846.84		$369.37
69700	T	Close mastoid fistula	0256	35.51	$1,846.84		$369.37
69710	E	Implant/replace hearing aid					
69711	T	Remove/repair hearing aid	0256	35.51	$1,846.84		$369.37
69714	T	Implant temple bone w/stimul	0256	35.51	$1,846.84		$369.37
69715	T	Temple bne implnt w/stimulat	0256	35.51	$1,846.84		$369.37
69717	T	Temple bone implant revision	0256	35.51	$1,846.84		$369.37
69718	T	Revise temple bone implant	0256	35.51	$1,846.84		$369.37
69720	T	Release facial nerve	0256	35.51	$1,846.84		$369.37
69725	T	Release facial nerve	0256	35.51	$1,846.84		$369.37
69740	T	Repair facial nerve	0256	35.51	$1,846.84		$369.37
69745	T	Repair facial nerve	0256	35.51	$1,846.84		$369.37
69799	T	Middle ear surgery procedure	0253	14.79	$769.21	$284.61	$153.84
69801	T	Incise inner ear	0256	35.51	$1,846.84		$369.37
69802	T	Incise inner ear	0256	35.51	$1,846.84		$369.37
69805	T	Explore inner ear	0256	35.51	$1,846.84		$369.37
69806	T	Explore inner ear	0256	35.51	$1,846.84		$369.37
69820	T	Establish inner ear window	0256	35.51	$1,846.84		$369.37
69840	T	Revise inner ear window	0256	35.51	$1,846.84		$369.37
69905	T	Remove inner ear	0256	35.51	$1,846.84		$369.37
69910	T	Remove inner ear & mastoid	0256	35.51	$1,846.84		$369.37
69915	T	Incise inner ear nerve	0256	35.51	$1,846.84		$369.37
69930	T	Implant cochlear device	0259	291.05	$15,137.22	$7,417.24	$3,027.44
69949	T	Inner ear surgery procedure	0253	14.79	$769.21	$284.61	$153.84
69950	C	Incise inner ear nerve					
69955	T	Release facial nerve	0256	35.51	$1,846.84		$369.37
69960	T	Release inner ear canal	0256	35.51	$1,846.84		$369.37

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69970	C	Remove inner ear lesion					
69979	T	Temporal bone surgery	0251	1.92	$99.86		$19.97
69990	N	Microsurgery add-on					
70010	S	Contrast x-ray of brain	0274	3.21	$166.95	$80.14	$33.39
70015	S	Contrast x-ray of brain	0274	3.21	$166.95	$80.14	$33.39
70030	X	X-ray eye for foreign body	0260	0.81	$42.13	$23.17	$8.43
70100	X	X-ray exam of jaw	0260	0.81	$42.13	$23.17	$8.43
70110	X	X-ray exam of jaw	0260	0.81	$42.13	$23.17	$8.43
70120	X	X-ray exam of mastoids	0260	0.81	$42.13	$23.17	$8.43
70130	X	X-ray exam of mastoids	0260	0.81	$42.13	$23.17	$8.43
70134	X	X-ray exam of middle ear	0261	1.37	$71.25	$34.15	$14.25
70140	X	X-ray exam of facial bones	0260	0.81	$42.13	$23.17	$8.43
70150	X	X-ray exam of facial bones	0260	0.81	$42.13	$23.17	$8.43
70160	X	X-ray exam of nasal bones	0260	0.81	$42.13	$23.17	$8.43
70170	X	X-ray exam of tear duct	0263	1.99	$103.50	$45.54	$20.70
70190	X	X-ray exam of eye sockets	0260	0.81	$42.13	$23.17	$8.43
70200	X	X-ray exam of eye sockets	0260	0.81	$42.13	$23.17	$8.43
70210	X	X-ray exam of sinuses	0260	0.81	$42.13	$23.17	$8.43
70220	X	X-ray exam of sinuses	0260	0.81	$42.13	$23.17	$8.43
70240	X	X-ray exam, pituitary saddle	0260	0.81	$42.13	$23.17	$8.43
70250	X	X-ray exam of skull	0260	0.81	$42.13	$23.17	$8.43
70260	X	X-ray exam of skull	0261	1.37	$71.25	$34.15	$14.25
70300	X	X-ray exam of teeth	0262	0.60	$31.21	$10.30	$6.24
70310	X	X-ray exam of teeth	0262	0.60	$31.21	$10.30	$6.24
70320	X	Full mouth x-ray of teeth	0262	0.60	$31.21	$10.30	$6.24
70328	X	X-ray exam of jaw joint	0260	0.81	$42.13	$23.17	$8.43
70330	X	X-ray exam of jaw joints	0260	0.81	$42.13	$23.17	$8.43
70332	S	X-ray exam of jaw joint	0275	3.09	$160.71	$69.09	$32.14
70336	S	Magnetic image, jaw joint	0335	6.46	$335.98	$151.46	$67.20
70350	X	X-ray head for orthodontia	0260	0.81	$42.13	$23.17	$8.43
70355	X	Panoramic x-ray of jaws	0260	0.81	$42.13	$23.17	$8.43
70360	X	X-ray exam of neck	0260	0.81	$42.13	$23.17	$8.43
70370	X	Throat x-ray & fluoroscopy	0272	1.38	$71.77	$38.64	$14.35
70371	X	Speech evaluation, complex	0272	1.38	$71.77	$38.64	$14.35
70373	X	Contrast x-ray of larynx	0263	1.99	$103.50	$45.54	$20.70
70380	X	X-ray exam of salivary gland	0260	0.81	$42.13	$23.17	$8.43
70390	X	X-ray exam of salivary duct	0264	2.75	$143.02	$77.23	$28.60
70450	S	Ct head/brain w/o dye	0332	3.62	$188.27	$91.27	$37.65
70460	S	Ct head/brain w/dye	0283	4.75	$247.04		$49.41
70470	S	Ct head/brain w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
70480	S	Ct orbit/ear/fossa w/o dye	0332	3.62	$188.27	$91.27	$37.65
70481	S	Ct orbit/ear/fossa w/dye	0283	4.75	$247.04		$49.41
70482	S	Ct orbit/ear/fossa w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
70486	S	Ct maxillofacial w/o dye	0332	3.62	$188.27	$91.27	$37.65
70487	S	Ct maxillofacial w/dye	0283	4.75	$247.04		$49.41
70488	S	Ct maxillofacial w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
70490	S	Ct soft tissue neck w/o dye	0332	3.62	$188.27	$91.27	$37.65
70491	S	Ct soft tissue neck w/dye	0283	4.75	$247.04		$49.41
70492	S	Ct sft tsue nck w/o & w/dye	0333	5.69	$295.93	$146.98	$59.19
70496	S	Ct angiography, head	0662	5.96	$309.97	$170.48	$61.99
70498	S	Ct angiography, neck	0662	5.96	$309.97	$170.48	$61.99
70540	S	Mri orbit/face/neck w/o dye	0336	7.01	$364.58	$176.94	$72.92
70542	S	Mri orbit/face/neck w/dye	0284	7.74	$402.55	$201.02	$80.51
70543	S	Mri orbt/fac/nck w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
70544	S	Mr angiography head w/o dye	0336	7.01	$364.58	$176.94	$72.92
70545	S	Mr angiography head w/dye	0284	7.74	$402.55	$201.02	$80.51
70546	S	Mr angiograph head w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
70547	S	Mr angiography neck w/o dye	0336	7.01	$364.58	$176.94	$72.92
70548	S	Mr angiography neck w/dye	0284	7.74	$402.55	$201.02	$80.51
70549	S	Mr angiograph neck w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
70551	S	Mri brain w/o dye	0336	7.01	$364.58	$176.94	$72.92
70552	S	Mri brain w/dye	0284	7.74	$402.55	$201.02	$80.51
70553	S	Mri brain w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
71010	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71015	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71020	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
71021	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71022	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71023	X	Chest x-ray and fluoroscopy	0272	1.38	$71.77	$38.64	$14.35
71030	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71034	X	Chest x-ray and fluoroscopy	0272	1.38	$71.77	$38.64	$14.35
71035	X	Chest x-ray	0260	0.81	$42.13	$23.17	$8.43
71040	X	Contrast x-ray of bronchi	0263	1.99	$103.50	$45.54	$20.70
71060	X	Contrast x-ray of bronchi	0264	2.75	$143.02	$77.23	$28.60
71090	X	X-ray & pacemaker insertion	0272	1.38	$71.77	$38.64	$14.35
71100	X	X-ray exam of ribs	0260	0.81	$42.13	$23.17	$8.43
71101	X	X-ray exam of ribs/chest	0260	0.81	$42.13	$23.17	$8.43
71110	X	X-ray exam of ribs	0260	0.81	$42.13	$23.17	$8.43
71111	X	X-ray exam of ribs/ chest	0261	1.37	$71.25	$34.15	$14.25
71120	X	X-ray exam of breastbone	0260	0.81	$42.13	$23.17	$8.43
71130	X	X-ray exam of breastbone	0260	0.81	$42.13	$23.17	$8.43
71250	S	Ct thorax w/o dye	0332	3.62	$188.27	$91.27	$37.65
71260	S	Ct thorax w/dye	0283	4.75	$247.04	.....	$49.41
71270	S	Ct thorax w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
71275	S	Ct angiography, chest	0662	5.96	$309.97	$170.48	$61.99
71550	S	Mri chest w/o dye	0336	7.01	$364.58	$176.94	$72.92
71551	S	Mri chest w/dye	0284	7.74	$402.55	$201.02	$80.51
71552	S	Mri chest w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
71555	E	Mri angio chest w or w/o dye	.....	.....	.....	.....	.....
72010	X	X-ray exam of spine	0261	1.37	$71.25	$34.15	$14.25
72020	X	X-ray exam of spine	0260	0.81	$42.13	$23.17	$8.43
72040	X	X-ray exam of neck spine	0260	0.81	$42.13	$23.17	$8.43
72050	X	X-ray exam of neck spine	0261	1.37	$71.25	$34.15	$14.25
72052	X	X-ray exam of neck spine	0261	1.37	$71.25	$34.15	$14.25
72069	X	X-ray exam of trunk spine	0260	0.81	$42.13	$23.17	$8.43
72070	X	X-ray exam of thoracic spine	0260	0.81	$42.13	$23.17	$8.43
72072	X	X-ray exam of thoracic spine	0260	0.81	$42.13	$23.17	$8.43
72074	X	X-ray exam of thoracic spine	0260	0.81	$42.13	$23.17	$8.43
72080	X	X-ray exam of trunk spine	0260	0.81	$42.13	$23.17	$8.43
72090	X	X-ray exam of trunk spine	0261	1.37	$71.25	$34.15	$14.25
72100	X	X-ray exam of lower spine	0260	0.81	$42.13	$23.17	$8.43
72110	X	X-ray exam of lower spine	0261	1.37	$71.25	$34.15	$14.25
72114	X	X-ray exam of lower spine	0261	1.37	$71.25	$34.15	$14.25
72120	X	X-ray exam of lower spine	0260	0.81	$42.13	$23.17	$8.43
72125	S	Ct neck spine w/o dye	0332	3.62	$188.27	$91.27	$37.65
72126	S	Ct neck spine w/dye	0283	4.75	$247.04	.....	$49.41
72127	S	Ct neck spine w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
72128	S	Ct chest spine w/o dye	0332	3.62	$188.27	$91.27	$37.65
72129	S	Ct chest spine w/dye	0283	4.75	$247.04	.....	$49.41
72130	S	Ct chest spine w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
72131	S	Ct lumbar spine w/o dye	0332	3.62	$188.27	$91.27	$37.65
72132	S	Ct lumbar spine w/dye	0283	4.75	$247.04	.....	$49.41
72133	S	Ct lumbar spine w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
72141	S	Mri neck spine w/o dye	0336	7.01	$364.58	$176.94	$72.92
72142	S	Mri neck spine w/dye	0284	7.74	$402.55	$201.02	$80.51
72146	S	Mri chest spine w/o dye	0336	7.01	$364.58	$176.94	$72.92
72147	S	Mri chest spine w/dye	0284	7.74	$402.55	$201.02	$80.51
72148	S	Mri lumbar spine w/o dye	0336	7.01	$364.58	$176.94	$72.92
72149	S	Mri lumbar spine w/dye	0284	7.74	$402.55	$201.02	$80.51
72156	S	Mri neck spine w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
72157	S	Mri chest spine w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
72158	S	Mri lumbar spine w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
72159	E	Mr angio spine w/o&w dye	.....	.....	.....	.....	.....
72170	X	X-ray exam of pelvis	0260	0.81	$42.13	$23.17	$8.43
72190	X	X-ray exam of pelvis	0260	0.81	$42.13	$23.17	$8.43
72191	S	Ct angiograph pelv w/o&w dye	0662	5.96	$309.97	$170.48	$61.99
72192	S	Ct pelvis w/o dye	0332	3.62	$188.27	$91.27	$37.65
72193	S	Ct pelvis w/dye	0283	4.75	$247.04	.....	$49.41
72194	S	Ct pelvis w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
72195	S	Mri pelvis w/o dye	0336	7.01	$364.58	$176.94	$72.92
72196	S	Mri pelvis w/dye	0284	7.74	$402.55	$201.02	$80.51
72197	S	Mri pelvis w/o & w dye	0337	9.86	$512.81	$240.77	$102.56

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72198	E	Mr angio pelvis w/o&w dye					
72200	X	X-ray exam sacroiliac joints	0260	0.81	$42.13	$23.17	$8.43
72202	X	X-ray exam sacroiliac joints	0260	0.81	$42.13	$23.17	$8.43
72220	X	X-ray exam of tailbone	0260	0.81	$42.13	$23.17	$8.43
72240	S	Contrast x-ray of neck spine	0274	3.21	$166.95	$80.14	$33.39
72255	S	Contrast x-ray, thorax spine	0274	3.21	$166.95	$80.14	$33.39
72265	S	Contrast x-ray, lower spine	0274	3.21	$166.95	$80.14	$33.39
72270	S	Contrast x-ray of spine	0274	3.21	$166.95	$80.14	$33.39
72275	S	Epidurography	0274	3.21	$166.95	$80.14	$33.39
72285	S	X-ray c/t spine disk	0274	3.21	$166.95	$80.14	$33.39
72295	S	X-ray of lower spine disk	0274	3.21	$166.95	$80.14	$33.39
73000	X	X-ray exam of collar bone	0260	0.81	$42.13	$23.17	$8.43
73010	X	X-ray exam of shoulder blade	0260	0.81	$42.13	$23.17	$8.43
73020	X	X-ray exam of shoulder	0260	0.81	$42.13	$23.17	$8.43
73030	X	X-ray exam of shoulder	0260	0.81	$42.13	$23.17	$8.43
73040	S	Contrast x-ray of shoulder	0275	3.09	$160.71	$69.09	$32.14
73050	X	X-ray exam of shoulders	0260	0.81	$42.13	$23.17	$8.43
73060	X	X-ray exam of humerus	0260	0.81	$42.13	$23.17	$8.43
73070	X	X-ray exam of elbow	0260	0.81	$42.13	$23.17	$8.43
73080	X	X-ray exam of elbow	0260	0.81	$42.13	$23.17	$8.43
73085	S	Contrast x-ray of elbow	0275	3.09	$160.71	$69.09	$32.14
73090	X	X-ray exam of forearm	0260	0.81	$42.13	$23.17	$8.43
73092	X	X-ray exam of arm, infant	0260	0.81	$42.13	$23.17	$8.43
73100	X	X-ray exam of wrist	0260	0.81	$42.13	$23.17	$8.43
73110	X	X-ray exam of wrist	0260	0.81	$42.13	$23.17	$8.43
73115	S	Contrast x-ray of wrist	0275	3.09	$160.71	$69.09	$32.14
73120	X	X-ray exam of hand	0260	0.81	$42.13	$23.17	$8.43
73130	X	X-ray exam of hand	0260	0.81	$42.13	$23.17	$8.43
73140	X	X-ray exam of finger(s)	0260	0.81	$42.13	$23.17	$8.43
73200	S	Ct upper extremity w/o dye	0332	3.62	$188.27	$91.27	$37.65
73201	S	Ct upper extremity w/dye	0283	4.75	$247.04		$49.41
73202	S	Ct uppr extremity w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
73206	S	Ct angio upr extrm w/o&w dye	0662	5.96	$309.97	$170.48	$61.99
73218	S	Mri upper extremity w/o dye	0336	7.01	$364.58	$176.94	$72.92
73219	S	Mri upper extremity w/dye	0284	7.74	$402.55	$201.02	$80.51
73220	S	Mri uppr extremity w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
73221	S	Mri joint upr extrem w/o dye	0336	7.01	$364.58	$176.94	$72.92
73222	S	Mri joint upr extrem w/ dye	0284	7.74	$402.55	$201.02	$80.51
73223	S	Mri joint upr extr w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
73225	E	Mr angio upr extr w/o&w dye					
73500	X	X-ray exam of hip	0260	0.81	$42.13	$23.17	$8.43
73510	X	X-ray exam of hip	0260	0.81	$42.13	$23.17	$8.43
73520	X	X-ray exam of hips	0260	0.81	$42.13	$23.17	$8.43
73525	S	Contrast x-ray of hip	0275	3.09	$160.71	$69.09	$32.14
73530	X	X-ray exam of hip	0261	1.37	$71.25	$34.15	$14.25
73540	X	X-ray exam of pelvis & hips	0260	0.81	$42.13	$23.17	$8.43
73542	S	X-ray exam, sacroiliac joint	0275	3.09	$160.71	$69.09	$32.14
73550	X	X-ray exam of thigh	0260	0.81	$42.13	$23.17	$8.43
73560	X	X-ray exam of knee, 1 or 2	0260	0.81	$42.13	$23.17	$8.43
73562	X	X-ray exam of knee, 3	0260	0.81	$42.13	$23.17	$8.43
73564	X	X-ray exam, knee, 4 or more	0260	0.81	$42.13	$23.17	$8.43
73565	X	X-ray exam of knees	0260	0.81	$42.13	$23.17	$8.43
73580	S	Contrast x-ray of knee joint	0275	3.09	$160.71	$69.09	$32.14
73590	X	X-ray exam of lower leg	0260	0.81	$42.13	$23.17	$8.43
73592	X	X-ray exam of leg, infant	0260	0.81	$42.13	$23.17	$8.43
73600	X	X-ray exam of ankle	0260	0.81	$42.13	$23.17	$8.43
73610	X	X-ray exam of ankle	0260	0.81	$42.13	$23.17	$8.43
73615	S	Contrast x-ray of ankle	0275	3.09	$160.71	$69.09	$32.14
73620	X	X-ray exam of foot	0260	0.81	$42.13	$23.17	$8.43
73630	X	X-ray exam of foot	0260	0.81	$42.13	$23.17	$8.43
73650	X	X-ray exam of heel	0260	0.81	$42.13	$23.17	$8.43
73660	X	X-ray exam of toe(s)	0260	0.81	$42.13	$23.17	$8.43
73700	S	Ct lower extremity w/o dye	0332	3.62	$188.27	$91.27	$37.65
73701	S	Ct lower extremity w/dye	0283	4.75	$247.04		$49.41
73702	S	Ct lwr extremity w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
73706	S	Ct angio lwr extr w/o&w dye	0662	5.96	$309.97	$170.48	$61.99

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73718	S	Mri lower extremity w/o dye	0336	7.01	$364.58	$176.94	$72.92
73719	S	Mri lower extremity w/dye	0284	7.74	$402.55	$201.02	$80.51
73720	S	Mri lwr extremity w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
73721	S	Mri joint of lwr extre w/o d	0336	7.01	$364.58	$176.94	$72.92
73722	S	Mri joint of lwr extr w/dye	0284	7.74	$402.55	$201.02	$80.51
73723	S	Mri joint lwr extr w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
73725	E	Mr ang lwr ext w or w/o dye					
74000	X	X-ray exam of abdomen	0260	0.81	$42.13	$23.17	$8.43
74010	X	X-ray exam of abdomen	0260	0.81	$42.13	$23.17	$8.43
74020	X	X-ray exam of abdomen	0260	0.81	$42.13	$23.17	$8.43
74022	X	X-ray exam series, abdomen	0261	1.37	$71.25	$34.15	$14.25
74150	S	Ct abdomen w/o dye	0332	3.62	$188.27	$91.27	$37.65
74160	S	Ct abdomen w/dye	0283	4.75	$247.04		$49.41
74170	S	Ct abdomen w/o&w dye	0333	5.69	$295.93	$146.98	$59.19
74175	S	Ct angio abdom w/o&w dye	0662	5.96	$309.97	$170.48	$61.99
74181	S	Mri abdomen w/o dye	0336	7.01	$364.58	$176.94	$72.92
74182	S	Mri abdomen w/dye	0284	7.74	$402.55	$201.02	$80.51
74183	S	Mri abdomen w/o&w dye	0337	9.86	$512.81	$240.77	$102.56
74185	E	Mri angio, abdom w or w/o dy					
74190	X	X-ray exam of peritoneum	0263	1.99	$103.50	$45.54	$20.70
74210	S	Contrst x-ray exam of throat	0276	1.69	$87.90	$41.72	$17.58
74220	S	Contrast x-ray, esophagus	0276	1.69	$87.90	$41.72	$17.58
74230	S	Cine/video x-ray, throat/eso	0276	1.69	$87.90	$41.72	$17.58
74235	S	Remove esophagus obstruction	0296	2.12	$110.26	$52.92	$22.05
74240	S	X-ray exam, upper gi tract	0276	1.69	$87.90	$41.72	$17.58
74241	S	X-ray exam, upper gi tract	0276	1.69	$87.90	$41.72	$17.58
74245	S	X-ray exam, upper gi tract	0277	2.50	$130.02	$60.47	$26.00
74246	S	Contrst x-ray uppr gi tract	0276	1.69	$87.90	$41.72	$17.58
74247	S	Contrst x-ray uppr gi tract	0276	1.69	$87.90	$41.72	$17.58
74249	S	Contrst x-ray uppr gi tract	0277	2.50	$130.02	$60.47	$26.00
74250	S	X-ray exam of small bowel	0276	1.69	$87.90	$41.72	$17.58
74251	S	X-ray exam of small bowel	0277	2.50	$130.02	$60.47	$26.00
74260	S	X-ray exam of small bowel	0277	2.50	$130.02	$60.47	$26.00
74270	S	Contrast x-ray exam of colon	0276	1.69	$87.90	$41.72	$17.58
74280	S	Contrast x-ray exam of colon	0277	2.50	$130.02	$60.47	$26.00
74283	S	Contrast x-ray exam of colon	0276	1.69	$87.90	$41.72	$17.58
74290	S	Contrast x-ray, gallbladder	0276	1.69	$87.90	$41.72	$17.58
74291	S	Contrast x-rays, gallbladder	0276	1.69	$87.90	$41.72	$17.58
74300	X	X-ray bile ducts/pancreas	0263	1.99	$103.50	$45.54	$20.70
74301	X	X-rays at surgery add-on	0263	1.99	$103.50	$45.54	$20.70
74305	X	X-ray bile ducts/pancreas	0263	1.99	$103.50	$45.54	$20.70
74320	X	Contrast x-ray of bile ducts	0264	2.75	$143.02	$77.23	$28.60
74327	S	X-ray bile stone removal	0296	2.12	$110.26	$52.92	$22.05
74328	N	Xray bile duct endoscopy					
74329	N	X-ray for pancreas endoscopy					
74330	N	X-ray bile/panc endoscopy					
74340	X	X-ray guide for GI tube	0272	1.38	$71.77	$38.64	$14.35
74350	X	X-ray guide, stomach tube	0263	1.99	$103.50	$45.54	$20.70
74355	X	X-ray guide, intestinal tube	0263	1.99	$103.50	$45.54	$20.70
74360	S	X-ray guide, GI dilation	0296	2.12	$110.26	$52.92	$22.05
74363	S	X-ray, bile duct dilation	0297	7.80	$405.67	$172.51	$81.13
74400	S	Contrst x-ray, urinary tract	0278	2.65	$137.82	$66.07	$27.56
74410	S	Contrst x-ray, urinary tract	0278	2.65	$137.82	$66.07	$27.56
74415	S	Contrst x-ray, urinary tract	0278	2.65	$137.82	$66.07	$27.56
74420	S	Contrst x-ray, urinary tract	0278	2.65	$137.82	$66.07	$27.56
74425	S	Contrst x-ray, urinary tract	0278	2.65	$137.82	$66.07	$27.56
74430	S	Contrast x-ray, bladder	0278	2.65	$137.82	$66.07	$27.56
74440	S	X-ray, male genital tract	0278	2.65	$137.82	$66.07	$27.56
74445	S	X-ray exam of penis	0278	2.65	$137.82	$66.07	$27.56
74450	S	X-ray, urethra/bladder	0278	2.65	$137.82	$66.07	$27.56
74455	S	X-ray, urethra/bladder	0278	2.65	$137.82	$66.07	$27.56
74470	X	X-ray exam of kidney lesion	0264	2.75	$143.02	$77.23	$28.60
74475	S	X-ray control, cath insert	0297	7.80	$405.67	$172.51	$81.13
74480	S	X-ray control, cath insert	0296	2.12	$110.26	$52.92	$22.05
74485	S	X-ray guide, GU dilation	0296	2.12	$110.26	$52.92	$22.05
74710	X	X-ray measurement of pelvis	0260	0.81	$42.13	$23.17	$8.43

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74740	X	X-ray, female genital tract	0264	2.75	$143.02	$77.23	$28.60
74742	X	X-ray, fallopian tube	0263	1.99	$103.50	$45.54	$20.70
74775	S	X-ray exam of perineum	0278	2.65	$137.82	$66.07	$27.56
75552	S	Heart mri for morph w/o dye	0336	7.01	$364.58	$176.94	$72.92
75553	S	Heart mri for morph w/dye	0284	7.74	$402.55	$201.02	$80.51
75554	S	Cardiac MRI/function	0335	6.46	$335.98	$151.46	$67.20
75555	S	Cardiac MRI/limited study	0335	6.46	$335.98	$151.46	$67.20
75556	E	Cardiac MRI/flow mapping	.....	.....	.....	.....	.....
75600	S	Contrast x-ray exam of aorta	0280	15.51	$806.66	$353.85	$161.33
75605	S	Contrast x-ray exam of aorta	0280	15.51	$806.66	$353.85	$161.33
75625	S	Contrast x-ray exam of aorta	0280	15.51	$806.66	$353.85	$161.33
75630	S	X-ray aorta, leg arteries	0280	15.51	$806.66	$353.85	$161.33
75635	S	Ct angio abdominal arteries	0662	5.96	$309.97	$170.48	$61.99
75650	S	Artery x-rays, head & neck	0280	15.51	$806.66	$353.85	$161.33
75658	S	Artery x-rays, arm	0280	15.51	$806.66	$353.85	$161.33
75660	S	Artery x-rays, head & neck	0279	8.41	$437.40	$174.57	$87.48
75662	S	Artery x-rays, head & neck	0279	8.41	$437.40	$174.57	$87.48
75665	S	Artery x-rays, head & neck	0280	15.51	$806.66	$353.85	$161.33
75671	S	Artery x-rays, head & neck	0280	15.51	$806.66	$353.85	$161.33
75676	S	Artery x-rays, neck	0280	15.51	$806.66	$353.85	$161.33
75680	S	Artery x-rays, neck	0280	15.51	$806.66	$353.85	$161.33
75685	S	Artery x-rays, spine	0279	8.41	$437.40	$174.57	$87.48
75705	S	Artery x-rays, spine	0279	8.41	$437.40	$174.57	$87.48
75710	S	Artery x-rays, arm/leg	0280	15.51	$806.66	$353.85	$161.33
75716	S	Artery x-rays, arms/legs	0280	15.51	$806.66	$353.85	$161.33
75722	S	Artery x-rays, kidney	0280	15.51	$806.66	$353.85	$161.33
75724	S	Artery x-rays, kidneys	0280	15.51	$806.66	$353.85	$161.33
75726	S	Artery x-rays, abdomen	0280	15.51	$806.66	$353.85	$161.33
75731	S	Artery x-rays, adrenal gland	0280	15.51	$806.66	$353.85	$161.33
75733	S	Artery x-rays, adrenals	0280	15.51	$806.66	$353.85	$161.33
75736	S	Artery x-rays, pelvis	0280	15.51	$806.66	$353.85	$161.33
75741	S	Artery x-rays, lung	0279	8.41	$437.40	$174.57	$87.48
75743	S	Artery x-rays, lungs	0280	15.51	$806.66	$353.85	$161.33
75746	S	Artery x-rays, lung	0279	8.41	$437.40	$174.57	$87.48
75756	S	Artery x-rays, chest	0279	8.41	$437.40	$174.57	$87.48
75774	S	Artery x-ray, each vessel	0668	5.36	$278.77	$122.66	$55.75
75790	S	Visualize A-V shunt	0281	5.23	$272.01	$115.16	$54.40
75801	X	Lymph vessel x-ray, arm/leg	0264	2.75	$143.02	$77.23	$28.60
75803	X	Lymph vessel x-ray,arms/legs	0264	2.75	$143.02	$77.23	$28.60
75805	X	Lymph vessel x-ray, trunk	0264	2.75	$143.02	$77.23	$28.60
75807	X	Lymph vessel x-ray, trunk	0264	2.75	$143.02	$77.23	$28.60
75809	X	Nonvascular shunt, x-ray	0263	1.99	$103.50	$45.54	$20.70
75810	S	Vein x-ray, spleen/liver	0279	8.41	$437.40	$174.57	$87.48
75820	S	Vein x-ray, arm/leg	0281	5.23	$272.01	$115.16	$54.40
75822	S	Vein x-ray, arms/legs	0281	5.23	$272.01	$115.16	$54.40
75825	S	Vein x-ray, trunk	0279	8.41	$437.40	$174.57	$87.48
75827	S	Vein x-ray, chest	0279	8.41	$437.40	$174.57	$87.48
75831	S	Vein x-ray, kidney	0287	7.13	$370.82	$114.51	$74.16
75833	S	Vein x-ray, kidneys	0279	8.41	$437.40	$174.57	$87.48
75840	S	Vein x-ray, adrenal gland	0287	7.13	$370.82	$114.51	$74.16
75842	S	Vein x-ray, adrenal glands	0287	7.13	$370.82	$114.51	$74.16
75860	S	Vein x-ray, neck	0287	7.13	$370.82	$114.51	$74.16
75870	S	Vein x-ray, skull	0287	7.13	$370.82	$114.51	$74.16
75872	S	Vein x-ray, skull	0287	7.13	$370.82	$114.51	$74.16
75880	S	Vein x-ray, eye socket	0287	7.13	$370.82	$114.51	$74.16
75885	S	Vein x-ray, liver	0279	8.41	$437.40	$174.57	$87.48
75887	S	Vein x-ray, liver	0280	15.51	$806.66	$353.85	$161.33
75889	S	Vein x-ray, liver	0279	8.41	$437.40	$174.57	$87.48
75891	S	Vein x-ray, liver	0279	8.41	$437.40	$174.57	$87.48
75893	N	Venous sampling by catheter	.....	.....	.....	.....	.....
75894	S	X-rays, transcath therapy	0297	7.80	$405.67	$172.51	$81.13
75896	S	X-rays, transcath therapy	0297	7.80	$405.67	$172.51	$81.13
75898	X	Follow-up angiography	0264	2.75	$143.02	$77.23	$28.60
75900	C	Arterial catheter exchange	.....	.....	.....	.....	.....
75940	X	X-ray placement, vein filter	0187	4.19	$217.92	$94.96	$43.58
75945	S	Intravascular us	0267	2.58	$134.18	$65.52	$26.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75946	S	Intravascular us add-on	0267	2.58	$134.18	$65.52	$26.84
75952	C	Endovasc repair abdom aorta					
75953	C	Abdom aneurysm endovas rpr					
75960	S	Transcatheter intro, stent	0280	15.51	$806.66	$353.85	$161.33
75961	S	Retrieval, broken catheter	0280	15.51	$806.66	$353.85	$161.33
75962	S	Repair arterial blockage	0280	15.51	$806.66	$353.85	$161.33
75964	S	Repair artery blockage, each	0280	15.51	$806.66	$353.85	$161.33
75966	S	Repair arterial blockage	0280	15.51	$806.66	$353.85	$161.33
75968	S	Repair artery blockage, each	0280	15.51	$806.66	$353.85	$161.33
75970	S	Vascular biopsy	0280	15.51	$806.66	$353.85	$161.33
75978	S	Repair venous blockage	0668	5.36	$278.77	$122.66	$55.75
75980	S	Contrast xray exam bile duct	0296	2.12	$110.26	$52.92	$22.05
75982	S	Contrast xray exam bile duct	0297	7.80	$405.67	$172.51	$81.13
75984	X	Xray control catheter change	0264	2.75	$143.02	$77.23	$28.60
75989	N	Abscess drainage under x-ray					
75992	S	Atherectomy, x-ray exam	0280	15.51	$806.66	$353.85	$161.33
75993	S	Atherectomy, x-ray exam	0280	15.51	$806.66	$353.85	$161.33
75994	S	Atherectomy, x-ray exam	0280	15.51	$806.66	$353.85	$161.33
75995	S	Atherectomy, x-ray exam	0280	15.51	$806.66	$353.85	$161.33
75996	S	Atherectomy, x-ray exam	0280	15.51	$806.66	$353.85	$161.33
76000	X	Fluoroscope examination	0272	1.38	$71.77	$38.64	$14.35
76001	N	Fluoroscope exam, extensive					
76003	N	Needle localization by x-ray					
76005	N	Fluoroguide for spine inject					
76006	X	X-ray stress view	0260	0.81	$42.13	$23.17	$8.43
76010	X	X-ray, nose to rectum	0260	0.81	$42.13	$23.17	$8.43
76012	S	Percut vertebroplasty fluor	0274	3.21	$166.95	$80.14	$33.39
76013	S	Percut vertebroplasty, ct	0274	3.21	$166.95	$80.14	$33.39
76020	X	X-rays for bone age	0260	0.81	$42.13	$23.17	$8.43
76040	X	X-rays, bone evaluation	0260	0.81	$42.13	$23.17	$8.43
76061	X	X-rays, bone survey	0261	1.37	$71.25	$34.15	$14.25
76062	X	X-rays, bone survey	0261	1.37	$71.25	$34.15	$14.25
76065	X	X-rays, bone evaluation	0261	1.37	$71.25	$34.15	$14.25
76066	X	Joint survey, single view	0260	0.81	$42.13	$23.17	$8.43
76070	E	CT scan, bone density study					
76075	S	Dual energy x-ray study	0288	1.38	$71.77		$14.35
76076	S	Dual energy x-ray study	0665	0.73	$37.97		$7.59
76078	X	Radiographic absorptiometry	0261	1.37	$71.25	$34.15	$14.25
76080	X	X-ray exam of fistula	0263	1.99	$103.50	$45.54	$20.70
76085	A	Computer mammogram add-on					
76086	X	X-ray of mammary duct	0263	1.99	$103.50	$45.54	$20.70
76088	X	X-ray of mammary ducts	0263	1.99	$103.50	$45.54	$20.70
76090	S	Mammogram, one breast	0271	0.69	$35.89	$16.80	$7.18
76091	S	Mammogram, both breasts	0271	0.69	$35.89	$16.80	$7.18
76092	A	Mammogram, screening					
76093	E	Magnetic image, breast					
76094	E	Magnetic image, both breasts					
76095	X	Stereotactic breast biopsy	0187	4.19	$217.92	$94.96	$43.58
76096	X	X-ray of needle wire, breast	0289	1.84	$95.70	$44.80	$19.14
76098	X	X-ray exam, breast specimen	0260	0.81	$42.13	$23.17	$8.43
76100	X	X-ray exam of body section	0261	1.37	$71.25	$34.15	$14.25
76101	X	Complex body section x-ray	0264	2.75	$143.02	$77.23	$28.60
76102	X	Complex body section x-rays	0264	2.75	$143.02	$77.23	$28.60
76120	X	Cine/video x-rays	0260	0.81	$42.13	$23.17	$8.43
76125	X	Cine/ video x-rays add-on	0260	0.81	$42.13	$23.17	$8.43
76140	E	X-ray consultation					
76150	X	X-ray exam, dry process	0260	0.81	$42.13	$23.17	$8.43
76350	N	Special x-ray contrast study					
76355	S	CAT scan for localization	0283	4.75	$247.04		$49.41
76360	S	CAT scan for needle biopsy	0283	4.75	$247.04		$49.41
76362	N	Cat scan for tissue ablation					
76370	S	CAT scan for therapy guide	0282	1.76	$91.54	$44.51	$18.31
76375	S	3d/holograph reconstr add-on	0282	1.76	$91.54	$44.51	$18.31
76380	S	CAT scan follow-up study	0282	1.76	$91.54	$44.51	$18.31
76390	E	Mr spectroscopy					
76393	N	Mr guidance for needle place					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76394	N	Mri for tissue ablation					
76400	S	Magnetic image, bone marrow	0335	6.46	$335.98	$151.46	$67.20
76490	N	Us for tissue ablation					
76499	X	Radiographic procedure	0260	0.81	$42.13	$23.17	$8.43
76506	S	Echo exam of head	0266	1.70	$88.42	$48.63	$17.68
76511	S	Echo exam of eye	0266	1.70	$88.42	$48.63	$17.68
76512	S	Echo exam of eye	0266	1.70	$88.42	$48.63	$17.68
76513	S	Echo exam of eye, water bath	0265	1.04	$54.09	$29.75	$10.82
76516	S	Echo exam of eye	0266	1.70	$88.42	$48.63	$17.68
76519	S	Echo exam of eye	0266	1.70	$88.42	$48.63	$17.68
76529	S	Echo exam of eye	0265	1.04	$54.09	$29.75	$10.82
76536	S	Us exam of head and neck	0266	1.70	$88.42	$48.63	$17.68
76604	S	Us exam, chest, b-scan	0266	1.70	$88.42	$48.63	$17.68
76645	S	Us exam, breast(s)	0265	1.04	$54.09	$29.75	$10.82
76700	S	Us exam, abdom, complete	0266	1.70	$88.42	$48.63	$17.68
76705	S	Us exam, abdom, limited	0266	1.70	$88.42	$48.63	$17.68
76770	S	Us exam abdo back wall, comp	0266	1.70	$88.42	$48.63	$17.68
76775	S	Us exam abdo back wall, lim	0266	1.70	$88.42	$48.63	$17.68
76778	S	Us exam kidney transplant	0266	1.70	$88.42	$48.63	$17.68
76800	S	Us exam, spinal canal	0266	1.70	$88.42	$48.63	$17.68
76805	S	Us exam, pg uterus, compl	0266	1.70	$88.42	$48.63	$17.68
76810	S	Us exam, pg uterus, mult	0265	1.04	$54.09	$29.75	$10.82
76815	S	Us exam, pg uterus limit	0265	1.04	$54.09	$29.75	$10.82
76816	S	Us exam pg uterus repeat	0265	1.04	$54.09	$29.75	$10.82
76818	S	Fetal biophy profile w/nst	0266	1.70	$88.42	$48.63	$17.68
76819	S	Fetal biophys profil w/o nst	0266	1.70	$88.42	$48.63	$17.68
76825	S	Echo exam of fetal heart	0671	1.68	$87.38	$45.44	$17.48
76826	S	Echo exam of fetal heart	0697	1.51	$78.53	$40.84	$15.71
76827	S	Echo exam of fetal heart	0671	1.68	$87.38	$45.44	$17.48
76828	S	Echo exam of fetal heart	0697	1.51	$78.53	$40.84	$15.71
76830	S	Us exam, transvaginal	0266	1.70	$88.42	$48.63	$17.68
76831	S	Echo exam, uterus	0266	1.70	$88.42	$48.63	$17.68
76856	S	Us exam, pelvic, complete	0266	1.70	$88.42	$48.63	$17.68
76857	S	Us exam, pelvic, limited	0265	1.04	$54.09	$29.75	$10.82
76870	S	Us exam, scrotum	0266	1.70	$88.42	$48.63	$17.68
76872	S	Echo exam, transrectal	0266	1.70	$88.42	$48.63	$17.68
76873	S	Echograp trans r, pros study	0266	1.70	$88.42	$48.63	$17.68
76880	S	Us exam, extremity	0266	1.70	$88.42	$48.63	$17.68
76885	S	Us exam infant hips, dynamic	0266	1.70	$88.42	$48.63	$17.68
76886	S	Us exam infant hips, static	0266	1.70	$88.42	$48.63	$17.68
76930	S	Echo guide, cardiocentesis	0268	1.48	$76.97		$15.39
76932	S	Echo guide for heart biopsy	0268	1.48	$76.97		$15.39
76936	S	Echo guide for artery repair	0268	1.48	$76.97		$15.39
76941	S	Echo guide for transfusion	0268	1.48	$76.97		$15.39
76942	S	Echo guide for biopsy	0268	1.48	$76.97		$15.39
76945	S	Echo guide, villus sampling	0268	1.48	$76.97		$15.39
76946	S	Echo guide for amniocentesis	0268	1.48	$76.97		$15.39
76948	S	Echo guide, ova aspiration	0268	1.48	$76.97		$15.39
76950	S	Echo guidance radiotherapy	0268	1.48	$76.97		$15.39
76965	S	Echo guidance radiotherapy	0268	1.48	$76.97		$15.39
76970	S	Ultrasound exam follow-up	0265	1.04	$54.09	$29.75	$10.82
76975	S	GI endoscopic ultrasound	0266	1.70	$88.42	$48.63	$17.68
76977	S	Us bone density measure	0265	1.04	$54.09	$29.75	$10.82
76986	S	Ultrasound guide intraoper	0266	1.70	$88.42	$48.63	$17.68
76999	S	Echo examination procedure	0265	1.04	$54.09	$29.75	$10.82
77261	E	Radiation therapy planning					
77262	E	Radiation therapy planning					
77263	E	Radiation therapy planning					
77280	X	Set radiation therapy field	0304	1.69	$87.90	$41.52	$17.58
77285	X	Set radiation therapy field	0305	3.87	$201.27	$91.38	$40.25
77290	X	Set radiation therapy field	0305	3.87	$201.27	$91.38	$40.25
77295	X	Set radiation therapy field	0310	14.38	$747.89	$339.05	$149.58
77299	E	Radiation therapy planning					
77300	X	Radiation therapy dose plan	0304	1.69	$87.90	$41.52	$17.58
77301	S	Radioltherapy dos plan, imrt	0712		$875.00		$175.00
77305	X	Radiation therapy dose plan	0304	1.69	$87.90	$41.52	$17.58

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77310	X	Radiation therapy dose plan	0304	1.69	$87.90	$41.52	$17.58
77315	X	Radiation therapy dose plan	0305	3.87	$201.27	$91.38	$40.25
77321	X	Radiation therapy port plan	0305	3.87	$201.27	$91.38	$40.25
77326	X	Radiation therapy dose plan	0305	3.87	$201.27	$91.38	$40.25
77327	X	Radiation therapy dose plan	0305	3.87	$201.27	$91.38	$40.25
77328	X	Radiation therapy dose plan	0305	3.87	$201.27	$91.38	$40.25
77331	X	Special radiation dosimetry	0304	1.69	$87.90	$41.52	$17.58
77332	X	Radiation treatment aid(s)	0303	2.93	$152.39	$68.58	$30.48
77333	X	Radiation treatment aid(s)	0303	2.93	$152.39	$68.58	$30.48
77334	X	Radiation treatment aid(s)	0303	2.93	$152.39	$68.58	$30.48
77336	X	Radiation physics consult	0304	1.69	$87.90	$41.52	$17.58
77370	X	Radiation physics consult	0305	3.87	$201.27	$91.38	$40.25
77399	X	External radiation dosimetry	0304	1.69	$87.90	$41.52	$17.58
77401	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77402	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77403	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77404	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77406	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77407	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77408	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77409	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77411	S	Radiation treatment delivery	0300	1.53	$79.57		$15.91
77412	S	Radiation treatment delivery	0301	2.22	$115.46		$23.09
77413	S	Radiation treatment delivery	0301	2.22	$115.46		$23.09
77414	S	Radiation treatment delivery	0301	2.22	$115.46		$23.09
77416	S	Radiation treatment delivery	0301	2.22	$115.46		$23.09
77417	X	Radiology port film(s)	0260	0.81	$42.13	$23.17	$8.43
77418	S	Radiation tx delivery, imrt	0710		$400.00		$80.00
77427	E	Radiation tx management, x5					
77431	E	Radiation therapy management					
77432	E	Stereotactic radiation trmt					
77470	S	Special radiation treatment	0299	6.20	$322.46		$64.49
77499	E	Radiation therapy management					
77520	S	Proton trmt, simple w/o comp	0664	11.03	$573.66		$114.73
77522	S	Proton trmt, simple w/comp	0664	11.03	$573.66		$114.73
77523	S	Proton trmt, intermediate	0664	11.03	$573.66		$114.73
77525	S	Proton treatment, complex	0664	11.03	$573.66		$114.73
77600	S	Hyperthermia treatment	0314	4.24	$220.52	$101.77	$44.10
77605	S	Hyperthermia treatment	0314	4.24	$220.52	$101.77	$44.10
77610	S	Hyperthermia treatment	0314	4.24	$220.52	$101.77	$44.10
77615	S	Hyperthermia treatment	0314	4.24	$220.52	$101.77	$44.10
77620	S	Hyperthermia treatment	0314	4.24	$220.52	$101.77	$44.10
77750	S	Infuse radioactive materials	0300	1.53	$79.57		$15.91
77761	S	Apply intrcav radiat simple	0312	4.23	$220.00		$44.00
77762	S	Apply intrcav radiat interm	0312	4.23	$220.00		$44.00
77763	S	Apply intrcav radiat compl	0312	4.23	$220.00		$44.00
77776	S	Apply interstit radiat simpl	0312	4.23	$220.00		$44.00
77777	S	Apply interstit radiat inter	0312	4.23	$220.00		$44.00
77778	S	Apply iterstit radiat compl	0312	4.23	$220.00		$44.00
77781	S	High intensity brachytherapy	0313	13.80	$717.72		$143.54
77782	S	High intensity brachytherapy	0313	13.80	$717.72		$143.54
77783	S	High intensity brachytherapy	0313	13.80	$717.72		$143.54
77784	S	High intensity brachytherapy	0313	13.80	$717.72		$143.54
77789	S	Apply surface radiation	0300	1.53	$79.57		$15.91
77790	N	Radiation handling					
77799	S	Radium/radioisotope therapy	0313	13.80	$717.72		$143.54
78000	S	Thyroid, single uptake	0290	2.16	$112.34	$56.17	$22.47
78001	S	Thyroid, multiple uptakes	0290	2.16	$112.34	$56.17	$22.47
78003	S	Thyroid suppress/stimul	0290	2.16	$112.34	$56.17	$22.47
78006	S	Thyroid imaging with uptake	0291	4.19	$217.92	$108.96	$43.58
78007	S	Thyroid image, mult uptakes	0292	4.53	$235.60	$117.80	$47.12
78010	S	Thyroid imaging	0291	4.19	$217.92	$108.96	$43.58
78011	S	Thyroid imaging with flow	0292	4.53	$235.60	$117.80	$47.12
78015	S	Thyroid met imaging	0291	4.19	$217.92	$108.96	$43.58
78016	S	Thyroid met imaging/studies	0292	4.53	$235.60	$117.80	$47.12
78018	S	Thyroid met imaging, body	0292	4.53	$235.60	$117.80	$47.12

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78020	S	Thyroid met uptake	0291	4.19	$217.92	$108.96	$43.58
78070	S	Parathyroid nuclear imaging	0292	4.53	$235.60	$117.80	$47.12
78075	S	Adrenal nuclear imaging	0292	4.53	$235.60	$117.80	$47.12
78099	S	Endocrine nuclear procedure	0291	4.19	$217.92	$108.96	$43.58
78102	S	Bone marrow imaging, ltd	0291	4.19	$217.92	$108.96	$43.58
78103	S	Bone marrow imaging, mult	0291	4.19	$217.92	$108.96	$43.58
78104	S	Bone marrow imaging, body	0291	4.19	$217.92	$108.96	$43.58
78110	S	Plasma volume, single	0290	2.16	$112.34	$56.17	$22.47
78111	S	Plasma volume, multiple	0290	2.16	$112.34	$56.17	$22.47
78120	S	Red cell mass, single	0290	2.16	$112.34	$56.17	$22.47
78121	S	Red cell mass, multiple	0290	2.16	$112.34	$56.17	$22.47
78122	S	Blood volume	0290	2.16	$112.34	$56.17	$22.47
78130	S	Red cell survival study	0290	2.16	$112.34	$56.17	$22.47
78135	S	Red cell survival kinetics	0290	2.16	$112.34	$56.17	$22.47
78140	S	Red cell sequestration	0290	2.16	$112.34	$56.17	$22.47
78160	S	Plasma iron turnover	0290	2.16	$112.34	$56.17	$22.47
78162	S	Iron absorption exam	0290	2.16	$112.34	$56.17	$22.47
78170	S	Red cell iron utilization	0290	2.16	$112.34	$56.17	$22.47
78172	S	Total body iron estimation	0290	2.16	$112.34	$56.17	$22.47
78185	S	Spleen imaging	0291	4.19	$217.92	$108.96	$43.58
78190	S	Platelet survival, kinetics	0290	2.16	$112.34	$56.17	$22.47
78191	S	Platelet survival	0292	4.53	$235.60	$117.80	$47.12
78195	S	Lymph system imaging	0292	4.53	$235.60	$117.80	$47.12
78199	S	Blood/lymph nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78201	S	Liver imaging	0291	4.19	$217.92	$108.96	$43.58
78202	S	Liver imaging with flow	0291	4.19	$217.92	$108.96	$43.58
78205	S	Liver imaging (3D)	0291	4.19	$217.92	$108.96	$43.58
78206	S	Liver image (3d) w/flow	0292	4.53	$235.60	$117.80	$47.12
78215	S	Liver and spleen imaging	0291	4.19	$217.92	$108.96	$43.58
78216	S	Liver & spleen image/flow	0291	4.19	$217.92	$108.96	$43.58
78220	S	Liver function study	0291	4.19	$217.92	$108.96	$43.58
78223	S	Hepatobiliary imaging	0292	4.53	$235.60	$117.80	$47.12
78230	S	Salivary gland imaging	0292	4.53	$235.60	$117.80	$47.12
78231	S	Serial salivary imaging	0292	4.53	$235.60	$117.80	$47.12
78232	S	Salivary gland function exam	0292	4.53	$235.60	$117.80	$47.12
78258	S	Esophageal motility study	0291	4.19	$217.92	$108.96	$43.58
78261	S	Gastric mucosa imaging	0291	4.19	$217.92	$108.96	$43.58
78262	S	Gastroesophageal reflux exam	0292	4.53	$235.60	$117.80	$47.12
78264	S	Gastric emptying study	0292	4.53	$235.60	$117.80	$47.12
78267	A	Breath tst attain/anal c-14					
78268	A	Breath test analysis, c-14					
78270	S	Vit B-12 absorption exam	0290	2.16	$112.34	$56.17	$22.47
78271	S	Vit B-12 absorp exam, IF	0290	2.16	$112.34	$56.17	$22.47
78272	S	Vit B-12 absorp, combined	0290	2.16	$112.34	$56.17	$22.47
78278	S	Acute GI blood loss imaging	0292	4.53	$235.60	$117.80	$47.12
78282	S	GI protein loss exam	0290	2.16	$112.34	$56.17	$22.47
78290	S	Meckel's divert exam	0292	4.53	$235.60	$117.80	$47.12
78291	S	Leveen/shunt patency exam	0292	4.53	$235.60	$117.80	$47.12
78299	S	GI nuclear procedure	0291	4.19	$217.92	$108.96	$43.58
78300	S	Bone imaging, limited area	0291	4.19	$217.92	$108.96	$43.58
78305	S	Bone imaging, multiple areas	0291	4.19	$217.92	$108.96	$43.58
78306	S	Bone imaging, whole body	0291	4.19	$217.92	$108.96	$43.58
78315	S	Bone imaging, 3 phase	0292	4.53	$235.60	$117.80	$47.12
78320	S	Bone imaging (3D)	0291	4.19	$217.92	$108.96	$43.58
78350	X	Bone mineral, single photon	0261	1.37	$71.25	$34.15	$14.25
78351	E	Bone mineral, dual photon					
78399	S	Musculoskeletal nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78414	S	Non-imaging heart function	0290	2.16	$112.34	$56.17	$22.47
78428	S	Cardiac shunt imaging	0291	4.19	$217.92	$108.96	$43.58
78445	S	Vascular flow imaging	0291	4.19	$217.92	$108.96	$43.58
78455	S	Venous thrombosis study	0290	2.16	$112.34	$56.17	$22.47
78456	S	Acute venous thrombus image	0292	4.53	$235.60	$117.80	$47.12
78457	S	Venous thrombosis imaging	0291	4.19	$217.92	$108.96	$43.58
78458	S	Ven thrombosis images, bilat	0292	4.53	$235.60	$117.80	$47.12
78459	E	Heart muscle imaging (PET)					
78460	S	Heart muscle blood, single	0286	6.94	$360.94	$198.52	$72.19

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78461	S	Heart muscle blood, multiple	0286	6.94	$360.94	$198.52	$72.19
78464	S	Heart image (3d), single	0286	6.94	$360.94	$198.52	$72.19
78465	S	Heart image (3d), multiple	0286	6.94	$360.94	$198.52	$72.19
78466	S	Heart infarct image	0291	4.19	$217.92	$108.96	$43.58
78468	S	Heart infarct image (ef)	0291	4.19	$217.92	$108.96	$43.58
78469	S	Heart infarct image (3D)	0291	4.19	$217.92	$108.96	$43.58
78472	S	Gated heart, planar, single	0286	6.94	$360.94	$198.52	$72.19
78473	S	Gated heart, multiple	0286	6.94	$360.94	$198.52	$72.19
78478	S	Heart wall motion add-on	0666	1.59	$82.69	$45.48	$16.54
78480	S	Heart function add-on	0666	1.59	$82.69	$45.48	$16.54
78481	S	Heart first pass, single	0286	6.94	$360.94	$198.52	$72.19
78483	S	Heart first pass, multiple	0286	6.94	$360.94	$198.52	$72.19
78491	E	Heart image (pet), single	.....	.....	.....	.....	.....
78492	E	Heart image (pet), multiple	.....	.....	.....	.....	.....
78494	S	Heart image, spect	0286	6.94	$360.94	$198.52	$72.19
78496	S	Heart first pass add-on	0666	1.59	$82.69	$45.48	$16.54
78499	S	Cardiovascular nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78580	S	Lung perfusion imaging	0291	4.19	$217.92	$108.96	$43.58
78584	S	Lung V/Q image single breath	0292	4.53	$235.60	$117.80	$47.12
78585	S	Lung V/Q imaging	0292	4.53	$235.60	$117.80	$47.12
78586	S	Aerosol lung image, single	0291	4.19	$217.92	$108.96	$43.58
78587	S	Aerosol lung image, multiple	0291	4.19	$217.92	$108.96	$43.58
78588	S	Perfusion lung image	0292	4.53	$235.60	$117.80	$47.12
78591	S	Vent image, 1 breath, 1 proj	0291	4.19	$217.92	$108.96	$43.58
78593	S	Vent image, 1 proj, gas	0291	4.19	$217.92	$108.96	$43.58
78594	S	Vent image, mult proj, gas	0291	4.19	$217.92	$108.96	$43.58
78596	S	Lung differential function	0292	4.53	$235.60	$117.80	$47.12
78599	S	Respiratory nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78600	S	Brain imaging, ltd static	0291	4.19	$217.92	$108.96	$43.58
78601	S	Brain imaging, ltd w/ flow	0291	4.19	$217.92	$108.96	$43.58
78605	S	Brain imaging, complete	0291	4.19	$217.92	$108.96	$43.58
78606	S	Brain imaging, compl w/flow	0291	4.19	$217.92	$108.96	$43.58
78607	S	Brain imaging (3D)	0291	4.19	$217.92	$108.96	$43.58
78608	E	Brain imaging (PET)	.....	.....	.....	.....	.....
78609	E	Brain imaging (PET)	.....	.....	.....	.....	.....
78610	S	Brain flow imaging only	0291	4.19	$217.92	$108.96	$43.58
78615	S	Cerebral vascular flow image	0291	4.19	$217.92	$108.96	$43.58
78630	S	Cerebrospinal fluid scan	0292	4.53	$235.60	$117.80	$47.12
78635	S	CSF ventriculography	0292	4.53	$235.60	$117.80	$47.12
78645	S	CSF shunt evaluation	0292	4.53	$235.60	$117.80	$47.12
78647	S	Cerebrospinal fluid scan	0292	4.53	$235.60	$117.80	$47.12
78650	S	CSF leakage imaging	0292	4.53	$235.60	$117.80	$47.12
78660	S	Nuclear exam of tear flow	0291	4.19	$217.92	$108.96	$43.58
78699	S	Nervous system nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78700	S	Kidney imaging, static	0291	4.19	$217.92	$108.96	$43.58
78701	S	Kidney imaging with flow	0291	4.19	$217.92	$108.96	$43.58
78704	S	Imaging renogram	0291	4.19	$217.92	$108.96	$43.58
78707	S	Kidney flow/function image	0291	4.19	$217.92	$108.96	$43.58
78708	S	Kidney flow/function image	0292	4.53	$235.60	$117.80	$47.12
78709	S	Kidney flow/function image	0292	4.53	$235.60	$117.80	$47.12
78710	S	Kidney imaging (3D)	0291	4.19	$217.92	$108.96	$43.58
78715	S	Renal vascular flow exam	0291	4.19	$217.92	$108.96	$43.58
78725	S	Kidney function study	0290	2.16	$112.34	$56.17	$22.47
78730	S	Urinary bladder retention	0291	4.19	$217.92	$108.96	$43.58
78740	S	Ureteral reflux study	0292	4.53	$235.60	$117.80	$47.12
78760	S	Testicular imaging	0291	4.19	$217.92	$108.96	$43.58
78761	S	Testicular imaging/flow	0291	4.19	$217.92	$108.96	$43.58
78799	S	Genitourinary nuclear exam	0291	4.19	$217.92	$108.96	$43.58
78800	S	Tumor imaging, limited area	0292	4.53	$235.60	$117.80	$47.12
78801	S	Tumor imaging, mult areas	0292	4.53	$235.60	$117.80	$47.12
78802	S	Tumor imaging, whole body	0292	4.53	$235.60	$117.80	$47.12
78803	S	Tumor imaging (3D)	0292	4.53	$235.60	$117.80	$47.12
78805	S	Abscess imaging, ltd area	0292	4.53	$235.60	$117.80	$47.12
78806	S	Abscess imaging, whole body	0292	4.53	$235.60	$117.80	$47.12
78807	S	Nuclear localization/abscess	0292	4.53	$235.60	$117.80	$47.12
78810	E	Tumor imaging (PET)	.....	.....	.....	.....	.....

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	N	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	0291	4.19	$217.92	$108.96	$43.58
79000	S	Init hyperthyroid therapy	0294	4.45	$231.44	$127.29	$46.29
79001	S	Repeat hyperthyroid therapy	0294	4.45	$231.44	$127.29	$46.29
79020	S	Thyroid ablation	0294	4.45	$231.44	$127.29	$46.29
79030	S	Thyroid ablation, carcinoma	0294	4.45	$231.44	$127.29	$46.29
79035	S	Thyroid metastatic therapy	0295	3.86	$200.75	$110.41	$40.15
79100	S	Hematopoetic nuclear therapy	0294	4.45	$231.44	$127.29	$46.29
79200	S	Intracavitary nuclear trmt	0295	3.86	$200.75	$110.41	$40.15
79300	S	Interstitial nuclear therapy	0294	4.45	$231.44	$127.29	$46.29
79400	S	Nonhemato nuclear therapy	0295	3.86	$200.75	$110.41	$40.15
79420	S	Intravascular nuclear ther	0295	3.86	$200.75	$110.41	$40.15
79440	S	Nuclear joint therapy	0294	4.45	$231.44	$127.29	$46.29
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	0294	4.45	$231.44	$127.29	$46.29
80048	A	Basic metabolic panel					
80050	A	General health panel					
80051	A	Electrolyte panel					
80053	A	Comprehen metabolic panel					
80055	A	Obstetric panel					
80061	A	Lipid panel					
80069	A	Renal function panel					
80074	A	Acute hepatitis panel					
80076	A	Hepatic function panel					
80090	A	Torch antibody panel					
80100	A	Drug screen, qualitate/multi					
80101	A	Drug screen, single					
80102	A	Drug confirmation					
80103	N	Drug analysis, tissue prep					
80150	A	Assay of amikacin					
80152	A	Assay of amitriptyline					
80154	A	Assay of benzodiazepines					
80156	A	Assay, carbamazepine, total					
80157	A	Assay, carbamazepine, free					
80158	A	Assay of cyclosporine					
80160	A	Assay of desipramine					
80162	A	Assay of digoxin					
80164	A	Assay, dipropylacetic acid					
80166	A	Assay of doxepin					
80168	A	Assay of ethosuximide					
80170	A	Assay of gentamicin					
80172	A	Assay of gold					
80173	A	Assay of haloperidol					
80174	A	Assay of imipramine					
80176	A	Assay of lidocaine					
80178	A	Assay of lithium					
80182	A	Assay of nortriptyline					
80184	A	Assay of phenobarbital					
80185	A	Assay of phenytoin, total					
80186	A	Assay of phenytoin, free					
80188	A	Assay of primidone					
80190	A	Assay of procainamide					
80192	A	Assay of procainamide					
80194	A	Assay of quinidine					
80196	A	Assay of salicylate					
80197	A	Assay of tacrolimus					
80198	A	Assay of theophylline					
80200	A	Assay of tobramycin					
80201	A	Assay of topiramate					
80202	A	Assay of vancomycin					
80299	A	Quantitative assay, drug					
80400	A	Acth stimulation panel					
80402	A	Acth stimulation panel					
80406	A	Acth stimulation panel					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
80408	A	Aldosterone suppression eval					
80410	A	Calcitonin stimul panel					
80412	A	CRH stimulation panel					
80414	A	Testosterone response					
80415	A	Estradiol response panel					
80416	A	Renin stimulation panel					
80417	A	Renin stimulation panel					
80418	A	Pituitary evaluation panel					
80420	A	Dexamethasone panel					
80422	A	Glucagon tolerance panel					
80424	A	Glucagon tolerance panel					
80426	A	Gonadotropin hormone panel					
80428	A	Growth hormone panel					
80430	A	Growth hormone panel					
80432	A	Insulin suppression panel					
80434	A	Insulin tolerance panel					
80435	A	Insulin tolerance panel					
80436	A	Metyrapone panel					
80438	A	TRH stimulation panel					
80439	A	TRH stimulation panel					
80440	A	TRH stimulation panel					
80500	X	Lab pathology consultation	0343	0.47	$24.44	$13.20	$4.89
80502	X	Lab pathology consultation	0342	0.23	$11.96	$5.88	$2.39
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82145	A	Assay of amphetamines					
82150	A	Assay of amylase					
82154	A	Androstanediol glucuronide					
82157	A	Assay of androstenedione					
82160	A	Assay of androsterone					
82163	A	Assay of angiotensin II					
82164	A	Angiotensin I enzyme test					
82172	A	Assay of apolipoprotein					
82175	A	Assay of arsenic					
82180	A	Assay of ascorbic acid					
82190	A	Atomic absorption					
82205	A	Assay of barbiturates					
82232	A	Assay of beta-2 protein					
82239	A	Bile acids, total					
82240	A	Bile acids, cholylglycine					
82247	A	Bilirubin, total					
82248	A	Bilirubin, direct					
82252	A	Fecal bilirubin test					
82261	A	Assay of biotinidase					
82270	A	Test for blood, feces					
82273	A	Test for blood, other source					
82274	A	Assay test for blood, fecal					
82286	A	Assay of bradykinin					
82300	A	Assay of cadmium					
82306	A	Assay of vitamin D					
82307	A	Assay of vitamin D					
82308	A	Assay of calcitonin					
82310	A	Assay of calcium					
82330	A	Assay of calcium					
82331	A	Calcium infusion test					
82340	A	Assay of calcium in urine					
82355	A	Calculus analysis, qual					
82360	A	Calculus assay, quant					
82365	A	Calculus spectroscopy					
82370	A	X-ray assay, calculus					
82373	A	Assay, c-d transfer measure					
82374	A	Assay, blood carbon dioxide					
82375	A	Assay, blood carbon monoxide					
82376	A	Test for carbon monoxide					
82378	A	Carcinoembryonic antigen					
82379	A	Assay of carnitine					
82380	A	Assay of carotene					
82382	A	Assay, urine catecholamines					
82383	A	Assay, blood catecholamines					
82384	A	Assay, three catecholamines					
82387	A	Assay of cathepsin-d					
82390	A	Assay of ceruloplasmin					
82397	A	Chemiluminescent assay					
82415	A	Assay of chloramphenicol					
82435	A	Assay of blood chloride					
82436	A	Assay of urine chloride					
82438	A	Assay, other fluid chlorides					
82441	A	Test for chlorohydrocarbons					
82465	A	Assay, bld/serum cholesterol					
82480	A	Assay, serum cholinesterase					
82482	A	Assay, rbc cholinesterase					
82485	A	Assay, chondroitin sulfate					
82486	A	Gas/liquid chromatography					
82487	A	Paper chromatography					
82488	A	Paper chromatography					
82489	A	Thin layer chromatography					
82491	A	Chromotography, quant, sing					
82492	A	Chromotography, quant, mult					
82495	A	Assay of chromium					
82507	A	Assay of citrate					
82520	A	Assay of cocaine					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82523	A	Collagen crosslinks					
82525	A	Assay of copper					
82528	A	Assay of corticosterone					
82530	A	Cortisol, free					
82533	A	Total cortisol					
82540	A	Assay of creatine					
82541	A	Column chromotography, qual					
82542	A	Column chromotography, quant					
82543	A	Column chromotograph/isotope					
82544	A	Column chromotograph/isotope					
82550	A	Assay of ck (cpk)					
82552	A	Assay of cpk in blood					
82553	A	Creatine, MB fraction					
82554	A	Creatine, isoforms					
82565	A	Assay of creatinine					
82570	A	Assay of urine creatinine					
82575	A	Creatinine clearance test					
82585	A	Assay of cryofibrinogen					
82595	A	Assay of cryoglobulin					
82600	A	Assay of cyanide					
82607	A	Vitamin B-12					
82608	A	B-12 binding capacity					
82615	A	Test for urine cystines					
82626	A	Dehydroepiandrosterone					
82627	A	Dehydroepiandrosterone					
82633	A	Desoxycorticosterone					
82634	A	Deoxycortisol					
82638	A	Assay of dibucaine number					
82646	A	Assay of dihydrocodeinone					
82649	A	Assay of dihydromorphinone					
82651	A	Assay of dihydrotestosterone					
82652	A	Assay of dihydroxyvitamin d					
82654	A	Assay of dimethadione					
82657	A	Enzyme cell activity					
82658	A	Enzyme cell activity, ra					
82664	A	Electrophoretic test					
82666	A	Assay of epiandrosterone					
82668	A	Assay of erythropoietin					
82670	A	Assay of estradiol					
82671	A	Assay of estrogens					
82672	A	Assay of estrogen					
82677	A	Assay of estriol					
82679	A	Assay of estrone					
82690	A	Assay of ethchlorvynol					
82693	A	Assay of ethylene glycol					
82696	A	Assay of etiocholanolone					
82705	A	Fats/lipids, feces, qual					
82710	A	Fats/lipids, feces, quant					
82715	A	Assay of fecal fat					
82725	A	Assay of blood fatty acids					
82726	A	Long chain fatty acids					
82728	A	Assay of ferritin					
82731	A	Assay of fetal fibronectin					
82735	A	Assay of fluoride					
82742	A	Assay of flurazepam					
82746	A	Blood folic acid serum					
82747	A	Assay of folic acid, rbc					
82757	A	Assay of semen fructose					
82759	A	Assay of rbc galactokinase					
82760	A	Assay of galactose					
82775	A	Assay galactose transferase					
82776	A	Galactose transferase test					
82784	A	Assay of gammaglobulin igm					
82785	A	Assay of gammaglobulin ige					
82787	A	Igg 1, 2, 3 or 4, each					
82800	A	Blood pH					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82803	A	Blood gases: pH, pO2 & pCO2					
82805	A	Blood gases W/02 saturation					
82810	A	Blood gases, O2 sat only					
82820	A	Hemoglobin-oxygen affinity					
82926	A	Assay of gastric acid					
82928	A	Assay of gastric acid					
82938	A	Gastrin test					
82941	A	Assay of gastrin					
82943	A	Assay of glucagon					
82945	A	Glucose other fluid					
82946	A	Glucagon tolerance test					
82947	A	Assay, glucose, blood quant					
82948	A	Reagent strip/blood glucose					
82950	A	Glucose test					
82951	A	Glucose tolerance test (GTT)					
82952	A	GTT-added samples					
82953	A	Glucose-tolbutamide test					
82955	A	Assay of g6pd enzyme					
82960	A	Test for G6PD enzyme					
82962	A	Glucose blood test					
82963	A	Assay of glucosidase					
82965	A	Assay of gdh enzyme					
82975	A	Assay of glutamine					
82977	A	Assay of GGT					
82978	A	Assay of glutathione					
82979	A	Assay, rbc glutathione					
82980	A	Assay of glutethimide					
82985	A	Glycated protein					
83001	A	Gonadotropin (FSH)					
83002	A	Gonadotropin (LH)					
83003	A	Assay, growth hormone (hgh)					
83008	A	Assay of guanosine					
83010	A	Assay of haptoglobin, quant					
83012	A	Assay of haptoglobins					
83013	A	H pylori analysis					
83014	A	H pylori drug admin/collect					
83015	A	Heavy metal screen					
83018	A	Quantitative screen, metals					
83020	A	Hemoglobin electrophoresis					
83021	A	Hemoglobin chromotography					
83026	A	Hemoglobin, copper sulfate					
83030	A	Fetal hemoglobin, chemical					
83033	A	Fetal hemoglobin assay, qual					
83036	A	Glycated hemoglobin test					
83045	A	Blood methemoglobin test					
83050	A	Blood methemoglobin assay					
83051	A	Assay of plasma hemoglobin					
83055	A	Blood sulfhemoglobin test					
83060	A	Blood sulfhemoglobin assay					
83065	A	Assay of hemoglobin heat					
83068	A	Hemoglobin stability screen					
83069	A	Assay of urine hemoglobin					
83070	A	Assay of hemosiderin, qual					
83071	A	Assay of hemosiderin, quant					
83080	A	Assay of b hexosaminidase					
83088	A	Assay of histamine					
83090	A	Assay of homocystine					
83150	A	Assay of for hva					
83491	A	Assay of corticosteroids					
83497	A	Assay of 5-hiaa					
83498	A	Assay of progesterone					
83499	A	Assay of progesterone					
83500	A	Assay, free hydroxyproline					
83505	A	Assay, total hydroxyproline					
83516	A	Immunoassay, nonantibody					
83518	A	Immunoassay, dipstick					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83519	A	Immunoassay, nonantibody					
83520	A	Immunoassay, RIA					
83525	A	Assay of insulin					
83527	A	Assay of insulin					
83528	A	Assay of intrinsic factor					
83540	A	Assay of iron					
83550	A	Iron binding test					
83570	A	Assay of idh enzyme					
83582	A	Assay of ketogenic steroids					
83586	A	Assay 17- ketosteroids					
83593	A	Fractionation, ketosteroids					
83605	A	Assay of lactic acid					
83615	A	Lactate (LD) (LDH) enzyme					
83625	A	Assay of ldh enzymes					
83632	A	Placental lactogen					
83633	A	Test urine for lactose					
83634	A	Assay of urine for lactose					
83655	A	Assay of lead					
83661	A	L/s ratio, fetal lung					
83662	A	Foam stability, fetal lung					
83663	A	Fluoro polarize, fetal lung					
83664	A	Lamellar bdy, fetal lung					
83670	A	Assay of lap enzyme					
83690	A	Assay of lipase					
83715	A	Assay of blood lipoproteins					
83716	A	Assay of blood lipoproteins					
83718	A	Assay of lipoprotein					
83719	A	Assay of blood lipoprotein					
83721	A	Assay of blood lipoprotein					
83727	A	Assay of lrh hormone					
83735	A	Assay of magnesium					
83775	A	Assay of md enzyme					
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83918	A	Organic acids, total, quant					
83919	A	Organic acids, qual, each					
83921	A	Organic acid, single, quant					
83925	A	Assay of opiates					
83930	A	Assay of blood osmolality					
83935	A	Assay of urine osmolality					
83937	A	Assay of osteocalcin					
83945	A	Assay of oxalate					
83950	A	Oncorprotein, her-2/neu					
83970	A	Assay of parathormone					
83986	A	Assay of body fluid acidity					
83992	A	Assay for phencyclidine					
84022	A	Assay of phenothiazine					
84030	A	Assay of blood pku					
84035	A	Assay of phenylketones					
84060	A	Assay acid phosphatase					
84061	A	Phosphatase, forensic exam					
84066	A	Assay prostate phosphatase					
84075	A	Assay alkaline phosphatase					
84078	A	Assay alkaline phosphatase					
84080	A	Assay alkaline phosphatases					
84081	A	Amniotic fluid enzyme test					
84085	A	Assay of rbc pg6d enzyme					
84087	A	Assay phosphohexose enzymes					
84100	A	Assay of phosphorus					
84105	A	Assay of urine phosphorus					
84106	A	Test for porphobilinogen					
84110	A	Assay of porphobilinogen					
84119	A	Test urine for porphyrins					
84120	A	Assay of urine porphyrins					
84126	A	Assay of feces porphyrins					
84127	A	Assay of feces porphyrins					
84132	A	Assay of serum potassium					
84133	A	Assay of urine potassium					
84134	A	Assay of prealbumin					
84135	A	Assay of pregnanediol					
84138	A	Assay of pregnanetriol					
84140	A	Assay of pregnenolone					
84143	A	Assay of 17-hydroxypregneno					
84144	A	Assay of progesterone					
84146	A	Assay of prolactin					
84150	A	Assay of prostaglandin					
84152	A	Assay of psa, complexed					
84153	A	Assay of psa, total					
84154	A	Assay of psa, free					
84155	A	Assay of protein					
84160	A	Assay of serum protein					
84165	A	Assay of serum proteins					
84181	A	Western blot test					
84182	A	Protein, western blot test					
84202	A	Assay RBC protoporphyrin					
84203	A	Test RBC protoporphyrin					
84206	A	Assay of proinsulin					
84207	A	Assay of vitamin b-6					
84210	A	Assay of pyruvate					
84220	A	Assay of pyruvate kinase					
84228	A	Assay of quinine					
84233	A	Assay of estrogen					
84234	A	Assay of progesterone					
84235	A	Assay of endocrine hormone					
84238	A	Assay, nonendocrine receptor					
84244	A	Assay of renin					
84252	A	Assay of vitamin b-2					
84255	A	Assay of selenium					
84260	A	Assay of serotonin					
84270	A	Assay of sex hormone globul					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	Reverse assay (t3)					
84484	A	Assay of troponin, quant					
84485	A	Assay duodenal fluid trypsin					
84488	A	Test feces for trypsin					
84490	A	Assay of feces for trypsin					
84510	A	Assay of tyrosine					
84512	A	Assay of troponin, qual					
84520	A	Assay of urea nitrogen					
84525	A	Urea nitrogen semi-quant					
84540	A	Assay of urine/urea-n					
84545	A	Urea-N clearance test					
84550	A	Assay of blood/uric acid					
84560	A	Assay of urine/uric acid					
84577	A	Assay of feces/urobilinogen					
84578	A	Test urine urobilinogen					
84580	A	Assay of urine urobilinogen					
84583	A	Assay of urine urobilinogen					
84585	A	Assay of urine vma					
84586	A	Assay of vip					
84588	A	Assay of vasopressin					
84590	A	Assay of vitamin a					
84591	A	Assay of nos vitamin					
84597	A	Assay of vitamin k					
84600	A	Assay of volatiles					
84620	A	Xylose tolerance test					
84630	A	Assay of zinc					
84681	A	Assay of c-peptide					
84702	A	Chorionic gonadotropin test					
84703	A	Chorionic gonadotropin assay					
84830	A	Ovulation tests					
84999	A	Clinical chemistry test					
85002	A	Bleeding time test					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85007	A	Differential WBC count					
85008	A	Nondifferential WBC count					
85009	A	Differential WBC count					
85013	A	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	0.23	$11.96	$5.88	$2.39
85097	X	Bone marrow interpretation	0343	0.47	$24.44	$13.20	$4.89
85130	A	Chromogenic substrate assay					
85170	A	Blood clot retraction					
85175	A	Blood clot lysis time					
85210	A	Blood clot factor II test					
85220	A	Blood clot factor V test					
85230	A	Blood clot factor VII test					
85240	A	Blood clot factor VIII test					
85244	A	Blood clot factor VIII test					
85245	A	Blood clot factor VIII test					
85246	A	Blood clot factor VIII test					
85247	A	Blood clot factor VIII test					
85250	A	Blood clot factor IX test					
85260	A	Blood clot factor X test					
85270	A	Blood clot factor XI test					
85280	A	Blood clot factor XII test					
85290	A	Blood clot factor XIII test					
85291	A	Blood clot factor XIII test					
85292	A	Blood clot factor assay					
85293	A	Blood clot factor assay					
85300	A	Antithrombin III test					
85301	A	Antithrombin III test					
85302	A	Blood clot inhibitor antigen					
85303	A	Blood clot inhibitor test					
85305	A	Blood clot inhibitor assay					
85306	A	Blood clot inhibitor test					
85307	A	Assay activated protein c					
85335	A	Factor inhibitor test					
85337	A	Thrombomodulin					
85345	A	Coagulation time					
85347	A	Coagulation time					
85348	A	Coagulation time					
85360	A	Euglobulin lysis					
85362	A	Fibrin degradation products					
85366	A	Fibrinogen test					
85370	A	Fibrinogen test					
85378	A	Fibrin degradation					
85379	A	Fibrin degradation					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85445	A	Heinz bodies, induced					
85460	A	Hemoglobin, fetal					
85461	A	Hemoglobin, fetal					
85475	A	Hemolysin					
85520	A	Heparin assay					
85525	A	Heparin					
85530	A	Heparin-protamine tolerance					
85536	A	Iron stain peripheral blood					
85540	A	Wbc alkaline phosphatase					
85547	A	RBC mechanical fragility					
85549	A	Muramidase					
85555	A	RBC osmotic fragility					
85557	A	RBC osmotic fragility					
85576	A	Blood platelet aggregation					
85585	A	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					
86001	A	Allergen specific igg					
86003	A	Allergen specific IgE					
86005	A	Allergen specific IgE					
86021	A	WBC antibody identification					
86022	A	Platelet antibodies					
86023	A	Immunoglobulin assay					
86038	A	Antinuclear antibodies					
86039	A	Antinuclear antibodies (ANA)					
86060	A	Antistreptolysin o, titer					
86063	A	Antistreptolysin o, screen					
86077	X	Physician blood bank service	0343	0.47	$24.44	$13.20	$4.89
86078	X	Physician blood bank service	0344	0.66	$34.33	$18.54	$6.87
86079	X	Physician blood bank service	0344	0.66	$34.33	$18.54	$6.87
86140	A	C-reactive protein					
86141	A	C-reactive protein, hs					
86146	A	Glycoprotein antibody					
86147	A	Cardiolipin antibody					
86148	A	Phospholipid antibody					
86155	A	Chemotaxis assay					
86156	A	Cold agglutinin, screen					
86157	A	Cold agglutinin, titer					
86160	A	Complement, antigen					
86161	A	Complement/function activity					
86162	A	Complement, total (CH50)					
86171	A	Complement fixation, each					
86185	A	Counterimmunoelectrophoresis					
86215	A	Deoxyribonuclease, antibody					
86225	A	DNA antibody					
86226	A	DNA antibody, single strand					
86235	A	Nuclear antigen antibody					
86243	A	Fc receptor					
86255	A	Fluorescent antibody, screen					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86256	A	Fluorescent antibody, titer					
86277	A	Growth hormone antibody					
86280	A	Hemagglutination inhibition					
86294	A	Immunoassay, tumor qual					
86300	A	Immunoassay, tumor ca 15-3					
86301	A	Immunoassay, tumor ca 19-9					
86304	A	Immunoassay, tumor, ca 125					
86308	A	Heterophile antibodies					
86309	A	Heterophile antibodies					
86310	A	Heterophile antibodies					
86316	A	Immunoassay, tumor other					
86317	A	Immunoassay,infectious agent					
86318	A	Immunoassay,infectious agent					
86320	A	Serum immunoelectrophoresis					
86325	A	Other immunoelectrophoresis					
86327	A	Immunoelectrophoresis assay					
86329	A	Immunodiffusion					
86331	A	Immunodiffusion ouchterlony					
86332	A	Immune complex assay					
86334	A	Immunofixation procedure					
86336	A	Inhibin A					
86337	A	Insulin antibodies					
86340	A	Intrinsic factor antibody					
86341	A	Islet cell antibody					
86343	A	Leukocyte histamine release					
86344	A	Leukocyte phagocytosis					
86353	A	Lymphocyte transformation					
86359	A	T cells, total count					
86360	A	T cell, absolute count/ratio					
86361	A	T cell, absolute count					
86376	A	Microsomal antibody					
86378	A	Migration inhibitory factor					
86382	A	Neutralization test, viral					
86384	A	Nitroblue tetrazolium dye					
86403	A	Particle agglutination test					
86406	A	Particle agglutination test					
86430	A	Rheumatoid factor test					
86431	A	Rheumatoid factor, quant					
86485	X	Skin test, candida	0341	0.16	$8.32	$3.08	$1.66
86490	X	Coccidioidomycosis skin test	0341	0.16	$8.32	$3.08	$1.66
86510	X	Histoplasmosis skin test	0341	0.16	$8.32	$3.08	$1.66
86580	X	TB intradermal test	0341	0.16	$8.32	$3.08	$1.66
86585	X	TB tine test	0341	0.16	$8.32	$3.08	$1.66
86586	X	Skin test, unlisted	0341	0.16	$8.32	$3.08	$1.66
86590	A	Streptokinase, antibody					
86592	A	Blood serology, qualitative					
86593	A	Blood serology, quantitative					
86602	A	Antinomyces antibody					
86603	A	Adenovirus antibody					
86606	A	Aspergillus antibody					
86609	A	Bacterium antibody					
86611	A	Bartonella antibody					
86612	A	Blastomyces antibody					
86615	A	Bordetella antibody					
86617	A	Lyme disease antibody					
86618	A	Lyme disease antibody					
86619	A	Borrelia antibody					
86622	A	Brucella antibody					
86625	A	Campylobacter antibody					
86628	A	Candida antibody					
86631	A	Chlamydia antibody					
86632	A	Chlamydia igm antibody					
86635	A	Coccidioides antibody					
86638	A	Q fever antibody					
86641	A	Cryptococcus antibody					
86644	A	CMV antibody					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86645	A	CMV antibody, IgM					
86648	A	Diphtheria antibody					
86651	A	Encephalitis antibody					
86652	A	Encephalitis antibody					
86653	A	Encephalitis antibody					
86654	A	Encephalitis antibody					
86658	A	Enterovirus antibody					
86663	A	Epstein-barr antibody					
86664	A	Epstein-barr antibody					
86665	A	Epstein-barr antibody					
86666	A	Ehrlichia antibody					
86668	A	Francisella tularensis					
86671	A	Fungus antibody					
86674	A	Giardia lamblia antibody					
86677	A	Helicobacter pylori					
86682	A	Helminth antibody					
86684	A	Hemophilus influenza					
86687	A	Htlv-i antibody					
86688	A	Htlv-ii antibody					
86689	A	HTLV/HIV confirmatory test					
86692	A	Hepatitis, delta agent					
86694	A	Herpes simplex test					
86695	A	Herpes simplex test					
86696	A	Herpes simplex type 2					
86698	A	Histoplasma					
86701	A	HIV-1					
86702	A	HIV-2					
86703	A	HIV-1/HIV-2, single assay					
86704	A	Hep b core antibody, total					
86705	A	Hep b core antibody, igm					
86706	A	Hep b surface antibody					
86707	A	Hep be antibody					
86708	A	Hep a antibody, total					
86709	A	Hep a antibody, igm					
86710	A	Influenza virus antibody					
86713	A	Legionella antibody					
86717	A	Leishmania antibody					
86720	A	Leptospira antibody					
86723	A	Listeria monocytogenes ab					
86727	A	Lymph choriomeningitis ab					
86729	A	Lympho venereum antibody					
86732	A	Mucormycosis antibody					
86735	A	Mumps antibody					
86738	A	Mycoplasma antibody					
86741	A	Neisseria meningitidis					
86744	A	Nocardia antibody					
86747	A	Parvovirus antibody					
86750	A	Malaria antibody					
86753	A	Protozoa antibody nos					
86756	A	Respiratory virus antibody					
86757	A	Rickettsia antibody					
86759	A	Rotavirus antibody					
86762	A	Rubella antibody					
86765	A	Rubeola antibody					
86768	A	Salmonella antibody					
86771	A	Shigella antibody					
86774	A	Tetanus antibody					
86777	A	Toxoplasma antibody					
86778	A	Toxoplasma antibody, igm					
86781	A	Treponema pallidum, confirm					
86784	A	Trichinella antibody					
86787	A	Varicella-zoster antibody					
86790	A	Virus antibody nos					
86793	A	Yersinia antibody					
86800	A	Thyroglobulin antibody					
86803	A	Hepatitis c ab test					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86804	A	Hep c ab test, confirm					
86805	A	Lymphocytotoxicity assay					
86806	A	Lymphocytotoxicity assay					
86807	A	Cytotoxic antibody screening					
86808	A	Cytotoxic antibody screening					
86812	A	HLA typing, A, B, or C					
86813	A	HLA typing, A, B, or C					
86816	A	HLA typing, DR/DQ					
86817	A	HLA typing, DR/DQ					
86821	A	Lymphocyte culture, mixed					
86822	A	Lymphocyte culture, primed					
86849	A	Immunology procedure					
86850	X	RBC antibody screen	0345	0.19	$9.88	$3.06	$1.98
86860	X	RBC antibody elution	0346	0.42	$21.84	$5.46	$4.37
86870	X	RBC antibody identification	0346	0.42	$21.84	$5.46	$4.37
86880	X	Coombs test	0341	0.16	$8.32	$3.08	$1.66
86885	X	Coombs test	0341	0.16	$8.32	$3.08	$1.66
86886	X	Coombs test	0341	0.16	$8.32	$3.08	$1.66
86890	X	Autologous blood process	0347	0.98	$50.97	$12.74	$10.19
86891	X	Autologous blood, op salvage	0345	0.19	$9.88	$3.06	$1.98
86900	X	Blood typing, ABO	0341	0.16	$8.32	$3.08	$1.66
86901	X	Blood typing, Rh (D)	0345	0.19	$9.88	$3.06	$1.98
86903	X	Blood typing, antigen screen	0345	0.19	$9.88	$3.06	$1.98
86904	X	Blood typing, patient serum	0345	0.19	$9.88	$3.06	$1.98
86905	X	Blood typing, RBC antigens	0345	0.19	$9.88	$3.06	$1.98
86906	X	Blood typing, Rh phenotype	0345	0.19	$9.88	$3.06	$1.98
86910	E	Blood typing, paternity test					
86911	E	Blood typing, antigen system					
86915	X	Bone marrow/stem cell prep	0346	0.42	$21.84	$5.46	$4.37
86920	X	Compatibility test	0346	0.42	$21.84	$5.46	$4.37
86921	X	Compatibility test	0345	0.19	$9.88	$3.06	$1.98
86922	X	Compatibility test	0346	0.42	$21.84	$5.46	$4.37
86927	X	Plasma, fresh frozen	0346	0.42	$21.84	$5.46	$4.37
86930	X	Frozen blood prep	0347	0.98	$50.97	$12.74	$10.19
86931	X	Frozen blood thaw	0347	0.98	$50.97	$12.74	$10.19
86932	X	Frozen blood freeze/thaw	0346	0.42	$21.84	$5.46	$4.37
86940	A	Hemolysins/agglutinins, auto					
86941	A	Hemolysins/agglutinins					
86945	X	Blood product/irradiation	0346	0.42	$21.84	$5.46	$4.37
86950	X	Leukacyte transfusion	0347	0.98	$50.97	$12.74	$10.19
86965	X	Pooling blood platelets	0346	0.42	$21.84	$5.46	$4.37
86970	X	RBC pretreatment	0345	0.19	$9.88	$3.06	$1.98
86971	X	RBC pretreatment	0345	0.19	$9.88	$3.06	$1.98
86972	X	RBC pretreatment	0345	0.19	$9.88	$3.06	$1.98
86975	X	RBC pretreatment, serum	0345	0.19	$9.88	$3.06	$1.98
86976	X	RBC pretreatment, serum	0345	0.19	$9.88	$3.06	$1.98
86977	X	RBC pretreatment, serum	0345	0.19	$9.88	$3.06	$1.98
86978	X	RBC pretreatment, serum	0345	0.19	$9.88	$3.06	$1.98
86985	X	Split blood or products	0347	0.98	$50.97	$12.74	$10.19
86999	X	Transfusion procedure	0345	0.19	$9.88	$3.06	$1.98
87001	A	Small animal inoculation					
87003	A	Small animal inoculation					
87015	A	Specimen concentration					
87040	A	Blood culture for bacteria					
87045	A	Feces culture, bacteria					
87046	A	Stool cultr, bacteria, each					
87070	A	Culture, bacteria, other					
87071	A	Culture bacteri aerobic othr					
87073	A	Culture bacteria anaerobic					
87075	A	Culture bacteria anaerobic					
87076	A	Culture anaerobe ident, each					
87077	A	Culture aerobic identify					
87081	A	Culture screen only					
87084	A	Culture of specimen by kit					
87086	A	Urine culture/colony count					
87088	A	Urine bacteria culture					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87101	A	Skin fungi culture					
87102	A	Fungus isolation culture					
87103	A	Blood fungus culture					
87106	A	Fungi identification, yeast					
87107	A	Fungi identification, mold					
87109	A	Mycoplasma					
87110	A	Chlamydia culture					
87116	A	Mycobacteria culture					
87118	A	Mycobacteric identification					
87140	A	Cultur type immunofluoresc					
87143	A	Culture typing, glc/hplc					
87147	A	Culture type, immunologic					
87149	A	Culture type, nucleic acid					
87152	A	Culture type pulse field gel					
87158	A	Culture typing, added method					
87164	A	Dark field examination					
87166	A	Dark field examination					
87168	A	Macroscopic exam arthropod					
87169	A	Macacroscopic exam parasite					
87172	A	Pinworm exam					
87176	A	Tissue homogenization, cultr					
87177	A	Ova and parasites smears					
87181	A	Microbe susceptible, diffuse					
87184	A	Microbe susceptible, disk					
87185	A	Microbe susceptible, enzyme					
87186	A	Microbe susceptible, mic					
87187	A	Microbe susceptible, mlc					
87188	A	Microbe suscept, macrobroth					
87190	A	Microbe suscept, mycobacteri					
87197	A	Bactericidal level, serum					
87198	A	Cytomegalovirus antibody dfa					
87199	A	Enterovirus antibody, dfa					
87205	A	Smear, gram stain					
87206	A	Smear, fluorescent/acid stai					
87207	A	Smear, special stain					
87210	A	Smear, wet mount, saline/ink					
87220	A	Tissue exam for fungi					
87230	A	Assay, toxin or antitoxin					
87250	A	Virus inoculate, eggs/animal					
87252	A	Virus inoculation, tissue					
87253	A	Virus inoculate tissue, addl					
87254	A	Virus inoculation, shell via					
87260	A	Adenovirus ag, if					
87265	A	Pertussis ag, if					
87270	A	Chlamydia trachomatis ag, if					
87272	A	Cryptosporidum/gardia ag, if					
87273	A	Herpes simplex 2, ag, if					
87274	A	Herpes simplex 1, ag, if					
87275	A	Influenza b, ag, if					
87276	A	Influenza a, ag, if					
87277	A	Legionella micdadei, ag, if					
87278	A	Legion pneumophilia ag, if					
87279	A	Parainfluenza, ag, if					
87280	A	Respiratory syncytial ag, if					
87281	A	Pneumocystis carinii, ag, if					
87283	A	Rubeola, ag, if					
87285	A	Treponema pallidum, ag, if					
87290	A	Varicella zoster, ag, if					
87299	A	Antibody detection, nos, if					
87300	A	Ag detection, polyval, if					
87301	A	Adenovirus ag, eia					
87320	A	Chylmd trach ag, eia					
87324	A	Clostridium ag, eia					
87327	A	Cryptococcus neoform ag, eia					
87328	A	Cryptospor ag, eia					
87332	A	Cytomegalovirus ag, eia					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87335	A	E coli 0157 ag, eia					
87336	A	Entamoeb hist dispr, ag, eia					
87337	A	Entamoeb hist group, ag, eia					
87338	A	Hpylori, stool, eia					
87339	A	H pylori ag, eia					
87340	A	Hepatitis b surface ag, eia					
87341	A	Hepatitis b surface, ag, eia					
87350	A	Hepatitis be ag, eia					
87380	A	Hepatitis delta ag, eia					
87385	A	Histoplasma capsul ag, eia					
87390	A	Hiv-1 ag, eia					
87391	A	Hiv-2 ag, eia					
87400	A	Influenza a/b, ag, eia					
87420	A	Resp syncytial ag, eia					
87425	A	Rotavirus ag, eia					
87427	A	Shiga-like toxin ag, eia					
87430	A	Strep a ag, eia					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					
87451	A	Ag detect polyval, eia, mult					
87470	A	Bartonella, dna, dir probe					
87471	A	Bartonella, dna, amp probe					
87472	A	Bartonella, dna, quant					
87475	A	Lyme dis, dna, dir probe					
87476	A	Lyme dis, dna, amp probe					
87477	A	Lyme dis, dna, quant					
87480	A	Candida, dna, dir probe					
87481	A	Candida, dna, amp probe					
87482	A	Candida, dna, quant					
87485	A	Chylmd pneum, dna, dir probe					
87486	A	Chylmd pneum, dna, amp probe					
87487	A	Chylmd pneum, dna, quant					
87490	A	Chylmd trach, dna, dir probe					
87491	A	Chylmd trach, dna, amp probe					
87492	A	Chylmd trach, dna, quant					
87495	A	Cytomeg, dna, dir probe					
87496	A	Cytomeg, dna, amp probe					
87497	A	Cytomeg, dna, quant					
87510	A	Gardner vag, dna, dir probe					
87511	A	Gardner vag, dna, amp probe					
87512	A	Gardner vag, dna, quant					
87515	A	Hepatitis b, dna, dir probe					
87516	A	Hepatitis b, dna, amp probe					
87517	A	Hepatitis b, dna, quant					
87520	A	Hepatitis c, rna, dir probe					
87521	A	Hepatitis c, rna, amp probe					
87522	A	Hepatitis c, rna, quant					
87525	A	Hepatitis g, dna, dir probe					
87526	A	Hepatitis g, dna, amp probe					
87527	A	Hepatitis g, dna, quant					
87528	A	Hsv, dna, dir probe					
87529	A	Hsv, dna, amp probe					
87530	A	Hsv, dna, quant					
87531	A	Hhv-6, dna, dir probe					
87532	A	Hhv-6, dna, amp probe					
87533	A	Hhv-6, dna, quant					
87534	A	Hiv-1, dna, dir probe					
87535	A	Hiv-1, dna, amp probe					
87536	A	Hiv-1, dna, quant					
87537	A	Hiv-2, dna, dir probe					
87538	A	Hiv-2, dna, amp probe					
87539	A	Hiv-2, dna, quant					
87540	A	Legion pneumo, dna, dir prob					
87541	A	Legion pneumo, dna, amp prob					
87542	A	Legion pneumo, dna, quant					
87550	A	Mycobacteria, dna, dir probe					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87551	A	Mycobacteria, dna, amp probe					
87552	A	Mycobacteria, dna, quant					
87555	A	M.tuberculo, dna, dir probe					
87556	A	M.tuberculo, dna, amp probe					
87557	A	M.tuberculo, dna, quant					
87560	A	M.avium-intra, dna, dir prob					
87561	A	M.avium-intra, dna, amp prob					
87562	A	M.avium-intra, dna, quant					
87580	A	M.pneumon, dna, dir probe					
87581	A	M.pneumon, dna, amp probe					
87582	A	M.pneumon, dna, quant					
87590	A	N.gonorrhoeae, dna, dir prob					
87591	A	N.gonorrhoeae, dna, amp prob					
87592	A	N.gonorrhoeae, dna, quant					
87620	A	Hpv, dna, dir probe					
87621	A	Hpv, dna, amp probe					
87622	A	Hpv, dna, quant					
87650	A	Strep a, dna, dir probe					
87651	A	Strep a, dna, amp probe					
87652	A	Strep a, dna, quant					
87797	A	Detect agent nos, dna, dir					
87798	A	Detect agent nos, dna, amp					
87799	A	Detect agent nos, dna, quant					
87800	A	Detect agnt mult, dna, direc					
87801	A	Detect agnt mult, dna, ampli					
87802	A	Strep b assay w/optic					
87803	A	Clostridium toxin a w/optic					
87804	A	Influenza assay w/optic					
87810	A	Chylmd trach assay w/optic					
87850	A	N. gonorrhoeae assay w/optic					
87880	A	Strep a assay w/optic					
87899	A	Agent nos assay w/optic					
87901	A	Genotype, dna, hiv reverse t					
87902	A	Genotype, dna, hepatitis C					
87903	A	Phenotype, dna hiv w/culture					
87904	A	Phenotype, dna hiv w/clt add					
87999	A	Microbiology procedure					
88000	E	Autopsy (necropsy), gross					
88005	E	Autopsy (necropsy), gross					
88007	E	Autopsy (necropsy), gross					
88012	E	Autopsy (necropsy), gross					
88014	E	Autopsy (necropsy), gross					
88016	E	Autopsy (necropsy), gross					
88020	E	Autopsy (necropsy), complete					
88025	E	Autopsy (necropsy), complete					
88027	E	Autopsy (necropsy), complete					
88028	E	Autopsy (necropsy), complete					
88029	E	Autopsy (necropsy), complete					
88036	E	Limited autopsy					
88037	E	Limited autopsy					
88040	E	Forensic autopsy (necropsy)					
88045	E	Coroner's autopsy (necropsy)					
88099	E	Necropsy (autopsy) procedure					
88104	X	Cytopathology, fluids	0343	0.47	$24.44	$13.20	$4.89
88106	X	Cytopathology, fluids	0343	0.47	$24.44	$13.20	$4.89
88107	X	Cytopathology, fluids	0343	0.47	$24.44	$13.20	$4.89
88108	X	Cytopath, concentrate tech	0343	0.47	$24.44	$13.20	$4.89
88125	X	Forensic cytopathology	0342	0.23	$11.96	$5.88	$2.39
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 lyr redo					
88144	A	Cytopath, c/v, thin lyr redo					
88145	A	Cytopath, c/v, thin lyr sel					
88147	A	Cytopath, c/v, automated					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.23	$11.96	$5.88	$2.39
88161	X	Cytopath smear, other source	0343	0.47	$24.44	$13.20	$4.89
88162	X	Cytopath smear, other source	0343	0.47	$24.44	$13.20	$4.89
88164	A	Cytopath tbs, c/v, manual					
88165	A	Cytopath tbs, c/v, redo					
88166	A	Cytopath tbs, c/v, auto redo					
88167	A	Cytopath tbs, c/v, select					
88172	X	Cytopathology eval of fna	0343	0.47	$24.44	$13.20	$4.89
88173	X	Cytopath eval, fna, report	0343	0.47	$24.44	$13.20	$4.89
88180	X	Cell marker study	0343	0.47	$24.44	$13.20	$4.89
88182	X	Cell marker study	0344	0.66	$34.33	$18.54	$6.87
88199	A	Cytopathology procedure					
88230	A	Tissue culture, lymphocyte					
88233	A	Tissue culture, skin/biopsy					
88235	A	Tissue culture, placenta					
88237	A	Tissue culture, bone marrow					
88239	A	Tissue culture, tumor					
88240	A	Cell cryopreserve/storage					
88241	A	Frozen cell preparation					
88245	A	Chromosome analysis, 20-25					
88248	A	Chromosome analysis, 50-100					
88249	A	Chromosome analysis, 100					
88261	A	Chromosome analysis, 5					
88262	A	Chromosome analysis, 15-20					
88263	A	Chromosome analysis, 45					
88264	A	Chromosome analysis, 20-25					
88267	A	Chromosome analys, placenta					
88269	A	Chromosome analys, amniotic					
88271	A	Cytogenetics, dna probe					
88272	A	Cytogenetics, 3-5					
88273	A	Cytogenetics, 10-30					
88274	A	Cytogenetics, 25-99					
88275	A	Cytogenetics, 100-300					
88280	A	Chromosome karyotype study					
88283	A	Chromosome banding study					
88285	A	Chromosome count, additional					
88289	A	Chromosome study, additional					
88291	A	Cyto/molecular report					
88299	X	Cytogenetic study	0342	0.23	$11.96	$5.88	$2.39
88300	X	Surgical path, gross	0342	0.23	$11.96	$5.88	$2.39
88302	X	Tissue exam by pathologist	0342	0.23	$11.96	$5.88	$2.39
88304	X	Tissue exam by pathologist	0343	0.47	$24.44	$13.20	$4.89
88305	X	Tissue exam by pathologist	0343	0.47	$24.44	$13.20	$4.89
88307	X	Tissue exam by pathologist	0344	0.66	$34.33	$18.54	$6.87
88309	X	Tissue exam by pathologist	0344	0.66	$34.33	$18.54	$6.87
88311	X	Decalcify tissue	0342	0.23	$11.96	$5.88	$2.39
88312	X	Special stains	0342	0.23	$11.96	$5.88	$2.39
88313	X	Special stains	0342	0.23	$11.96	$5.88	$2.39
88314	X	Histochemical stain	0342	0.23	$11.96	$5.88	$2.39
88318	X	Chemical histochemistry	0342	0.23	$11.96	$5.88	$2.39
88319	X	Enzyme histochemistry	0342	0.23	$11.96	$5.88	$2.39
88321	X	Microslide consultation	0342	0.23	$11.96	$5.88	$2.39
88323	X	Microslide consultation	0343	0.47	$24.44	$13.20	$4.89
88325	X	Comprehensive review of data	0344	0.66	$34.33	$18.54	$6.87
88329	X	Path consult introp	0342	0.23	$11.96	$5.88	$2.39
88331	X	Path consult intraop, 1 bloc	0343	0.47	$24.44	$13.20	$4.89
88332	X	Path consult intraop, addl	0342	0.23	$11.96	$5.88	$2.39
88342	X	Immunocytochemistry	0344	0.66	$34.33	$18.54	$6.87
88346	X	Immunofluorescent study	0343	0.47	$24.44	$13.20	$4.89
88347	X	Immunofluorescent study	0344	0.66	$34.33	$18.54	$6.87

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88348	X	Electron microscopy	0661	3.46	$179.95	$98.97	$35.99
88349	X	Scanning electron microscopy	0661	3.46	$179.95	$98.97	$35.99
88355	X	Analysis, skeletal muscle	0344	0.66	$34.33	$18.54	$6.87
88356	X	Analysis, nerve	0344	0.66	$34.33	$18.54	$6.87
88358	X	Analysis, tumor	0344	0.66	$34.33	$18.54	$6.87
88362	X	Nerve teasing preparations	0343	0.47	$24.44	$13.20	$4.89
88365	X	Tissue hybridization	0344	0.66	$34.33	$18.54	$6.87
88371	A	Protein, western blot tissue					
88372	A	Protein analysis w/probe					
88380	A	Microdissection					
88399	A	Surgical pathology procedure					
88400	A	Bilirubin total transcut					
89050	A	Body fluid cell count					
89051	A	Body fluid cell count					
89060	A	Exam synovial fluid crystals					
89100	X	Sample intestinal contents	0360	1.65	$85.81	$42.91	$17.16
89105	X	Sample intestinal contents	0360	1.65	$85.81	$42.91	$17.16
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89132	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89135	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89136	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89140	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89141	X	Sample stomach contents	0360	1.65	$85.81	$42.91	$17.16
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					
89250	X	Fertilization of oocyte	0348	0.83	$43.17		$8.63
89251	X	Culture oocyte w/embryos	0348	0.83	$43.17		$8.63
89252	X	Assist oocyte fertilization	0348	0.83	$43.17		$8.63
89253	X	Embryo hatching	0348	0.83	$43.17		$8.63
89254	X	Oocyte identification	0348	0.83	$43.17		$8.63
89255	X	Prepare embryo for transfer	0348	0.83	$43.17		$8.63
89256	X	Prepare cryopreserved embryo	0348	0.83	$43.17		$8.63
89257	X	Sperm identification	0348	0.83	$43.17		$8.63
89258	X	Cryopreservation, embryo	0348	0.83	$43.17		$8.63
89259	X	Cryopreservation, sperm	0348	0.83	$43.17		$8.63
89260	X	Sperm isolation, simple	0348	0.83	$43.17		$8.63
89261	X	Sperm isolation, complex	0348	0.83	$43.17		$8.63
89264	X	Identify sperm tissue	0348	0.83	$43.17		$8.63
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89321	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	0344	0.66	$34.33	$18.54	$6.87
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	0344	0.66	$34.33	$18.54	$6.87
89365	A	Water load test					
89399	A	Pathology lab procedure					
90281	E	Human ig, im					
90283	E	Human ig, iv					
90287	E	Botulinum antitoxin					
90288	E	Botulism ig, iv					
90291	E	Cmv ig, iv					
90296	N	Diphtheria antitoxin					
90371	K	Hep b ig, im	0356	0.69	$35.89		$7.18
90375	K	Rabies ig, im/sc	0356	0.69	$35.89		$7.18
90376	K	Rabies ig, heat treated	0356	0.69	$35.89		$7.18
90378	N	Rsv ig, im, 50mg					
90379	N	Rsv ig, iv					
90384	E	Rh ig, full-dose, im					
90385	N	Rh ig, minidose, im					
90386	E	Rh ig, iv					
90389	N	Tetanus ig, im					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90393	N	Vaccina ig, im					
90396	N	Varicella-zoster ig, im					
90399	E	Immune globulin					
90471	N	Immunization admin					
90472	N	Immunization admin, each add					
90473	E	Immune admin oral/nasal					
90474	E	Immune admin oral/nasal addl					
90476	N	Adenovirus vaccine, type 4					
90477	N	Adenovirus vaccine, type 7					
90581	K	Anthrax vaccine, sc	0356	0.69	$35.89		$7.18
90585	N	Bcg vaccine, percut					
90586	N	Bcg vaccine, intravesical					
90632	N	Hep a vaccine, adult im					
90633	N	Hep a vacc, ped/adol, 2 dose					
90634	N	Hep a vacc, ped/adol, 3 dose					
90636	K	Hep a/hep b vacc, adult im	0355	0.24	$12.48		$2.50
90645	N	Hib vaccine, hboc, im					
90646	N	Hib vaccine, prp-d, im					
90647	N	Hib vaccine, prp-omp, im					
90648	N	Hib vaccine, prp-t, im					
90657	K	Flu vaccine, 6-35 mo, im	0354	0.09	$4.68		
90658	K	Flu vaccine, 3 yrs, im	0354	0.09	$4.68		
90659	K	Flu vaccine, whole, im	0354	0.09	$4.68		
90660	E	Flu vaccine, nasal					
90665	N	Lyme disease vaccine, im					
90669	E	Pneumococcal vacc, ped<5					
90675	N	Rabies vaccine, im					
90676	N	Rabies vaccine, id					
90680	N	Rotovirus vaccine, oral					
90690	N	Typhoid vaccine, oral					
90691	N	Typhoid vaccine, im					
90692	N	Typhoid vaccine, h-p, sc/id					
90693	K	Typhoid vaccine, akd, sc	0356	0.69	$35.89		$7.18
90700	N	Dtap vaccine, im					
90701	N	Dtp vaccine, im					
90702	N	Dt vaccine < 7, im					
90703	N	Tetanus vaccine, im					
90704	N	Mumps vaccine, sc					
90705	N	Measles vaccine, sc					
90706	N	Rubella vaccine, sc					
90707	N	Mmr vaccine, sc					
90708	N	Measles-rubella vaccine, sc					
90709	K	Rubella & mumps vaccine, sc	0356	0.69	$35.89		$7.18
90710	N	Mmrv vaccine, sc					
90712	N	Oral poliovirus vaccine					
90713	N	Poliovirus, ipv, sc					
90716	N	Chicken pox vaccine, sc					
90717	N	Yellow fever vaccine, sc					
90718	N	Td vaccine > 7, im					
90719	N	Diphtheria vaccine, im					
90720	N	Dtp/hib vaccine, im					
90721	N	Dtap/hib vaccine, im					
90723	K	Dtap-hep b-ipv vaccine, im	0356	0.69	$35.89		$7.18
90725	N	Cholera vaccine, injectable					
90727	N	Plague vaccine, im					
90732	K	Pneumococcal vaccine	0354	0.09	$4.68		
90733	N	Meningococcal vaccine, sc					
90735	N	Encephalitis vaccine, sc					
90740	K	Hepb vacc, ill pat 3 dose im	0356	0.69	$35.89		$7.18
90743	K	Hep b vacc, adol, 2 dose, im	0356	0.69	$35.89		$7.18
90744	K	Hepb vacc ped/adol 3 dose im	0356	0.69	$35.89		$7.18
90746	K	Hep b vaccine, adult, im	0356	0.69	$35.89		$7.18
90747	K	Hepb vacc, ill pat 4 dose im	0356	0.69	$35.89		$7.18
90748	K	Hep b/hib vaccine, im	0355	0.24	$12.48		$2.50
90749	N	Vaccine toxoid					
90780	E	IV infusion therapy, 1 hour					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90781	E	IV infusion, additional hour					
90782	X	Injection, sc/im	0353	0.43	$22.36		$4.47
90783	X	Injection, ia	0359	0.83	$43.17		$8.63
90784	X	Injection, iv	0359	0.83	$43.17		$8.63
90788	X	Injection of antibiotic	0359	0.83	$43.17		$8.63
90799	X	Ther/prophylactic/dx inject	0352	0.14	$7.28		$1.46
90801	S	Psy dx interview	0323	1.95	$101.42	$21.26	$20.28
90802	S	Intac psy dx interview	0323	1.95	$101.42	$21.26	$20.28
90804	S	Psytx, office, 20-30 min	0322	1.44	$74.89	$12.40	$14.98
90805	S	Psytx, off, 20-30 min w/e&m	0322	1.44	$74.89	$12.40	$14.98
90806	S	Psytx, off, 45-50 min	0323	1.95	$101.42	$21.26	$20.28
90807	S	Psytx, off, 45-50 min w/e&m	0323	1.95	$101.42	$21.26	$20.28
90808	S	Psytx, office, 75-80 min	0323	1.95	$101.42	$21.26	$20.28
90809	S	Psytx, off, 75-80, w/e&m	0323	1.95	$101.42	$21.26	$20.28
90810	S	Intac psytx, off, 20-30 min	0322	1.44	$74.89	$12.40	$14.98
90811	S	Intac psytx, 20-30, w/e&m	0322	1.44	$74.89	$12.40	$14.98
90812	S	Intac psytx, off, 45-50 min	0323	1.95	$101.42	$21.26	$20.28
90813	S	Intac psytx, 45-50 min w/e&m	0323	1.95	$101.42	$21.26	$20.28
90814	S	Intac psytx, off, 75-80 min	0323	1.95	$101.42	$21.26	$20.28
90815	S	Intac psytx, 75-80 w/e&m	0323	1.95	$101.42	$21.26	$20.28
90816	S	Psytx, hosp, 20-30 min	0322	1.44	$74.89	$12.40	$14.98
90817	S	Psytx, hosp, 20-30 min w/e&m	0322	1.44	$74.89	$12.40	$14.98
90818	S	Psytx, hosp, 45-50 min	0323	1.95	$101.42	$21.26	$20.28
90819	S	Psytx, hosp, 45-50 min w/e&m	0323	1.95	$101.42	$21.26	$20.28
90821	S	Psytx, hosp, 75-80 min	0323	1.95	$101.42	$21.26	$20.28
90822	S	Psytx, hosp, 75-80 min w/e&m	0323	1.95	$101.42	$21.26	$20.28
90823	S	Intac psytx, hosp, 20-30 min	0322	1.44	$74.89	$12.40	$14.98
90824	S	Intac psytx, hsp 20-30 w/e&m	0322	1.44	$74.89	$12.40	$14.98
90826	S	Intac psytx, hosp, 45-50 min	0323	1.95	$101.42	$21.26	$20.28
90827	S	Intac psytx, hsp 45-50 w/e&m	0323	1.95	$101.42	$21.26	$20.28
90828	S	Intac psytx, hosp, 75-80 min	0323	1.95	$101.42	$21.26	$20.28
90829	S	Intac psytx, hsp 75-80 w/e&m	0323	1.95	$101.42	$21.26	$20.28
90845	S	Psychoanalysis	0323	1.95	$101.42	$21.26	$20.28
90846	S	Family psytx w/o patient	0324	2.71	$140.94		$28.19
90847	S	Family psytx w/patient	0324	2.71	$140.94		$28.19
90849	S	Multiple family group psytx	0325	1.55	$80.61	$18.27	$16.12
90853	S	Group psychotherapy	0325	1.55	$80.61	$18.27	$16.12
90857	S	Intac group psytx	0325	1.55	$80.61	$18.27	$16.12
90862	X	Medication management	0374	1.20	$62.41		$12.48
90865	S	Narcosynthesis	0323	1.95	$101.42	$21.26	$20.28
90870	S	Electroconvulsive therapy	0320	4.46	$231.96	$80.06	$46.39
90871	S	Electroconvulsive therapy	0320	4.46	$231.96	$80.06	$46.39
90875	E	Psychophysiological therapy					
90876	E	Psychophysiological therapy					
90880	S	Hypnotherapy	0323	1.95	$101.42	$21.26	$20.28
90882	E	Environmental manipulation					
90885	N	Psy evaluation of records					
90887	N	Consultation with family					
90889	N	Preparation of report					
90899	S	Psychiatric service/therapy	0322	1.44	$74.89	$12.40	$14.98
90901	S	Biofeedback train, any meth	0321	1.27	$66.05	$21.78	$13.21
90911	S	Biofeedback peri/uro/rectal	0321	1.27	$66.05	$21.78	$13.21
90918	A	ESRD related services, month					
90919	A	ESRD related services, month					
90920	A	ESRD related services, month					
90921	A	ESRD related services, month					
90922	A	ESRD related services, day					
90923	A	Esrd related services, day					
90924	A	Esrd related services, day					
90925	A	Esrd related services, day					
90935	S	Hemodialysis, one evaluation	0170	4.79	$249.12		$49.82
90937	E	Hemodialysis, repeated eval					
90939	N	Hemodialysis study, transcut					
90940	N	Hemodialysis access study					
90945	S	Dialysis, one evaluation	0170	4.79	$249.12		$49.82
90947	E	Dialysis, repeated eval					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90989	E	Dialysis training, complete					
90993	E	Dialysis training, incompl					
90997	E	Hemoperfusion					
90999	E	Dialysis procedure					
91000	X	Esophageal intubation	0361	3.55	$184.63	$83.23	$36.93
91010	X	Esophagus motility study	0361	3.55	$184.63	$83.23	$36.93
91011	X	Esophagus motility study	0361	3.55	$184.63	$83.23	$36.93
91012	X	Esophagus motility study	0361	3.55	$184.63	$83.23	$36.93
91020	X	Gastric motility	0361	3.55	$184.63	$83.23	$36.93
91030	X	Acid perfusion of esophagus	0361	3.55	$184.63	$83.23	$36.93
91032	X	Esophagus, acid reflux test	0361	3.55	$184.63	$83.23	$36.93
91033	X	Prolonged acid reflux test	0361	3.55	$184.63	$83.23	$36.93
91052	X	Gastric analysis test	0361	3.55	$184.63	$83.23	$36.93
91055	X	Gastric intubation for smear	0360	1.65	$85.81	$42.91	$17.16
91060	X	Gastric saline load test	0360	1.65	$85.81	$42.91	$17.16
91065	X	Breath hydrogen test	0360	1.65	$85.81	$42.91	$17.16
91100	X	Pass intestine bleeding tube	0360	1.65	$85.81	$42.91	$17.16
91105	X	Gastric intubation treatment	0360	1.65	$85.81	$42.91	$17.16
91122	T	Anal pressure record	0156	3.10	$161.23	$48.37	$32.25
91123	N	Irrigate fecal impaction					
91132	X	Electrogastrography	0360	1.65	$85.81	$42.91	$17.16
91133	X	Electrogastrography w/test	0360	1.65	$85.81	$42.91	$17.16
91299	X	Gastroenterology procedure	0360	1.65	$85.81	$42.91	$17.16
92002	V	Eye exam, new patient	0601	1.04	$54.09		$10.82
92004	V	Eye exam, new patient	0602	1.57	$81.65		$16.33
92012	V	Eye exam established pat	0600	0.91	$47.33		$9.47
92014	V	Eye exam & treatment	0602	1.57	$81.65		$16.33
92015	E	Refraction					
92018	T	New eye exam & treatment	0699	2.37	$123.26	$55.47	$24.65
92019	S	Eye exam & treatment	0698	1.01	$52.53	$20.49	$10.51
92020	S	Special eye evaluation	0230	0.78	$40.57	$15.82	$8.11
92060	S	Special eye evaluation	0230	0.78	$40.57	$15.82	$8.11
92065	S	Orthoptic/pleoptic training	0230	0.78	$40.57	$15.82	$8.11
92070	N	Fitting of contact lens					
92081	S	Visual field examination(s)	0230	0.78	$40.57	$15.82	$8.11
92082	S	Visual field examination(s)	0698	1.01	$52.53	$20.49	$10.51
92083	S	Visual field examination(s)	0698	1.01	$52.53	$20.49	$10.51
92100	N	Serial tonometry exam(s)					
92120	S	Tonography & eye evaluation	0230	0.78	$40.57	$15.82	$8.11
92130	S	Water provocation tonography	0698	1.01	$52.53	$20.49	$10.51
92135	S	Opthalmic dx imaging	0230	0.78	$40.57	$15.82	$8.11
92136	S	Ophthalmic biometry	0230	0.78	$40.57	$15.82	$8.11
92140	S	Glaucoma provocative tests	0698	1.01	$52.53	$20.49	$10.51
92225	S	Special eye exam, initial	0698	1.01	$52.53	$20.49	$10.51
92226	S	Special eye exam, subsequent	0698	1.01	$52.53	$20.49	$10.51
92230	T	Eye exam with photos	0699	2.37	$123.26	$55.47	$24.65
92235	T	Eye exam with photos	0699	2.37	$123.26	$55.47	$24.65
92240	S	Icg angiography	0231	2.24	$116.50	$52.43	$23.30
92250	S	Eye exam with photos	0230	0.78	$40.57	$15.82	$8.11
92260	S	Ophthalmoscopy/dynamometry	0230	0.78	$40.57	$15.82	$8.11
92265	S	Eye muscle evaluation	0231	2.24	$116.50	$52.43	$23.30
92270	S	Electro-oculography	0698	1.01	$52.53	$20.49	$10.51
92275	S	Electroretinography	0231	2.24	$116.50	$52.43	$23.30
92283	S	Color vision examination	0230	0.78	$40.57	$15.82	$8.11
92284	S	Dark adaptation eye exam	0698	1.01	$52.53	$20.49	$10.51
92285	S	Eye photography	0230	0.78	$40.57	$15.82	$8.11
92286	S	Internal eye photography	0698	1.01	$52.53	$20.49	$10.51
92287	S	Internal eye photography	0231	2.24	$116.50	$52.43	$23.30
92310	E	Contact lens fitting					
92311	X	Contact lens fitting	0362	2.83	$147.19		$29.44
92312	X	Contact lens fitting	0362	2.83	$147.19		$29.44
92313	X	Contact lens fitting	0362	2.83	$147.19		$29.44
92314	E	Prescription of contact lens					
92315	X	Prescription of contact lens	0362	2.83	$147.19		$29.44
92316	X	Prescription of contact lens	0362	2.83	$147.19		$29.44
92317	X	Prescription of contact lens	0362	2.83	$147.19		$29.44

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92325	X	Modification of contact lens	0362	2.83	$147.19		$29.44
92326	X	Replacement of contact lens	0362	2.83	$147.19		$29.44
92330	S	Fitting of artificial eye	0230	0.78	$40.57	$15.82	$8.11
92335	N	Fitting of artificial eye					
92340	E	Fitting of spectacles					
92341	E	Fitting of spectacles					
92342	E	Fitting of spectacles					
92352	X	Special spectacles fitting	0362	2.83	$147.19		$29.44
92353	X	Special spectacles fitting	0362	2.83	$147.19		$29.44
92354	X	Special spectacles fitting	0362	2.83	$147.19		$29.44
92355	X	Special spectacles fitting	0362	2.83	$147.19		$29.44
92358	X	Eye prosthesis service	0362	2.83	$147.19		$29.44
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	0362	2.83	$147.19		$29.44
92390	E	Supply of spectacles					
92391	E	Supply of contact lenses					
92392	E	Supply of low vision aids					
92393	E	Supply of artificial eye					
92395	E	Supply of spectacles					
92396	E	Supply of contact lenses					
92499	S	Eye service or procedure	0230	0.78	$40.57	$15.82	$8.11
92502	T	Ear and throat examination	0251	1.92	$99.86		$19.97
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	1.01	$52.53	$14.18	$10.51
92512	X	Nasal function studies	0363	0.76	$39.53	$14.63	$7.91
92516	X	Facial nerve function test	0660	1.65	$85.81	$31.75	$17.16
92520	X	Laryngeal function studies	0660	1.65	$85.81	$31.75	$17.16
92525	A	Oral function evaluation					
92526	A	Oral function therapy					
92531	N	Spontaneous nystagmus study					
92532	N	Positional nystagmus test					
92533	N	Caloric vestibular test					
92534	N	Optokinetic nystagmus test					
92541	X	Spontaneous nystagmus test	0363	0.76	$39.53	$14.63	$7.91
92542	X	Positional nystagmus test	0363	0.76	$39.53	$14.63	$7.91
92543	X	Caloric vestibular test	0660	1.65	$85.81	$31.75	$17.16
92544	X	Optokinetic nystagmus test	0363	0.76	$39.53	$14.63	$7.91
92545	X	Oscillating tracking test	0363	0.76	$39.53	$14.63	$7.91
92546	X	Sinusoidal rotational test	0660	1.65	$85.81	$31.75	$17.16
92547	X	Supplemental electrical test	0363	0.76	$39.53	$14.63	$7.91
92548	X	Posturography	0660	1.65	$85.81	$31.75	$17.16
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	0364	0.45	$23.40	$9.13	$4.68
92553	X	Audiometry, air & bone	0365	1.31	$68.13	$20.16	$13.63
92555	X	Speech threshold audiometry	0364	0.45	$23.40	$9.13	$4.68
92556	X	Speech audiometry, complete	0364	0.45	$23.40	$9.13	$4.68
92557	X	Comprehensive hearing test	0365	1.31	$68.13	$20.16	$13.63
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	0365	1.31	$68.13	$20.16	$13.63
92562	X	Loudness balance test	0364	0.45	$23.40	$9.13	$4.68
92563	X	Tone decay hearing test	0364	0.45	$23.40	$9.13	$4.68
92564	X	Sisi hearing test	0364	0.45	$23.40	$9.13	$4.68
92565	X	Stenger test, pure tone	0364	0.45	$23.40	$9.13	$4.68
92567	X	Tympanometry	0364	0.45	$23.40	$9.13	$4.68
92568	X	Acoustic reflex testing	0364	0.45	$23.40	$9.13	$4.68
92569	X	Acoustic reflex decay test	0364	0.45	$23.40	$9.13	$4.68
92571	X	Filtered speech hearing test	0364	0.45	$23.40	$9.13	$4.68
92572	X	Staggered spondaic word test	0364	0.45	$23.40	$9.13	$4.68
92573	X	Lombard test	0364	0.45	$23.40	$9.13	$4.68
92575	X	Sensorineural acuity test	0365	1.31	$68.13	$20.16	$13.63
92576	X	Synthetic sentence test	0364	0.45	$23.40	$9.13	$4.68

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92577	X	Stenger test, speech	0365	1.31	$68.13	$20.16	$13.63
92579	X	Visual audiometry (vra)	0365	1.31	$68.13	$20.16	$13.63
92582	X	Conditioning play audiometry	0365	1.31	$68.13	$20.16	$13.63
92583	X	Select picture audiometry	0364	0.45	$23.40	$9.13	$4.68
92584	X	Electrocochleography	0660	1.65	$85.81	$31.75	$17.16
92585	S	Auditor evoke potent, compre	0216	3.06	$159.15	$71.62	$31.83
92586	S	Auditor evoke potent, limit	0218	1.06	$55.13		$11.03
92587	X	Evoked auditory test	0363	0.76	$39.53	$14.63	$7.91
92588	X	Evoked auditory test	0660	1.65	$85.81	$31.75	$17.16
92589	X	Auditory function test(s)	0364	0.45	$23.40	$9.13	$4.68
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	1.31	$68.13	$20.16	$13.63
92597	E	Voice Prosthetic Evaluation					
92598	E	Voice Prosthetic Modification					
92599	X	ENT procedure/service	0364	0.45	$23.40	$9.13	$4.68
92950	S	Heart/lung resuscitation cpr	0094	2.68	$139.38	$47.39	$27.88
92953	S	Temporary external pacing	0094	2.68	$139.38	$47.39	$27.88
92960	S	Cardioversion electric, ext	0679	5.70	$296.45	$100.79	$59.29
92961	S	Cardioversion, electric, int	0679	5.70	$296.45	$100.79	$59.29
92970	C	Cardioassist, internal					
92971	C	Cardioassist, external					
92973	T	Percut coronary thrombectomy	0973		$250.00		$50.00
92974	T	Cath place, cardio brachytx	0981		$2,250.00		$450.00
92975	C	Dissolve clot, heart vessel					
92977	T	Dissolve clot, heart vessel	0676	4.62	$240.28	$64.88	$48.06
92978	S	Intravasc us, heart add-on	0670	14.78	$768.69	$276.73	$153.74
92979	S	Intravasc us, heart add-on	0670	14.78	$768.69	$276.73	$153.74
92980	T	Insert intracoronary stent	0104	72.72	$3,782.09		$756.42
92981	T	Insert intracoronary stent	0104	72.72	$3,782.09		$756.42
92982	T	Coronary artery dilation	0083	47.83	$2,487.59		$497.52
92984	T	Coronary artery dilation	0083	47.83	$2,487.59		$497.52
92986	T	Revision of aortic valve	0083	47.83	$2,487.59		$497.52
92987	T	Revision of mitral valve	0083	47.83	$2,487.59		$497.52
92990	T	Revision of pulmonary valve	0083	47.83	$2,487.59		$497.52
92992	C	Revision of heart chamber					
92993	C	Revision of heart chamber					
92995	T	Coronary atherectomy	0082	75.42	$3,922.52	$1,137.53	$784.50
92996	T	Coronary atherectomy add-on	0082	75.42	$3,922.52	$1,137.53	$784.50
92997	T	Pul art balloon repr, percut	0081	22.69	$1,180.08		$236.02
92998	T	Pul art balloon repr, percut	0081	22.69	$1,180.08		$236.02
93000	E	Electrocardiogram, complete					
93005	S	Electrocardiogram, tracing	0099	0.38	$19.76		$3.95
93010	A	Electrocardiogram report					
93012	N	Transmission of ecg					
93014	E	Report on transmitted ecg					
93015	E	Cardiovascular stress test					
93016	E	Cardiovascular stress test					
93017	X	Cardiovascular stress test	0100	1.34	$69.69	$38.33	$13.94
93018	E	Cardiovascular stress test					
93024	X	Cardiac drug stress test	0100	1.34	$69.69	$38.33	$13.94
93025	X	Microvolt t-wave assess	0100	1.34	$69.69	$38.33	$13.94
93040	E	Rhythm ECG with report					
93041	S	Rhythm ECG, tracing	0099	0.38	$19.76		$3.95
93042	E	Rhythm ECG, report					
93224	E	ECG monitor/report, 24 hrs					
93225	X	ECG monitor/record, 24 hrs	0100	1.34	$69.69	$38.33	$13.94
93226	X	ECG monitor/report, 24 hrs	0100	1.34	$69.69	$38.33	$13.94
93227	E	ECG monitor/review, 24 hrs					
93230	E	ECG monitor/report, 24 hrs					
93231	X	Ecg monitor/record, 24 hrs	0100	1.34	$69.69	$38.33	$13.94
93232	X	ECG monitor/report, 24 hrs	0100	1.34	$69.69	$38.33	$13.94

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93233	E	ECG monitor/review, 24 hrs					
93235	E	ECG monitor/report, 24 hrs					
93236	X	ECG monitor/report, 24 hrs	0100	1.34	$69.69	$38.33	$13.94
93237	E	ECG monitor/review, 24 hrs					
93268	E	ECG record/review					
93270	X	ECG recording	0097	0.84	$43.69	$23.80	$8.74
93271	X	Ecg/monitoring and analysis	0097	0.84	$43.69	$23.80	$8.74
93272	E	Ecg/review, interpret only					
93278	S	ECG/signal-averaged	0099	0.38	$19.76		$3.95
93303	S	Echo transthoracic	0269	3.42	$177.87	$92.49	$35.57
93304	S	Echo transthoracic	0697	1.51	$78.53	$40.84	$15.71
93307	S	Echo exam of heart	0269	3.42	$177.87	$92.49	$35.57
93308	S	Echo exam of heart	0697	1.51	$78.53	$40.84	$15.71
93312	S	Echo transesophageal	0270	5.65	$293.85	$146.79	$58.77
93313	S	Echo transesophageal	0270	5.65	$293.85	$146.79	$58.77
93314	N	Echo transesophageal					
93315	S	Echo transesophageal	0270	5.65	$293.85	$146.79	$58.77
93316	S	Echo transesophageal	0270	5.65	$293.85	$146.79	$58.77
93317	N	Echo transesophageal					
93318	S	Echo transesophageal intraop	0270	5.65	$293.85	$146.79	$58.77
93320	S	Doppler echo exam, heart	0671	1.68	$87.38	$45.44	$17.48
93321	S	Doppler echo exam, heart	0697	1.51	$78.53	$40.84	$15.71
93325	S	Doppler color flow add-on	0697	1.51	$78.53	$40.84	$15.71
93350	S	Echo transthoracic	0269	3.42	$177.87	$92.49	$35.57
93501	T	Right heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93503	T	Insert/place heart catheter	0103	11.26	$585.62	$210.82	$117.12
93505	T	Biopsy of heart lining	0103	11.26	$585.62	$210.82	$117.12
93508	T	Cath placement, angiography	0080	35.64	$1,853.60	$838.92	$370.72
93510	T	Left heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93511	T	Left heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93514	T	Left heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93524	T	Left heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93526	T	Rt & Lt heart catheters	0080	35.64	$1,853.60	$838.92	$370.72
93527	T	Rt & Lt heart catheters	0080	35.64	$1,853.60	$838.92	$370.72
93528	T	Rt & Lt heart catheters	0080	35.64	$1,853.60	$838.92	$370.72
93529	T	Rt&lt heart catheterization	0080	35.64	$1,853.60	$838.92	$370.72
93530	T	Rt heart cath, congenital	0080	35.64	$1,853.60	$838.92	$370.72
93531	T	R & l heart cath, congenital	0080	35.64	$1,853.60	$838.92	$370.72
93532	T	R & l heart cath, congenital	0080	35.64	$1,853.60	$838.92	$370.72
93533	T	R & l heart cath, congenital	0080	35.64	$1,853.60	$838.92	$370.72
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	T	Bundle of His recording	0087	5.81	$302.17		$60.43
93602	T	Intra-atrial recording	0087	5.81	$302.17		$60.43
93603	T	Right ventricular recording	0087	5.81	$302.17		$60.43
93609	T	Map tachycardia, add-on	0087	5.81	$302.17		$60.43
93610	T	Intra-atrial pacing	0087	5.81	$302.17		$60.43
93612	T	Intraventricular pacing	0087	5.81	$302.17		$60.43
93613	T	Electrophys map, 3d, add-on	0087	5.81	$302.17		$60.43
93615	T	Esophageal recording	0087	5.81	$302.17		$60.43
93616	T	Esophageal recording	0087	5.81	$302.17		$60.43
93618	T	Heart rhythm pacing	0087	5.81	$302.17		$60.43
93619	T	Electrophysiology evaluation	0085	31.77	$1,652.33	$363.51	$330.47
93620	T	Electrophysiology evaluation	0085	31.77	$1,652.33	$363.51	$330.47
93621	T	Electrophysiology evaluation	0085	31.77	$1,652.33	$363.51	$330.47

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93622	T	Electrophysiology evaluation	0085	31.77	$1,652.33	$363.51	$330.47
93623	T	Stimulation, pacing heart	0087	5.81	$302.17		$60.43
93624	S	Electrophysiologic study	0084	9.60	$499.29		$99.86
93631	T	Heart pacing, mapping	0087	5.81	$302.17		$60.43
93640	S	Evaluation heart device	0084	9.60	$499.29		$99.86
93641	S	Electrophysiology evaluation	0084	9.60	$499.29		$99.86
93642	S	Electrophysiology evaluation	0084	9.60	$499.29		$99.86
93650	T	Ablate heart dysrhythm focus	0086	43.70	$2,272.79	$772.75	$454.56
93651	T	Ablate heart dysrhythm focus	0086	43.70	$2,272.79	$772.75	$454.56
93652	T	Ablate heart dysrhythm focus	0086	43.70	$2,272.79	$772.75	$454.56
93660	S	Tilt table evaluation	0101	4.40	$228.84	$105.27	$45.77
93662	S	Intracardiac ecg (ice)	0670	14.78	$768.69	$276.73	$153.74
93668	E	Peripheral vascular rehab					
93701	S	Bioimpedance, thoracic	0099	0.38	$19.76		$3.95
93720	E	Total body plethysmography					
93721	X	Plethysmography tracing	0368	0.96	$49.93	$24.97	$9.99
93722	E	Plethysmography report					
93724	S	Analyze pacemaker system	0690	0.45	$23.40	$10.63	$4.68
93727	S	Analyze ilr system	0690	0.45	$23.40	$10.63	$4.68
93731	S	Analyze pacemaker system	0690	0.45	$23.40	$10.63	$4.68
93732	S	Analyze pacemaker system	0690	0.45	$23.40	$10.63	$4.68
93733	S	Telephone analy, pacemaker	0690	0.45	$23.40	$10.63	$4.68
93734	S	Analyze pacemaker system	0690	0.45	$23.40	$10.63	$4.68
93735	S	Analyze pacemaker system	0690	0.45	$23.40	$10.63	$4.68
93736	S	Telephone analy, pacemaker	0690	0.45	$23.40	$10.63	$4.68
93740	X	Temperature gradient studies	0367	0.60	$31.21	$15.61	$6.24
93741	S	Analyze ht pace device sngl	0689	0.60	$31.21	$12.03	$6.24
93742	S	Analyze ht pace device sngl	0689	0.60	$31.21	$12.03	$6.24
93743	S	Analyze ht pace device dual	0689	0.60	$31.21	$12.03	$6.24
93744	S	Analyze ht pace device dual	0689	0.60	$31.21	$12.03	$6.24
93760	E	Cephalic thermogram					
93762	E	Peripheral thermogram					
93770	N	Measure venous pressure					
93784	E	Ambulatory BP monitoring					
93786	X	Ambulatory BP recording	0097	0.84	$43.69	$23.80	$8.74
93788	E	Ambulatory BP analysis					
93790	E	Review/report BP recording					
93797	S	Cardiac rehab	0095	0.66	$34.33	$16.73	$6.87
93798	S	Cardiac rehab/monitor	0095	0.66	$34.33	$16.73	$6.87
93799	S	Cardiovascular procedure	0096	1.82	$94.66	$48.15	$18.93
93875	S	Extracranial study	0096	1.82	$94.66	$48.15	$18.93
93880	S	Extracranial study	0267	2.58	$134.18	$65.52	$26.84
93882	S	Extracranial study	0267	2.58	$134.18	$65.52	$26.84
93886	S	Intracranial study	0267	2.58	$134.18	$65.52	$26.84
93888	S	Intracranial study	0266	1.70	$88.42	$48.63	$17.68
93922	S	Extremity study	0096	1.82	$94.66	$48.15	$18.93
93923	S	Extremity study	0096	1.82	$94.66	$48.15	$18.93
93924	S	Extremity study	0096	1.82	$94.66	$48.15	$18.93
93925	S	Lower extremity study	0267	2.58	$134.18	$65.52	$26.84
93926	S	Lower extremity study	0267	2.58	$134.18	$65.52	$26.84
93930	S	Upper extremity study	0267	2.58	$134.18	$65.52	$26.84
93931	S	Upper extremity study	0266	1.70	$88.42	$48.63	$17.68
93965	S	Extremity study	0096	1.82	$94.66	$48.15	$18.93
93970	S	Extremity study	0267	2.58	$134.18	$65.52	$26.84
93971	S	Extremity study	0267	2.58	$134.18	$65.52	$26.84
93975	S	Vascular study	0267	2.58	$134.18	$65.52	$26.84
93976	S	Vascular study	0267	2.58	$134.18	$65.52	$26.84
93978	S	Vascular study	0267	2.58	$134.18	$65.52	$26.84
93979	S	Vascular study	0267	2.58	$134.18	$65.52	$26.84
93980	S	Penile vascular study	0267	2.58	$134.18	$65.52	$26.84
93981	S	Penile vascular study	0267	2.58	$134.18	$65.52	$26.84
93990	S	Doppler flow testing	0267	2.58	$134.18	$65.52	$26.84
94010	X	Breathing capacity test	0368	0.96	$49.93	$24.97	$9.99
94014	X	Patient recorded spirometry	0367	0.60	$31.21	$15.61	$6.24
94015	X	Patient recorded spirometry	0367	0.60	$31.21	$15.61	$6.24
94016	A	Review patient spirometry					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94060	X	Evaluation of wheezing	0368	0.96	$49.93	$24.97	$9.99
94070	X	Evaluation of wheezing	0369	2.39	$124.30	$41.02	$24.86
94150	X	Vital capacity test	0367	0.60	$31.21	$15.61	$6.24
94200	X	Lung function test (MBC/MVV)	0367	0.60	$31.21	$15.61	$6.24
94240	X	Residual lung capacity	0368	0.96	$49.93	$24.97	$9.99
94250	X	Expired gas collection	0367	0.60	$31.21	$15.61	$6.24
94260	X	Thoracic gas volume	0368	0.96	$49.93	$24.97	$9.99
94350	X	Lung nitrogen washout curve	0368	0.96	$49.93	$24.97	$9.99
94360	X	Measure airflow resistance	0367	0.60	$31.21	$15.61	$6.24
94370	X	Breath airway closing volume	0367	0.60	$31.21	$15.61	$6.24
94375	X	Respiratory flow volume loop	0367	0.60	$31.21	$15.61	$6.24
94400	X	CO2 breathing response curve	0367	0.60	$31.21	$15.61	$6.24
94450	X	Hypoxia response curve	0367	0.60	$31.21	$15.61	$6.24
94620	X	Pulmonary stress test/simple	0368	0.96	$49.93	$24.97	$9.99
94621	X	Pulm stress test/complex	0369	2.39	$124.30	$41.02	$24.86
94640	S	Airway inhalation treatment	0077	0.26	$13.52	$7.44	$2.70
94642	S	Aerosol inhalation treatment	0078	0.68	$35.37	$15.21	$7.07
94650	S	Pressure breathing (IPPB)	0077	0.26	$13.52	$7.44	$2.70
94651	S	Pressure breathing (IPPB)	0077	0.26	$13.52	$7.44	$2.70
94652	C	Pressure breathing (IPPB)					
94656	S	Initial ventilator mgmt	0079	1.63	$84.77	$16.80	$16.95
94657	S	Continued ventilator mgmt	0079	1.63	$84.77	$16.80	$16.95
94660	S	Pos airway pressure, CPAP	0068	1.59	$82.69	$45.48	$16.54
94662	S	Neg press ventilation, cnp	0079	1.63	$84.77	$16.80	$16.95
94664	S	Aerosol or vapor inhalations	0077	0.26	$13.52	$7.44	$2.70
94665	S	Aerosol or vapor inhalations	0077	0.26	$13.52	$7.44	$2.70
94667	S	Chest wall manipulation	0077	0.26	$13.52	$7.44	$2.70
94668	S	Chest wall manipulation	0077	0.26	$13.52	$7.44	$2.70
94680	X	Exhaled air analysis, o2	0367	0.60	$31.21	$15.61	$6.24
94681	X	Exhaled air analysis, o2/co2	0368	0.96	$49.93	$24.97	$9.99
94690	X	Exhaled air analysis	0367	0.60	$31.21	$15.61	$6.24
94720	X	Monoxide diffusing capacity	0368	0.96	$49.93	$24.97	$9.99
94725	X	Membrane diffusion capacity	0368	0.96	$49.93	$24.97	$9.99
94750	X	Pulmonary compliance study	0367	0.60	$31.21	$15.61	$6.24
94760	N	Measure blood oxygen level					
94761	N	Measure blood oxygen level					
94762	N	Measure blood oxygen level					
94770	X	Exhaled carbon dioxide test	0367	0.60	$31.21	$15.61	$6.24
94772	X	Breath recording, infant	0369	2.39	$124.30	$41.02	$24.86
94799	X	Pulmonary service/procedure	0367	0.60	$31.21	$15.61	$6.24
95004	X	Allergy skin tests	0370	0.74	$38.49	$11.16	$7.70
95010	X	Sensitivity skin tests	0370	0.74	$38.49	$11.16	$7.70
95015	X	Sensitivity skin tests	0370	0.74	$38.49	$11.16	$7.70
95024	X	Allergy skin tests	0370	0.74	$38.49	$11.16	$7.70
95027	X	Skin end point titration	0370	0.74	$38.49	$11.16	$7.70
95028	X	Allergy skin tests	0370	0.74	$38.49	$11.16	$7.70
95044	X	Allergy patch tests	0370	0.74	$38.49	$11.16	$7.70
95052	X	Photo patch test	0370	0.74	$38.49	$11.16	$7.70
95056	X	Photosensitivity tests	0370	0.74	$38.49	$11.16	$7.70
95060	X	Eye allergy tests	0370	0.74	$38.49	$11.16	$7.70
95065	X	Nose allergy test	0370	0.74	$38.49	$11.16	$7.70
95070	X	Bronchial allergy tests	0369	2.39	$124.30	$41.02	$24.86
95071	X	Bronchial allergy tests	0369	2.39	$124.30	$41.02	$24.86
95075	X	Ingestion challenge test	0361	3.55	$184.63	$83.23	$36.93
95078	X	Provocative testing	0370	0.74	$38.49	$11.16	$7.70
95115	X	Immunotherapy, one injection	0352	0.14	$7.28		$1.46
95117	X	Immunotherapy injections	0353	0.43	$22.36		$4.47
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	0.50	$26.00		$5.20
95145	X	Antigen therapy services	0371	0.50	$26.00		$5.20

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95146	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95147	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95148	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95149	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95165	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95170	X	Antigen therapy services	0371	0.50	$26.00		$5.20
95180	X	Rapid desensitization	0370	0.74	$38.49	$11.16	$7.70
95199	X	Allergy immunology services	0370	0.74	$38.49	$11.16	$7.70
95250	T	Glucose monitoring, cont	0972		$150.00		$30.00
95805	S	Multiple sleep latency test	0209	12.09	$628.79	$280.58	$125.76
95806	S	Sleep study, unattended	0213	3.38	$175.79	$70.41	$35.16
95807	S	Sleep study, attended	0209	12.09	$628.79	$280.58	$125.76
95808	S	Polysomnography, 1-3	0209	12.09	$628.79	$280.58	$125.76
95810	S	Polysomnography, 4 or more	0209	12.09	$628.79	$280.58	$125.76
95811	S	Polysomnography w/cpap	0209	12.09	$628.79	$280.58	$125.76
95812	S	Electroencephalogram (EEG)	0213	3.38	$175.79	$70.41	$35.16
95813	S	Electroencephalogram (EEG)	0213	3.38	$175.79	$70.41	$35.16
95816	S	Electroencephalogram (EEG)	0214	2.37	$123.26	$61.63	$24.65
95819	S	Electroencephalogram (EEG)	0214	2.37	$123.26	$61.63	$24.65
95822	S	Sleep electroencephalogram	0214	2.37	$123.26	$61.63	$24.65
95824	S	Electroencephalography	0214	2.37	$123.26	$61.63	$24.65
95827	S	Night electroencephalogram	0209	12.09	$628.79	$280.58	$125.76
95829	S	Surgery electrocorticogram	0214	2.37	$123.26	$61.63	$24.65
95830	E	Insert electrodes for EEG					
95831	N	Limb muscle testing, manual					
95832	N	Hand muscle testing, manual					
95833	N	Body muscle testing, manual					
95834	N	Body muscle testing, manual					
95851	N	Range of motion measurements					
95852	N	Range of motion measurements					
95857	S	Tensilon test	0218	1.06	$55.13		$11.03
95858	S	Tensilon test & myogram	0218	1.06	$55.13		$11.03
95860	S	Muscle test, one limb	0218	1.06	$55.13		$11.03
95861	S	Muscle test, two limbs	0218	1.06	$55.13		$11.03
95863	S	Muscle test, 3 limbs	0218	1.06	$55.13		$11.03
95864	S	Muscle test, 4 limbs	0218	1.06	$55.13		$11.03
95867	S	Muscle test, head or neck	0218	1.06	$55.13		$11.03
95868	S	Muscle test, head or neck	0218	1.06	$55.13		$11.03
95869	S	Muscle test, thor paraspinal	0215	0.60	$31.21		$6.24
95870	S	Muscle test, nonparaspinal	0218	1.06	$55.13		$11.03
95872	S	Muscle test, one fiber	0218	1.06	$55.13		$11.03
95875	S	Limb exercise test	0215	0.60	$31.21		$6.24
95900	S	Motor nerve conduction test	0218	1.06	$55.13		$11.03
95903	S	Motor nerve conduction test	0218	1.06	$55.13		$11.03
95904	S	Sense nerve conduction test	0215	0.60	$31.21		$6.24
95920	S	Intraop nerve test add-on	0216	3.06	$159.15	$71.62	$31.83
95921	S	Autonomic nerv function test	0218	1.06	$55.13		$11.03
95922	S	Autonomic nerv function test	0218	1.06	$55.13		$11.03
95923	S	Autonomic nerv function test	0215	0.60	$31.21		$6.24
95925	S	Somatosensory testing	0216	3.06	$159.15	$71.62	$31.83
95926	S	Somatosensory testing	0216	3.06	$159.15	$71.62	$31.83
95927	S	Somatosensory testing	0216	3.06	$159.15	$71.62	$31.83
95930	S	Visual evoked potential test	0218	1.06	$55.13		$11.03
95933	S	Blink reflex test	0215	0.60	$31.21		$6.24
95934	S	H-reflex test	0215	0.60	$31.21		$6.24
95936	S	H-reflex test	0215	0.60	$31.21		$6.24
95937	S	Neuromuscular junction test	0218	1.06	$55.13		$11.03
95950	S	Ambulatory eeg monitoring	0213	3.38	$175.79	$70.41	$35.16
95951	S	EEG monitoring/videorecord	0209	12.09	$628.79	$280.58	$125.76
95953	S	EEG monitoring/computer	0209	12.09	$628.79	$280.58	$125.76
95954	S	EEG monitoring/giving drugs	0214	2.37	$123.26	$61.63	$24.65
95955	S	EEG during surgery	0214	2.37	$123.26	$61.63	$24.65
95956	S	Eeg monitoring, cable/radio	0214	2.37	$123.26	$61.63	$24.65
95957	S	EEG digital analysis	0214	2.37	$123.26	$61.63	$24.65
95958	S	EEG monitoring/function test	0213	3.38	$175.79	$70.41	$35.16
95961	S	Electrode stimulation, brain	0216	3.06	$159.15	$71.62	$31.83

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95962	S	Electrode stim, brain add-on	0216	3.06	$159.15	$71.62	$31.83
95965	S	Meg, spontaneous	0717		$2,250.00		$450.00
95966	S	Meg, evoked, single	0714		$1,375.00		$275.00
95967	S	Meg, evoked, each addl	0712		$875.00		$175.00
95970	S	Analyze neurostim, no prog	0692	0.85	$44.21	$24.32	$8.84
95971	S	Analyze neurostim, simple	0692	0.85	$44.21	$24.32	$8.84
95972	S	Analyze neurostim, complex	0692	0.85	$44.21	$24.32	$8.84
95973	S	Analyze neurostim, complex	0692	0.85	$44.21	$24.32	$8.84
95974	S	Cranial neurostim, complex	0692	0.85	$44.21	$24.32	$8.84
95975	S	Cranial neurostim, complex	0692	0.85	$44.21	$24.32	$8.84
95999	S	Neurological procedure	0215	0.60	$31.21		$6.24
96000	S	Motion analysis, video/3d	0708		$150.00		$30.00
96001	S	Motion test w/ft press meas	0708		$150.00		$30.00
96002	S	Dynamic surface emg	0708		$150.00		$30.00
96003	S	Dynamic fine wire emg	0708		$150.00		$30.00
96004	E	Phys review of motion tests					
96100	X	Psychological testing	0373	2.37	$123.26		$24.65
96105	X	Assessment of aphasia	0373	2.37	$123.26		$24.65
96110	X	Developmental test, lim	0373	2.37	$123.26		$24.65
96111	X	Developmental test, extend	0373	2.37	$123.26		$24.65
96115	X	Neurobehavior status exam	0373	2.37	$123.26		$24.65
96117	X	Neuropsych test battery	0373	2.37	$123.26		$24.65
96150	S	Assess hlth/behave, init	0322	1.44	$74.89	$12.40	$14.98
96151	S	Assess hlth/behave, subseq	0322	1.44	$74.89	$12.40	$14.98
96152	S	Intervene hlth/behave, indiv	0322	1.44	$74.89	$12.40	$14.98
96153	S	Intervene hlth/behave, group	0322	1.44	$74.89	$12.40	$14.98
96154	S	Interv hlth/behav, fam w/pt	0322	1.44	$74.89	$12.40	$14.98
96155	S	Interv hlth/behav fam no pt	0322	1.44	$74.89	$12.40	$14.98
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	T	Pump refilling, maintenance	0125	1.73	$89.98		$18.00
96530	T	Pump refilling, maintenance	0125	1.73	$89.98		$18.00
96542	E	Chemotherapy injection					
96545	E	Provide chemotherapy agent					
96549	E	Chemotherapy, unspecified					
96567	T	Photodynamic tx, skin	0972		$150.00		$30.00
96570	T	Photodynamic tx, 30 min	0973		$250.00		$50.00
96571	T	Photodynamic tx, addl 15 min	0973		$250.00		$50.00
96900	S	Ultraviolet light therapy	0001	0.43	$22.36	$7.88	$4.47
96902	N	Trichogram					
96910	S	Photochemotherapy with UV-B	0001	0.43	$22.36	$7.88	$4.47
96912	S	Photochemotherapy with UV-A	0001	0.43	$22.36	$7.88	$4.47
96913	S	Photochemotherapy, UV-A or B	0683	2.11	$109.74	$39.51	$21.95
96999	T	Dermatological procedure	0010	0.70	$36.41	$10.56	$7.28
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					
97003	A	Ot evaluation					
97004	A	Ot re-evaluation					
97005	E	Athletic train eval					
97006	E	Athletic train reeval					
97010	A	Hot or cold packs therapy					
97012	A	Mechanical traction therapy					
97014	A	Electric stimulation therapy					
97016	A	Vasopneumatic device therapy					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97018	A	Paraffin bath therapy					
97020	A	Microwave therapy					
97022	A	Whirlpool therapy					
97024	A	Diathermy treatment					
97026	A	Infrared therapy					
97028	A	Ultraviolet therapy					
97032	A	Electrical stimulation					
97033	A	Electric current therapy					
97034	A	Contrast bath therapy					
97035	A	Ultrasound therapy					
97036	A	Hydrotherapy					
97039	A	Physical therapy treatment					
97110	A	Therapeutic exercises					
97112	A	Neuromuscular reeducation					
97113	A	Aquatic therapy/exercises					
97116	A	Gait training therapy					
97124	A	Massage therapy					
97139	A	Physical medicine procedure					
97140	A	Manual therapy					
97150	A	Group therapeutic procedures					
97504	A	Orthotic training					
97520	A	Prosthetic training					
97530	A	Therapeutic activities					
97532	A	Cognitive skills development					
97533	A	Sensory integration					
97535	A	Self care mngment training					
97537	A	Community/work reintegration					
97542	A	Wheelchair mngment training					
97545	A	Work hardening					
97546	A	Work hardening add-on					
97601	A	Wound(s) care, selective					
97602	N	Wound(s) care non-selective					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
97780	E	Acupuncture w/o stimul					
97781	E	Acupuncture w/stimul					
97799	A	Physical medicine procedure					
97802	A	Medical nutrition, indiv, in					
97803	A	Med nutrition, indiv, subseq					
97804	A	Medical nutrition, group					
98925	S	Osteopathic manipulation	0060	0.36	$18.72		$3.74
98926	S	Osteopathic manipulation	0060	0.36	$18.72		$3.74
98927	S	Osteopathic manipulation	0060	0.36	$18.72		$3.74
98928	S	Osteopathic manipulation	0060	0.36	$18.72		$3.74
98929	S	Osteopathic manipulation	0060	0.36	$18.72		$3.74
98940	S	Chiropractic manipulation	0060	0.36	$18.72		$3.74
98941	S	Chiropractic manipulation	0060	0.36	$18.72		$3.74
98942	S	Chiropractic manipulation	0060	0.36	$18.72		$3.74
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	N	Group health education					
99080	E	Special reports or forms					
99082	E	Unusual physician travel					
99090	E	Computer data analysis					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99091	E	Collect/review data from pt					
99100	E	Special anesthesia service					
99116	E	Anesthesia with hypothermia					
99135	E	Special anesthesia procedure					
99140	E	Emergency anesthesia					
99141	N	Sedation, iv/im or inhalant					
99142	N	Sedation, oral/rectal/nasal					
99170	T	Anogenital exam, child	0191	0.22	$11.44	$3.32	$2.29
99172	E	Ocular function screen					
99173	E	Visual acuity screen					
99175	N	Induction of vomiting					
99183	E	Hyperbaric oxygen therapy					
99185	N	Regional hypothermia					
99186	N	Total body hypothermia					
99190	C	Special pump services					
99191	C	Special pump services					
99192	C	Special pump services					
99195	X	Phlebotomy	0372	0.56	$29.13	$10.09	$5.83
99199	E	Special service/proc/report					
99201	V	Office/outpatient visit, new	0600	0.91	$47.33		$9.47
99202	V	Office/outpatient visit, new	0600	0.91	$47.33		$9.47
99203	V	Office/outpatient visit, new	0601	1.04	$54.09		$10.82
99204	V	Office/outpatient visit, new	0602	1.57	$81.65		$16.33
99205	V	Office/outpatient visit, new	0602	1.57	$81.65		$16.33
99211	V	Office/outpatient visit, est	0600	0.91	$47.33		$9.47
99212	V	Office/outpatient visit, est	0600	0.91	$47.33		$9.47
99213	V	Office/outpatient visit, est	0601	1.04	$54.09		$10.82
99214	V	Office/outpatient visit, est	0602	1.57	$81.65		$16.33
99215	V	Office/outpatient visit, est	0602	1.57	$81.65		$16.33
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	N	Observ/hosp same date					
99235	N	Observ/hosp same date					
99236	N	Observ/hosp same date					
99238	E	Hospital discharge day					
99239	E	Hospital discharge day					
99241	V	Office consultation	0600	0.91	$47.33		$9.47
99242	V	Office consultation	0600	0.91	$47.33		$9.47
99243	V	Office consultation	0601	1.04	$54.09		$10.82
99244	V	Office consultation	0602	1.57	$81.65		$16.33
99245	V	Office consultation	0602	1.57	$81.65		$16.33
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	0.91	$47.33		$9.47
99272	V	Confirmatory consultation	0600	0.91	$47.33		$9.47
99273	V	Confirmatory consultation	0601	1.04	$54.09		$10.82
99274	V	Confirmatory consultation	0602	1.57	$81.65		$16.33
99275	V	Confirmatory consultation	0602	1.57	$81.65		$16.33
99281	V	Emergency dept visit	0610	1.49	$77.49	$19.57	$15.50
99282	V	Emergency dept visit	0610	1.49	$77.49	$19.57	$15.50
99283	V	Emergency dept visit	0611	2.66	$138.34	$36.47	$27.67
99284	V	Emergency dept visit	0612	4.53	$235.60	$54.14	$47.12

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99285	V	Emergency dept visit	0612	4.53	$235.60	$54.14	$47.12
99288	E	Direct advanced life support					
99289	N	Pt transport, 30-74 min					
99290	N	Pt transport, addl 30 min					
99291	S	Critical care, first hour	0620	10.25	$533.09	$150.55	$106.62
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					
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					
99377	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	Nursing fac care supervision					
99381	E	Prev visit, new, infant					
99382	E	Prev visit, new, age 1-4					
99383	E	Prev visit, new, age 5-11					
99384	E	Prev visit, new, age 12-17					
99385	E	Prev visit, new, age 18-39					
99386	E	Prev visit, new, age 40-64					
99387	E	Prev visit, new, 65 & over					
99391	E	Prev visit, est, infant					
99392	E	Prev visit, est, age 1-4					
99393	E	Prev visit, est, age 5-11					
99394	E	Prev visit, est, age 12-17					
99395	E	Prev visit, est, age 18-39					
99396	E	Prev visit, est, age 40-64					
99397	E	Prev visit, est, 65 & over					
99401	E	Preventive counseling, indiv					
99402	E	Preventive counseling, indiv					
99403	E	Preventive counseling, indiv					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99404	E	Preventive counseling, indiv					
99411	E	Preventive counseling, group					
99412	E	Preventive counseling, group					
99420	E	Health risk assessment test					
99429	E	Unlisted preventive service					
99431	V	Initial care, normal newborn	0600	0.91	$47.33		$9.47
99432	N	Newborn care, not in hosp					
99433	C	Normal newborn care/hospital					
99435	E	Newborn discharge day hosp					
99436	N	Attendance, birth					
99440	S	Newborn resuscitation	0094	2.68	$139.38	$47.39	$27.88
99450	E	Life/disability evaluation					
99455	E	Disability examination					
99456	E	Disability examination					
99499	E	Unlisted e&m service					
99500	E	Home visit, prenatal					
99501	E	Home visit, postnatal					
99502	E	Home visit, nb care					
99503	E	Home visit, resp therapy					
99504	E	Home visit mech ventilator					
99505	E	Home visit, stoma care					
99506	E	Home visit, im injection					
99507	E	Home visit, cath maintain					
99508	E	Home visit, sleep studies					
99509	E	Home visit day life activity					
99510	E	Home visit, sing/m/fam couns					
99511	E	Home visit, fecal/enema mgmt					
99512	E	Home visit, hemodialysis					
99539	E	Home visit, nos					
99551	E	Home infus, pain mgmt, iv/sc					
99552	E	Hm infus pain mgmt, epid/ith					
99553	E	Home infuse, tocolytic tx					
99554	E	Home infus, hormone/platelet					
99555	E	Home infuse, chemotheraphy					
99556	E	Home infus, antibio/fung/vir					
99557	E	Home infuse, anticoagulant					
99558	E	Home infuse, immunotherapy					
99559	E	Home infus, periton dialysis					
99560	E	Home infus, entero nutrition					
99561	E	Home infuse, hydration tx					
99562	E	Home infus, parent nutrition					
99563	E	Home admin, pentamidine					
99564	E	Hme infus, antihemophil agnt					
99565	E	Home infus, proteinase inhib					
99566	E	Home infuse, iv therapy					
99567	E	Home infuse, sympath agent					
99568	E	Home infus, misc drug, daily					
99569	E	Home infuse, each addl tx					
A0021	E	Outside state ambulance serv					
A0080	E	Noninterest escort in non er					
A0090	E	Interest escort in non er					
A0100	E	Nonemergency transport taxi					
A0110	E	Nonemergency transport bus					
A0120	E	Noner transport mini-bus					
A0130	E	Noner transport wheelch van					
A0140	E	Nonemergency transport air					
A0160	E	Noner transport case worker					
A0170	E	Noner transport parking fees					
A0180	E	Noner transport lodgng recip					
A0190	E	Noner transport meals recip					
A0200	E	Noner transport lodgng escrt					
A0210	E	Noner transport meals escort					
A0225	A	Neonatal emergency transport					
A0380	A	Basic life support mileage					
A0382	A	Basic support routine suppls					
A0384	A	Bls defibrillation supplies					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A0390	A	Advanced life support mileag					
A0392	A	Als defibrillation supplies					
A0394	A	Als IV drug therapy supplies					
A0396	A	Als esophageal intub suppls					
A0398	A	Als routine disposble suppls					
A0420	A	Ambulance waiting 1/2 hr					
A0422	A	Ambulance 02 life sustaining					
A0424	A	Extra ambulance attendant					
A0425	A	Ground mileage					
A0426	A	Als 1					
A0427	A	ALS1-emergency					
A0428	A	bls					
A0429	A	BLS-emergency					
A0430	A	Fixed wing air transport					
A0431	A	Rotary wing air transport					
A0432	A	PI volunteer ambulance co					
A0433	A	als 2					
A0434	A	Specialty care transport					
A0435	A	Fixed wing air mileage					
A0436	A	Rotary wing air mileage					
A0888	E	Noncovered ambulance mileage					
A0999	A	Unlisted ambulance service					
A4206	A	1 CC sterile syringe&needle					
A4207	A	2 CC sterile syringe&needle					
A4208	A	3 CC sterile syringe&needle					
A4209	E	5+ CC sterile syringe&needle					
A4210	E	Nonneedle injection device					
A4211	E	Supp for self-adm injections					
A4212	E	Non coring needle or stylet					
A4213	E	20+ CC syringe only					
A4214	A	30 CC sterile water/saline					
A4215	E	Sterile needle					
A4220	A	Infusion pump refill kit					
A4221	A	Maint drug infus cath per wk					
A4222	A	Drug infusion pump supplies					
A4230	A	Infus insulin pump non needl					
A4231	A	Infusion insulin pump needle					
A4232	A	Syringe w/needle insulin 3cc					
A4244	E	Alcohol or peroxide per pint					
A4245	E	Alcohol wipes per box					
A4246	E	Betadine/phisohex solution					
A4247	E	Betadine/iodine swabs/wipes					
A4250	E	Urine reagent strips/tablets					
A4253	A	Blood glucose/reagent strips					
A4254	A	Battery for glucose monitor					
A4255	A	Glucose monitor platforms					
A4256	A	Calibrator solution/chips					
A4257	A	Replace Lensshield Cartridge					
A4258	A	Lancet device each					
A4259	A	Lancets per box					
A4260	E	Levonorgestrel implant					
A4261	E	Cervical cap contraceptive					
A4262	N	Temporary tear duct plug					
A4263	N	Permanent tear duct plug					
A4265	A	Paraffin					
A4270	A	Disposable endoscope sheath					
A4280	A	Brst prsths adhsv attchmnt					
A4290	E	Sacral nerve stim test lead					
A4300	E	Cath impl vasc access portal					
A4301	E	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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4314	A	Cath w/drainage 2-way latex					
A4315	A	Cath w/drainage 2-way silcne					
A4316	A	Cath w/drainage 3-way					
A4319	A	Sterile H2O irrigation solut					
A4320	A	Irrigation tray					
A4321	A	Cath therapeutic irrig agent					
A4322	A	Irrigation syringe					
A4323	A	Saline irrigation solution					
A4324	A	Male ext cath w/adh coating					
A4325	A	Male ext cath w/adh strip					
A4326	A	Male external catheter					
A4327	A	Fem urinary collect dev cup					
A4328	A	Fem urinary collect pouch					
A4330	A	Stool collection pouch					
A4331	A	Extension drainage tubing					
A4332	A	Lubricant for cath insertion					
A4333	A	Urinary cath anchor device					
A4334	A	Urinary cath leg strap					
A4335	A	Incontinence supply					
A4338	A	Indwelling catheter latex					
A4340	A	Indwelling catheter special					
A4344	A	Cath indw foley 2 way silicn					
A4346	A	Cath indw foley 3 way					
A4347	A	Male external catheter					
A4348	A	Male ext cath extended wear					
A4351	A	Straight tip urine catheter					
A4352	A	Coude tip urinary catheter					
A4353	A	Intermittent urinary cath					
A4354	A	Cath insertion tray w/bag					
A4355	A	Bladder irrigation tubing					
A4356	A	Ext ureth clmp or compr dvc					
A4357	A	Bedside drainage bag					
A4358	A	Urinary leg or abdomen bag					
A4359	A	Urinary suspensory w/o leg b					
A4360	A	Adult incontinence garment					
A4361	A	Ostomy face plate					
A4362	A	Solid skin barrier					
A4364	A	Adhesive, liquid or equal					
A4365	A	Adhesive remover wipes					
A4367	A	Ostomy belt					
A4368	A	Ostomy filter					
A4369	A	Skin barrier liquid per oz					
A4370	A	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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4394	A	Ostomy pouch liq deodorant					
A4395	A	Ostomy pouch solid deodorant					
A4396	A	Peristomal hernia supprt blt					
A4397	A	Irrigation supply sleeve					
A4398	A	Ostomy irrigation bag					
A4399	A	Ostomy irrig cone/cath w brs					
A4400	A	Ostomy irrigation set					
A4402	A	Lubricant per ounce					
A4404	A	Ostomy ring each					
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					
A4464	A	Joint support device/garment					
A4465	A	Non-elastic extremity binder					
A4470	A	Gravlee jet washer					
A4480	A	Vabra aspirator					
A4481	A	Tracheostoma filter					
A4483	A	Moisture exchanger					
A4490	E	Above knee surgical stocking					
A4495	E	Thigh length surg stocking					
A4500	E	Below knee surgical stocking					
A4510	E	Full length surg stocking					
A4550	E	Surgical trays					
A4554	E	Disposable underpads					
A4556	A	Electrodes, pair					
A4557	A	Lead wires, pair					
A4558	A	Conductive paste or gel					
A4561	N	Pessary rubber, any type					
A4562	N	Pessary, non rubber,any type					
A4565	A	Slings					
A4570	N	Splint					
A4572	A	Rib belt					
A4575	E	Hyperbaric o2 chamber disps					
A4580	N	Cast supplies (plaster)					
A4590	N	Special casting material					
A4595	A	TENS suppl 2 lead per month					
A4608	A	Transtracheal oxygen cath					
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					
A4642	N	Satumomab pendetide per dose					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4643	N	High dose contrast MRI					
A4644	N	Contrast 100-199 MGs iodine					
A4645	N	Contrast 200-299 MGs iodine					
A4646	N	Contrast 300-399 MGs iodine					
A4647	N	Supp- paramagnetic contr mat					
A4649	A	Surgical supplies					
A4651	A	Calibrated microcap tube					
A4652	A	Microcapillary tube sealant					
A4656	A	Dialysis needle					
A4657	A	Dialysis syringe w/wo needle					
A4660	A	Sphyg/bp app w cuff and stet					
A4663	A	Dialysis blood pressure cuff					
A4670	E	Automatic bp monitor, dial					
A4680	A	Activated carbon filter, ea					
A4690	A	Dialyzer, each					
A4706	A	Bicarbonate conc sol per gal					
A4707	A	Bicarbonate conc pow per pac					
A4708	A	Acetate conc sol per gallon					
A4709	A	Acid conc sol per gallon					
A4712	A	Sterile water inj per 10 ml					
A4714	A	Treated water per gallon					
A4719	A	''Y set'' tubing					
A4720	A	Dialysat sol fld vol > 249cc					
A4721	A	Dialysat sol fld vol > 999cc					
A4722	A	Dialys sol fld vol > 1999cc					
A4723	A	Dialys sol fld vol > 2999cc					
A4724	A	Dialys sol fld vol > 3999cc					
A4725	A	Dialys sol fld vol > 4999cc					
A4726	A	Dialys sol fld vol > 5999cc					
A4730	A	Fistula cannulation set, ea					
A4736	A	Topical anesthetic, per gram					
A4737	A	Inj anesthetic per 10 ml					
A4740	A	Shunt accessory					
A4750	A	Art or venous blood tubing					
A4755	A	Comb art/venous blood tubing					
A4760	A	Dialysate sol test kit, each					
A4765	A	Dialysate conc pow per pack					
A4766	A	Dialysate conc sol add 10 ml					
A4770	A	Blood collection tube/vacuum					
A4771	A	Serum clotting time tube					
A4772	A	Blood glucose test strips					
A4773	A	Occult blood test strips					
A4774	A	Ammonia test strips					
A4801	A	Heparin per 1000 units					
A4802	A	Protamine sulfate per 50 mg					
A4860	A	Disposable catheter tips					
A4870	A	Plumb/elec wk hm hemo equip					
A4890	A	Repair/maint cont hemo equip					
A4911	A	Drain bag/bottle					
A4913	A	Misc dialysis supplies noc					
A4918	A	Venous pressure clamp					
A4927	A	Non-sterile gloves					
A4928	A	Surgical mask					
A4929	A	Tourniquet for dialysis, ea					
A5051	A	Pouch clsd w barr attached					
A5052	A	Clsd ostomy pouch w/o barr					
A5053	A	Clsd ostomy pouch faceplate					
A5054	A	Clsd ostomy pouch w/flange					
A5055	A	Stoma cap					
A5061	A	Pouch drainable w barrier at					
A5062	A	Drnble ostomy pouch w/o barr					
A5063	A	Drain ostomy pouch w/flange					
A5071	A	Urinary pouch w/barrier					
A5072	A	Urinary pouch w/o barrier					
A5073	A	Urinary pouch on barr w/flng					
A5081	A	Continent stoma plug					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A5200	A	Percutaneous catheter anchor					
A5500	A	Diab shoe for density insert					
A5501	A	Diabetic custom molded shoe					
A5503	A	Diabetic shoe w/roller/rockr					
A5504	A	Diabetic shoe with wedge					
A5505	A	Diab shoe w/metatarsal bar					
A5506	A	Diabetic shoe w/off set heel					
A5507	A	Modification diabetic shoe					
A5508	A	Diabetic deluxe shoe					
A5509	A	Direct heat form shoe insert					
A5510	A	Compression form shoe insert					
A5511	A	Custom fab molded shoe inser					
A6000	A	Wound warming wound cover					
A6010	A	Collagen based wound filler					
A6021	A	Collagen dressing <=16 sq in					
A6022	A	Collagen drsg>6<=48 sq in					
A6023	A	Collagen dressing >48 sq in					
A6024	A	Collagen dsg wound filler					
A6025	E	Silicone gel sheet, each					
A6154	A	Wound pouch each					
A6196	A	Alginate dressing <=16 sq in					
A6197	A	Alginate drsg >16 <=48 sq in					
A6198	A	alginate dressing > 48 sq in					
A6199	A	Alginate drsg wound filler					
A6200	A	Compos drsg <=16 no border					
A6201	A	Compos drsg >16<=48 no bdr					
A6202	A	Compos drsg >48 no border					
A6203	A	Composite drsg <= 16 sq in					
A6204	A	Composite drsg >16<=48 sq in					
A6205	A	Composite drsg > 48 sq in					
A6206	A	Contact layer <= 16 sq in					
A6207	A	Contact layer >16<= 48 sq in					
A6208	A	Contact layer > 48 sq in					
A6209	A	Foam drsg <=16 sq in w/o bdr					
A6210	A	Foam drg >16<=48 sq in w/o b					
A6211	A	Foam drg > 48 sq in w/o brdr					
A6212	A	Foam drg <=16 sq in w/border					
A6213	A	Foam drg >16<=48 sq in w/bdr					
A6214	A	Foam drg > 48 sq in w/border					
A6215	A	Foam dressing wound filler					
A6216	A	Non-sterile gauze<=16 sq in					
A6217	A	Non-sterile gauze>16<=48 sq					
A6218	A	Non-sterile gauze > 48 sq in					
A6219	A	Gauze <= 16 sq in w/border					
A6220	A	Gauze >16 <=48 sq in w/bordr					
A6221	A	Gauze > 48 sq in w/border					
A6222	A	Gauze <=16 in no w/sal w/o b					
A6223	A	Gauze >16<=48 no w/sal w/o b					
A6224	A	Gauze > 48 in no w/sal w/o b					
A6228	A	Gauze <= 16 sq in water/sal					
A6229	A	Gauze >16<=48 sq in watr/sal					
A6230	A	Gauze > 48 sq in water/salne					
A6231	A	Hydrogel dsg<=16 sq in					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6232	A	Hydrogel dsg>16<=48 sq in					
A6233	A	Hydrogel dressing >48 sq in					
A6234	A	Hydrocolld drg <=16 w/o bdr					
A6235	A	Hydrocolld drg >16<=48 w/o b					
A6236	A	Hydrocolld drg > 48 in w/o b					
A6237	A	Hydrocolld drg <=16 in w/bdr					
A6238	A	Hydrocolld drg >16<=48 w/bdr					
A6239	A	Hydrocolld drg > 48 in w/bdr					
A6240	A	Hydrocolld drg filler paste					
A6241	A	Hydrocolloid drg filler dry					
A6242	A	Hydrogel drg <=16 in w/o bdr					
A6243	A	Hydrogel drg >16<=48 w/o bdr					
A6244	A	Hydrogel drg >48 in w/o bdr					
A6245	A	Hydrogel drg <= 16 in w/bdr					
A6246	A	Hydrogel drg >16<=48 in w/b					
A6247	A	Hydrogel drg > 48 sq in w/b					
A6248	A	Hydrogel drsg gel filler					
A6250	A	Skin seal protect moisturizr					
A6251	A	Absorpt drg <=16 sq in w/o b					
A6252	A	Absorpt drg >16 <=48 w/o bdr					
A6253	A	Absorpt drg > 48 sq in w/o b					
A6254	A	Absorpt drg <=16 sq in w/bdr					
A6255	A	Absorpt drg >16<=48 in w/bdr					
A6256	A	Absorpt drg > 48 sq in w/bdr					
A6257	A	Transparent film <= 16 sq in					
A6258	A	Transparent film >16<=48 in					
A6259	A	Transparent film > 48 sq in					
A6260	A	Wound cleanser any type/size					
A6261	A	Wound filler gel/paste /oz					
A6262	A	Wound filler dry form / gram					
A6263	A	Non-sterile elastic gauze/yd					
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					
A7018	A	Water distilled w/nebulizer					
A7019	A	Saline solution dispenser					
A7020	A	Sterile H2O or NSS w lgv neb					
A7501	A	Tracheostoma valve w diaphra					
A7502	A	Replacement diaphragm/fplate					
A7503	A	HMES filter holder or cap					
A7504	A	Tracheostoma HMES filter					
A7505	A	HMES or trach valve housing					
A7506	A	HMES/trachvalve adhesivedisk					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7507	A	Integrated filter & holder					
A7508	A	Housing & Integrated Adhesiv					
A7509	A	Heat & moisture exchange sys					
A9150	E	Misc/exper non-prescript dru					
A9270	E	Non-covered item or service					
A9300	E	Exercise equipment					
A9500	N	Technetium TC 99m sestamibi					
A9502	N	Technetium TC99M tetrofosmin					
A9503	N	Technetium TC 99m medronate					
A9504	N	Technetium tc 99m apcitide					
A9505	N	Thallous chloride TL 201/mci					
A9507	K	Indium/111 capromab pendetid	1604	5.91	$307.37		$61.47
A9508	N	Iobenguane sulfate I-131					
A9510	N	Technetium TC99m Disofenin					
A9511	K	Technetium TC 99m depreotide	1095	0.25	$13.00		$2.60
A9600	K	Strontium-89 chloride	0701	6.43	$334.42		$66.88
A9605	K	Samarium sm153 lexidronamm	0702	15.02	$781.18		$156.24
A9700	G	Echocardiography Contrast	9016		$118.75		$17.00
A9900	A	Supply/accessory/service					
A9901	A	Delivery/set up/dispensing					
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
B4036	A	Enteral feed sup kit grav by					
B4081	A	Enteral ng tubing w/ stylet					
B4082	A	Enteral ng tubing w/o stylet					
B4083	A	Enteral stomach tube levine					
B4086	A	Gastrostomy/jejunostomy tube					
B4150	A	Enteral formulae category i					
B4151	A	Enteral formulae cat1natural					
B4152	A	Enteral formulae category ii					
B4153	A	Enteral formulae categoryIII					
B4154	A	Enteral formulae category IV					
B4155	A	Enteral formulae category v					
B4156	A	Enteral formulae category vi					
B4164	A	Parenteral 50% dextrose solu					
B4168	A	Parenteral sol amino acid 3.					
B4172	A	Parenteral sol amino acid 5.					
B4176	A	Parenteral sol amino acid 7-					
B4178	A	Parenteral sol amino acid >					
B4180	A	Parenteral sol carb > 50%					
B4184	A	Parenteral sol lipids 10%					
B4186	A	Parenteral sol lipids 20%					
B4189	A	Parenteral sol amino acid &					
B4193	A	Parenteral sol 52-73 gm prot					
B4197	A	Parenteral sol 74-100 gm pro					
B4199	A	Parenteral sol > 100gm prote					
B4216	A	Parenteral nutrition additiv					
B4220	A	Parenteral supply kit premix					
B4222	A	Parenteral supply kit homemi					
B4224	A	Parenteral administration ki					
B5000	A	Parenteral sol renal-amirosy					
B5100	A	Parenteral sol hepatic-fream					
B5200	A	Parenteral sol stres-brnch c					
B9000	A	Enter infusion pump w/o alrm					
B9002	A	Enteral infusion pump w/ ala					
B9004	A	Parenteral infus pump portab					
B9006	A	Parenteral infus pump statio					
B9998	A	Enteral supp not otherwise c					
B9999	A	Parenteral supp not othrws c					
C1010	K	Blood, L/R, CMV-NEG	1010	1.67	$86.86		$17.37
C1011	K	Platelets, HLA-m, L/R, unit	1011	6.03	$313.61		$62.72
C1012	K	PLATELET CONC, L/R, Irrad	0954	1.59	$82.69		$16.54
C1013	K	PLATELET CONC, L/R, Unit	1013	0.91	$47.33		$9.47
C1014	K	Platelet,Aph/Pher, L/R, unit	9501	5.10	$265.25		$53.05
C1016	K	BLOOD,L/R,FROZ/DEGLY/Washed	1016	1.09	$56.69		$11.34
C1017	K	Plt, APH/PHER,L/R,CMV-NEG	1017	4.78	$248.60		$49.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1018	K	Blood, L/R, IRRADIATED	1018	1.90	$98.82		$19.76
C1058	G	TC 99M oxidronate, per vial	1058		$36.74		$5.26
C1064	G	I-131 cap, each add mCi	1064		$5.86		$.75
C1065	G	I-131 sol, each add mCi	1065		$15.81		$2.03
C1066	N	IN 111 satumomab pendetide					
C1079	N	CO 57/58 per 0.5 uCi					
C1087	N	I-123 per 100 uCi					
C1088	T	LASER OPTIC TR Sys	0980		$1,875.00		$375.00
C1091	K	IN111 oxyquinoline,per0.5mCi	1091	4.36	$226.76		$45.35
C1092	K	IN 111 pentetate per 0.5 mCi	1092	4.78	$248.60		$49.72
C1094	N	TC99Malbumin aggr,per 1.0mCi					
C1096	K	TC 99M EXAMETAZIME, PER Dose	1096	3.35	$174.23		$34.85
C1097	N	TC 99M MEBROFENIN, PER Vial					
C1098	N	TC 99M PENTETATE, PER Vial					
C1099	N	TC 99M PYROPHOSPHATE,PER Via.					
C1122	K	Tc 99M ARCITUMOMAB PER VIAL	1122	8.33	$433.23		$86.65
C1166	N	CYTARABINE LIPOSOMAL, 10 mg					
C1167	K	EPIRUBICIN HCL, 2 mg	1167	0.32	$16.64		$3.33
C1178	K	BUSULFAN IV, 6 Mg	1178	0.53	$27.56		$5.51
C1188	N	I-131 cap, per 1-5 mCi					
C1200	N	TC 99M Sodium Glucoheptonat					
C1201	N	TC 99M SUCCIMER, PER Vial					
C1202	N	TC 99M SULFUR COLLOID, Vial					
C1207	K	OCTREOTIDE ACETATE DEPOT 1mg.	1207	1.22	$63.45		$12.69
C1300	S	HYPERBARIC Oxygen	0659	3.12	$162.27		$32.45
C1305	K	Apligraf	1305	12.47	$648.55		$129.71
C1348	K	I-131 sol, per 1-6 mCi	1348	0.19	$9.88		$1.98
C1713	N	Anchor/screw bn/bn,tis/bn					
C1714	N	Cath, trans atherectomy, dir					
C1715	N	Brachytherapy needle					
C1716	K	Brachytx seed, Gold 198	1716	0.35	$18.20		$3.64
C1717	N	Brachytx seed, HDR Ir-192					
C1718	K	Brachytx seed, Iodine 125	1718	0.64	$33.29		$6.66
C1719	K	Brachytx seed,Non-HDR Ir-192	1719	0.57	$29.65		$5.93
C1720	K	Brachytx seed, Palladium 103	1720	0.89	$46.29		$9.26
C1721	N	AICD, dual chamber					
C1722	N	AICD, single chamber					
C1724	N	Cath, trans atherec,rotation					
C1725	N	Cath, translumin non-laser					
C1726	N	Cath, bal dil, non-vascular					
C1727	N	Cath, bal tis dis, non-vas					
C1728	N	Cath, brachytx seed adm					
C1729	N	Cath, drainage					
C1730	N	Cath, EP, 19 or few elect					
C1731	N	Cath, EP, 20 or more elec					
C1732	N	Cath, EP, diag/abl, 3D/vect					
C1733	N	Cath, EP, othr than cool-tip					
C1750	N	Cath, hemodialysis,long-term					
C1751	N	Cath, inf, per/cent/midline					
C1752	N	Cath,hemodialysis,short-term					
C1753	N	Cath, intravas ultrasound					
C1754	N	Catheter, intradiscal					
C1755	N	Catheter, intraspinal					
C1756	N	Cath, pacing, transesoph					
C1757	N	Cath, thrombectomy/embolect					
C1758	N	Catheter, ureteral					
C1759	N	Cath, intra echocardiography					
C1760	N	Closure dev, vasc					
C1762	N	Conn tiss, human(inc fascia)					
C1763	N	Conn tiss, non-human					
C1764	N	Event recorder, cardiac					
C1765	H	Adhesion barrier	1765				
C1766	N	Intro/sheath,strble,non-peel					
C1767	N	Generator, neurostim, imp					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1768	N	Graft, vascular					
C1769	N	Guide wire					
C1770	N	Imaging coil, MR, insertable					
C1771	N	Rep dev, urinary, w/sling					
C1772	N	Infusion pump, programmable					
C1773	N	Ret dev, insertable					
C1774	G	Darbepoetin alfa, 1 mcg	0734		$4.74		$.68
C1775	G	FDG, per dose (4-40 mCi/ml)	1775		$475.00		$68.00
C1776	N	Joint device (implantable)					
C1777	N	Lead, AICD, endo single coil					
C1778	N	Lead, neurostimulator					
C1779	N	Lead, pmkr, transvenous VDD					
C1780	N	Lens, intraocular (new tech)					
C1781	N	Mesh (implantable)					
C1782	N	Morcellator					
C1783	H	Ocular imp, aqueous drain dev	1783				
C1784	N	Ocular dev, intraop, det ret					
C1785	N	Pmkr, dual, rate-resp					
C1786	N	Pmkr, single, rate-resp					
C1787	N	Patient progr, neurostim					
C1788	N	Port, indwelling, imp					
C1789	N	Prosthesis, breast, imp					
C1813	N	Prosthesis, penile, inflatab					
C1815	N	Pros, urinary sph, imp					
C1816	N	Receiver/transmitter, neuro					
C1817	N	Septal defect imp sys					
C1874	N	Stent, coated/cov w/del sys					
C1875	N	Stent, coated/cov w/o del sy					
C1876	N	Stent, non-coa/non-cov w/del					
C1877	N	Stent, non-coat/cov w/o del					
C1878	N	Matrl for vocal cord					
C1879	N	Tissue marker, implantable					
C1880	N	Vena cava filter					
C1881	N	Dialysis access system					
C1882	N	AICD, other than sing/dual					
C1883	N	Adapt/ext, pacing/neuro lead					
C1885	N	Cath, translumin angio laser					
C1887	N	Catheter, guiding					
C1888	H	Endovas non-cardiac abl cath	1888				
C1891	N	Infusion pump,non-prog, perm					
C1892	N	Intro/sheath,fixed,peel-away					
C1893	N	Intro/sheath, fixed,non-peel					
C1894	N	Intro/sheath, non-laser					
C1895	N	Lead, AICD, endo dual coil					
C1896	N	Lead, AICD, non sing/dual					
C1897	N	Lead, neurostim test kit					
C1898	N	Lead, pmkr, other than trans					
C1899	N	Lead, pmkr/AICD combination					
C1900	H	Lead coronary venous	1900				
C2615	N	Sealant, pulmonary, liquid					
C2616	N	Brachytx seed, Yttrium-90					
C2617	N	Stent, non-cor, tem w/o del					
C2618	H	Probe, cryoablation	2618				
C2619	N	Pmkr, dual, non rate-resp					
C2620	N	Pmkr, single, non rate-resp					
C2621	N	Pmkr, other than sing/dual					
C2622	N	Prosthesis, penile, non-inf					
C2625	N	Stent, non-cor, tem w/del sy					
C2626	N	Infusion pump, non-prog,temp					
C2627	N	Cath, suprapubic/cystoscopic					
C2628	N	Catheter, occlusion					
C2629	N	Intro/sheath, laser					
C2630	N	Cath, EP, cool-tip					
C2631	N	Rep dev, urinary, w/o sling					
C8900	S	MRA w/cont, abd	0284	7.74	$402.55	$201.02	$80.51
C8901	S	MRA w/o cont, abd	0336	7.01	$364.58	$176.94	$72.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8902	S	MRA w/o fol w/cont, abd	0337	9.86	$512.81	$240.77	$102.56
C8903	S	MRI w/cont, breast, uni	0284	7.74	$402.55	$201.02	$80.51
C8904	S	MRI w/o cont, breast, uni	0336	7.01	$364.58	$176.94	$72.92
C8905	S	MRI w/o fol w/cont, brst, un	0337	9.86	$512.81	$240.77	$102.56
C8906	S	MRI w/cont, breast, bi	0284	7.74	$402.55	$201.02	$80.51
C8907	S	MRI w/o cont, breast, bi	0336	7.01	$364.58	$176.94	$72.92
C8908	S	MRI w/o fol w/cont, breast,	0337	9.86	$512.81	$240.77	$102.56
C8909	S	MRA w/cont, chest	0284	7.74	$402.55	$201.02	$80.51
C8910	S	MRA w/o cont, chest	0336	7.01	$364.58	$176.94	$72.92
C8911	S	MRA w/o fol w/cont, chest	0337	9.86	$512.81	$240.77	$102.56
C8912	S	MRA w/cont, lwr ext	0284	7.74	$402.55	$201.02	$80.51
C8913	S	MRA w/o cont, lwr ext	0336	7.01	$364.58	$176.94	$72.92
C8914	S	MRA w/o fol w/cont, lwr ext	0337	9.86	$512.81	$240.77	$102.56
C9000	N	Na chromateCr51, per 0.25mCi					
C9003	K	Palivizumab, per 50 mg	9003	9.34	$485.76		$97.15
C9007	N	Baclofen Intrathecal kit-1am					
C9008	N	Baclofen Refill Kit-500mcg					
C9009	K	Baclofen Refill Kit-2000mcg	9009	0.79	$41.09		$8.22
C9010	K	Baclofen Refill Kit--4000mcg	9010	0.95	$49.41		$9.88
C9013	N	Co 57 cobaltous chloride					
C9019	G	Caspofungin acetate, 5 mg	9019		$34.20		$4.90
C9020	K	Sirolimussolution, 1 mg	9020	0.05	$2.60		$.52
C9100	N	Iodinated I-131 Albumin					
C9102	N	51 Na Chromate, 50mCi					
C9103	N	Na Iothalamate I-125, 10 uCi					
C9105	K	Hep B imm glob, per 1 ml	9105	1.58	$82.17		$16.43
C9108	K	Thyrotropin alfa, 1.1 mg	9108	8.79	$457.16		$91.43
C9109	K	Tirofiban hcl, 6.25 mg	9109	2.32	$120.66		$24.13
C9110	G	Alemtuzumab, per 10mg/ml	9110		$486.88		$69.70
C9111	G	Inj, bivalirudin, 250mg vial	9111		$397.81		$56.95
C9112	G	Perflutren lipid micro, 2ml	9112		$148.20		$21.22
C9113	G	Inj pantoprazole sodium, via	9113		$22.80		$3.26
C9114	G	Nesiritide, per 1.5 mg vial	9114		$433.20		$62.02
C9115	G	Inj, zoledronic acid, 2 mg	9115		$406.78		$58.23
C9200	G	Orcel, per 36 cm2	9200		$1,135.25		$162.52
C9201	G	Dermagraft, per 37.5 sq cm	9201		$577.60		$82.69
C9503	K	Fresh frozen plasma, ea unit	9503	0.77	$40.05		$8.01
C9701	T	Stretta System	0980		$1,875.00		$375.00
C9703	T	Bard Endoscopic Suturing Sys	0979		$1,625.00		$325.00
C9708	T	Preview Tx Planning Software	0973		$250.00		$50.00
C9711	T	H.E.L.P. Apheresis System	0978		$1,375.00		$275.00
D0120	E	Periodic oral evaluation					
D0140	E	Limit oral eval problm focus					
D0150	S	Comprehensve oral evaluation	0330	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D0250	S	Extraoral first film	0330	0.64	$33.29		$6.66
D0260	S	Extraoral ea additional film	0330	0.64	$33.29		$6.66
D0270	S	Dental bitewing single film	0330	0.64	$33.29		$6.66
D0272	S	Dental bitewings two films	0330	0.64	$33.29		$6.66
D0274	S	Dental bitewings four films	0330	0.64	$33.29		$6.66
D0277	S	Vert bitewings-sev to eight	0330	0.64	$33.29		$6.66
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D0460	S	Pulp vitality test	0330	0.64	$33.29		$6.66
D0470	E	Diagnostic casts					
D0472	S	Gross exam, prep & report	0330	0.64	$33.29		$6.66
D0473	S	Micro exam, prep & report	0330	0.64	$33.29		$6.66
D0474	S	Micro w exam of surg margins	0330	0.64	$33.29		$6.66
D0480	S	Cytopath smear prep & report	0330	0.64	$33.29		$6.66
D0501	S	Histopathologic examinations	0330	0.64	$33.29		$6.66
D0502	S	Other oral pathology procedu	0330	0.64	$33.29		$6.66
D0999	S	Unspecified diagnostic proce	0330	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D1515	S	Fixed bilat space maintainer	0330	0.64	$33.29		$6.66
D1520	S	Remove unilat space maintain	0330	0.64	$33.29		$6.66
D1525	S	Remove bilat space maintain	0330	0.64	$33.29		$6.66
D1550	S	Recement space maintainer	0330	0.64	$33.29		$6.66
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.64	$33.29		$6.66
D2980	E	Crown repair					
D2999	S	Dental unspec restorative pr	0330	0.64	$33.29		$6.66
D3110	E	Pulp cap direct					
D3120	E	Pulp cap indirect					
D3220	E	Therapeutic pulpotomy					
D3221	E	Gross pulpal debridement					
D3230	E	Pulpal therapy anterior prim					
D3240	E	Pulpal therapy posterior pri					
D3310	E	Anterior					
D3320	E	Root canal therapy 2 canals					
D3330	E	Root canal therapy 3 canals					
D3331	E	Non-surg tx root canal obs					
D3332	E	Incomplete endodontic tx					
D3333	E	Internal root repair					
D3346	E	Retreat root canal anterior					
D3347	E	Retreat root canal bicuspid					
D3348	E	Retreat root canal molar					
D3351	E	Apexification/recalc initial					
0001T	C	Endovas repr abdo ao aneurys					
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	0.64	$33.29		$6.66
D3470	E	Intentional replantation					
D3910	E	Isolation- tooth w rubb dam					
D3920	E	Tooth splitting					
D3950	E	Canal prep/fitting of dowel					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D3999	S	Endodontic procedure	0330	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D4263	S	Bone replce graft first site	0330	0.64	$33.29		$6.66
D4264	S	Bone replce graft each add	0330	0.64	$33.29		$6.66
D4266	E	Guided tiss regen resorble					
D4267	E	Guided tiss regen nonresorb					
D4268	S	Surgical revision procedure	0330	0.64	$33.29		$6.66
D4270	S	Pedicle soft tissue graft pr	0330	0.64	$33.29		$6.66
D4271	S	Free soft tissue graft proc	0330	0.64	$33.29		$6.66
D4273	S	Subepithelial tissue graft	0330	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D4381	S	Localized chemo delivery	0330	0.64	$33.29		$6.66
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.64	$33.29		$6.66
D5912	S	Facial moulage complete	0330	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D5984	S	Radiation shield	0330	0.64	$33.29		$6.66
D5985	S	Radiation cone locator	0330	0.64	$33.29		$6.66
D5986	E	Fluoride applicator					
D5987	S	Commissure splint	0330	0.64	$33.29		$6.66
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.64	$33.29		$6.66
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	0.64	$33.29		$6.66
D7120	S	Each add tooth extraction	0330	0.64	$33.29		$6.66
D7130	S	Tooth root removal	0330	0.64	$33.29		$6.66
D7210	S	Rem imp tooth w mucoper flp	0330	0.64	$33.29		$6.66
D7220	S	Impact tooth remov soft tiss	0330	0.64	$33.29		$6.66
D7230	S	Impact tooth remov part bony	0330	0.64	$33.29		$6.66
D7240	S	Impact tooth remov comp bony	0330	0.64	$33.29		$6.66
D7241	S	Impact tooth rem bony w/comp	0330	0.64	$33.29		$6.66
D7250	S	Tooth root removal	0330	0.64	$33.29		$6.66
D7260	S	Oral antral fistula closure	0330	0.64	$33.29		$6.66
D7270	E	Tooth reimplantation					
D7272	E	Tooth transplantation					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7280	E	Exposure impact tooth orthod					
D7281	E	Exposure tooth aid eruption					
D7285	E	Biopsy of oral tissue hard					
D7286	E	Biopsy of oral tissue soft					
D7290	E	Repositioning of teeth					
D7291	S	Transseptal fiberotomy	0330	0.64	$33.29		$6.66
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.64	$33.29		$6.66
D7941	E	Bone cutting ramus closed					
D7943	E	Cutting ramus open w/graft					
D7944	E	Bone cutting segmented					
D7945	E	Bone cutting body mandible					
D7946	E	Reconstruction maxilla total					
D7947	E	Reconstruct maxilla segment					
D7948	E	Reconstruct midface no graft					
D7949	E	Reconstruct midface w/graft					
D7950	E	Mandible graft					
D7955	E	Repair maxillofacial defects					
D7960	E	Frenulectomy/frenulotomy					
D7970	E	Excision hyperplastic tissue					
D7971	E	Excision pericoronal gingiva					
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	N	Sedation (non-iv)					
D9310	E	Dental consultation					
D9410	E	Dental house call					
D9420	E	Hospital call					
D9430	E	Office visit during hours					
D9440	E	Office visit after hours					
D9610	E	Dent therapeutic drug inject					
D9630	S	Other drugs/medicaments	0330	0.64	$33.29		$6.66
D9910	E	Dent appl desensitizing med					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D9911	E	Appl desensitizing resin					
D9920	E	Behavior management					
D9930	S	Treatment of complications	0330	0.64	$33.29		$6.66
D9940	S	Dental occlusal guard	0330	0.64	$33.29		$6.66
D9941	E	Fabrication athletic guard					
D9950	S	Occlusion analysis	0330	0.64	$33.29		$6.66
D9951	S	Limited occlusal adjustment	0330	0.64	$33.29		$6.66
D9952	S	Complete occlusal adjustment	0330	0.64	$33.29		$6.66
D9970	E	Enamel microabrasion					
D9971	E	Odontoplasty 1-2 teeth					
D9972	E	Extrnl bleaching per arch					
D9973	E	Extrnl bleaching per tooth					
D9974	E	Intrnl bleaching per tooth					
D9999	E	Adjunctive procedure					
E0100	A	Cane adjust/fixed with tip					
E0105	A	Cane adjust/fixed quad/3 pro					
E0110	A	Crutch forearm pair					
E0111	A	Crutch forearm each					
E0112	A	Crutch underarm pair wood					
E0113	A	Crutch underarm each wood					
E0114	A	Crutch underarm pair no wood					
E0116	A	Crutch underarm each no wood					
E0130	A	Walker rigid adjust/fixed ht					
E0135	A	Walker folding adjust/fixed					
E0141	A	Rigid walker wheeled wo seat					
E0142	A	Walker rigid wheeled with se					
E0143	A	Walker folding wheeled w/o s					
E0144	A	Enclosed walker w rear seat					
E0145	A	Walker whled seat/crutch att					
E0146	A	Folding walker wheels w seat					
E0147	A	Walker variable wheel resist					
E0148	A	Heavyduty walker no wheels					
E0149	A	Heavy duty wheeled walker					
E0153	A	Forearm crutch platform atta					
E0154	A	Walker platform attachment					
E0155	A	Walker wheel attachment,pair					
E0156	A	Walker seat attachment					
E0157	A	Walker crutch attachment					
E0158	A	Walker leg extenders set of4					
E0159	A	Brake for wheeled walker					
E0160	A	Sitz type bath or equipment					
E0161	A	Sitz bath/equipment w/faucet					
E0162	A	Sitz bath chair					
E0163	A	Commode chair stationry fxd					
E0164	A	Commode chair mobile fixed a					
E0165	A	Commode chair stationry det					
E0166	A	Commode chair mobile detach					
E0167	A	Commode chair pail or pan					
E0168	A	Heavyduty/wide commode chair					
E0169	A	Seatlift incorp commodechair					
E0175	A	Commode chair foot rest					
E0176	A	Air pressre pad/cushion nonp					
E0177	A	Water press pad/cushion nonp					
E0178	A	Gel pressre pad/cushion nonp					
E0179	A	Dry pressre pad/cushion nonp					
E0180	A	Press pad alternating w pump					
E0181	A	Press pad alternating w/ pum					
E0182	A	Pressure pad alternating pum					
E0184	A	Dry pressure mattress					
E0185	A	Gel pressure mattress pad					
E0186	A	Air pressure mattress					
E0187	A	Water pressure mattress					
E0188	E	Synthetic sheepskin pad					
E0189	E	Lambswool sheepskin pad					
E0191	A	Protector heel or elbow					
E0192	A	Pad wheelchr low press/posit					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	E	Water circ cold pad w pump					
E0220	A	Hot water bottle					
E0221	A	Infrared heating pad system					
E0225	A	Hydrocollator unit					
E0230	A	Ice cap or collar					
E0231	A	Wound warming device					
E0232	A	Warming card for NWT					
E0235	A	Paraffin bath unit portable					
E0236	A	Pump for water circulating p					
E0238	A	Heat pad non-electric moist					
E0239	A	Hydrocollator unit portable					
E0241	E	Bath tub wall rail					
E0242	E	Bath tub rail floor					
E0243	E	Toilet rail					
E0244	E	Toilet seat raised					
E0245	E	Tub stool or bench					
E0246	E	Transfer tub rail attachment					
E0249	A	Pad water circulating heat u					
E0250	A	Hosp bed fixed ht w/ mattres					
E0251	A	Hosp bed fixd ht w/o mattres					
E0255	A	Hospital bed var ht w/ mattr					
E0256	A	Hospital bed var ht w/o matt					
E0260	A	Hosp bed semi-electr w/ matt					
E0261	A	Hosp bed semi-electr w/o mat					
E0265	A	Hosp bed total electr w/ mat					
E0266	A	Hosp bed total elec w/o matt					
E0270	E	Hospital bed institutional t					
E0271	A	Mattress innerspring					
E0272	A	Mattress foam rubber					
E0273	E	Bed board					
E0274	E	Over-bed table					
E0275	A	Bed pan standard					
E0276	A	Bed pan fracture					
E0277	A	Powered pres-redu air mattrs					
E0280	A	Bed cradle					
E0290	A	Hosp bed fx ht w/o rails w/m					
E0291	A	Hosp bed fx ht w/o rail w/o					
E0292	A	Hosp bed var ht w/o rail w/o					
E0293	A	Hosp bed var ht w/o rail w/					
E0294	A	Hosp bed semi-elect w/ mattr					
E0295	A	Hosp bed semi-elect w/o matt					
E0296	A	Hosp bed total elect w/ matt					
E0297	A	Hosp bed total elect w/o mat					
E0305	A	Rails bed side half length					
E0310	A	Rails bed side full length					
E0315	E	Bed accessory brd/tbl/supprt					
E0316	A	Bed safety enclosure					
E0325	A	Urinal male jug-type					
E0326	A	Urinal female jug-type					
E0350	E	Control unit bowel system					
E0352	E	Disposable pack w/bowel syst					
E0370	E	Air elevator for heel					
E0371	A	Nonpower mattress overlay					
E0372	A	Powered air mattress overlay					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0373	A	Nonpowered pressure mattress					
E0424	A	Stationary compressed gas 02					
E0425	E	Gas system stationary compre					
E0430	E	Oxygen system gas portable					
E0431	A	Portable gaseous 02					
E0434	A	Portable liquid 02					
E0435	E	Oxygen system liquid portabl					
E0439	A	Stationary liquid 02					
E0440	E	Oxygen system liquid station					
E0441	A	Oxygen contents, gaseous					
E0442	A	Oxygen contents, liquid					
E0443	A	Portable 02 contents, gas					
E0444	A	Portable 02 contents, liquid					
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					
E0481	A	Intrpulmnry percuss vent sys					
E0482	A	Cough stimulating device					
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					
E0571	A	Aerosol compressor for svneb					
E0572	A	Aerosol compressor adjust pr					
E0574	A	Ultrasonic generator w svneb					
E0575	A	Nebulizer ultrasonic					
E0580	A	Nebulizer for use w/ regulat					
E0585	A	Nebulizer w/ compressor & he					
E0590	A	Dispensing fee dme neb drug					
E0600	A	Suction pump portab hom modl					
E0601	A	Cont airway pressure device					
E0602	E	Manual breast pump					
E0603	A	Electric breast pump					
E0604	A	Hosp grade elec breast pump					
E0605	A	Vaporizer room type					
E0606	A	Drainage board postural					
E0607	A	Blood glucose monitor home					
E0608	A	Apnea monitor					
E0610	A	Pacemaker monitr audible/vis					
E0615	A	Pacemaker monitr digital/vis					
E0616	N	Cardiac event recorder					
E0617	A	Automatic ext defibrillator					
E0620	A	Cap bld skin piercing laser					
E0621	A	Patient lift sling or seat					
E0625	E	Patient lift bathroom or toi					
E0627	A	Seat lift incorp lift-chair					
E0628	A	Seat lift for pt furn-electr					
E0629	A	Seat lift for pt furn-non-el					
E0630	A	Patient lift hydraulic					
E0635	A	Patient lift electric					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	E	Safety equipment					
E0710	E	Restraints any type					
E0720	A	Tens two lead					
E0730	A	Tens four lead					
E0731	A	Conductive garment for tens/					
E0740	E	Incontinence treatment systm					
E0744	A	Neuromuscular stim for scoli					
E0745	A	Neuromuscular stim for shock					
E0746	E	Electromyograph biofeedback					
E0747	A	Elec osteogen stim not spine					
E0748	A	Elec osteogen stim spinal					
E0749	N	Elec osteogen stim implanted					
E0752	E	Neurostimulator electrode					
E0754	A	Pulsegenerator pt programmer					
E0755	E	Electronic salivary reflex s					
E0756	E	Implantable pulse generator					
E0757	E	Implantable RF receiver					
E0758	A	External RF transmitter					
E0759	A	Replace rdfrquncy transmittr					
E0760	E	Osteogen ultrasound stimltor					
E0765	E	Nerve stimulator for tx n&v					
E0776	A	Iv pole					
E0779	A	Amb infusion pump mechanical					
E0780	A	Mech amb infusion pump <8hrs					
E0781	A	External ambulatory infus pu					
E0782	E	Non-programble infusion pump					
E0783	E	Programmable infusion pump					
E0784	A	Ext amb infusn pump insulin					
E0785	E	Replacement impl pump cathet					
E0786	E	Implantable pump replacement					
E0791	A	Parenteral infusion pump sta					
E0830	N	Ambulatory traction device					
E0840	A	Tract frame attach headboard					
E0850	A	Traction stand free standing					
E0855	A	Cervical traction equipment					
E0860	A	Tract equip cervical tract					
E0870	A	Tract frame attach footboard					
E0880	A	Trac stand free stand extrem					
E0890	A	Traction frame attach pelvic					
E0900	A	Trac stand free stand pelvic					
E0910	A	Trapeze bar attached to bed					
E0920	A	Fracture frame attached to b					
E0930	A	Fracture frame free standing					
E0935	A	Exercise device passive moti					
E0940	A	Trapeze bar free standing					
E0941	A	Gravity assisted traction de					
E0942	A	Cervical head harness/halter					
E0943	A	Cervical pillow					
E0944	A	Pelvic belt/harness/boot					
E0945	A	Belt/harness extremity					
E0946	A	Fracture frame dual w cross					
E0947	A	Fracture frame attachmnts pe					
E0948	A	Fracture frame attachmnts ce					
E0950	E	Tray					
E0951	E	Loop heel					
E0952	E	Loop tie					
E0953	E	Pneumatic tire					
E0954	E	Wheelchair semi-pneumatic ca					
E0958	A	Whlchr att- conv 1 arm drive					
E0959	E	Amputee adapter					
E0961	E	Wheelchair brake extension					
E0962	A	Wheelchair 1 inch cushion					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0963	A	Wheelchair 2 inch cushion					
E0964	A	Wheelchair 3 inch cushion					
E0965	A	Wheelchair 4 inch cushion					
E0966	E	Wheelchair head rest extensi					
E0967	E	Wheelchair hand rims					
E0968	A	Wheelchair commode seat					
E0969	E	Wheelchair narrowing device					
E0970	E	Wheelchair no. 2 footplates					
E0971	E	Wheelchair anti-tipping devi					
E0972	A	Transfer board or device					
E0973	E	Wheelchair adjustabl height					
E0974	E	Wheelchair grade-aid					
E0975	E	Wheelchair reinforced seat u					
E0976	E	Wheelchair reinforced back u					
E0977	E	Wheelchair wedge cushion					
E0978	E	Wheelchair belt w/airplane b					
E0979	E	Wheelchair belt with velcro					
E0980	E	Wheelchair safety vest					
E0990	E	Whellchair elevating leg res					
E0991	E	Wheelchair upholstry seat					
E0992	E	Wheelchair solid seat insert					
E0993	E	Wheelchair back upholstery					
E0994	E	Wheelchair arm rest					
E0995	E	Wheelchair calf rest					
E0996	E	Wheelchair tire solid					
E0997	E	Wheelchair caster w/ a fork					
E0998	E	Wheelchair caster w/o a fork					
E0999	E	Wheelchr pneumatic tire w/wh					
E1000	E	Wheelchair tire pneumatic ca					
E1001	E	Wheelchair wheel					
E1031	A	Rollabout chair with casters					
E1035	E	Patient transfer system					
E1050	A	Whelchr fxd full length arms					
E1060	A	Wheelchair detachable arms					
E1065	E	Wheelchair power attachment					
E1066	E	Wheelchair battery charger					
E1069	E	Wheelchair deep cycle batter					
E1070	A	Wheelchair detachable foot r					
E1083	A	Hemi-wheelchair fixed arms					
E1084	A	Hemi-wheelchair detachable a					
E1085	A	Hemi-wheelchair fixed arms					
E1086	A	Hemi-wheelchair detachable a					
E1087	A	Wheelchair lightwt fixed arm					
E1088	A	Wheelchair lightweight det a					
E1089	A	Wheelchair lightwt fixed arm					
E1090	A	Wheelchair lightweight det a					
E1091	A	Wheelchair youth					
E1092	A	Wheelchair wide w/ leg rests					
E1093	A	Wheelchair wide w/ foot rest					
E1100	A	Whchr s-recl fxd arm leg res					
E1110	A	Wheelchair semi-recl detach					
E1130	A	Whlchr stand fxd arm ft rest					
E1140	A	Wheelchair standard detach a					
E1150	A	Wheelchair standard w/ leg r					
E1160	A	Wheelchair fixed arms					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1220	A	Whlchr special size/constrc					
E1221	A	Wheelchair spec size w foot					
E1222	A	Wheelchair spec size w/ leg					
E1223	A	Wheelchair spec size w foot					
E1224	A	Wheelchair spec size w/ leg					
E1225	A	Wheelchair spec sz semi-recl					
E1226	E	Wheelchair spec sz full-recl					
E1227	E	Wheelchair spec sz spec ht a					
E1228	A	Wheelchair spec sz spec ht b					
E1230	A	Power operated vehicle					
E1240	A	Whchr litwt det arm leg rest					
E1250	A	Wheelchair lightwt fixed arm					
E1260	A	Wheelchair lightwt foot rest					
E1270	A	Wheelchair lightweight leg r					
E1280	A	Whchr h-duty det arm leg res					
E1285	A	Wheelchair heavy duty fixed					
E1290	A	Wheelchair hvy duty detach a					
E1295	A	Wheelchair heavy duty fixed					
E1296	A	Wheelchair special seat heig					
E1297	A	Wheelchair special seat dept					
E1298	A	Wheelchair spec seat depth/w					
E1300	E	Whirlpool portable					
E1310	A	Whirlpool non-portable					
E1340	A	Repair for DME, per 15 min					
E1353	A	Oxygen supplies regulator					
E1355	A	Oxygen supplies stand/rack					
E1372	A	Oxy suppl heater for nebuliz					
E1390	A	Oxygen concentrator					
E1399	A	Durable medical equipment mi					
E1405	A	O2/water vapor enrich w/heat					
E1406	A	O2/water vapor enrich w/o he					
E1500	A	Centrifuge					
E1510	A	Kidney dialysate delivry sys					
E1520	A	Heparin infusion pump					
E1530	A	Replacement air bubble detec					
E1540	A	Replacement pressure alarm					
E1550	A	Bath conductivity meter					
E1560	A	Replace blood leak detector					
E1570	A	Adjustable chair for esrd pt					
E1575	A	Transducer protect/fld bar					
E1580	A	Unipuncture control system					
E1590	A	Hemodialysis machine					
E1592	A	Auto interm peritoneal dialy					
E1594	A	Cycler dialysis machine					
E1600	A	Deli/install chrg hemo equip					
E1610	A	Reverse osmosis h2o puri sys					
E1615	A	Deionizer H2O puri system					
E1620	A	Replacement blood pump					
E1625	A	Water softening system					
E1630	A	Reciprocating peritoneal dia					
E1632	A	Wearable artificial kidney					
E1635	A	Compact travel hemodialyzer					
E1636	A	Sorbent cartridges per 10					
E1637	A	Hemostats for dialysis, each					
E1638	A	Peri dialysis heating pad					
E1639	A	Dialysis scale					
E1699	A	Dialysis equipment noc					
E1700	A	Jaw motion rehab system					
E1701	A	Repl cushions for jaw motion					
E1702	A	Repl measr scales jaw motion					
E1800	A	Adjust elbow ext/flex device					
E1801	A	SPS elbow device					
E1805	A	Adjust wrist ext/flex device					
E1806	A	SPS wrist device					
E1810	A	Adjust knee ext/flex device					
E1811	A	SPS knee device					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1815	A	Adjust ankle ext/flex device					
E1816	A	SPS ankle device					
E1818	A	SPS forearm device					
E1820	A	Soft interface material					
E1821	A	Replacement interface SPSD					
E1825	A	Adjust finger ext/flex devc					
E1830	A	Adjust toe ext/flex device					
E1840	A	Adj shoulder ext/flex device					
E1902	A	AAC non-electronic board					
E2000	A	Gastric suction pump hme mdl					
E2100	A	Bld glucose monitor w voice					
E2101	A	Bld glucose monitor w lance					
G0001	A	Drawing blood for specimen					
G0002	X	Temporary urinary catheter	0340	0.66	$34.33		$6.87
G0004	E	ECG transm phys review & int					
G0005	X	ECG 24 hour recording	0097	0.84	$43.69	$23.80	$8.74
G0006	X	ECG transmission & analysis	0097	0.84	$43.69	$23.80	$8.74
G0007	N	ECG phy review & interpret					
G0008	K	Admin influenza virus vac	0354	0.09	$4.68		
G0009	K	Admin pneumococcal vaccine	0354	0.09	$4.68		
G0010	K	Admin hepatitis b vaccine	0355	0.24	$12.48		$2.50
G0015	X	Post symptom ECG tracing	0097	0.84	$43.69	$23.80	$8.74
G0025	N	Collagen skin test kit					
G0026	A	Fecal leukocyte examination					
G0027	A	Semen analysis					
G0030	S	PET imaging prev PET single	0285	16.73	$870.11	$374.15	$174.02
G0031	S	PET imaging prev PET multple	0285	16.73	$870.11	$374.15	$174.02
G0032	S	PET follow SPECT 78464 singl	0285	16.73	$870.11	$374.15	$174.02
G0033	S	PET follow SPECT 78464 mult	0285	16.73	$870.11	$374.15	$174.02
G0034	S	PET follow SPECT 76865 singl	0285	16.73	$870.11	$374.15	$174.02
G0035	S	PET follow SPECT 78465 mult	0285	16.73	$870.11	$374.15	$174.02
G0036	S	PET follow cornry angio sing	0285	16.73	$870.11	$374.15	$174.02
G0037	S	PET follow cornry angio mult	0285	16.73	$870.11	$374.15	$174.02
G0038	S	PET follow myocard perf sing	0285	16.73	$870.11	$374.15	$174.02
G0039	S	PET follow myocard perf mult	0285	16.73	$870.11	$374.15	$174.02
G0040	S	PET follow stress echo singl	0285	16.73	$870.11	$374.15	$174.02
G0041	S	PET follow stress echo mult	0285	16.73	$870.11	$374.15	$174.02
G0042	S	PET follow ventriculogm sing	0285	16.73	$870.11	$374.15	$174.02
G0043	S	PET follow ventriculogm mult	0285	16.73	$870.11	$374.15	$174.02
G0044	S	PET following rest ECG singl	0285	16.73	$870.11	$374.15	$174.02
G0045	S	PET following rest ECG mult	0285	16.73	$870.11	$374.15	$174.02
G0046	S	PET follow stress ECG singl	0285	16.73	$870.11	$374.15	$174.02
G0047	S	PET follow stress ECG mult	0285	16.73	$870.11	$374.15	$174.02
G0050	S	Residual urine by ultrasound	0265	1.04	$54.09	$29.75	$10.82
G0101	V	CA screen;pelvic/breast exam	0600	0.91	$47.33		$9.47
G0102	N	Prostate ca screening; dre					
G0103	A	Psa, total screening					
G0104	S	CA screen;flexi sigmoidscope	0159	2.48	$128.98		$32.25
G0105	T	Colorectal scrn; hi risk ind	0158	7.56	$393.19		$98.30
G0106	S	Colon CA screen;barium enema	0157	2.73	$141.98	$22.19	$28.40
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					
G0117	S	Glaucoma scrn hgh risk direc	0230	0.78	$40.57	$15.82	$8.11
G0118	S	Glaucoma scrn hgh risk direc	0230	0.78	$40.57	$15.82	$8.11
G0120	S	Colon ca scrn; barium enema	0157	2.73	$141.98	$22.19	$28.40
G0121	T	Colon ca scrn not hi rsk ind	0158	7.56	$393.19		$98.30
G0122	E	Colon ca scrn; barium enema					
G0123	A	Screen cerv/vag thin layer					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0124	A	Screen c/v thin layer by MD					
G0125	S	PET img WhBD sgl pulm ring	0667	18.68	$971.53		$194.31
G0127	T	Trim nail(s)	0009	0.68	$35.37	$8.34	$7.07
G0128	E	CORF skilled nursing service					
G0129	P	Partial hosp prog service	0033	4.96	$257.96		$51.59
G0130	X	Single energy x-ray study	0260	0.81	$42.13	$23.17	$8.43
G0131	S	CT scan, bone density study	0288	1.38	$71.77		$14.35
G0132	S	CT scan, bone density study	0665	0.73	$37.97		$7.59
G0141	E	Scr c/v cyto,autosys and md					
G0143	A	Scr c/v cyto,thinlayer,rescr					
G0144	A	Scr c/v cyto,thinlayer,rescr					
G0145	A	Scr c/v cyto,thinlayer,rescr					
G0147	A	Scr c/v cyto, automated sys					
G0148	A	Scr c/v cyto, autosys, rescr					
G0151	E	HHCP-serv of pt,ea 15 min					
G0152	E	HHCP-serv of ot,ea 15 min					
G0153	E	HHCP-svs of s/l path,ea 15mn					
G0154	E	HHCP-svs of rn,ea 15 min					
G0155	E	HHCP-svs of csw,ea 15 min					
G0156	E	HHCP-svs of aide,ea 15 min					
G0166	T	Extrnl counterpulse, per tx	0678	2.55	$132.62		$26.52
G0167	E	Hyperbaric oz tx;no md reqrd					
G0168	X	Wound closure by adhesive	0340	0.66	$34.33		$6.87
G0173	S	Stereo radoisurgery,complete	0663	63.69	$3,312.45		$662.49
G0175	V	OPPS Service,sched team conf	0602	1.57	$81.65		$16.33
G0176	P	OPPS/PHP;activity therapy	0033	4.96	$257.96		$51.59
G0177	P	OPPS/PHP; train & educ serv	0033	4.96	$257.96		$51.59
G0179	E	MD recertification HHA PT					
G0180	E	MD certification HHA patient					
G0181	E	Home health care supervision					
G0182	E	Hospice care supervision					
G0185	T	Transpuppillary thermotx	0235	5.62	$292.29	$81.84	$58.46
G0186	T	Dstry eye lesn,fdr vssl tech	0235	5.62	$292.29	$81.84	$58.46
G0187	T	Dstry mclr drusen,photocoag	0235	5.62	$292.29	$81.84	$58.46
G0192	N	Immunization oral/intranasal					
G0193	A	Endoscopicstudyswallowfunctn					
G0194	A	Sensorytestingendoscopicstud					
G0195	A	Clinicalevalswallowingfunct					
G0196	A	Evalofswallowingwithradioopa					
G0197	A	Evalofptforprescipspeechdevi					
G0198	A	Patientadapation&trainforspe					
G0199	A	Reevaluationofpatientusespec					
G0200	A	Evalofpatientprescipofvoicep					
G0201	A	Modifortraininginusevoicepro					
G0202	A	Screeningmammographydigital					
G0204	S	Diagnosticmammographydigital	0669	0.95	$49.41		$9.88
G0206	S	Diagnosticmammographydigital	0669	0.95	$49.41		$9.88
G0210	S	PET img whbd ring dxlung ca	0667	18.68	$971.53		$194.31
G0211	S	PET img whbd ring init lung	0667	18.68	$971.53		$194.31
G0212	S	PET img whbd ring restag lun	0667	18.68	$971.53		$194.31
G0213	S	PET img whbd ring dx colorec	0667	18.68	$971.53		$194.31
G0214	S	PET img whbd ring init colre	0667	18.68	$971.53		$194.31
G0215	S	PET img whbd restag col	0667	18.68	$971.53		$194.31
G0216	S	PET img whbd ring dx melanom	0667	18.68	$971.53		$194.31
G0217	S	PET img whbd ring init melan	0667	18.68	$971.53		$194.31
G0218	S	PET img whbd ring restag mel	0667	18.68	$971.53		$194.31
G0219	E	PET img whbd ring noncov ind					
G0220	S	PET img whbd ring dx lymphom	0667	18.68	$971.53		$194.31
G0221	S	PET img whbd ring init lymph	0667	18.68	$971.53		$194.31
G0222	S	PET img whbd ring resta lymp	0667	18.68	$971.53		$194.31
G0223	S	PET img whbd reg ring dx hea	0667	18.68	$971.53		$194.31
G0224	S	PETimg whbd reg ring ini hea	0667	18.68	$971.53		$194.31
G0225	S	PET img whbd ring restag hea	0667	18.68	$971.53		$194.31
G0226	S	PET img whbd dx esophag	0667	18.68	$971.53		$194.31
G0227	S	PET img whbd ring ini esopha	0667	18.68	$971.53		$194.31
G0228	S	PET img whbd ring restg esop	0667	18.68	$971.53		$194.31

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0229	S	PET img metabolic brain ring	0667	18.68	$971.53		$194.31
G0230	S	PET myocard viability ring	0667	18.68	$971.53		$194.31
G0231	S	PET WhBD colorec; gamma cam	0667	18.68	$971.53		$194.31
G0232	S	PET whbd lymphoma; gamma cam	0667	18.68	$971.53		$194.31
G0233	S	PET whbd melanoma; gamma cam	0667	18.68	$971.53		$194.31
G0234	S	PET WhBD pulm nod; gamma cam	0667	18.68	$971.53		$194.31
G0236	S	Digital film convert diag ma	0706		$25.00		$5.00
G0237	T	Therapeutic procd strg endur	0970		$25.00		$5.00
G0238	T	Oth resp proc, indiv	0970		$25.00		$5.00
G0239	T	Oth resp proc, group	0970		$25.00		$5.00
G0240	A	Critic care by MD transport					
G0241	A	Each additional 30 minutes					
G0242	S	Multisource photon ster plan	0714		$1,375.00		$275.00
G0243	S	Multisour photon stero treat	0721		$5,500.00		$1,100.00
G0244	S	Observ care by facility topt	0339	7.60	$395.27		$79.05
G0245	V	Initial Foot Exam PTLOPS	0600	0.91	$47.33		$9.47
G0246	V	Follow-up Eval of Foot PTLOPS	0600	0.91	$47.33		$9.47
G0247	T	Routine footcare w LOPS	0009	0.68	$35.37	$8.34	$7.07
G0248	S	Demonstrate use home INR mon	0708		$150.00		$30.00
G0249	S	Provide test material,equipm	0708		$150.00		$30.00
G0250	E	MD review interpret of test					
G9001	E	MCCD, initial rate					
G9002	E	MCCD,maintenance rate					
G9003	E	MCCD, risk adj hi, initial					
G9004	E	MCCD, risk adj lo, initial					
G9005	E	MCCD, risk adj, maintenance					
G9006	E	MCCD, Home monitoring					
G9007	E	MCCD, sch team conf					
G9008	E	Mccd,phys coor-care ovrsght					
G9009	E	MCCD, risk adj, level 3					
G9010	E	MCCD, risk adj, level 4					
G9011	E	MCCD, risk adj, level 5					
G9012	E	Other Specified Case Mgmt					
G9016	A	Demo-smoking cessation coun					
H0001	E	Alcohol and/or drug assess					
H0002	E	Alcohol and/or drug screenin					
H0003	E	Alcohol and/or drug screenin					
H0004	E	Alcohol and/or drug services					
H0005	E	Alcohol and/or drug services					
H0006	E	Alcohol and/or drug services					
H0007	E	Alcohol and/or drug services					
H0008	E	Alcohol and/or drug services					
H0009	E	Alcohol and/or drug services					
H0010	E	Alcohol and/or drug services					
H0011	E	Alcohol and/or drug services					
H0012	E	Alcohol and/or drug services					
H0013	E	Alcohol and/or drug services					
H0014	E	Alcohol and/or drug services					
H0015	E	Alcohol and/or drug services					
H0016	E	Alcohol and/or drug services					
H0017	E	Alcohol and/or drug services					
H0018	E	Alcohol and/or drug services					
H0019	E	Alcohol and/or drug services					
H0020	E	Alcohol and/or drug services					
H0021	E	Alcohol and/or drug training					
H0022	E	Alcohol and/or drug interven					
H0023	E	Alcohol and/or drug outreach					
H0024	E	Alcohol and/or drug preventi					
H0025	E	Alcohol and/or drug preventi					
H0026	E	Alcohol and/or drug preventi					
H0027	E	Alcohol and/or drug preventi					
H0028	E	Alcohol and/or drug preventi					
H0029	E	Alcohol and/or drug preventi					
H0030	E	Alcohol and/or drug hotline					
H1000	A	Prenatal care atrisk assessm					
H1001	A	Antepartum management					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
H1002	A	Carecoordination prenatal					
H1003	A	Prenatal at risk education					
H1004	A	Follow up home visit/prental					
H1005	A	Prenatalcare enhanced srv pk					
J0120	N	Tetracyclin injection					
J0130	K	Abciximab injection	1605	5.82	$302.69		$60.54
J0150	N	Injection adenosine 6 MG					
J0151	E	Adenosine injection					
J0170	N	Adrenalin epinephrin inject					
J0190	N	Inj biperiden lactate/5 mg					
J0200	N	Alatrofloxacin mesylate					
J0205	K	Alglucerase injection	0900	0.53	$27.56		$5.51
J0207	K	Amifostine	7000	4.46	$231.96		$46.39
J0210	N	Methyldopate hcl injection					
J0256	K	Alpha 1 proteinase inhibitor	0901	0.02	$1.04		$.21
J0270	E	Alprostadil for injection					
J0275	E	Alprostadil urethral suppos					
J0280	N	Aminophyllin 250 MG inj					
J0282	N	Amiodarone HCl					
J0285	N	Amphotericin B					
J0286	K	Amphotericin B lipid complex	7001	2.05	$106.62		$21.32
J0290	N	Ampicillin 500 MG inj					
J0295	N	Ampicillin sodium per 1.5 gm					
J0300	N	Amobarbital 125 MG inj					
J0330	N	Succinycholine chloride inj					
J0350	N	Injection anistreplase 30 u					
J0360	N	Hydralazine hcl injection					
J0380	N	Inj metaraminol bitartrate					
J0390	N	Chloroquine injection					
J0395	N	Arbutamine HCl injection					
J0456	N	Azithromycin					
J0460	N	Atropine sulfate injection					
J0470	N	Dimecaprol injection					
J0475	N	Baclofen 10 MG injection					
J0476	E	Baclofen intrathecal trial					
J0500	N	Dicyclomine injection					
J0515	N	Inj benztropine mesylate					
J0520	N	Bethanechol chloride inject					
J0530	N	Penicillin g benzathine inj					
J0540	N	Penicillin g benzathine inj					
J0550	N	Penicillin g benzathine inj					
J0560	N	Penicillin g benzathine inj					
J0570	N	Penicillin g benzathine inj					
J0580	N	Penicillin g benzathine inj					
J0585	K	Botulinum toxin a per unit	0902	0.05	$2.60		$.52
J0587	G	Botulinum toxin type B	9018		$8.79		$1.26
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					
J0640	N	Leucovorin calcium injection					
J0670	N	Inj mepivacaine HCL/10 ml					
J0690	N	Cefazolin sodium injection					
J0692	N	Cefepime HCl for injection					
J0694	N	Cefoxitin sodium injection					
J0696	N	Ceftriaxone sodium injection					
J0697	N	Sterile cefuroxime injection					
J0698	N	Cefotaxime sodium injection					
J0702	N	Betamethasone acet&sod phosp					
J0704	N	Betamethasone sod phosp/4 MG					
J0706	N	Caffeine citrate injection					
J0710	N	Cephapirin sodium injection					
J0713	N	Inj ceftazidime per 500 mg					
J0715	N	Ceftizoxime sodium / 500 MG					
J0720	N	Chloramphenicol sodium injec					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0725	N	Chorionic gonadotropin/1000u					
J0735	N	Clonidine hydrochloride					
J0740	N	Cidofovir injection					
J0743	N	Cilastatin sodium injection					
J0744	N	Ciprofloxacin iv					
J0745	N	Inj codeine phosphate /30 MG					
J0760	N	Colchicine injection					
J0770	N	Colistimethate sodium inj					
J0780	N	Prochlorperazine injection					
J0800	N	Corticotropin injection					
J0835	N	Inj cosyntropin per 0.25 MG					
J0850	K	Cytomegalovirus imm IV /vial	0903	0.34	$17.68		$3.54
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					
J1056	E	MA/EC contraceptiveinjection					
J1060	N	Testosterone cypionate 1 ML					
J1070	N	Testosterone cypionat 100 MG					
J1080	N	Testosterone cypionat 200 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					
J1190	K	Dexrazoxane HCl injection	0726	2.40	$124.82		$24.96
J1200	N	Diphenhydramine hcl injectio					
J1205	N	Chlorothiazide sodium inj					
J1212	N	Dimethyl sulfoxide 50% 50 ML					
J1230	N	Methadone injection					
J1240	N	Dimenhydrinate injection					
J1245	N	Dipyridamole injection					
J1250	N	Inj dobutamine HCL/250 mg					
J1260	N	Dolasetron mesylate					
J1270	N	Injection, doxercalciferol					
J1320	N	Amitriptyline injection					
J1325	N	Epoprostenol injection					
J1327	N	Eptifibatide injection					
J1330	N	Ergonovine maleate injection					
J1364	N	Erythro lactobionate /500 MG					
J1380	N	Estradiol valerate 10 MG inj					
J1390	N	Estradiol valerate 20 MG inj					
J1410	N	Inj estrogen conjugate 25 MG					
J1435	N	Injection estrone per 1 MG					
J1436	N	Etidronate disodium inj					
J1438	N	Etanercept injection					
J1440	K	Filgrastim 300 mcg injection	0728	2.24	$116.50		$23.30
J1441	K	Filgrastim 480 mcg injection	7049	3.37	$175.27		$35.05
J1450	N	Fluconazole					
J1452	N	Intraocular Fomivirsen na					
J1455	N	Foscarnet sodium injection					
J1460	N	Gamma globulin 1 CC inj					
J1470	E	Gamma globulin 2 CC inj					
J1480	E	Gamma globulin 3 CC inj					
J1490	E	Gamma globulin 4 CC inj					
J1500	E	Gamma globulin 5 CC inj					
J1510	E	Gamma globulin 6 CC inj					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1520	E	Gamma globulin 7 CC inj					
J1530	E	Gamma globulin 8 CC inj					
J1540	E	Gamma globulin 9 CC inj					
J1550	E	Gamma globulin 10 CC inj					
J1560	E	Gamma globulin > 10 CC inj					
J1561	K	Immune globulin 500 mg	0905	0.45	$23.40		$4.68
J1563	E	IV immune globulin					
J1565	N	RSV-ivig					
J1570	N	Ganciclovir sodium injection					
J1580	N	Garamycin gentamicin inj					
J1590	N	Gatifloxacin injection					
J1600	N	Gold sodium thiomaleate inj					
J1610	N	Glucagon hydrochloride/1 MG					
J1620	N	Gonadorelin hydroch/ 100 mcg					
J1626	N	Granisetron HCl injection					
J1630	N	Haloperidol injection					
J1631	N	Haloperidol decanoate inj					
J1642	N	Inj heparin sodium per 10 u					
J1644	N	Inj heparin sodium per 1000u					
J1645	N	Dalteparin sodium					
J1650	E	Inj enoxaparin sodium					
J1655	N	Tinzaparin sodium injection					
J1670	N	Tetanus immune globulin inj					
J1700	N	Hydrocortisone acetate inj					
J1710	N	Hydrocortisone sodium ph inj					
J1720	N	Hydrocortisone sodium succ i					
J1730	N	Diazoxide injection					
J1742	N	Ibutilide fumarate injection					
J1745	K	Infliximab injection	7043	0.74	$38.49		$7.70
J1750	N	Iron dextran					
J1755	N	Iron sucrose injection					
J1785	K	Injection imiglucerase /unit	0916	0.05	$2.60		$.52
J1790	N	Droperidol injection					
J1800	N	Propranolol injection					
J1810	E	Droperidol/fentanyl inj					
J1820	N	Insulin injection					
J1825	K	Interferon beta-1a	0909	2.77	$144.06		$28.81
J1830	N	Interferon beta-1b / .25 MG					
J1835	N	Itraconazole injection					
J1840	N	Kanamycin sulfate 500 MG inj					
J1850	N	Kanamycin sulfate 75 MG inj					
J1885	N	Ketorolac tromethamine inj					
J1890	N	Cephalothin sodium injection					
J1910	N	Kutapressin injection					
J1940	N	Furosemide injection					
J1950	K	Leuprolide acetate /3.75 MG	0800	4.15	$215.84		$43.17
J1955	E	Inj levocarnitine per 1 gm					
J1956	N	Levofloxacin injection					
J1960	N	Levorphanol tartrate inj					
J1980	N	Hyoscyamine sulfate inj					
J1990	N	Chlordiazepoxide injection					
J2000	N	Lidocaine injection					
J2010	N	Lincomycin injection					
J2020	N	Linezolid injection					
J2060	N	Lorazepam injection					
J2150	N	Mannitol injection					
J2175	N	Meperidine hydrochl /100 MG					
J2180	N	Meperidine/promethazine inj					
J2210	N	Methylergonovin maleate inj					
J2250	N	Inj midazolam hydrochloride					
J2260	N	Inj milrinone lactate / 5 ML					
J2270	N	Morphine sulfate injection					
J2271	N	Morphine so4 injection 100mg					
J2275	N	Morphine sulfate injection					
J2300	N	Inj nalbuphine hydrochloride					
J2310	N	Inj naloxone hydrochloride					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2320	N	Nandrolone decanoate 50 MG					
J2321	N	Nandrolone decanoate 100 MG					
J2322	N	Nandrolone decanoate 200 MG					
J2352	K	Octreotide acetate injection	7031	0.90	$46.81		$9.36
J2355	K	Oprelvekin injection	7011	2.52	$131.06		$26.21
J2360	N	Orphenadrine injection					
J2370	N	Phenylephrine hcl injection					
J2400	N	Chloroprocaine hcl injection					
J2405	N	Ondansetron hcl injection					
J2410	N	Oxymorphone hcl injection					
J2430	K	Pamidronate disodium /30 MG	0730	3.46	$179.95		$35.99
J2440	N	Papaverin hcl injection					
J2460	N	Oxytetracycline injection					
J2500	N	Paricalcitol					
J2510	N	Penicillin g procaine inj					
J2515	N	Pentobarbital sodium inj					
J2540	N	Penicillin g potassium inj					
J2543	N	Piperacillin/tazobactam					
J2545	A	Pentamidine isethionte/300mg					
J2550	N	Promethazine hcl injection					
J2560	N	Phenobarbital sodium inj					
J2590	N	Oxytocin injection					
J2597	N	Inj desmopressin acetate					
J2650	N	Prednisolone acetate inj					
J2670	N	Totazoline hcl injection					
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					
J2765	N	Metoclopramide hcl injection					
J2770	N	Quinupristin/dalfopristin					
J2780	N	Ranitidine hydrochloride inj					
J2790	K	Rho d immune globulin inj	0884	0.70	$36.41		$7.28
J2792	K	Rho(D) immune globulin h, sd	1609	0.22	$11.44		$2.29
J2795	N	Ropivacaine HCl injection					
J2800	N	Methocarbamol injection					
J2810	N	Inj theophylline per 40 MG					
J2820	N	Sargramostim injection					
J2910	N	Aurothioglucose injeciton					
J2912	N	Sodium chloride injection					
J2915	N	NA Ferric Gluconate Complex					
J2920	N	Methylprednisolone injection					
J2930	N	Methylprednisolone injection					
J2940	N	Somatrem injection					
J2941	K	Somatropin injection	7034	0.78	$40.57		$8.11
J2950	N	Promazine hcl injection					
J2993	K	Reteplase injection	9005	10.84	$563.78		$112.76
J2995	N	Inj streptokinase /250000 IU					
J2997	N	Alteplase recombinant					
J3000	N	Streptomycin injection					
J3010	N	Fentanyl citrate injeciton					
J3030	N	Sumatriptan succinate / 6 MG					
J3070	N	Pentazocine hcl injection					
J3100	K	Tenecteplase injection	9002	25.46	$1,324.15		$264.83
J3105	N	Terbutaline sulfate inj					
J3120	N	Testosterone enanthate inj					
J3130	N	Testosterone enanthate inj					
J3140	N	Testosterone suspension inj					
J3150	N	Testosteron propionate inj					
J3230	N	Chlorpromazine hcl injection					
J3240	E	Thyrotropin injection					
J3245	K	Tirofiban hydrochloride	7041	4.82	$250.68		$50.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J3250	N	Trimethobenzamide hcl inj					
J3260	N	Tobramycin sulfate injection					
J3265	N	Injection torsemide 10 mg/ml					
J3280	N	Thiethylperazine maleate inj					
J3301	N	Triamcinolone acetonide inj					
J3302	N	Triamcinolone diacetate inj					
J3303	N	Triamcinolone hexacetonl inj					
J3305	K	Inj trimetrexate glucoronate	7045	1.23	$63.97		$12.79
J3310	N	Perphenazine injeciton					
J3320	N	Spectinomycn di-hcl inj					
J3350	N	Urea injection					
J3360	N	Diazepam injection					
J3364	N	Urokinase 5000 IU injection					
J3365	N	Urokinase 250,000 IU inj					
J3370	N	Vancomycin hcl injection					
J3395	K	Verteporfin injection	1203	16.26	$845.67		$169.13
J3400	N	Triflupromazine hcl inj					
J3410	N	Hydroxyzine hcl injection					
J3420	N	Vitamin b12 injection					
J3430	N	Vitamin k phytonadione inj					
J3470	N	Hyaluronidase injection					
J3475	N	Inj magnesium sulfate					
J3480	N	Inj potassium chloride					
J3485	N	Zidovudine					
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					
J7190	K	Factor viii	0925	0.01	$.52		$.10
J7191	K	Factor VIII (porcine)	0926	0.02	$1.04		$.21
J7192	K	Factor viii recombinant	0927	0.01	$.52		$.10
J7193	K	Factor IX non-recombinant	0931	0.01	$.52		$.10
J7194	K	Factor ix complex	0928	0.01	$.52		$.10
J7195	K	Factor IX recombinant	0932	0.03	$1.56		$.31
J7197	K	Antithrombin iii injection	0930	0.01	$.52		$.10
J7198	K	Anti-inhibitor	0929	0.01	$.52		$.10
J7199	E	Hemophilia clot factor noc					
J7300	E	Intraut copper contraceptive					
J7302	E	Levonorgestrel iu contracept					
J7308	N	Aminolevulinic acid hcl top					
J7310	N	Ganciclovir long act implant					
J7316	N	Sodium hyaluronate injection					
J7320	K	Hylan G-F 20 injection	1611	2.43	$126.38		$25.28
J7330	K	Cultured chondrocytes implnt	1059	43.64	$2,269.67		$453.93
J7340	E	Metabolic active D/E tissue					
J7500	N	Azathioprine oral 50mg					
J7501	N	Azathioprine parenteral					
J7502	K	Cyclosporine oral 100 mg	0888	0.04	$2.08		$.42
J7504	K	Lymphocyte immune globulin	0890	3.64	$189.31		$37.86
J7505	K	Monoclonal antibodies	7038	4.43	$230.40		$46.08
J7506	N	Prednisone oral					
J7507	K	Tacrolimus oral per 1 MG	0891	0.02	$1.04		$.21
J7508	E	Tacrolimus oral per 5 MG					
J7509	N	Methylprednisolone oral					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7510	N	Prednisolone oral per 5 mg					
J7511	K	Antithymocyte globuln rabbit	9104	1.97	$102.46		$20.49
J7513	K	Daclizumab, parenteral	1612	3.77	$196.07		$39.21
J7515	N	Cyclosporine oral 25 mg					
J7516	N	Cyclosporin parenteral 250mg					
J7517	G	Mycophenolate mofetil oral	9015		$2.40		$.34
J7520	K	Sirolimus, oral	9106	0.05	$2.60		$.52
J7525	N	Tacrolimus injection					
J7599	E	Immunosuppressive drug noc					
J7608	A	Acetylcysteine inh sol u d					
J7618	A	Albuterol inh sol con					
J7619	A	Albuterol inh sol u d					
J7622	A	Beclomethasone inhalatn sol					
J7624	A	Betamethasone inhalation sol					
J7626	A	Budesonide inhalation sol					
J7628	A	Bitolterol mes inhal sol con					
J7629	A	Bitolterol mes inh sol u d					
J7631	A	Cromolyn sodium inh sol u d					
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					
J7639	A	Dornase alpha inhal sol u d					
J7641	A	Flunisolide, inhalation sol					
J7642	A	Glycopyrrolate inhal sol con					
J7643	A	Glycopyrrolate inhal sol u d					
J7644	A	Ipratropium brom inh sol u d					
J7648	A	Isoetharine hcl inh sol con					
J7649	A	Isoetharine hcl inh sol u d					
J7658	A	Isoproterenolhcl inh sol con					
J7659	A	Isoproterenol hcl inh sol ud					
J7668	A	Metaproterenol inh sol con					
J7669	A	Metaproterenol inh sol u d					
J7680	A	Terbutaline so4 inh sol con					
J7681	A	Terbutaline so4 inh sol u d					
J7682	A	Tobramycin inhalation sol					
J7683	A	Triamcinolone inh sol con					
J7684	A	Triamcinolone inh sol u d					
J7699	A	Inhalation solution for DME					
J7799	A	Non-inhalation drug for DME					
J8499	E	Oral prescrip drug non chemo					
J8510	N	Oral busulfan					
J8520	K	Capecitabine, oral, 150 mg	7042	0.03	$1.56		$.31
J8521	E	Capecitabine, oral, 500 mg					
J8530	N	Cyclophosphamide oral 25 MG					
J8560	K	Etoposide oral 50 MG	0802	0.54	$28.08		$5.62
J8600	N	Melphalan oral 2 MG					
J8610	N	Methotrexate oral 2.5 MG					
J8700	K	Temozolmide	1086	0.05	$2.60		$.52
J8999	E	Oral prescription drug chemo					
J9000	N	Doxorubic hcl 10 MG vl chemo					
J9001	K	Doxorubicin hcl liposome inj	7046	4.54	$236.12		$47.22
J9015	K	Aldesleukin/single use vial	0807	6.09	$316.73		$63.35
J9017	G	Arsenic trioxide	9012		$23.75		$3.40
J9020	N	Asparaginase injection					
J9031	N	Bcg live intravesical vac					
J9040	K	Bleomycin sulfate injection	0857	3.10	$161.23		$32.25
J9045	K	Carboplatin injection	0811	1.58	$82.17		$16.43
J9050	N	Carmus bischl nitro inj					
J9060	K	Cisplatin 10 MG injection	0813	0.47	$24.44		$4.89
J9062	E	Cisplatin 50 MG injection					
J9065	K	Inj cladribine per 1 MG	0858	0.84	$43.69		$8.74
J9070	N	Cyclophosphamide 100 MG inj					
J9080	E	Cyclophosphamide 200 MG inj					
J9090	E	Cyclophosphamide 500 MG inj					
J9091	E	Cyclophosphamide 1.0 grm inj					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9092	E	Cyclophosphamide 2.0 grm inj					
J9093	N	Cyclophosphamide lyophilized					
J9094	E	Cyclophosphamide lyophilized					
J9095	E	Cyclophosphamide lyophilized					
J9096	E	Cyclophosphamide lyophilized					
J9097	E	Cyclophosphamide lyophilized					
J9100	N	Cytarabine hcl 100 MG inj					
J9110	E	Cytarabine hcl 500 MG inj					
J9120	N	Dactinomycin actinomycin d					
J9130	N	Dacarbazine 10 MG inj					
J9140	E	Dacarbazine 200 MG inj					
J9150	K	Daunorubicin	0820	2.27	$118.06		$23.61
J9151	K	Daunorubicin citrate liposom	0821	3.17	$164.87		$32.97
J9160	K	Denileukin diftitox, 300 mcg	1084	13.94	$725.01		$145.00
J9165	K	Diethylstilbestrol injection	0822	2.21	$114.94		$22.99
J9170	K	Docetaxel	0823	4.01	$208.56		$41.71
J9180	E	Epirubicin HCl injection					
J9181	N	Etoposide 10 MG inj					
J9182	E	Etoposide 100 MG inj					
J9185	K	Fludarabine phosphate inj	0842	3.30	$171.63		$34.33
J9190	N	Fluorouracil injection					
J9200	K	Floxuridine injection	0827	2.42	$125.86		$25.17
J9201	K	Gemcitabine HCl	0828	1.49	$77.49		$15.50
J9202	K	Goserelin acetate implant	0810	5.94	$308.93		$61.79
J9206	K	Irinotecan injection	0830	1.86	$96.74		$19.35
J9208	K	Ifosfomide injection	0831	2.06	$107.14		$21.43
J9209	K	Mesna injection	0732	0.55	$28.60		$5.72
J9211	K	Idarubicin hcl injection	0832	4.57	$237.68		$47.54
J9212	N	Interferon alfacon-1					
J9213	N	Interferon alfa-2a inj					
J9214	N	Interferon alfa-2b inj					
J9215	N	Interferon alfa-n3 inj					
J9216	K	Interferon gamma 1-b inj	0838	2.49	$129.50		$25.90
J9217	K	Leuprolide acetate suspnsion	9217	6.30	$327.66		$65.53
J9218	K	Leuprolide acetate injeciton	0861	0.84	$43.69		$8.74
J9219	G	Leuprolide acetate implant	7051		$5,399.80		$773.02
J9230	N	Mechlorethamine hcl inj					
J9245	K	Inj melphalan hydrochl 50 MG	0840	4.09	$212.72		$42.54
J9250	N	Methotrexate sodium inj					
J9260	E	Methotrexate sodium inj					
J9265	K	Paclitaxel injection	0863	2.50	$130.02		$26.00
J9266	K	Pegaspargase/singl dose vial	0843	2.38	$123.78		$24.76
J9268	K	Pentostatin injection	0844	21.32	$1,108.83		$221.77
J9270	N	Plicamycin (mithramycin) inj					
J9280	K	Mitomycin 5 MG inj	0862	1.18	$61.37		$12.27
J9290	E	Mitomycin 20 MG inj					
J9291	E	Mitomycin 40 MG inj					
J9293	K	Mitoxantrone hydrochl / 5 MG	0864	3.02	$157.07		$31.41
J9300	K	Gemtuzumab ozogamicin	9004	1.05	$54.61		$10.92
J9310	K	Rituximab cancer treatment	0849	5.71	$296.97		$59.39
J9320	N	Streptozocin injection					
J9340	N	Thiotepa injection					
J9350	K	Topotecan	0852	7.61	$395.79		$79.16
J9355	K	Trastuzumab	1613	0.66	$34.33		$6.87
J9357	K	Valrubicin, 200 mg	1614	2.04	$106.10		$21.22
J9360	N	Vinblastine sulfate inj					
J9370	N	Vincristine sulfate 1 MG inj					
J9375	E	Vincristine sulfate 2 MG inj					
J9380	E	Vincristine sulfate 5 MG inj					
J9390	K	Vinorelbine tartrate/10 mg	0855	1.10	$57.21		$11.44
J9600	K	Porfimer sodium	0856	26.35	$1,370.44		$274.09
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0005	A	Ultralightweight wheelchair					
K0006	A	Heavy duty wheelchair					
K0007	A	Extra heavy duty wheelchair					
K0009	A	Other manual wheelchair/base					
K0010	A	Stnd wt frame power whlchr					
K0011	A	Stnd wt pwr whlchr w control					
K0012	A	Ltwt portbl power whlchr					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	Detach adjust armrst cmplete					
K0017	A	Detach adjust armrest base					
K0018	A	Detach adjust armrst upper					
K0019	A	Arm pad each					
K0020	A	Fixed adjust armrest pair					
K0021	A	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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
K0107	A	Wheelchair tray					
K0108	A	W/c component-accessory NOS					
K0112	A	Trunk vest supprt innr frame					
K0113	A	Trunk vest suprt w/o inr frm					
K0114	A	Whlchr back suprt inr frame					
K0115	A	Back module orthotic system					
K0116	A	Back & seat modul orthot sys					
K0183	A	Nasal application device					
K0184	A	Nasal pillow or face seal					
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					
K0415	E	RX antiemetic drg, oral NOS					
K0416	E	Rx antiemetic drg,rectal NOS					
K0452	A	Wheelchair bearings					
K0455	A	Pump uninterrupted infusion					
K0460	A	WC power add-on joystick					
K0461	A	WC power add-on tiller cntrl					
K0462	A	Temporary replacement eqpmnt					
K0531	A	Heated humidifier used w pap					
K0532	A	Noninvasive assist wo backup					
K0533	A	Noninvasive assist w backup					
K0534	A	Invasive assist w backup					
K0538	A	Neg pressure wnd thrpy pump					
K0539	A	Neg pres wnd thrpy dsg set					
K0540	A	Neg pres wnd thrp canister					
K0541	A	SGD prerecorded msg <= 8 min					
K0542	A	SGD prerecorded msg > 8 min					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0543	A	SGD msg formed by spelling					
K0544	A	SGD w multi methods msg/accs					
K0545	A	SGD sftwre prgrm for PC/PDA					
K0546	A	SGD accessory,mounting systm					
K0547	A	SGD accessory NOC					
K0548	A	Insulin lispro					
K0549	A	Hosp bed hvy dty xtra wide					
K0550	A	Hosp bed xtra hvy dty x wide					
K0551	A	Residual limb support system					
L0100	A	Cranial orthosis/helmet mold					
L0110	A	Cranial orthosis/helmet nonm					
L0120	A	Cerv flexible non-adjustable					
L0130	A	Flex thermoplastic collar mo					
L0140	A	Cervical semi-rigid adjustab					
L0150	A	Cerv semi-rig adj molded chn					
L0160	A	Cerv semi-rig wire occ/mand					
L0170	A	Cervical collar molded to pt					
L0172	A	Cerv col thermplas foam 2 pi					
L0174	A	Cerv col foam 2 piece w thor					
L0180	A	Cer post col occ/man sup adj					
L0190	A	Cerv collar supp adj cerv ba					
L0200	A	Cerv col supp adj bar & thor					
L0210	A	Thoracic rib belt					
L0220	A	Thor rib belt custom fabrica					
L0300	A	TLSO flex surgical support					
L0310	A	Tlso flexible custom fabrica					
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					
L0321	A	Tlso anti-post-cntrl prefab					
L0330	A	Tlso ant-pos-lateral control					
L0331	A	Tlso ant-post-lat cntrl prfb					
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					
L0391	A	Tlso ant-post-lat-rot cntrl					
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					
L0561	A	Prefab lso					
L0565	A	Lso a-p-l control custom					
L0600	A	Sacroiliac flex surg support					
L0610	A	Sacroiliac flexible custm fa					
L0620	A	Sacroiliac semi-rig w apron					
L0700	A	Ctlso a-p-l control molded					
L0710	A	Ctlso a-p-l control w/ inter					
L0810	A	Halo cervical into jckt vest					
L0820	A	Halo cervical into body jack					
L0830	A	Halo cerv into milwaukee typ					
L0860	A	Magnetic resonanc image comp					
L0900	A	Torso/ptosis support					
L0910	A	Torso & ptosis supp custm fa					
L0920	A	Torso/pendulous abd support					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L0986	A	Spinal orth abdm pnl prefab					
L0999	A	Add to spinal orthosis NOS					
L1000	A	Ctlso milwauke initial model					
L1005	A	Tension based scoliosis orth					
L1010	A	Ctlso axilla sling					
L1020	A	Kyphosis pad					
L1025	A	Kyphosis pad floating					
L1030	A	Lumbar bolster pad					
L1040	A	Lumbar or lumbar rib pad					
L1050	A	Sternal pad					
L1060	A	Thoracic pad					
L1070	A	Trapezius sling					
L1080	A	Outrigger					
L1085	A	Outrigger bil w/ vert extens					
L1090	A	Lumbar sling					
L1100	A	Ring flange plastic/leather					
L1110	A	Ring flange plas/leather mol					
L1120	A	Covers for upright each					
L1200	A	Furnsh initial orthosis only					
L1210	A	Lateral thoracic extension					
L1220	A	Anterior thoracic extension					
L1230	A	Milwaukee type superstructur					
L1240	A	Lumbar derotation pad					
L1250	A	Anterior asis pad					
L1260	A	Anterior thoracic derotation					
L1270	A	Abdominal pad					
L1280	A	Rib gusset (elastic) each					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L2090	A	Hkafo unilat torsion ball br					
L2102	E	Afo tibial fx cast plstr mol					
L2104	E	Afo tib fx cast synthetic mo					
L2106	A	Afo tib fx cast plaster mold					
L2108	A	Afo tib fx cast molded to pt					
L2112	A	Afo tibial fracture soft					
L2114	A	Afo tib fx semi-rigid					
L2116	A	Afo tibial fracture rigid					
L2122	E	Kafo fem fx cast plaster mol					
L2124	E	Kafo fem fx cast synthet mol					
L2126	A	Kafo fem fx cast thermoplas					
L2128	A	Kafo fem fx cast molded to p					
L2132	A	Kafo femoral fx cast soft					
L2134	A	Kafo fem fx cast semi-rigid					
L2136	A	Kafo femoral fx cast rigid					
L2180	A	Plas shoe insert w ank joint					
L2182	A	Drop lock knee					
L2184	A	Limited motion knee joint					
L2186	A	Adj motion knee jnt lerman t					
L2188	A	Quadrilateral brim					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2190	A	Waist belt					
L2192	A	Pelvic band & belt thigh fla					
L2200	A	Limited ankle motion ea jnt					
L2210	A	Dorsiflexion assist each joi					
L2220	A	Dorsi & plantar flex ass/res					
L2230	A	Split flat caliper stirr & p					
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					
L2650	A	Pelv & thor control gluteal					
L2660	A	Thoracic control thoracic ba					
L2670	A	Thorac cont paraspinal uprig					
L2680	A	Thorac cont lat support upri					
L2750	A	Plating chrome/nickel pr bar					
L2755	A	Carbon graphite lamination					
L2760	A	Extension per extension per					
L2768	A	Ortho sidebar disconnect					
L2770	A	Low ext orthosis per bar/jnt					
L2780	A	Non-corrosive finish					
L2785	A	Drop lock retainer each					
L2795	A	Knee control full kneecap					
L2800	A	Knee cap medial or lateral p					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2810	A	Knee control condylar pad					
L2820	A	Soft interface below knee se					
L2830	A	Soft interface above knee se					
L2840	A	Tibial length sock fx or equ					
L2850	A	Femoral lgth sock fx or equa					
L2860	A	Torsion mechanism knee/ankle					
L2999	A	Lower extremity orthosis NOS					
L3000	E	Ft insert ucb berkeley shell					
L3001	E	Foot insert remov molded spe					
L3002	E	Foot insert plastazote or eq					
L3003	E	Foot insert silicone gel eac					
L3010	E	Foot longitudinal arch suppo					
L3020	E	Foot longitud/metatarsal sup					
L3030	E	Foot arch support remov prem					
L3040	E	Ft arch suprt premold longit					
L3050	E	Foot arch supp premold metat					
L3060	E	Foot arch supp longitud/meta					
L3070	E	Arch suprt att to sho longit					
L3080	E	Arch supp att to shoe metata					
L3090	E	Arch supp att to shoe long/m					
L3100	E	Hallus-valgus nght dynamic s					
L3140	E	Abduction rotation bar shoe					
L3150	E	Abduct rotation bar w/o shoe					
L3160	E	Shoe styled positioning dev					
L3170	E	Foot plastic heel stabilizer					
L3201	E	Oxford w supinat/pronat inf					
L3202	E	Oxford w/ supinat/pronator c					
L3203	E	Oxford w/ supinator/pronator					
L3204	E	Hightop w/ supp/pronator inf					
L3206	E	Hightop w/ supp/pronator chi					
L3207	E	Hightop w/ supp/pronator jun					
L3208	E	Surgical boot each infant					
L3209	E	Surgical boot each child					
L3211	E	Surgical boot each junior					
L3212	E	Benesch boot pair infant					
L3213	E	Benesch boot pair child					
L3214	E	Benesch boot pair junior					
L3215	E	Orthopedic ftwear ladies oxf					
L3216	E	Orthoped ladies shoes dpth i					
L3217	E	Ladies shoes hightop depth i					
L3218	E	Ladies surgical boot each					
L3219	E	Orthopedic mens shoes oxford					
L3221	E	Orthopedic mens shoes dpth i					
L3222	E	Mens shoes hightop depth inl					
L3223	E	Mens surgical boot each					
L3224	A	Woman's shoe oxford brace					
L3225	A	Man's shoe oxford brace					
L3230	E	Custom shoes depth inlay					
L3250	E	Custom mold shoe remov prost					
L3251	E	Shoe molded to pt silicone s					
L3252	E	Shoe molded plastazote cust					
L3253	E	Shoe molded plastazote cust					
L3254	E	Orth foot non-stndard size/w					
L3255	E	Orth foot non-standard size/					
L3257	E	Orth foot add charge split s					
L3260	E	Ambulatory surgical boot eac					
L3265	E	Plastazote sandal each					
L3300	E	Sho lift taper to metatarsal					
L3310	E	Shoe lift elev heel/sole neo					
L3320	E	Shoe lift elev heel/sole cor					
L3330	E	Lifts elevation metal extens					
L3332	E	Shoe lifts tapered to one-ha					
L3334	E	Shoe lifts elevation heel /i					
L3340	E	Shoe wedge sach					
L3350	E	Shoe heel wedge					
L3360	E	Shoe sole wedge outside sole					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3370	E	Shoe sole wedge between sole					
L3380	E	Shoe clubfoot wedge					
L3390	E	Shoe outflare wedge					
L3400	E	Shoe metatarsal bar wedge ro					
L3410	E	Shoe metatarsal bar between					
L3420	E	Full sole/heel wedge btween					
L3430	E	Sho heel count plast reinfor					
L3440	E	Heel leather reinforced					
L3450	E	Shoe heel sach cushion type					
L3455	E	Shoe heel new leather standa					
L3460	E	Shoe heel new rubber standar					
L3465	E	Shoe heel thomas with wedge					
L3470	E	Shoe heel thomas extend to b					
L3480	E	Shoe heel pad & depress for					
L3485	E	Shoe heel pad removable for					
L3500	E	Ortho shoe add leather insol					
L3510	E	Orthopedic shoe add rub insl					
L3520	E	O shoe add felt w leath insl					
L3530	E	Ortho shoe add half sole					
L3540	E	Ortho shoe add full sole					
L3550	E	O shoe add standard toe tap					
L3560	E	O shoe add horseshoe toe tap					
L3570	E	O shoe add instep extension					
L3580	E	O shoe add instep velcro clo					
L3590	E	O shoe convert to sof counte					
L3595	E	Ortho shoe add march bar					
L3600	E	Trans shoe calip plate exist					
L3610	E	Trans shoe caliper plate new					
L3620	E	Trans shoe solid stirrup exi					
L3630	E	Trans shoe solid stirrup new					
L3640	E	Shoe dennis browne splint bo					
L3649	E	Orthopedic shoe modifica NOS					
L3650	A	Shlder fig 8 abduct restrain					
L3660	A	Abduct restrainer canvas&web					
L3670	A	Acromio/clavicular canvas&we					
L3675	A	Canvas vest SO					
L3677	A	SO hard plastic stabilizer					
L3700	A	Elbow orthoses elas w stays					
L3710	A	Elbow elastic with metal joi					
L3720	A	Forearm/arm cuffs free motio					
L3730	A	Forearm/arm cuffs ext/flex a					
L3740	A	Cuffs adj lock w/ active con					
L3760	A	EO withjoint, Prefabricated					
L3800	A	Whfo short opponen no attach					
L3805	A	Whfo long opponens no attach					
L3807	A	WHFO,no joint, prefabricated					
L3810	A	Whfo thumb abduction bar					
L3815	A	Whfo second m.p. abduction a					
L3820	A	Whfo ip ext asst w/ mp ext s					
L3825	A	Whfo m.p. extension stop					
L3830	A	Whfo m.p. extension assist					
L3835	A	Whfo m.p. spring extension a					
L3840	A	Whfo spring swivel thumb					
L3845	A	Whfo thumb ip ext ass w/ mp					
L3850	A	Action wrist w/ dorsiflex as					
L3855	A	Whfo adj m.p. flexion contro					
L3860	A	Whfo adj m.p. flex ctrl & i.					
L3890	E	Torsion mechanism wrist/elbo					
L3900	A	Hinge extension/flex wrist/f					
L3901	A	Hinge ext/flex wrist finger					
L3902	A	Whfo ext power compress gas					
L3904	A	Whfo electric custom fitted					
L3906	A	Wrist gauntlet molded to pt					
L3907	A	Whfo wrst gauntlt thmb spica					
L3908	A	Wrist cock-up non-molded					
L3910	A	Whfo swanson design					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3912	A	Flex glove w/elastic finger					
L3914	A	WHO wrist extension cock-up					
L3916	A	Whfo wrist extens w/ outrigg					
L3918	A	HFO knuckle bender					
L3920	A	Knuckle bender with outrigge					
L3922	A	Knuckle bend 2 seg to flex j					
L3923	A	HFO, no joint, prefabricated					
L3924	A	Oppenheimer					
L3926	A	Thomas suspension					
L3928	A	Finger extension w/ clock sp					
L3930	A	Finger extension with wrist					
L3932	A	Safety pin spring wire					
L3934	A	Safety pin modified					
L3936	A	Palmer					
L3938	A	Dorsal wrist					
L3940	A	Dorsal wrist w/ outrigger at					
L3942	A	Reverse knuckle bender					
L3944	A	Reverse knuckle bend w/ outr					
L3946	A	HFO composite elastic					
L3948	A	Finger knuckle bender					
L3950	A	Oppenheimer w/ knuckle bend					
L3952	A	Oppenheimer w/ rev knuckle 2					
L3954	A	Spreading hand					
L3956	A	Add joint upper ext orthosis					
L3960	A	Sewho airplan desig abdu pos					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L4398	A	Foot drop splint recumbent					
L5000	A	Sho insert w arch toe filler					
L5010	A	Mold socket ank hgt w/ toe f					
L5020	A	Tibial tubercle hgt w/ toe f					
L5050	A	Ank symes mold sckt sach ft					
L5060	A	Symes met fr leath socket ar					
L5100	A	Molded socket shin sach foot					
L5105	A	Plast socket jts/thgh lacer					
L5150	A	Mold sckt ext knee shin sach					
L5160	A	Mold socket bent knee shin s					
L5200	A	Kne sing axis fric shin sach					
L5210	A	No knee/ankle joints w/ ft b					
L5220	A	No knee joint with artic ali					
L5230	A	Fem focal defic constant fri					
L5250	A	Hip canad sing axi cons fric					
L5270	A	Tilt table locking hip sing					
L5280	A	Hemipelvect canad sing axis					
L5301	A	BK mold socket SACH ft endo					
L5311	A	Knee disart, SACH ft, endo					
L5321	A	AK open end SACH					
L5331	A	Hip disart canadian SACH ft					
L5341	A	Hemipelvectomy canadian SACH					
L5400	A	Postop dress & 1 cast chg bk					
L5410	A	Postop dsg bk ea add cast ch					
L5420	A	Postop dsg & 1 cast chg ak/d					
L5430	A	Postop dsg ak ea add cast ch					
L5450	A	Postop app non-wgt bear dsg					
L5460	A	Postop app non-wgt bear dsg					
L5500	A	Init bk ptb plaster direct					
L5505	A	Init ak ischal plstr direct					
L5510	A	Prep BK ptb plaster molded					
L5520	A	Perp BK ptb thermopls direct					
L5530	A	Prep BK ptb thermopls molded					
L5535	A	Prep BK ptb open end socket					
L5540	A	Prep BK ptb laminated socket					
L5560	A	Prep AK ischial plast molded					
L5570	A	Prep AK ischial direct form					
L5580	A	Prep AK ischial thermo mold					
L5585	A	Prep AK ischial open end					
L5590	A	Prep AK ischial laminated					
L5595	A	Hip disartic sach thermopls					
L5600	A	Hip disart sach laminat mold					
L5610	A	Above knee hydracadence					
L5611	A	Ak 4 bar link w/fric swing					
L5613	A	Ak 4 bar ling w/hydraul swig					
L5614	A	4-bar link above knee w/swng					
L5616	A	Ak univ multiplex sys frict					
L5617	A	AK/BK self-aligning unit ea					
L5618	A	Test socket symes					
L5620	A	Test socket below knee					
L5622	A	Test socket knee disarticula					
L5624	A	Test socket above knee					
L5626	A	Test socket hip disarticulat					
L5628	A	Test socket hemipelvectomy					
L5629	A	Below knee acrylic socket					
L5630	A	Syme typ expandabl wall sckt					
L5631	A	Ak/knee disartic acrylic soc					
L5632	A	Symes type ptb brim design s					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5644	A	Above knee wood socket					
L5645	A	Bk flex inner socket ext fra					
L5646	A	Below knee air cushion socke					
L5647	A	Below knee suction socket					
L5648	A	Above knee air cushion socke					
L5649	A	Isch containmt/narrow m-l so					
L5650	A	Tot contact ak/knee disart s					
L5651	A	Ak flex inner socket ext fra					
L5652	A	Suction susp ak/knee disart					
L5653	A	Knee disart expand wall sock					
L5654	A	Socket insert symes					
L5655	A	Socket insert below knee					
L5656	A	Socket insert knee articulat					
L5658	A	Socket insert above knee					
L5660	A	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					
L5665	A	Multi-durometer below knee					
L5666	A	Below knee cuff suspension					
L5668	A	Socket insert w/o lock lower					
L5670	A	Bk molded supracondylar susp					
L5671	A	BK/AK locking mechanism					
L5672	A	Bk removable medial brim sus					
L5674	A	Bk suspension sleeve					
L5675	A	Bk heavy duty susp sleeve					
L5676	A	Bk knee joints single axis p					
L5677	A	Bk knee joints polycentric p					
L5678	A	Bk joint covers pair					
L5680	A	Bk thigh lacer non-molded					
L5682	A	Bk thigh lacer glut/ischia m					
L5684	A	Bk fork strap					
L5686	A	Bk back check					
L5688	A	Bk waist belt webbing					
L5690	A	Bk waist belt padded and lin					
L5692	A	Ak pelvic control belt light					
L5694	A	Ak pelvic control belt pad/l					
L5695	A	Ak sleeve susp neoprene/equa					
L5696	A	Ak/knee disartic pelvic join					
L5697	A	Ak/knee disartic pelvic band					
L5698	A	Ak/knee disartic silesian ba					
L5699	A	Shoulder harness					
L5700	A	Replace socket below knee					
L5701	A	Replace socket above knee					
L5702	A	Replace socket hip					
L5704	A	Custom shape cover BK					
L5705	A	Custom shape cover AK					
L5706	A	Custom shape cvr knee disart					
L5707	A	Custom shape cvr hip disart					
L5710	A	Kne-shin exo sng axi mnl loc					
L5711	A	Knee-shin exo mnl lock ultra					
L5712	A	Knee-shin exo frict swg & st					
L5714	A	Knee-shin exo variable frict					
L5716	A	Knee-shin exo mech stance ph					
L5718	A	Knee-shin exo frct swg & sta					
L5722	A	Knee-shin pneum swg frct exo					
L5724	A	Knee-shin exo fluid swing ph					
L5726	A	Knee-shin ext jnts fld swg e					
L5728	A	Knee-shin fluid swg & stance					
L5780	A	Knee-shin pneum/hydra pneum					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5812	A	Endo knee-shin frct swg & st					
L5814	A	Endo knee-shin hydral swg ph					
L5816	A	Endo knee-shin polyc mch sta					
L5818	A	Endo knee-shin frct swg & st					
L5822	A	Endo knee-shin pneum swg frc					
L5824	A	Endo knee-shin fluid swing p					
L5826	A	Miniature knee joint					
L5828	A	Endo knee-shin fluid swg/sta					
L5830	A	Endo knee-shin pneum/swg pha					
L5840	A	Multi-axial knee/shin system					
L5845	A	Knee-shin sys stance flexion					
L5846	A	Knee-shin sys microprocessor					
L5847	A	Microprocessor cntrl feature					
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					
L5970	A	Foot external keel sach foot					
L5972	A	Flexible keel foot					
L5974	A	Foot single axis ankle/foot					
L5975	A	Combo ankle/foot prosthesis					
L5976	A	Energy storing foot					
L5978	A	Ft prosth multiaxial ankl/ft					
L5979	A	Multi-axial ankle/ft prosth					
L5980	A	Flex foot system					
L5981	A	Flex-walk sys low ext prosth					
L5982	A	Exoskeletal axial rotation u					
L5984	A	Endoskeletal axial rotation					
L5985	A	Lwr ext dynamic prosth pylon					
L5986	A	Multi-axial rotation unit					
L5987	A	Shank ft w vert load pylon					
L5988	A	Vertical shock reducing pylo					
L5989	A	Pylon w elctrnc force sensor					
L5990	A	User adjustable heel height					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6795	A	Hooks-2 load or equal					
L6800	A	Hooks-aprl vc or equal					
L6805	A	Modifier wrist flexion unit					
L6806	A	Trs grip vc or equal					
L6807	A	Term device grip1/2 or equal					
L6808	A	Term device infant or child					
L6809	A	Trs super sport passive					
L6810	A	Pincher tool otto bock or eq					
L6825	A	Hands dorrance vo					
L6830	A	Hand aprl vc					
L6835	A	Hand sierra vo					
L6840	A	Hand becker imperial					
L6845	A	Hand becker lock grip					
L6850	A	Term dvc-hand becker plylite					
L6855	A	Hand robin-aids vo					
L6860	A	Hand robin-aids vo soft					
L6865	A	Hand passive hand					
L6867	A	Hand detroit infant hand					
L6868	A	Passive inf hand steeper/hos					
L6870	A	Hand child mitt					
L6872	A	Hand nyu child hand					
L6873	A	Hand mech inf steeper or equ					
L6875	A	Hand bock vc					
L6880	A	Hand bock vo					
L6881	A	Autograsp feature ul term dv					
L6882	A	Microprocessor control uplmb					
L6890	A	Production glove					
L6895	A	Custom glove					
L6900	A	Hand restorat thumb/1 finger					
L6905	A	Hand restoration multiple fi					
L6910	A	Hand restoration no fingers					
L6915	A	Hand restoration replacmnt g					
L6920	A	Wrist disarticul switch ctrl					
L6925	A	Wrist disart myoelectronic c					
L6930	A	Below elbow switch control					
L6935	A	Below elbow myoelectronic ct					
L6940	A	Elbow disarticulation switch					
L6945	A	Elbow disart myoelectronic c					
L6950	A	Above elbow switch control					
L6955	A	Above elbow myoelectronic ct					
L6960	A	Shldr disartic switch contro					
L6965	A	Shldr disartic myoelectronic					
L6970	A	Interscapular-thor switch ct					
L6975	A	Interscap-thor myoelectronic					
L7010	A	Hand otto back steeper/eq sw					
L7015	A	Hand sys teknik village swit					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L8001	A	Breast prosthesis bra & form					
L8002	A	Brst prsth bra & bilat form					
L8010	A	Mastectomy sleeve					
L8015	A	Ext breastprosthesis garment					
L8020	A	Mastectomy form					
L8030	A	Breast prosthesis silicone/e					
L8035	A	Custom breast prosthesis					
L8039	A	Breast prosthesis NOS					
L8040	A	Nasal prosthesis					
L8041	A	Midfacial prosthesis					
L8042	A	Orbital prosthesis					
L8043	A	Upper facial prosthesis					
L8044	A	Hemi-facial prosthesis					
L8045	A	Auricular prosthesis					
L8046	A	Partial facial prosthesis					
L8047	A	Nasal septal prosthesis					
L8048	A	Unspec maxillofacial prosth					
L8049	A	Repair maxillofacial prosth					
L8100	E	Compression stocking BK18-30					
L8110	E	Compression stocking BK30-40					
L8120	E	Compression stocking BK40-50					
L8130	E	Gc stocking thighlngth 18-30					
L8140	E	Gc stocking thighlngth 30-40					
L8150	E	Gc stocking thighlngth 40-50					
L8160	E	Gc stocking full lngth 18-30					
L8170	E	Gc stocking full lngth 30-40					
L8180	E	Gc stocking full lngth 40-50					
L8190	E	Gc stocking waistlngth 18-30					
L8195	E	Gc stocking waistlngth 30-40					
L8200	E	Gc stocking waistlngth 40-50					
L8210	E	Gc stocking custom made					
L8220	E	Gc stocking lymphedema					
L8230	E	Gc stocking garter belt					
L8239	E	G compression stocking NOS					
L8300	A	Truss single w/ standard pad					
L8310	A	Truss double w/ standard pad					
L8320	A	Truss addition to std pad wa					
L8330	A	Truss add to std pad scrotal					
L8400	A	Sheath below knee					
L8410	A	Sheath above knee					
L8415	A	Sheath upper limb					
L8417	A	Pros sheath/sock w gel cushn					
L8420	A	Prosthetic sock multi ply BK					
L8430	A	Prosthetic sock multi ply AK					
L8435	A	Pros sock multi ply upper lm					
L8440	A	Shrinker below knee					
L8460	A	Shrinker above knee					
L8465	A	Shrinker upper limb					
L8470	A	Pros sock single ply BK					
L8480	A	Pros sock single ply AK					
L8485	A	Pros sock single ply upper l					
L8490	A	Air seal suction reten systm					
L8499	A	Unlisted misc prosthetic ser					
L8500	A	Artificial larynx					
L8501	A	Tracheostomy speaking valve					
L8505	A	Artificial larynx, accessory					
L8507	A	Trach-esoph voice pros pt in					
L8509	A	Trach-esoph voice pros md in					
L8510	A	Voice amplifier					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8600	N	Implant breast silicone/eq					
L8603	N	Collagen imp urinary 2.5 ml					
L8606	A	Synthetic implnt urinary 1ml					
L8610	N	Ocular implant					
L8612	N	Aqueous shunt prosthesis					
L8613	N	Ossicular implant					
L8614	N	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	N	Metacarpophalangeal implant					
L8641	N	Metatarsal joint implant					
L8642	N	Hallux implant					
L8658	N	Interphalangeal joint implnt					
L8670	N	Vascular graft, synthetic					
L8699	N	Prosthetic implant NOS					
L9900	A	O&P supply/accessory/service					
M0064	X	Visit for drug monitoring	0374	1.20	$62.41		$12.48
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0300	E	IV chelationtherapy					
M0301	E	Fabric wrapping of aneurysm					
P2028	A	Cephalin floculation test					
P2029	A	Congo red blood test					
P2031	E	Hair analysis					
P2033	A	Blood thymol turbidity					
P2038	A	Blood mucoprotein					
P3000	A	Screen pap by tech w md supv					
P3001	E	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
P9010	K	Whole blood for transfusion	0950	1.25	$65.01		$13.00
P9011	E	Blood split unit					
P9012	K	Cryoprecipitate each unit	0952	0.53	$27.56		$5.51
P9016	K	RBC leukocytes reduced	0954	1.59	$82.69		$16.54
P9017	K	One donor fresh frozn plasma	0955	0.71	$36.93		$7.39
P9019	K	Platelets, each unit	0957	0.67	$34.85		$6.97
P9020	K	Plaelet rich plasma unit	0958	1.12	$58.25		$11.65
P9021	K	Red blood cells unit	0959	1.12	$58.25		$11.65
P9022	K	Washed red blood cells unit	0960	1.42	$73.85		$14.77
P9023	K	Frozen plasma, pooled, sd	0949	1.26	$65.53		$13.11
P9031	K	Platelets leukocytes reduced	1013	0.91	$47.33		$9.47
P9032	K	Platelets, irradiated	9500	0.92	$47.85		$9.57
P9033	K	Platelets leukoreduced irrad	0954	1.59	$82.69		$16.54
P9034	K	Platelets, pheresis	9501	5.10	$265.25		$53.05
P9035	K	Platelet pheres leukoreduced	9501	5.10	$265.25		$53.05
P9036	K	Platelet pheresis irradiated	9502	1.99	$103.50		$20.70
P9037	K	Plate pheres leukoredu irrad	1019	6.93	$360.42		$72.08
P9038	K	RBC irradiated	9505	1.82	$94.66		$18.93
P9039	K	RBC deglycerolized	9504	1.91	$99.34		$19.87
P9040	K	RBC leukoreduced irradiated	9504	1.91	$99.34		$19.87
P9041	K	Albumin (human),5%, 50ml	0961	0.47	$24.44		$4.89
P9043	K	Plasma protein fract,5%,50ml	0956	1.94	$100.90		$20.18
P9044	K	Cryoprecipitatereducedplasma	1009	0.66	$34.33		$6.87
P9045	K	Albumin (human), 5%, 250 ml	0963	2.37	$123.26		$24.65
P9046	K	Albumin (human), 25%, 20 ml	0964	0.50	$26.00		$5.20
P9047	K	Albumin (human), 25%, 50ml	0965	1.25	$65.01		$13.00
P9048	K	Plasmaprotein fract,5%,250ml	0966	9.71	$505.01		$101.00
P9050	K	Granulocytes, pheresis unit	9506	0.45	$23.40		$4.68
P9603	A	One-way allow prorated miles					
P9604	A	One-way allow prorated trip					
P9612	N	Catheterize for urine spec					
P9615	N	Urine specimen collect mult					
Q0035	X	Cardiokymography	0100	1.34	$69.69	$38.33	$13.94
Q0081	T	Infusion ther other than che	0120	1.81	$94.14	$25.42	$18.83
Q0083	S	Chemo by other than infusion	0116	0.85	$44.21		$8.84
Q0084	S	Chemotherapy by infusion	0117	3.87	$201.27	$52.33	$40.25
Q0085	S	Chemo by both infusion and o	0118	5.68	$295.41	$72.03	$59.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0086	A	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	0191	0.22	$11.44	$3.32	$2.29
Q0092	N	Set up port xray equipment					
Q0111	A	Wet mounts/ w preparations					
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
Q0136	K	Non esrd epoetin alpha inj	0733	0.19	$9.88		$1.98
Q0163	N	Diphenhydramine HCl 50mg					
Q0164	N	Prochlorperazine maleate 5mg					
Q0165	E	Prochlorperazine maleate10mg					
Q0166	N	Granisetron HCl 1 mg oral					
Q0167	N	Dronabinol 2.5mg oral					
Q0168	E	Dronabinol 5mg oral					
Q0169	N	Promethazine HCl 12.5mg oral					
Q0170	E	Promethazine HCl 25 mg oral					
Q0171	N	Chlorpromazine HCl 10mg oral					
Q0172	E	Chlorpromazine HCl 25mg oral					
Q0173	N	Trimethobenzamide HCl 250mg					
Q0174	N	Thiethylperazine maleate10mg					
Q0175	N	Perphenazine 4mg oral					
Q0176	E	Perphenazine 8mg oral					
Q0177	N	Hydroxyzine pamoate 25mg					
Q0178	E	Hydroxyzine pamoate 50mg					
Q0179	N	Ondansetron HCl 8mg oral					
Q0180	N	Dolasetron mesylate oral					
Q0181	E	Unspecified oral anti-emetic					
Q0183	N	Nonmetabolic active tissue					
Q0184	N	Metabolically active tissue					
Q0187	K	Factor viia recombinant	1409	13.53	$703.68		$140.74
Q1001	E	Ntiol category 1					
Q1002	E	Ntiol category 2					
Q1003	E	Ntiol category 3					
Q1004	E	Ntiol category 4					
Q1005	E	Ntiol category 5					
Q2001	N	Oral cabergoline 0.5 mg					
Q2002	N	Elliotts b solution per ml					
Q2003	N	Aprotinin, 10,000 kiu					
Q2004	N	Bladder calculi irrig sol					
Q2005	K	Corticorelin ovine triflutat	7024	4.62	$240.28		$48.06
Q2006	K	Digoxin immune fab (ovine)	7025	2.77	$144.06		$28.81
Q2007	N	Ethanolamine oleate 100 mg					
Q2008	N	Fomepizole, 15 mg					
Q2009	N	Fosphenytoin, 50 mg					
Q2010	N	Glatiramer acetate, per dose					
Q2011	K	Hemin, per 1 mg	7030	0.01	$.52		$.10
Q2012	N	Pegademase bovine, 25 iu					
Q2013	N	Pentastarch 10% solution					
Q2014	N	Sermorelin acetate, 0.5 mg					
Q2017	K	Teniposide, 50 mg	7035	1.24	$64.49		$12.90
Q2018	N	Urofollitropin, 75 iu					
Q2019	K	Basiliximab	1615	9.64	$501.37		$100.27
Q2020	E	Histrelin acetate					
Q2021	N	Lepirudin					
Q2022	K	VonWillebrandFactrCmplxperIU	1618	0.01	$.52		$.10
Q3001	N	Brachytherapy Radioelements					
Q3002	N	Gallium ga 67					
Q3003	K	Technetium tc99m bicisate	1620	2.80	$145.63		$29.13
Q3004	N	Xenon xe 133					
Q3005	N	Technetium tc99m mertiatide					
Q3006	N	Technetium tc99m glucepatate					
Q3007	N	Sodium phosphate p32					
Q3008	K	Indium 111-in pentetreotide	1625	4.57	$237.68		$47.54
Q3009	N	Technetium tc99m oxidronate					
Q3010	N	Technetium tc99mlabeledrbcs					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3011	K	Chromic phosphate p32	1628	1.35	$70.21		$14.04
Q3012	N	Cyanocobalamin cobalt co57					
Q3014	A	Telehealth facility fee					
Q3017	E	ALS assessment					
Q3019	A	ALS emer trans no ALS serv					
Q3020	A	ALS nonemer trans no ALS se					
Q4001	A	Cast sup body cast plaster					
Q4002	A	Cast sup body cast fiberglas					
Q4003	A	Cast sup shoulder cast plstr					
Q4004	A	Cast sup shoulder cast fbrgl					
Q4005	A	Cast sup long arm adult plst					
Q4006	A	Cast sup long arm adult fbrg					
Q4007	A	Cast sup long arm ped plster					
Q4008	A	Cast sup long arm ped fbrgls					
Q4009	A	Cast sup sht arm adult plstr					
Q4010	A	Cast sup sht arm adult fbrgl					
Q4011	A	Cast sup sht arm ped plaster					
Q4012	A	Cast sup sht arm ped fbrglas					
Q4013	A	Cast sup gauntlet plaster					
Q4014	A	Cast sup gauntlet fiberglass					
Q4015	A	Cast sup gauntlet ped plster					
Q4016	A	Cast sup gauntlet ped fbrgls					
Q4017	A	Cast sup lng arm splint plst					
Q4018	A	Cast sup lng arm splint fbrg					
Q4019	A	Cast sup lng arm splnt ped p					
Q4020	A	Cast sup lng arm splnt ped f					
Q4021	A	Cast sup sht arm splint plst					
Q4022	A	Cast sup sht arm splint fbrg					
Q4023	A	Cast sup sht arm splnt ped p					
Q4024	A	Cast sup sht arm splnt ped f					
Q4025	A	Cast sup hip spica plaster					
Q4026	A	Cast sup hip spica fiberglas					
Q4027	A	Cast sup hip spica ped plstr					
Q4028	A	Cast sup hip spica ped fbrgl					
Q4029	A	Cast sup long leg plaster					
Q4030	A	Cast sup long leg fiberglass					
Q4031	A	Cast sup lng leg ped plaster					
Q4032	A	Cast sup lng leg ped fbrgls					
Q4033	A	Cast sup lng leg cylinder pl					
Q4034	A	Cast sup lng leg cylinder fb					
Q4035	A	Cast sup lngleg cylndr ped p					
Q4036	A	Cast sup lngleg cylndr ped f					
Q4037	A	Cast sup shrt leg plaster					
Q4038	A	Cast sup shrt leg fiberglass					
Q4039	A	Cast sup shrt leg ped plster					
Q4040	A	Cast sup shrt leg ped fbrgls					
Q4041	A	Cast sup lng leg splnt plstr					
Q4042	A	Cast sup lng leg splnt fbrgl					
Q4043	A	Cast sup lng leg splnt ped p					
Q4044	A	Cast sup lng leg splnt ped f					
Q4045	A	Cast sup sht leg splnt plstr					
Q4046	A	Cast sup sht leg splnt fbrgl					
Q4047	A	Cast sup sht leg splnt ped p					
Q4048	A	Cast sup sht leg splnt ped f					
Q4049	A	Finger splint, static					
Q4050	A	Cast supplies unlisted					
Q4051	A	Splint supplies misc					
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					
Q9923	A	Epoetin with hct = 23					
Q9924	A	Epoetin with hct = 24					
Q9925	A	Epoetin with hct = 25					
Q9926	A	Epoetin with hct = 26					
Q9927	A	Epoetin with hct = 27					
Q9928	A	Epoetin with hct = 28					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q9929	A	Epoetin with hct = 29					
Q9930	A	Epoetin with hct = 30					
Q9931	A	Epoetin with hct = 31					
Q9932	A	Epoetin with hct = 32					
Q9933	A	Epoetin with hct = 33					
Q9934	A	Epoetin with hct = 34					
Q9935	A	Epoetin with hct = 35					
Q9936	A	Epoetin with hct = 36					
Q9937	A	Epoetin with hct = 37					
Q9938	A	Epoetin with hct = 38					
Q9939	A	Epoetin with hct = 39					
Q9940	A	Epoetin with hct >= 40					
R0070	N	Transport portable x-ray					
R0075	N	Transport port x-ray multipl					
R0076	N	Transport portable EKG					
T1015	E	Clinic service					
V2020	A	Vision svcs frames purchases					
V2025	E	Eyeglasses delux frames					
V2100	A	Lens spher single plano 4.00					
V2101	A	Single visn sphere 4.12-7.00					
V2102	A	Singl visn sphere 7.12-20.00					
V2103	A	Spherocylindr 4.00d/12-2.00d					
V2104	A	Spherocylindr 4.00d/2.12-4d					
V2105	A	Spherocylinder 4.00d/4.25-6d					
V2106	A	Spherocylinder 4.00d/>6.00d					
V2107	A	Spherocylinder 4.25d/12-2d					
V2108	A	Spherocylinder 4.25d/2.12-4d					
V2109	A	Spherocylinder 4.25d/4.25-6d					
V2110	A	Spherocylinder 4.25d/over 6d					
V2111	A	Spherocylindr 7.25d/.25-2.25					
V2112	A	Spherocylindr 7.25d/2.25-4d					
V2113	A	Spherocylindr 7.25d/4.25-6d					
V2114	A	Spherocylinder over 12.00d					
V2115	A	Lens lenticular bifocal					
V2116	A	Nonaspheric lens bifocal					
V2117	A	Aspheric lens bifocal					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2306	A	Lens sphcyl trifocal 4.00/>6					
V2307	A	Lens sphcy trifocal 4.25-7/.					
V2308	A	Lens sphc trifocal 4.25-7/2.					
V2309	A	Lens sphc trifocal 4.25-7/4.					
V2310	A	Lens sphc trifocal 4.25-7/>6					
V2311	A	Lens sphc trifo 7.25-12/.25-					
V2312	A	Lens sphc trifo 7.25-12/2.25					
V2313	A	Lens sphc trifo 7.25-12/4.25					
V2314	A	Lens sphcyl trifocal over 12					
V2315	A	Lens lenticular trifocal					
V2316	A	Lens lenticular nonaspheric					
V2317	A	Lens lenticular aspheric tri					
V2318	A	Lens aniseikonic trifocal					
V2319	A	Lens trifocal seg width > 28					
V2320	A	Lens trifocal add over 3.25d					
V2399	A	Lens trifocal speciality					
V2410	A	Lens variab asphericity sing					
V2430	A	Lens variable asphericity bi					
V2499	A	Variable asphericity lens					
V2500	A	Contact lens pmma spherical					
V2501	A	Cntct lens pmma-toric/prism					
V2502	A	Contact lens pmma bifocal					
V2503	A	Cntct lens pmma color vision					
V2510	A	Cntct gas permeable sphericl					
V2511	A	Cntct toric prism ballast					
V2512	A	Cntct lens gas permbl bifocl					
V2513	A	Contact lens extended wear					
V2520	A	Contact lens hydrophilic					
V2521	A	Cntct lens hydrophilic toric					
V2522	A	Cntct lens hydrophil bifocl					
V2523	A	Cntct lens hydrophil extend					
V2530	A	Contact lens gas impermeable					
V2531	A	Contact lens gas permeable					
V2599	A	Contact lens/es other type					
V2600	A	Hand held low vision aids					
V2610	A	Single lens spectacle mount					
V2615	A	Telescop/othr compound lens					
V2623	A	Plastic eye prosth custom					
V2624	A	Polishing artifical eye					
V2625	A	Enlargemnt of eye prosthesis					
V2626	A	Reduction of eye prosthesis					
V2627	A	Scleral cover shell					
V2628	A	Fabrication & fitting					
V2629	A	Prosthetic eye other type					
V2630	N	Anter chamber intraocul lens					
V2631	N	Iris support intraoclr lens					
V2632	N	Post chmbr intraocular lens					
V2700	A	Balance lens					
V2710	A	Glass/plastic slab off prism					
V2715	A	Prism lens/es					
V2718	A	Fresnell prism press-on lens					
V2730	A	Special base curve					
V2740	A	Rose tint plastic					
V2741	A	Non-rose tint plastic					
V2742	A	Rose tint glass					
V2743	A	Non-rose tint glass					
V2744	A	Tint photochromatic lens/es					
V2750	A	Anti-reflective coating					
V2755	A	UV lens/es					
V2760	A	Scratch resistant coating					
V2770	A	Occluder lens/es					
V2780	A	Oversize lens/es					
V2781	E	Progressive lens per lens					
V2785	F	Corneal tissue processing					
V2790	N	Amniotic membrane					
V2799	A	Miscellaneous vision service					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5008	E	Hearing screening					
V5010	E	Assessment for hearing aid					
V5011	E	Hearing aid fitting/checking					
V5014	E	Hearing aid repair/modifying					
V5020	E	Conformity evaluation					
V5030	E	Body-worn hearing aid air					
V5040	E	Body-worn hearing aid bone					
V5050	E	Hearing aid monaural in ear					
V5060	E	Behind ear hearing aid					
V5070	E	Glasses air conduction					
V5080	E	Glasses bone conduction					
V5090	E	Hearing aid dispensing fee					
V5100	E	Body-worn bilat hearing aid					
V5110	E	Hearing aid dispensing fee					
V5120	E	Body-worn binaur hearing aid					
V5130	E	In ear binaural hearing aid					
V5140	E	Behind ear binaur hearing ai					
V5150	E	Glasses binaural hearing aid					
V5160	E	Dispensing fee binaural					
V5170	E	Within ear cros hearing aid					
V5180	E	Behind ear cros hearing aid					
V5190	E	Glasses cros hearing aid					
V5200	E	Cros hearing aid dispens fee					
V5210	E	In ear bicros hearing aid					
V5220	E	Behind ear bicros hearing ai					
V5230	E	Glasses bicros hearing aid					
V5240	E	Dispensing fee bicros					
V5241	E	Dispensing fee, monaural					
V5242	E	Hearing aid, monaural, cic					
V5243	E	Hearing aid, monaural, itc					
V5244	E	Hearing aid, prog, mon, cic					
V5245	E	Hearing aid, prog, mon, itc					
V5246	E	Hearing aid, prog, mon, ite					
V5247	E	Hearing aid, prog, mon, bte					
V5248	E	Hearing aid, binaural, cic					
V5249	E	Hearing aid, binaural, itc					
V5250	E	Hearing aid, prog, bin, cic					
V5251	E	Hearing aid, prog, bin, itc					
V5252	E	Hearing aid, prog, bin, ite					
V5253	E	Hearing aid, prog, bin, bte					
V5254	E	Hearing id, digit, mon, cic					
V5255	E	Hearing aid, digit, mon, itc					
V5256	E	Hearing aid, digit, mon, ite					
V5257	E	Hearing aid, digit, mon, bte					
V5258	E	Hearing aid, digit, bin, cic					
V5259	E	Hearing aid, digit, bin, itc					
V5260	E	Hearing aid, digit, bin, ite					
V5261	E	Hearing aid, digit, bin, bte					
V5262	E	Hearing aid, disp, monaural					
V5263	E	Hearing aid, disp, binaural					
V5264	E	Ear mold/insert					
V5265	E	Ear mold/insert, disp					
V5266	E	Battery for hearing device					
V5267	E	Hearing aid supply/accessory					
V5268	E	ALD Telephone Amplifier					
V5269	E	Alerting device, any type					
V5270	E	ALD, TV amplifier, any type					
V5271	E	ALD, TV caption decoder					
V5272	E	Tdd					
V5273	E	ALD for cochlear implant					
V5274	E	ALD unspecified					
V5275	E	Ear impression					
V5299	E	Hearing service					
V5336	E	Repair communication device					
V5362	A	Speech screening					
V5363	A	Language screening					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2003—Continued

CPT/ HCPCS	Status indicator	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5364	A	Dysphagia screening	.....	.....	.....	.....	.....

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Ambulance	Ambulance Fee Schedule.
A	Clinical Diagnostic Laboratory Services.	Laboratory Fee Schedule.
A	Durable Medical Equipment, Prosthetics and Orthotics (excluding implanted DME and prosthetics).	DMEPOS Fee Schedule.
A	EPO for ESRD Patients.	National Rate.
A	Physical, Occupational and Speech Therapy.	Physician Fee Schedule.
A	Physician Services for ESRD Patients.	Physician Fee Schedule.
A	Screening Mammography.	Physician Fee Schedule.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Indicator	Service	Status
C	Inpatient Procedures.	Not Payable under OPPS; Admit Patient; Bill as Inpatient.
D	Deleted Code	Deleted Effective Beginning of Calendar Year.
E	Non-Covered Items and Services, Codes not Reportable in Hospital Outpatient Settings.	Not Paid Under Medicare or When Performed in a Hospital Outpatient Setting.
F	Acquisition of Corneal Tissue.	Paid at Reasonable Cost.
G	Drug/Biological Pass-Through.	Paid Under OPPS; Separate APC Payment Includes Pass Through Amount.
H	Device Category Pass-Through.	Paid Under OPPS; Separate Cost Based Pass Through Payment.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Indicator	Service	Status
K	Non Pass-Through Drug/Biological, Certain Brachytherapy seeds.	Paid Under OPPS; Separate APC.
N	Items and Services Packaged into APC Rate.	Paid under OPPS; Payment Is Packaged Into Payment for Other Services.
P	Partial Hospitalization.	Paid under OPPS; Per Diem APC.
S	Significant Procedure, Not Discounted When Multiple.	Paid Under OPPS; Separate APC.
T	Significant Procedure, Multiple Procedure Reduction Applies.	Paid Under OPPS; Separate APC.
V	Visit to Clinic or Emergency Department.	Paid Under OPPS; Separate PC.
X	Ancillary Service.	Paid Under OPPS; Separate APC

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
0001T	C	Endovas repr abdo ao aneurys
0002T	C	Endovas repr abdo ao aneurys
0005T	C	Perc cath stent/brain cv art
0006T	C	Perc cath stent/brain cv art
0007T	C	Perc cath stent/brain cv art
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
00215	C	Anesth, skull repair/fract
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
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
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, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Incise burn scab, addl incis
19200	C	Removal of breast
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply,remove fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant, forearm, complete
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone/skin graft, metatarsal
20973	C	Bone/skin graft, great toe
21045	C	Extensive jaw surgery
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconst lwr jaw w/o graft
21194	C	Reconst lwr jaw w/graft
21195	C	Reconst lwr jaw w/o fixation
21196	C	Reconst lwr jaw w/fixation
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck/chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22612	C	Lumbar spine fusion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip arthroplasty
27132	C	Total hip arthroplasty
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
33979	C	Insert intracorporeal device

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
33980	C	Remove intracorporeal device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34804	C	Endovasc abdo repr w/device
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Xpose for endoprosth, femorl
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, addl
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35600	C	Harvest artery for cabg
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Parital removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty congential
43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/taper, cong
44127	C	Enterectomy w/o taper, cong
44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservoir
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47380	C	Open ablate liver tumor rf
47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47570	C	Laparo cholecystoenterostomy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49201	C	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Renal abscess, open drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove k/ureter
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy/radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54411	C	Remv/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58150	C	Total hysterectomy
58152	C	Total hysterectomy

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr , simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61862	C	Implant neurostimul, subcort

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, addl cervical
63044	C	Laminotomy, addl lumbar
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
94652	C	Pressure breathing (IPPB)
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2003]

CPT/ HCPCS	Status indicator	Description
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

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.9268
Taylor, TX	
0060 Aguadilla, PR	0.4634
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9685
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0835
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8633
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9372
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7929
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9833
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9300
Blair, PA	
0320 Amarillo, TX Potter, TX	0.9051
Randall, TX	
0380 Anchorage, AK	1.2610
Anchorage, AK	
0440 Ann Arbor, MI	1.1217
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8126
Calhoun, AL	
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9229
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 [2] Arecibo, PR	0.4400
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9682
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0308
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0091
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1058
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8306
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0364
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.9529
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	1.0186
Kern, CA	
0720 [1] Baltimore, MD	0.9757
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9791
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3127
Barnstable, MA	
0760 Baton Rouge, LA	0.8388
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8389
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2407
Whatcom, WA	
0870 Benton Harbor, MI	0.9072
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.2100
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9114
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8830
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 [2] Binghamton, NY	0.8633
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9301
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7881
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8997
Monroe, IN	
1040 Bloomington-Normal, IL	0.9202
McLean, IL	
1080 Boise City, ID	0.9403
Ada, ID	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Canyon, ID	
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH ..	1.1304
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	0.9688
Boulder, CO	
1145 Brazoria, TX	0.8617
Brazoria, TX	
1150 Bremerton, WA	1.1056
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8992
Cameron, TX	
1260 Bryan-College Station, TX ..	0.8410
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9464
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0176
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4453
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9026
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9788
Natrona, WY	
1360 Cedar Rapids, IA	0.9149
Linn, IA	
1400 Champaign-Urbana, IL	0.9983
Champaign, IL	
1440 [2] Charleston-North Charleston, SC	0.8607
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8765
Kanawha, WV	
Putnam, WV	
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9839
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0583
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
1560 Chattanooga, TN-GA	0.9069
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 [2] Cheyenne, WY	0.8890
Laramie, WY	
1600 [1] Chicago, IL	1.1088
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 [2] Chico-Paradise, CA	0.9934
Butte, CA	
1640 [1] Cincinnati, OH-KY-IN	0.9354
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8386
Christian, KY	
Montgomery, TN	
1680 [1] Cleveland-Lorain-Elyria, OH	0.9295
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9968
El Paso, CO	
1740 Columbia, MO	0.8737
Boone, MO	
1760 Columbia, SC	0.8990
Lexington, SC	
Richland, SC	
1800 Columbus, GA-ALRussell, AL	0.8450
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1] Columbus, OH	0.9705
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8154
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1569
Benton, OR	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.8855
Allegany, MD	
Mineral, WV	
1900 [2] Cumberland, MD-WV (WV Hospitals)	0.8053
Allegany, MD	
Mineral, WV	
1920 [1] Dallas, TX	0.9831
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8785
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8872
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9378
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9133
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.9066
Lawrence, AL	
Morgan, AL	
2040 [2] Decatur, IL	0.8301
Macon, IL	
2080 [1] Denver, CO	1.0401
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8908
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1] Detroit, MI	1.0506
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8028
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9452
Kent, DE	
2200 Dubuque, IA	0.8801
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0462
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0793
Dutchess, NY	
2290 [2] Eau Claire, WI	0.9229
Chippewa, WI	
Eau Claire, WI	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
2320 El Paso, TX	0.9137
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9851
Elkhart, IN	
2335 [2] Elmira, NY	0.8633
Chemung, NY	
2340 Enid, OK	0.8387
Garfield, OK	
2360 Erie, PA	0.9016
Erie, PA	
2400 Eugene-Springfield, OR	1.1077
Lane, OR	
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8796
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8254
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9783
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.9055
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8182
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0791
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1233
Genesee, MI	
2650 Florence, AL	0.7960
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8869
Florence, SC	
2670 Fort Collins-Loveland, CO	0.9923
Larimer, CO	
2680 [1] Ft. Lauderdale, FL	1.0792
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9456
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9959
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7811
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9651
Okaloosa, FL	
2760 Fort Wayne, IN	0.9499
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1] Forth Worth-Arlington, TX	0.9620
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0340
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8684
Etowah, AL	
2900 Gainesville, FL	0.9730
Alachua, FL	
2920 Galveston-Texas City, TX	0.9603
Galveston, TX	
2960 Gary, IN	0.9676
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8633
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8982
Wayne, NC	
2985 Grand Forks, ND-MN	0.9338
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9824
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9664
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9057
Cascade, MT	
3060 Greeley, CO	0.9219
Weld, CO	
3080 Green Bay, WI	0.9599
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9270
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NCGuilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9257
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9177
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9362
Washington, MD	
3200 Hamilton-Middletown, OH	0.9484
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9315
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 \1, 2\ Hartford, CT	1.2520
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7759
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.8958
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1121
Honolulu, HI	
3350 Houma, LA	0.8470
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	0.9746
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9744
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8901
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9828
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	1.0025
Johnson, IA	
3520 Jackson, MI	0.9591
Jackson, MI	
3560 Jackson, MS	0.8713
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9370
Madison, TN	
Chester, TN	
3600 [1] Jacksonville, FL	0.9341
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 [2] Jacksonville, NC	0.8714
Onslow, NC	
3610 [2] Jamestown, NY	0.8633
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9696
Rock, WI	
3640 Jersey City, NJ	1.1200
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8384
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8494
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 [2] Johnstown, PA	0.8525
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7906
Craighead, AR	
3710 Joplin, MO	0.8700
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0689
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9591
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9809
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9741
Kenosha, WI	
3810 Killeen-Temple, TX	0.8447
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.9090
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9031
Howard, IN	
Tipton, IN	
3870 [2] La Crosse, WI-MN (WI Hospitals)	0.9229
Houston, MN	
La Crosse, WI	
3870 [2] La Crosse, WI-MN (MN Hospitals)	0.9249
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8550
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9515
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.8030
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9170
Polk, FL	
4000 Lancaster, PA	0.9171
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9827
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8504
Webb, TX	
4100 Las Cruces, NM	0.8888
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1018
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7964
Douglas, KS	
4200 Lawton, OK	0.8251
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9249
Androscoggin, ME	
4280 Lexington, KY	0.8629
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9515
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9133
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.9045
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8588
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.2044
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9517
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.7809
Lubbock, TX	
4640 Lynchburg, VA	0.9311
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9296
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0188
Dane, WI	
4800 Mansfield, OH	0.8989
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4921
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8419
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0605
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	1.0782
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.8839
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9937
Merced, CA	
5000 [1] Miami, FL	0.9878
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1454
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9901
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.0969
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	
5140 Missoula, MT	0.9250
Missoula, MT	
5160 Mobile, AL	0.8181
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0606
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1290
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8191
Ouachita, LA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
5240 [2] Montgomery, AL	0.7853
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9150
Delaware, IN	
5330 Myrtle Beach, SC	0.9141
Horry, SC	
5345 Naples, FL	0.9803
Collier, FL	
5360 [1] Nashville, TN	0.9456
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3441
Nassau, NY	
Suffolk, NY	
5483 \1, 2\New Haven-Bridgeport-Stamford-Waterbury-	1.2520
Danbury, CT	
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2520
New London, CT	
5560 [1] New Orleans, LA	0.9050
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 [1] New York, NY	1.4069
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.1546
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1434
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8553
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 [1] Oakland, CA	1.5324
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9526
Marion, FL	
5800 Odessa-Midland, TX	0.9233
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8997
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1071
Thurston, WA	
5920 Omaha, NE-IA	1.0089
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1726
Orange, CA	
5960 [1] Orlando, FL	0.9537
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8283
Daviess, KY	
6015 Panama City, FL	0.8926
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8210
Washington, OH	
Wood, WV	
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8675
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8907
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8854
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA-NJ	1.0675
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	0.9562
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7866
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.9403
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.1257
Berkshire, MA	
6340 Pocatello, ID	0.9013
Bannock, ID	
6360 Ponce, PR	0.5221
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9932
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR-WA	1.0792
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0558
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0190
Utah, UT	
6560 [2] Pueblo, CO	0.9104
Pueblo, CO	
6580 [2] Punta Gorda, FL	0.8907
Charlotte, FL	
6600 Racine, WI	0.9413
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	1.0083
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8936
Pennington, SD	
6680 Reading, PA	0.9308
Berks, PA	
6690 Redding, CA	1.1249
Shasta, CA	
6720 Reno, NV	1.0664
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1608
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9735
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 [1] Riverside-San Bernardino, CA	1.1251
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8703
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.2263
Olmsted, MN	
6840 [1] Rochester, NY	0.9133
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9456
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9322
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1636
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9709
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9858
Benton, MN	
Stearns, MN	
7000 [2] St. Joseph, MO	0.8099
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.8907
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0473
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4772
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	1.0035
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7956
Tom Green, TX	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
7240 [1] San Antonio, TX	0.8649
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 [1] San Diego, CA	1.1247
San Diego, CA	
7360 [1] San Francisco, CA	1.4288
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.4162
Santa Clara, CA	
7440 [1] San Juan-Bayamon, PR	0.4706
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1386
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0588
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3630
Santa Cruz, CA	
7490 Santa Fe, NM	1.0822
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3179
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9367
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9961
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 [2] Scranton—Wilkes-Barre—Hazleton, PA	0.8525
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
7600 [1] Seattle-Bellevue-Everett, WA	1.1571
Island, WA	
King, WA	
Snohomish, WA	
7610 [2] Sharon, PA	0.8525
Mercer, PA	
7620 [2] Sheboygan, WI	0.9229
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9334
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8813
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9138
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9098
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9902
St. Joseph, IN	
7840 Spokane, WA	1.0961
Spokane, WA	
7880 Springfield, IL	0.8654
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8510
Christian, MO	
Greene, MO	
Webster, MO	
8003 [2] Springfield, MA	1.1257
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9032
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8893
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0630
San Joaquin, CA	
8140 [2] Sumter, SC	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9519
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1052
Pierce, WA	
8240 [2] Tallahassee, FL	0.8907
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9238
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 [2] Terre Haute, IN	0.8796
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8193
Miller, AR	
Bowie, TX	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
8400 Toledo, OH	0.9863
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8952
Shawnee, KS	
8480 Trenton, NJ	1.0710
Mercer, NJ	
8520 Tucson, AZ	0.8993
Pima, AZ	
8560 Tulsa, OK	0.8398
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8303
Tuscaloosa, AL	
8640 Tyler, TX	0.9650
Smith, TX	
8680 [2] Utica-Rome, NY	0.8633
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3544
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1209
Ventura, CA	
8750 Victoria, TX	0.8814
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0296
Cumberland, NJ	
8780 2Visalia-Tulare-Porterville, CA	0.9934
Tulare, CA	
8800 Waco, TX	0.8802
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0852
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8970
Black Hawk, IA	
8940 Wausau, WI	0.9882
Marathon, WI	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
8960 [1] West Palm Beach-Boca Raton, FL	0.9929
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8053
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8675
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9571
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8023
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8624
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1287
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9471
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0676
Yakima, WA	
9270 [2] Yolo, CA	0.9934
Yolo, CA	
9280 York, PA	0.9140
York, PA	
9320 Youngstown-Warren, OH	0.9485
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0310
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8677
Yuma, AZ	

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7853
Alaska	1.2323
Arizona	0.8483
Arkansas	0.7670
California	0.9934
Colorado	0.9104
Connecticut	1.2520
Delaware	0.9126
Florida	0.8907
Georgia	0.8254
Hawaii	1.0342
Idaho	0.8799
Illinois	0.8301
Indiana	0.8796
Iowa	0.8395

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Kansas	0.7964
Kentucky	0.8079
Louisiana	0.7719
Maine	0.8754
Maryland	0.8855
Massachusetts	1.1257
Michigan	0.8961
Minnesota	0.9249
Mississippi	0.7759
Missouri	0.8099
Montana	0.8567
Nebraska	0.8283
Nevada	0.9519
New Hampshire	0.9882
New Jersey [1]	.....
New Mexico	0.8645
New York	0.8633
North Carolina	0.8714
North Dakota	0.7830
Ohio	0.8675
Oklahoma	0.7664
Oregon	1.0408
Pennsylvania	0.8525
Puerto Rico	0.4400
Rhode Island [1]	.....
South Carolina	0.8607
South Dakota	0.7895
Tennessee	0.7873
Texas	0.7759
Utah	0.9426
Vermont	0.9402
Virginia	0.8494
Washington	1.0274
West Virginia	0.8053
Wisconsin	0.9229
Wyoming	0.8890

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Abilene, TX	0.8534
Akron, OH	0.9685
Albany, GA	1.0658
Albuquerque, NM	0.9372
Alexandria, LA	0.7929
Allentown-Bethlehem-Easton, PA	0.9833
Altoona, PA	0.9300
Amarillo, TX	0.8900
Anchorage, AK	1.2610
Ann Arbor, MI	1.1217
Anniston, AL	0.7983
Asheville, NC	0.9448
Athens, GA	1.0161
Atlanta, GA	0.9985
Augusta-Aiken, GA-SC	0.9981
Austin-San Marcos, TX	0.9529
Barnstable-Yarmouth, MA	1.2894
Baton Rouge, LA	0.8281
Bellingham, WA	1.2139
Benton Harbor, MI	0.9072
Bergen-Passaic, NJ	1.2100
Billings, MT	0.9114
Biloxi-Gulfport-Pascagoula, MS	0.8417
Binghamton, NY	0.8525

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Birmingham, AL	0.9301
Bismarck, ND	0.7881
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1304
Burlington, VT	0.9667
Caguas, PR	0.4453
Casper, WY	0.9655
Champaign-Urbana, IL	0.9334
Charleston-North Charleston, SC	0.8607
Charleston, WV	0.8602
Charlotte-Gastonia-Rock Hill, NC-SC	0.9839
Charlottesville, VA	1.0252
Chattanooga, TN-GA	0.8878
Chicago, IL	1.0953
Cincinnati, OH-KY-IN	0.9354
Clarksville-Hopkinsville, TN-KY	0.8239
Cleveland-Lorain-Elyria, OH	0.9295
Columbia, MO	0.8737
Columbia, SC	0.8990
Columbus, GA-AL (GA Hospitals)	0.8254
Columbus, GA-AL (AL Hospitals)	0.8041
Columbus, OH	0.9521
Corpus Christi, TX	0.8154
Dallas, TX	0.9831
Danville, VA	0.8530
Davenport-Moline-Rock Island, IA-IL	0.8872
Dayton-Springfield, OH	0.9378
Denver, CO	1.0401
Des Moines, IA	0.8908
Detroit, MI	1.0506
Dothan, AL	0.8028
Dover, DE	0.9274
Duluth-Superior, MN-WI	1.0462
Eau Claire, WI	0.9229
Elkhart-Goshen, IN	0.9484
Erie, PA	0.8850
Eugene-Springfield, OR	1.1077
Fargo-Moorhead, ND-MN	0.9564
Fayetteville, NC	0.9055
Flagstaff, AZ-UT	1.0234
Flint, MI	1.1041
Florence, AL	0.7960
Florence, SC	0.8869
Fort Collins-Loveland, CO	0.9923
Ft. Lauderdale, FL	1.0792
Fort Pierce-Port St. Lucie, FL	0.9959
Fort Smith, AR-OK	0.7681
Fort Walton Beach, FL	0.9365
Forth Worth-Arlington, TX	0.9620
Gadsden, AL	0.8684
Grand Forks, ND-MN	0.9338
Grand Junction, CO	0.9824
Grand Rapids-Muskegon-Holland, MI	0.9664
Great Falls, MT	0.9057
Greeley, CO	0.9219
Green Bay, WI	0.9347
Greensboro-Winston-Salem-High Point, NC	0.9131
Greenville, NC	0.9257
Harrisburg-Lebanon-Carlisle, PA	0.9315
Hartford, CT	1.1550
Hattiesburg, MS	0.7759
Hickory-Morganton-Lenoir, NC	0.8958
Houston, TX	0.9746
Huntington-Ashland, WV-KY-OH	0.9251
Huntsville, AL	0.8901
Indianapolis, IN	0.9828
Iowa City, IA	0.9828
Jackson, MS	0.8587
Jackson, TN	0.9032
Jacksonville, FL	0.9225
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8494
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8384
Johnstown, PA	0.0000
Jonesboro, AR (AR Hospitals)	0.7906
Jonesboro, AR (MO Hospitals)	0.8099
Joplin, MO	0.8700
Kalamazoo-Battlecreek, MI	1.0490
Kansas City, KS-MO	0.9809
Knoxville, TN	0.9090
Kokomo, IN	0.9031
Lafayette, LA	0.8392
Lakeland-Winter Haven, FL	0.9170
Las Vegas, NV-AZ	1.1018
Lawton, OK	0.8073
Lexington, KY	0.8629
Lima, OH	0.9515
Lincoln, NE	0.9133
Little Rock-North Little Rock, AR	0.8926
Longview-Marshall, TX	0.8588
Los Angeles-Long Beach, CA	1.2044
Louisville, KY-IN	0.9382
Lubbock, TX	0.7809
Lynchburg, VA	0.9114
Macon, GA	0.9296
Madison, WI	1.0188
Mansfield, OH	0.8989
Medford-Ashland, OR	1.0408
Memphis, TN-AR-MS	0.8667
Miami, FL	0.9878
Milwaukee-Waukesha, WI	0.9901
Minneapolis-St. Paul, MN-WI	1.0969
Missoula, MT	0.9139
Mobile, AL	0.8181
Modesto, CA	1.0606
Monmouth-Ocean, NJ	1.1290
Monroe, LA	0.8191
Montgomery, AL	0.7853
Nashville, TN	0.9283
New Haven-Bridgeport-Stamford-Waterbury-.	
Danbury, CT	1.2520
New London-Norwich, CT	1.1683
New Orleans, LA	0.9050
New York, NY	1.3936
Newark, NJ	1.1546
Newburgh, NY-PA	1.0820
Norfolk-Virginia Beach-Newport News, VA-NC	0.8714
Oakland, CA	1.5324
Ocala, FL	0.9343
Odessa-Midland, TX	0.8910
Oklahoma City, OK	0.8997
Omaha, NE-IA	1.0089
Orange County, CA	1.1726
Orlando, FL	0.9537
Peoria-Pekin, IL	0.8854
Philadelphia, PA-NJ	1.0675
Phoenix-Mesa, AZ	0.9562
Pine Bluff, AR	0.7760
Pittsburgh, PA	0.9268
Pittsfield, MA	0.9869
Pocatello, ID	0.9013
Portland, ME	0.9698
Portland-Vancouver, OR-WA	1.0792
Provo-Orem, UT	1.0088
Raleigh-Durham-Chapel Hill, NC	0.9978
Rapid City, SD	0.8936
Reading, PA	0.9126
Redding, CA	1.1249
Reno, NV	1.0445
Richland-Kennewick-Pasco, WA	1.1209
Richmond-Petersburg, VA	0.9735
Roanoke, VA	0.8703
Rochester, MN	1.2263
Rockford, IL	0.9456
Sacramento, CA	1.1636
Saginaw-Bay City-Midland, MI	0.9709
St. Cloud, MN	0.9858
St. Joseph, MO	0.8300
St. Louis, MO-IL	0.8907
Salinas, CA	1.4772
Salt Lake City-Ogden, UT	1.0035
San Antonio, TX	0.8649
San Diego, CA	1.1247
Santa Fe, NM	0.9927
Santa Rosa, CA	1.2891
Sarasota-Bradenton, FL	0.9367
Savannah, GA	0.9841
Seattle-Bellevue-Everett, WA	1.1571
Sherman-Denison, TX	0.9090
Shreveport-Bossier City, LA	0.8813
Sioux City, IA-NE	0.8736
Sioux Falls, SD	0.8950
South Bend, IN	0.9902
Spokane, WA	1.0770
Springfield, IL	0.8654
Springfield, MO	0.8236
Stockton-Lodi, CA	1.0630
Syracuse, NY	0.9519
Tampa-St. Petersburg-Clearwater, FL	0.9238
Texarkana,AR-Texarkana, TX	0.8193
Toledo, OH	0.9863
Topeka, KS	0.8840
Tucson, AZ	0.8993
Tulsa, OK	0.8398
Tuscaloosa, AL	0.8303
Tyler, TX	0.9249
Vallejo-Fairfield-Napa, CA	1.3544
Victoria, TX	0.8668
Waco, TX	0.8671
Washington, DC-MD-VA-WV	1.0852
Waterloo-Cedar Falls, IA	0.8970
Wausau, WI	0.9710
West Palm Beach-Boca Raton, FL	0.9929
Wichita, KS	0.9235
Wichita Falls, TX	0.7918
Wilmington-Newark, DE-MD	1.0973
Wilmington, NC	0.9336
York, PA	0.9140
Youngstown-Warren, OH	0.9485
Rural Alabama	0.7853
Rural Florida	0.8907
Rural Illinois (IA Hospitals)	0.8395
Rural Illinois (MO Hospitals)	0.8301
Rural Kentucky	0.8079
Rural Louisiana	0.7719
Rural Massachusetts	1.0417
Rural Michigan	0.8961
Rural Minnesota	0.9249
Rural Mississippi	0.7759

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Rural Missouri	0.8099
Rural Montana	0.8567
Rural Nebraska	0.8283
Rural Nevada	0.9097
Rural Texas	0.7759
Rural Washington	1.0274
Rural Wyoming	0.8890

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