Prosthesis, is no longer on the list, and APC 0259, Level VI ENT Procedures, has been added to the list. These changes result from the application of the limit on the variation of costs of services classified within a group (the ''two-times'' rule). APC 0185 has been deleted due to the application of this rule. The device-related procedures that had been included with APC 0185 have been incorporated into APC 0259. As a result, APC 0259 has been added to the list of APCs with device costs reflected in their rates, on the basis of the same costs that had been included in APC 0185.

We received several comments on this proposal, which are summarized below.

Comment: Several commenters asked for clarification of the methodology used in selecting the 25 APCs for which we calculated reductions.

Response: We described our methodology for selecting the 25 APCs in some detail in the proposed rule (66 FR 44706). As we stated there, we reviewed the APCs to determine which of them contained services that are associated with a category of devices eligible for a transitional pass-through payment. We carefully examined those APCs with a high frequency of claims in the data, and those that were associated with high-cost devices. We selected those APCs with patterns of billing that could be reasonably associated with devices, that is, with charges in revenue centers that are likely to be used for devices (revenue codes 272 (sterile supplies), 275 (pacemakers), and 278 (other implants)).

Comment: Several commenters noted that for 11 of the 25 APCs for which we have identified offsets, the amount of the proposed APC payment for 2002 has either decreased or increased by less than the amount of the offset. For these 11 APCs, Medicare's combined payments for the device and procedure would thus be reduced effective January 1, 2002.

Response: The estimate of the offset did not affect the APC rates. Any changes in the APC rates were due to the recalibration of the relative weights using the 1999–2000 data. The offset amount will be subtracted from the pass-through payment amount that would have been made otherwise. Thus, the combined payment for the device and procedure is necessarily reduced for all 25 APCs relative to what the payment would have been in 2002 without the offset. In other words, payments for all 25 device/procedure combinations would have been higher in 2002 by the amount of the offset if we had not identified the packaged costs and applied the offset. We assume, however, that the commenter means that payments for the device/procedure combinations associated with 11 of the 25 APCs will decrease in 2002 relative to the combined payments in 2001. Relative to the payments for 2001, the combined payment for the device and procedure could increase or decrease due to a number of factors affecting the relative weights for the APCs and the costs of the devices themselves. In the cases identified by the commenter, these factors decreased the proposed rates, or increased those rates by less than the amount of the offset, and thus decreased the payment in 2002 for the device/procedure combination relative to the payment for the combination in 2001.

Comment: One commenter endorsed the idea of making a reduction in pass-through payments for the costs already represented in the APC rates. However, the commenter expressed concern that reducing the pass-through payment will likely result in underpayments to hospitals that are using the associated devices with procedures, and overpayments to hospitals performing procedures without using the associated devices.

Response: We are not certain that the commenter understands how the pass-through offset works. The purpose of this measure is to ensure that the Medicare program pays only for the incremental costs of the new technology, over and above what is already represented in the APC rate for the associated procedure. The offset is applied only when a hospital bills for a device or other pass-through item in conjunction with billing for a procedure in an associated APC. When a hospital bills for a pass-through item along with a procedure, the hospital receives the full APC payment for the procedure. The offset is subtracted from the cost of the pass-through item. The hospital thus receives payment for the cost of the pass-through item over and above the offset amount. Without applying the offset, hospitals would be paid twice for the same costs. There is thus no underpayment for hospitals that are using pass-through items. When a hospital does not bill for a pass-through item with an APC, the hospital receives the full APC payment but no pass-through payment. The offset is not applied in the absence of a bill for a pass-through item. There is thus no overpayment for hospitals that are not using pass-through items. The hospital is paid only for the technology costs incorporated into the base APC rate, not for the incremental costs of new technologies.

Comment: One commenter raised a question about a possible consequence of applying predetermined amounts to subtract from pass-through payments as offsets for the device-related costs already included in the APC rates. The commenter observed that use of a hospital-wide cost-to-charge ratio in determining the amount of a pass-through payment makes it possible for the predetermined offset amount to exceed the calculated cost of a device to the hospital. The commenter therefore recommended that the reduction for the costs included in the APC rates never exceed the amount of the pass-through payment.

Response: We agree that the application of the pass-through offset should never result in a negative payment amount to the hospital. Our systems do not in fact compute pass-through payment amounts of less than zero.

Comment: One commenter recommended that, if we implement a pro rata reduction in the transitional pass-through payments, the same percentage reduction should be applied to the offsets for the technology costs already represented in the APCs associated with pass-through items. Such a reduction in the offset would help hospitals to maintain beneficiary access to new technology services in the event of a substantial pro rata reduction.

Response: The statute provides for applying a pro rata reduction only to the pass-through payments themselves, not to the offsets that are required to account for the costs that are represented in the payment rates for associated APCs. Reducing the offset would also increase the estimate of pass-through spending and require a larger pro rata reduction. We are therefore unable to accept the commenter's recommendation. We note, however, that the pro rata reduction is applied to the pass-through payment amount only *after* the offset.

Comment: One commenter endorsed the concept of incorporating pass-through device costs into their associated APCs, but raised a specific question about the device costs associated with APC 0182, Insertion of Penile Prosthesis. The commenter contended that a review of the median cost files suggests that numerous claims could not have included device costs, even though the whole point of the procedure is to implant a device. As a result, the commenter contended that both the pass-through offset for the device and any upward adjustment to incorporate device costs into the APC can only be understated. Two commenters inquired about APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads. The

commenter contended that the $5,768 that we have determined as representing device costs in that APC is far too low, since the average device costs between $22,000 and $23,000 in 1996.

Response: The first commenter is mistaken in thinking that we published a methodology for incorporating device costs into the APCs in the proposed rule. Rather, we published a methodology for identifying device costs that are *already* represented in the rates. (We published a methodology for incorporating device costs into the APCs in the November 2, 2001 final rule announcing the CY 2002 conversion factor and the pro rata reduction of transitional pass-through payments (66 FR 55857).) In developing our estimate of the device costs included in the APC rates, we used that portion of hospital costs that were allocated to those revenue centers in which device charges were likely to be billed. Hospitals have considerable flexibility in determining which revenue centers to assign charges, and we believe that in many cases they have allocated device charges to general supply centers. We are unable to separate the device charges from the other charges assigned to those revenue centers. We were thus unable to use costs from those centers in developing our estimates of the device costs associated with the APC rates. As a result, our estimate of the device costs in the APC rates might conceivably be understated. We believe that it does represent, however, a reasonably conservative estimate. We do not know the source of the other commenter's information about the cost for a specific device, but we believe that our offsets accurately capture the costs for device costs that are included in the current APC rates, net of all discounts, rebates, etc.

Comment: Several commenters questioned whether we would deduct from pass-through payments the full amount of the offset for the device costs reflected in associated APCs in cases where the payment for the associated APC is reduced due to the multiple procedures discount. Some of these commenters also recommended a methodology for making an appropriate adjustment. Specifically, they recommended that the multiple procedure discount be applied only to the nondevice-related portion of the APC payment amount.

Response: We agree with the commenters that the full pass-through offset should not be applied when the APC associated with the use of the device is subject to the multiple procedure discount of 50 percent. The purpose of the offset is to ensure that the program is not making double payment for any portion of the cost associated with the use of a pass-through item. The offset should therefore reflect that portion of the cost for the pass-through item actually reflected in the payment that is received for the associated APC. We believe that the most straightforward methodology for applying this principle is simply to reduce the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC.

Comment: One commenter asked how the offset is applied when one pass-through device is billed with more than one of the 25 APCs in which we have identified costs associated with pass-through items. And conversely, the commenter wondered what happens when two or more devices are billed with only one of the 25 APCs with offsets.

Response: The purpose of the offset is to avoid paying twice for costs that are represented both in the APC rates and in the costs of pass-through items. When one pass-through device is billed with two or more APCs with device-related costs, we would be double paying for some costs if we applied only one offset to the pass-through payment. We therefore apply all the offsets for the APCs on a bill when only one device is billed. As we have discussed above, however, the offset for the second APC would be reduced by 50 percent when the multiple service discount applies to that APC. Conversely, the offset is applied only once when one APC is billed, no matter how many devices are billed along with the APC. To apply the offset more than once would be to double-count the pass-through costs represented in that APC.

We employed the following methodology in incorporating 75 percent of the device pass-through costs into the costs that are used to establish the APC relative weights. We used a crosswalk that we developed as part of the methodology for estimating total pass-through spending as the basis for determining the device costs that are to be included in setting the relative weight for each APC. This crosswalk matches devices to the primary procedures in which they are used. In developing the total pass-through estimate, we used this crosswalk to produce a device package for each APC associated with device use, based on the one or more devices used in the procedures included in the APC. We then adjusted the costs of each package by subtracting the costs already represented in the payment amount for the APC. (These are the costs that are shown in column 3 of Table 5 below.) In order to account for these costs in determining the new relative weights, we added 75 percent of the costs in this adjusted package to the costs at the claim level for each procedure that uses the package of devices in the APC. At this point, we determined a revised median cost for the APC. That new median cost in turn was used as the basis for calculating the APC's new relative weight.

It is important to note that the median cost of an APC will not necessarily increase by the same amount as the costs that are folded into the APC. The middle number (that is, the median) in the ordered sequence of the costs for services in an APC would only vary by the same amount as the folded-in costs if every number in the sequence were increased by the amount of those folded-in costs. However, as we explained in the November 2, 2001 final rule concerning the pro rata reduction on transitional pass-through payments (FR 66 55862–5863), the device costs folded into an APC will not be uniformly distributed among the procedures in that APC. This is because procedures in an APC may require different types or numbers of devices, and some procedures may not require devices at all. Therefore, the increase in median cost for an APC is unlikely to exactly equal the amount of the costs folded into the APC. In the November 2, 2001 final rule, we also discuss in detail how the increase in APC rates due to the incorporation of these pass-through costs will be offset against the 2002 pass-through payments.

Table 5 shows the amount of the offsets that we will apply for each APC that contains device costs. Column 4 of Table 5 shows the amount of the offset for each APC into which costs have been folded employing the methodology we have just described. Column 5 then shows the total offset that is to be applied for each APC. For the 25 APCs in which we had previously identified device costs, the amount of the offset in column 5 is the sum of the amount in column 3 (the amount of the offset due to the device costs that we had previously identified in the APC) and the amount in column 4 (the amount of the offset due to the costs that have just been folded in). For all the other APCs listed in the table, the amounts in column 4 and column 5 are identical (and there is no entry in column 3). This is because we had not previously identified device costs that were already represented in the payment amounts for these APCs.

TABLE 5.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	Device costs already reflected in APC rate	Additional device costs folded into APC rate	Total office for device costs
1	2	3	4	5
0032	Insertion of Central Venous/Arterial Catheter	$73.79	$276.41	$350.20
0046	Open/Percutaneous Treatment Fracture or Dislocation	NA	91.63	91.63
0048	Arthroplasty with Prosthesis	NA	501.91	501.91
0057	Bunion Procedures	NA	155.76	155.76
0070	Thoracentesis/Lavage Procedures	NA	24.94	24.94
0080	Diagnostic Cardiac Catheterization	164.27	124.21	288.48
0081	Non-Coronary Angioplasty or Atherectomy	307.06	353.78	660.84
0082	Coronary Atherectomy	242.95	1,187.08	1,430.03
0083	Coronary Angioplasty	528.64	365.49	894.13
0084	Level I Electrophysiologic Evaluation	NA	9,783.24	9,783.24
0085	Level II Electrophysiologic Evaluation	NA	580.82	580.82
0086	Ablate Heart Dysrhythm Focus	NA	1,299.58	1,299.58
0087	Cardiac Electrophysiologic Recording/Mapping	NA	1,964.38	1,964.38
0088	Thrombectomy	162.72	251.47	414.19
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	3,175.70	3,242.08	6,417.78
0090	Insertion/Replacement of Pacemaker Pulse Generator	2,921.06	2,196.00	5,117.06
0094	Resuscitation and Cardioversion	NA	17.31	17.31
0103	Miscellaneous Vascular Procedures	NA	202.60	202.60
0104	Transcatheter Placement of Intracoronary Stents	428.16	798.68	1,226.84
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	657.59	1,038.44	1,696.03
0107	Insertion of Cardioverter-Defibrillator	6,803.85	10,987.63	17,791.48
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	6,940.27	19,438.20	26,378.47
0111	Blood Product Exchange	NA	203.11	203.11
0115	Cannula/Access Device Procedures	NA	121.15	121.15
0117	Chemotherapy Administration by Infusion Only	NA	29.02	29.02
0118	Chemotherapy Administration by Both Infusion and Other Technique	NA	27.49	27.49
0119	Implantation of Devices	NA	3,325.05	3,325.05
0120	Infusion Therapy Except Chemotherapy	NA	34.10	34.10
0121	Level I Tube Changes and Repositioning	NA	5.09	5.09
0122	Level II Tube Changes and Repositioning	72.55	212.27	284.82
0124	Revision of Implanted Infusion Pump	NA	3,282.80	3,282.80
0144	Diagnostic Anoscopy	NA	126.75	126.75
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	60.92	0.00	60.92
0152	Percutaneous Biliary Endoscopic Procedures	107.61	0.00	107.61
0153	Peritoneal and Abdominal Procedures	NA	33.60	33.60
0154	Hernia/Hydrocele Procedures	108.11	369.57	477.68
0161	Level II Cystourethroscopy and other Genitourinary Procedures	NA	7.12	7.12
0162	Level III Cystourethroscopy and other Genitourinary Procedures	NA	312.55	312.55
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	NA	889.80	889.80
0179	Urinary Incontinence Procedures	NA	3,359.66	3,359.66
0182	Insertion of Penile Prosthesis	2,238.90	543.66	2,782.56
0202	Level VIII Female Reproductive Proc	505.32	1,215.08	1,720.40
0203	Level V Nerve Injections	NA	416.39	416.39
0207	Level IV Nerve Injections	NA	61.60	61.60
0222	Implantation of Neurological Device	4,458.57	9,510.40	13,968.97
0223	Implantation of Pain Management Device	421.33	3,307.74	3,729.07
0225	Implantation of Neurostimulator Electrodes	1,182.00	11,862.15	13,044.15
0226	Implantation of Drug Infusion Reservoir	NA	3,341.85	3,341.85
0227	Implantation of Drug Infusion Device	3,810.46	2,354.31	6,164.77
0229	Transcatherter Placement of Intravascular Shunts	1,074.41	391.45	1,465.86
0237	Level III Posterior Segment Eye Procedures	NA	138.46	138.46
0246	Cataract Procedures with IOL Insert	146.82	0.00	146.82
0248	Laser Retinal Procedures	NA	1,262.93	1,262.93
0259	Level VI ENT Procedures	12,407.52	3,724.65	16,132.17
0264	Level II Miscellaneous Radiology Procedures	NA	60.06	60.06
0312	Radioelement Applications	NA	1,201.84	1,201.84
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	NA	208.20	208.20
0686	Level V Skin Repair	NA	458.65	458.65
0687	Revision/Removal of Neurostimulator Electrodes	NA	1,432.44	1,432.44
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	NA	6,195.52	6,195.52
0692	Electronic Analysis of Neurostimulator Pulse Generators	NA	639.86	639.86

VIII. Conversion Factor Update for CY 2002

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, as redesignated by section 401 of the BIPA, provides that for 2002, 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, reduced by one percentage point. Further, section 401 of the BIPA increased the conversion factor for 2001 to reflect an update equal to the full market basket percentage increase amount.

In the November 2, 2001 final rule, we announced that the conversion factor for CY 2002 is $50.904 (66 FR 55864) based on an increase factor of 2.3 percent for 2002 and a wage index budget neutrality adjustment of 0.9936.

IX. Summary of and Responses to MedPAC Recommendations

On March 1, 2001 the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the OPPS. In the August 24, 2001 proposed rule, we responded to these recommendations (66 FR 44707–44708).

MedPAC Recommendation: MedPAC has offered two recommendations regarding the update to the conversion factor in the OPPS. The first recommendation is that the Secretary should not use an expenditure target to update the conversion factor. The second recommendation is that Congress should require an annual update of the conversion factor in the OPPS that is based on the relevant factors influencing the costs of efficiently providing hospital outpatient care, and not just the change in input prices.

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. Finally, section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered hospital outpatient services, and section 1833(t)(9)(C) of the Act authorizes the Secretary to adjust the update to the conversion factor if the volume of services increased beyond the amount established under section 1833(t)(2)(F) of the Act.

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 has had the effect of providing a full market basket update in 2001. We are, however, working with a contractor to study the option of developing an outpatient-specific market basket and would welcome comments and recommendations regarding appropriate data sources. We will also study the feasibility of developing appropriate adjustments for factors that influence the costs of efficiently providing hospital outpatient care, such as productivity increases and the introduction of new technologies, and the availability of appropriate sources of data for calculating the factors.

In the September 8, 1998 proposed rule on the OPPS, we proposed employing a modified version of the physicians' sustainable growth rate system (SGR) as an adjustment in the update framework to control for excess increases in the volume of covered outpatient services (63 FR 47586–47587). In response to comments on this proposal, we announced in the April 7, 2000 final rule that we had decided to delay implementation of a volume control mechanism, and to continue to study the options with a contractor (65 FR 18503). We will take MedPAC's recommendation into consideration in making a decision, and before implementing volume control mechanism we will publish a proposed rule with an opportunity for public comment.

MedPAC Recommendation: MedPAC recommends that the Secretary should develop formalized procedures in the OPPS for expeditiously assigning codes, updating relative weights, and investigating the need for service classification changes to recognize the costs of new and substantially improved technologies.

Response: Beginning with the April 7, 2000 final rule implementing the OPPS, we have outlined a comprehensive process to recognize the costs of new technology in the new system. One component of this process is the provision for pass-through payments for devices, drugs, and biologicals (see the discussion in conjunction with the next MedPAC recommendation). The other component is the creation of new APC groups to accommodate payment for new technology services that are not eligible for transitional pass-through payments. We assign new technology services that cannot be appropriately placed within existing APC groups to new technology APC groups, using costs alone (rather than costs plus clinical coherence) as the basis for the assignment. We describe revised criteria for assignment to a new technology group in section VI.G. of this preamble. When it is necessary, creation of new technology APC groups involves establishment of new codes. New codes are established through a well-ordered process that operates on an annual cycle. The cycle starts with submission of information by interested parties no later than April 1 of each year and ends with the announcement of new codes in October. As we stated previously, in the absence of an appropriate HCPCS code, we would consider creating a HCPCS code that describes the procedure or service. These codes would be solely for hospitals to use when billing under the OPPS.

We have also provided a mechanism for moving these services from the new technology APCs to clinically related APCs as part of the annual update of the APC groups. As described in section VI of this preamble, a service is retained within a new technology APC group until we have acquired adequate data that allow us to assign the service to an appropriate APC. We use the annual APC update cycle to assign the service to an existing APC that is similar both clinically and in terms of resource costs. If no such APC exists, we create a new APC for the service.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies should be made in the OPPS only when a technology is new or substantially improved and adds substantially to the cost of care in an APC. MedPAC believes that the definition of ''new'' should not include items whose costs were included in the 1996 data used to set the OPPS payment rates.

Response: The statute requires that, under the OPPS, transitional pass-through payments are made for certain drugs, devices, and biologicals. The

items designated by the statute to receive these pass-through payments include the following:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act.
- Current drugs and biologicals used for the treatment of cancer, and brachytherapy and temperature monitored cryoablation devices used for the treatment of cancer.
- Current radiopharmaceutical drugs and biologicals.
- New drugs and biologicals in instances in which the item was not being paid as a hospital outpatient service as of December 31, 1996, and when the cost of the item is ''not insignificant'' in relation to the OPPS payment amount.
- Effective April 1, 2001, categories of Medical devices when the cost of the category is ''not insignificant'' in relation to the OPPS payment amount.

We are publishing a separate interim final rule in which we lay out the criteria for establishing categories of devices eligible for pass-through payments.

Section 1833(t)(6) of the Act provides that once a category is established, a specific device may receive a pass-through payment for 2 to 3 years if the device is described by an existing category, regardless of whether it was being paid as a hospital outpatient service as of December 31, 1996 or its cost meets the ''not insignificant'' criterion. Thus, the statute allows for certain devices that do not meet MedPAC's recommended limitation on a ''new'' device to receive transitional pass-through payments. However, no categories are created on the basis of devices that were paid for on or before December 31, 1996. That is, while devices paid for on or before December 31, 1996 can be included in a category, we would establish a category only on the basis of devices that were not being paid as hospital outpatient services as of December 31, 1996.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies in the OPPS should be made on a budget-neutral basis and that the costs of new or substantially improved technologies should be factored into the update of the outpatient conversion factor.

Response: The statute requires that the transitional pass-through payments for drugs, devices, and biologicals be made on a budget neutral basis. Estimated pass-through payments are limited under the statute to 2.5 percent (and up to 2.0 percent for 2004 and thereafter) of estimated total program payments for covered hospital outpatient services. We adjust the conversion factor to account for the proportion of total program payments for covered hospital outpatient services, up to the statutory limit, that we estimate will be made in pass-through payments. As we have discussed in response to MedPAC's recommendation concerning an update framework for the OPPS conversion factor, we will study the feasibility of including appropriate adjustments for factors, including introduction of new technologies, that influence the costs of efficiently providing hospital outpatient care within such a framework.

MedPAC Recommendation: MedPAC recommends that the Congress should continue the reduction in outpatient coinsurance to achieve a 20 percent coinsurance rate by 2010.

Response: For most services that Medicare covers, the program is responsible for 80 percent of the total payment amount, and beneficiaries pay 20 percent. However, under the cost-based payment system in place for outpatient services before the OPPS, beneficiaries paid 20 percent of the hospital's charges for these services. As a result, coinsurance was often more than 20 percent of the total payment amount for the services.

The BBA established a formula under the OPPS that was designed to reduce coinsurance gradually to 20 percent of the total payment amount. Under this formula, a national copayment amount was set for each service category, and that amount is to remain frozen as payment rates increase until the coinsurance percentage falls to 20 percent for all services. On average, beneficiaries paid about 16 percent less in copayments for hospital outpatient services during 2000 under the OPPS than they would have paid under the previous system. However, it is true that the coinsurance remains higher than 20 percent of the Medicare payment amount for many services.

Subsequent legislation has placed caps on the coinsurance percentages to speed up this process. Specifically, section 111 of BIPA amended section 1833(t)(8)(C)(ii) of the Act to reduce beneficiary coinsurance liability by phasing in a cap on the coinsurance percentage for each service. Starting on April 1, 2001, coinsurance for a single service furnished in 2001 cannot exceed 57 percent of the total payment amount for the service. The cap will be 55 percent in 2002 and 2003, and will be reduced by 5 percentage points each year from 2004 to 2006 until coinsurance is limited to 40 percent of the total payment for each service. The underlying process for decreasing coinsurance will also continue during this period (see discussion in section IV.A. of this preamble). However, MedPAC projects that under current law, it would take until 2029 to reach the goal of 20 percent coinsurance for all services.

We agree with MedPAC's goal of continuing the reduction in outpatient coinsurance, and we would welcome enactment of a practical measure to do so.

We received no comments on our responses to the MedPAC recommendations.

X. Provider-Based Issues

A. Background and April 7, 2000 Regulations

On April 7, 2000, we published a final rule specifying the criteria that must be met for a determination regarding provider-based status (65 FR 18504). Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple departments, locations, and facilities. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare for those services.

The regulations at § 413.65 define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' Section 413.65(b)(2) states that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally set at October 10, 2000, but was subsequently delayed and is now in effect for cost reporting periods beginning on or after January 10, 2001. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual—Part 1 (PRM–

1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in item X.C below).

B. Provider-Based Issues/Frequently Asked Questions

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) These Qs and As did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

C. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

1. Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000 will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria in the regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations will not be exempt from the Emergency Medical Treatment and Active Labor Act (EMTALA) responsibilities of provider-based facilities and organizations (revised § 489.24(b) and new § 489.24(i)) or from the obligations of hospital outpatient departments and hospital-based entities in § 413.65(g), such as the responsibility of off-campus facilities provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not pre-empted by the grandfather provisions of BIPA section 404 because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

2. Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the new regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or critical access hospital. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria are permanent. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering provision noted above, the geographic location criteria at section 404(b) of BIPA and the regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. Beginning October 1, 2002, these criteria will also apply to the grandfathered facilities.

3. Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA also provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000 and before October 1, 2002 shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively for noncompliance with the provider-based criteria once a request for a determination during that time period has been made. For hospitals that do not qualify for grandfathering under section 404(a) of BIPA, a request for provider-based status should be submitted to the appropriate CMS Regional Office (RO). Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation to demonstrate compliance with the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based (as long as that date is on or after October 1, 2000) until the effective date of a CMS determination that the facility or organization is not provider-based.

Facilities requesting a provider-based status determination on or after October 1, 2002 will not be covered by the provision concerning temporary treatment as provider-based in section 404(c) of BIPA. Thus, as stated in § 413.65(n), CMS ROs will make provider-based status effective as of the earliest date on which a request for determination has been made and all requirements for provider-based status in effect as of the date of the request are shown to have been met, not on the date

of the formal CMS determination. If a facility or organization does not qualify for provider-based status and CMS learns that the provider has treated the facility or organization as provider-based without having obtained a provider-based determination under applicable regulations, CMS will review all payments and may seek recovery for overpayments in accordance with the regulations at § 413.65(j), including overpayments made for the period of time between submission of the request or application for provider-based status and the issuance of a formal CMS determination.

D. Commitment To Re-Examine EMTALA Applicability to Off-Campus Hospital Locations, and to Further Revise Provider-Based Regulations

As explained in the proposed rule published on August 24, 2001, (p. 44709) we are aware that many hospitals and physicians continue to have significant concerns with our policy on the applicability of EMTALA to provider-based facilities and organizations. We intend to re-examine these regulations and, in particular, reconsider the appropriateness of applying EMTALA to off-campus locations. We plan to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. At the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole. Because of these considerations, we stated in the preamble to our August 24, 2001 proposals that we intend to publish a proposed rule to address these issues more fully.

In response to our statements, we received several comments, which are summarized below.

Comment: Several commenters expressed approval of the statement, in the preamble to the August 24, 2001 proposed rule, that CMS plans to reconsider the appropriateness of applying EMTALA to off-campus hospital locations. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

Comment: One commenter stated that since CMS is planning to reconsider the appropriateness of applying EMTALA to off-campus hospital locations it should, while the review is taking place, either withdraw the regulations requiring EMTALA compliance at off-campus hospital facilities, or not implement those regulations.

Response: We agree that the issues need to be reviewed carefully. EMTALA affords important protections to individuals who come to hospitals to seek care for possible emergency medical conditions. Thus, any change in the scope of the EMTALA regulations must be considered very thoroughly before it is undertaken. At the same time, we are well aware that many hospitals continue to be concerned about what they view as the excessive financial and administrative burden of complying with EMTALA at off-campus locations. In view of the complexity of the issues under view, and in consideration of the very significant impact that any change could have on the health and safety of hospital patients, we remain convinced that it would not be appropriate to anticipate the conclusion of that review by withdrawing or rescinding the regulations at this time. For the same reason, we are not adopting the suggestion that we suspend implementation of the current regulations.

Comment: Several commenters recommended that CMS publish additional regulations clarifying various issues related to the criteria for provider-based status. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

E. Changes to Provider-Based Regulations

To fully implement the provisions of section 404 of BIPA and to codify the clarifications currently stated only in the Qs and As on provider-based status, as described above, we proposed to revise the regulations as follows.

1. Clarification of Requirements for Adequate Cost Data and Cost Finding (§ 413.24(d))

As part of the April 7, 2000, final rule implementing the prospective payment system for hospital outpatient services to Medicare beneficiaries, under § 413.24, Adequate Cost Data and Cost Finding, we added a new paragraph (d)(6), entitled ''Management Contracts.'' Since publication of the final rule, we have received several questions concerning the new paragraph.

In response to these questions, we proposed to revise that paragraph to clarify its meaning. In addition, for further clarity, we proposed to revise the coding and title of that material. We proposed to redesignate § 413.24(d)(6)(i) as § 413.24(d)(6) and § 413.24(d)(6)(ii) as § 413.24(d)(7). As revised, paragraph (d)(6) would address the situation when the main provider in a provider-based complex purchases services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center that duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Therefore, when a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the provider cannot be separately identified, the costs of the services purchased through a contract for the provider-based entity or provider department must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

For costs of services furnished to free-standing entities, we proposed to clarify in revised § 413.24(d)(7), that the costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

This revision is not a change in the policy, but instead is a clarification to the policy set forth in the April 7, 2000

final rule. We received no comments on this proposal and are adopting it without change.

2. Scope and Definitions (§ 413.65(a))

In Q/A 9 published on the CMS (formerly, HCFA) web site at *www.hcfa.gov/medlearn/provqa.htm,*we identified specific types of facilities for which provider-based determinations would not be made, since their status would not affect either Medicare payment levels or beneficiary liability. (This document may also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) The facilities identified in Q/A 9 are ambulatory surgical centers (ASCs); comprehensive outpatient rehabilitation facilities (CORFs); home health agencies (HHAs); skilled nursing facilities (SNFs); hospices; inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services; independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests; facilities furnishing only physical, occupational or speech therapy to ambulatory patients, for as long as the $1500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation; and end-stage renal disease (ESRD) facilities. Determinations for ESRD facilities are made under § 413.174.

We proposed to revise the regulations at § 413.65(a) to clarify that these facilities are not subject to the provider-based requirements and that provider-based determinations will not be made for them.

We received a few comments on this proposal, which are summarized below.

Comment: One commenter expressed approval of the proposed revision, but suggested that we expand the list of facilities or organizations for which provider-based status is not required to include specific types of neonatal intensive care units and outpatient departments providing specialty pediatric care. The commenter believed such a change would permit these facilities to be treated as provider-based after the grandfather provisions of BIPA section 404 expire, even though they do not meet all criteria in 42 CFR 413.65(d).

Response: In Q/A 9 published on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm* we identified specific types of facilities for which provider-based determinations will not be made because any determinations regarding their status would not affect either Medicare payment levels or beneficiary liability. In the August 24, 2001 proposed rule, we proposed to codify this list of facilities. Because the comment was submitted in response to this part of our proposal, we considered it in that context. However, the commenter did not succeed in establishing that the units and specialized outpatient departments meet the criteria for inclusion on a list of facilities for which a determination about provider-based status would not affect either Medicare payment levels or beneficiary liability. (On the contrary, the commenter argued that if determinations were made on such units and departments, payments would be reduced significantly.) Moreover, the primary focus of the comment is not to ask that no determinations be made for these units and departments, but instead that those facilities be treated as provider-based even though they do not meet some or all of the provider-based criteria in § 413.65(d). We did not propose to extend provider-based status to such facilities (except insofar as BIPA section 404 requires us to do so), nor can such a proposal be logically inferred from the provisions included in the proposed rule. Thus, while we reviewed this comment with interest, we did not adopt it. We received no other comments on this proposed revision and are adopting it without change.

3. BIPA Provisions on Grandfathering and Temporary Treatment as Provider-Based (§§ 413.65(b)(2) and (b)(5))

Currently, § 413.65(b)(2) states that a main provider or a facility must contact CMS (formerly, HCFA), and CMS must determine that the facility is provider-based before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report. However, as explained earlier, sections 404(a) and (c) of BIPA require that certain facilities be grandfathered for a 2-year period, and that facilities applying between October 1, 2000 and October 1, 2002 for provider-based status with respect to a hospital be given provider-based status on a temporary basis, pending a decision on their applications. To implement these provisions, we proposed to revise the regulations in § 413.65(b)(2) to state that if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002, and the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of § 413.65 will not apply to that hospital or CAH with respect to that facility until October 1, 2002. We further proposed that for purposes of paragraph (b)(2), a facility would be considered to have been treated as provider-based on October 1, 2000, if on that date it either had a written determination from CMS (formerly, HCFA) that it was provider-based as of that date, or was billing and being paid as a provider-based department or entity of the hospital.

In addition, we proposed to add a new § 413.65(b)(2) to state that a facility for which a determination of provider-based status in relation to a hospital or CAH is requested on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS (formerly, HCFA) determines that the facility does not qualify for provider-based status.

We received one comment on this proposal, which is summarized below.

Comment: One commenter stated that our proposed revision to these sections does not adequately implement section 404(c) of BIPA, in that it would require temporary treatment as provider-based for a facility or organization for which such status is requested on or before October 1, 2000 only from October 1, 2000 forward. The commenter believes this is inappropriate because section 404(c) of BIPA provides that such a facility or organization is to be treated as provider-based for ''any period before a determination is made.'' Under the commenter's recommended interpretation of the provision, such temporary treatment would also be available for any period before October 1, 2000.

Response: We believe this interpretation of the provision is overly literal, and does not accurately reflect the role of paragraph (c) in the total statutory scheme established by section 404 of BIPA. Section 404(a)(1) describes the treatment to be accorded to facilities treated as provider-based on October 1, 2000, by providing that such facilities will continue to be treated as provider-based until October 1, 2002. Thus, paragraph (a) of section 404 addresses the situation of facilities that existed and were treated as provider based on October 1, 2000. Section 404(c) of BIPA complements this provision by mandating a grace period for those facilities seeking provider-based status determinations on or after October 1, 2000 that either (i) existed on October 1, 2000 but were not treated as provider-based, or (ii) did not exist as of October

1, 2000 (that is, were opened after that date). Taken together, paragraphs (a) and (c) specify the treatment to be given to facilities treated as provider-based on the reference date of October 1, 2000 and to those facilities for which provider-based status is sought within 2 years after the reference date. However, we find no indication that the statute was intended to extend provider-based status for any period before the reference date. Such an extension would not be necessary to protect a provider from possible retroactive liability based on possible delay in considering a provider-based application, and could inappropriately prevent collection of overpayments incurred well before October 1, 2000. Thus, we did not adopt this comment.

We received no other comments on this proposal and we are adopting it without change.

4. Reporting (§ 413.65(c)(1))

Currently, § 413.65(c) states that a main provider that creates or acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to CMS (formerly, HCFA) if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider's cost report would increase the total costs on the provider's cost report by at least 5 percent, and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status. Concern has been expressed that such reporting would duplicate the requirement for obtaining approval of a facility as provider-based before billing its services that way or including its costs on the cost report of the main provider (current § 413.65(b)(2)). To prevent any unnecessary duplicate reporting, we proposed to delete the current requirement from § 413.65(c)(1). We proposed, however, to retain the requirement that a main provider that has had one or more facilities considered provider-based also report to CMS (formerly, HCFA) any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that could affect the provider-based status of the facility.

We received one comment on this proposal, which is summarized below.

Comment: A commenter stated that more guidance is needed on the rules regarding reporting to CMS any significant changes in the relationship between a main provider and its provider-based facilities. The commenter asked that we explain the meaning of ''significant changes,'' prescribe the format of such reporting, and specify to whom such reports are to be made.

Response: Although the commenter refers to reporting any significant changes, the regulations at § 413.65(c)(1) speak of reporting any ''material'' changes in the relationship between it and any provider-based facility. As explained in the August 24, 2001 proposed rule, we would consider a ''material'' change to be anything that may interfere with compliance with the provider-based rules. The August 24, 2001 document further explains that such a change may include but is not limited to a change of ownership, entry into a new or different management contract, or change in the financial operations of the facility or the main provider. The main provider may report such material changes in the form of a letter submitted to its CMS Regional Office with a copy to its fiscal intermediary. While we are responding in this preamble to the commenter's questions and hope that this information is helpful, we do not believe it is essential to include this level of detail in the Code of Federal Regulations. Therefore, we did not revise the regulations based on this comment.

We received no other comments on the proposal and are adopting it without change.

5. Geographic Location Criteria (§ 413.65(d)(7))

As explained earlier in X.C.2 of this preamble, section 404(b) of BIPA mandates that facilities seeking provider-based status be considered to meet any geographic location criteria if they are located not more than 35 miles from the main campus of the hospital or CAH to which they wish to be based, or meet other specific criteria relating to their ownership and operation. To implement this provision, we proposed to revise § 413.65(d)(7) to state that a facility will meet provider-based location criteria if it and the main provider are located on the same campus, or if one of the following three criteria are met:

- The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider.
- The facility or organization is owned and operated by a hospital or CAH that—

(A) Is owned or operated by a unit of State or local government;

(B) Is a public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) Is a private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to ensure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan); and

(D) Has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act.

- The facility meets the criteria currently set forth in § 413.65(d)(7)(i) for service to the same patient population as the main provider.

We received no comments on this proposal and we are adopting it without change.

6. Notice to Beneficiaries of Coinsurance Liability (§ 413.65(g)(7))

Currently § 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand.

We clarified in the preamble to an interim final rule with comment period published on August 3, 2000 (65 FR 47670) that if the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains the fact that the beneficiary will incur a coinsurance liability to the hospital that they would not incur if the facility were not provider-based. The interim final rule further explained that the hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual

services furnished by the hospital if the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

We proposed to amend § 413.65(g)(7) to include this clarifying language. We received no comments on this proposal, and we are adopting it without change.

7. Clarification of Protocols for Off-Campus Departments (§ 489.24(i)(2)(ii))

Currently, § 489.24(i) specifies the anti-dumping obligations that hospitals have for individuals who come to off-campus hospital departments for the examination or treatment of a potential emergency medical condition. These obligations are sometimes known as EMTALA obligations, after the Emergency Medical Treatment and Labor Act, which is the legislation that first imposed the obligations. Currently, hospitals are responsible for ensuring that personnel at their off-campus departments are trained and given appropriate protocols for the handling of emergency cases.

In the case of off-campus departments not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus before arranging an appropriate transfer to a medical facility other than the main hospital.

Some concern had been expressed that taking the time needed to make such contacts might inappropriately delay the appropriate transfer of emergency patients in cases in which the patient's condition was deteriorating rapidly. In response to this concern, we clarified in the preamble to the interim final rule with comment period published on August 3, 2000 cited above (65 FR 47670) that in any case of the kind described in § 489.24(i)(2)(ii), the contact with emergency personnel at the main hospital campus should be made either concurrently with or after the actions needed to arrange an appropriate transfer, if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. This does not relieve the off-campus department of the responsibility for making the contact, but only clarifies that the contact may be delayed in specific cases in which doing otherwise would endanger a patient subject to EMTALA protection.

We proposed to amend § 489.24(i)(2)(ii) to include this clarifying language. We received two comments on this proposal, which are summarized below.

Comment: Two commenters expressed approval of the change and recommended that it be adopted in the final rule. However, the commenter recommended that we further clarify the rule by spelling out the circumstances under which personnel at off-campus locations would be expected to call EMS before seeking guidance from the emergency department staff at the main campus delay.

Response: As noted above, we plan to reconsider the general issue of the appropriateness of applying EMTALA to off-campus hospital locations. We will consider the commenter's specific suggestion in the course of that more general review. Therefore, we have not made any change in the final rule based on this comment.

Comment: One commenter expressed approval of the proposed clarification at § 489.24(i)(2)(ii), under which personnel in off-campus departments that are not routinely staffed with physicians, RNs, or LPNs, may delay contacting the main hospital's emergency department according to protocols if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. However, the commenter pointed out that the introductory paragraph of § 489.24(i)(2) applies the protocol requirement to all off-campus departments (whether or not staffed by physicians and nurses). Therefore, the commenter suggested that we move this provision to the introductory paragraph of § 489.24(i)(2), and so that it will apply to all off-campus departments. The commenter believes that this change would be consistent with the policy stated by CMS on its website (CMS EMTALA guidance, 7/20/01, Q/A ##7 and 13–16).

Response: We agree that it would be appropriate, and consistent with our policy in this area, to apply this provision concerning the delay of contact in certain situations to all off-campus departments. As the commeter suggested, we are amending § 489.24(i)(2) to include the clarifying language that had been proposed at § 489.24(i)(2)(ii).

8. Other Changes

In addition to the changes cited previously, we proposed to make the following conforming and clarifying changes:

• Correcting date references in §§ 413.65(i)(1)(i) and (i)(2), in order to take into account the effective date of the current regulations.

• Substituting ''CMS'' for ''HCFA'' throughout the revised sections of part 413, to reflect the renaming of the Health Care Financing Administration (HCFA) as the Centers for Medicare & Medicaid Services (CMS).

We received no comments on these proposals and are adopting them without change.

F. Comments on Other Issues

We also received a number of comments recommending various changes in the provider-based regulations that were not in our August 24, proposed rule and cannot logically be inferred from those proposals. While we read these comments with interest, we have not made any changes in the final rule based on them.

XI. Summary of the Final Rule

This final rule revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This final rule also announces a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments.

This final rule finalizes a number of policies discussed in the August 24, 2001 proposed rule as follows:

• We are implementing BIPA provisions that affect the OPPS in 2002, including the following:

+ The national coinsurance rate for OPPS services is limited to 55 percent of the APC payment rate established for a procedure or service.

+ Children s hospitals receive the same hold-harmless protection accorded to cancer hospitals under BBRA.

+ Special payment provisions for certain services, including screening for glaucoma, payment for contrast agents, and new technology diagnostic mammography.

• We adjust payments to hospitals for geographic wage differences, as required by the statute, using the FY 2002 hospital inpatient PPS wage index. We have recalibrated the APC weights, also as required by the statute, using median costs drawn from claims data for hospital services furnished on or after July 1, 1999 through June 30, 2000.

• The methodology that we followed to calculate the final APC relative weights for CY 2002 is similar to the proposed methodology except that we have incorporated pass-through device

costs in device-related procedures. Specifically, we have incorporated 75 percent of the estimated cost for pass-through devices into the base APC costs.

• We have revised and updated the APC groups in accordance with several factors. These changes would affect more than half of the approximately 340 existing APC groups.

• As a result of consultations with the advisory panel on APC groups, we have reviewed and are accepting a number of the Panel's recommendations. In some cases, we have made additional changes to the APCs based on the use of new data and application of the 2 times rule.

• We have received recommendations from commenters and interested parties to establish separate APCs for observation services. As proposed, we are creating a new APC to make separate payment for observation services for patients with chest pain, asthma, and congestive heart failure, when certain clinical criteria are met. We have made some minor changes based on public comment.

• Based on public comment, we made several modifications to our proposed coding scheme for stereotactic radiosurgery.

• We have revised the criteria for the new technology APC groups that we created to allow payment at an appropriate level for new technologies that do not meet the statutory requirements for pass-through payments. These changes are intended to allow us to reserve these special new technology APC groups for services that are a new, ''complete'' procedure and not just modifications of existing technologies.

• We are changing the aggregate method currently used for calculating outlier payments and will begin determining outliers on an APC-by-APC basis rather than the entire bill. To do this, we allocate packaged items on a bill to APCs based on their relative weight.

• We are excluding from the OPPS the Part B-only services furnished to inpatients of hospitals that do no other billing for hospital outpatient services under Part B. This is in response to complaints we received from State psychiatric hospitals that did not have outpatient departments and, therefore, bill under OPPS only for inpatients. This policy would exempt them from having to make costly revisions to their billing systems.

• We are excluding from the OPPS hospitals that are located outside the 50 States or the District of Columbia or Puerto Rico, that is, hospitals in Guam, Saipan, American Samoa, and the Virgin Islands. This policy is consistent with their current exclusion from the inpatient PPS and will also save these hospitals from billing system revisions.

• We will continue to use a list of certain procedures that are designated as inpatient procedures and therefore are not paid by Medicare under the OPPS. Based on comments, we have made minor changes to this list.

• We are revising the regulations affecting provider-based entities to implement technical BIPA provisions on grandfathering, temporary treatment as provider-based, and certain geographic location criteria; and to clarify requirements for adequate cost data and cost finding, certain reporting requirements, requirements regarding notice to beneficiaries of coinsurance liability, and clarification of anti-patient dumping rules (EMTALA obligations) in off-campus departments.

• In response to public comments regarding provider-based issues, we are moving the provision concerning the delay of contact in certain situations to the introductory paragraph of § 489.24(i)(2) so that it will apply to all off-campus departments.

• In addition, we are making editorial and technical revisions to our regulations. We made minor editorial changes in paragraphs (b)(2), (b)(4), (b)(5), (c), (d)(7)(iv), and (g)(7) of § 413.65. In § 413.65(i)(2), we modified the presentation of our language to more clearly present our policy.

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the 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.

Sections 413.65 and 419.42 of this final rule contain information collection requirements that are subject to review by OMB under the Paperwork Reduction Act of 1995. However, §§ 413.65 and 419.42 have been approved by OMB under approval number 0938–0798, with a current expiration date of August 31, 2003 and OMB approval number 0938–0802, with a current expiration date of December 31, 2001.

Process and Information Required To Apply for Transitional Pass-through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, Under the Hospital Outpatient Prospective Payment System

The application itself for Transitional Pass-Through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, may be found at <*www.hcfa.gov*>. Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations governing transitional pass-through payments for eligible drugs and biologicals remain unchanged. The process to apply for transitional pass-through payment for eligible drugs and biological agents, including radiopharmaceuticals, can be found in the April 7, 2000 **Federal Register** (65 FR 18481) and on the CMS web site at *http://www.hcfa.gov/medlearn/appdead.htm*. If we revise the application instructions in any way, we will post the revisions on our web site and submit the changes for the Office of Management and Budget (OMB) review under the Paperwork Reduction Act. The application process for new categories can be found on the CMS web site at http://www.hcfa.gov//medicare/newcatapp1030f.rtf.

We estimate that approximately 100 entities will file an application yearly. We believe it will take each of these entities around 16 hours to gather the necessary information and fill out the application.

We have submitted a copy of this final rule to OMB for its review of the information collection requirement described above. The requirement is not effective until it has been approved by OMB.

XIV. Regulatory Impact Analysis

A. General

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993; Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980; Public Law 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).

The provisions of this final rule do not result in impacts that exceed $100 million per year. The effects of the changes in this rule are redistributional and do not result in additional expenditures. The impacts discussed below reflect the effects of the final rule published on November 2, 2001. Therefore, this final rule is not an economically significant rule under Executive Order 12866, nor a major rule under 5 U.S.C. 804(2).

We note, however, that on November 2, 2001, we published a final rule that announced the updated conversion factor for payments under the OPPS (66 FR 55857). As discussed in more detail in that document, we estimated that the total impact of the changes for CY 2002 payments compared to CY 2001 payments as set forth in the November 2 rule would be approximately a $450 million increase (66 FR 55864).

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 $5 to $25 million or less annually (see 65 FR 69432). For purposes of the RFA, all providers of hospital outpatient services are considered small entities. 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 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital 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.

It is clear that the changes in this final rule 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 final rule, constitutes a regulatory impact analysis.

Section 202 of the Unfunded Mandate 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 one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule does not mandate any requirements for State, local, or tribal governments.

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 final rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local or tribal governments.

B. Changes in This Final Rule

In this final rule, we are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments used to determine the APC payment rates. In addition, we must review the clinical integrity of payment groups and the relative weights at least annually. Accordingly, in this final rule, we are updating the wage index adjustment for hospital outpatient services furnished beginning January 1, 2002. We are also revising the relative APC payment weights based on claims data from July 1, 1999 through June 30, 2000. Finally, we are beginning to calculate outlier payments on an APC-specific basis rather than the current method of calculating outlier payments for each claim. In addition, as an administrative action, we have incorporated 75 percent of the estimated cost of the pass-through devices into the base APC rates.

As described in the preamble, budget neutrality adjustments are made to the weights to assure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. In addition, the parameters for outlier payments have been modified so that outlier payments for 2002 are projected to equal the established policy target of 2.0 percent of total payments. Because we are not revising the target percentage, there is no estimated aggregate impact from modifying the method of determining outlier payments.

The impact of the wage index, APC reclassification and recalibration, and outlier changes do vary somewhat by hospital group. Estimates of these impacts are displayed on Table 6.

We received no specific comments on the impact analysis. However, in commenting on certain proposed policies, commenters sometimes referred to the impact of a policy on hospitals or a specific group of hospitals. We have addressed these comments elsewhere in the preamble to this final rule. The following is a discussion of how the final policies set forth in this rule affect hospitals and beneficiaries. As an informational matter, the impact of changes set forth in Table 6 include the impact of the update to the conversion factor, which was implemented in the November 2 final rule.

C. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes as well as statutory changes effective for 2002, 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. Finally, we do not model the impact of the transitional corridor payments, which protect hospitals from losses in 2002 compared to their 1996 payments. We are unable to model this impact because we do not yet have filed cost reports from hospitals for the services furnished under the PPS. The raw cost report data are generally not available until at least 7 months after the end of the cost reporting period.

D. Estimated Impacts of This Final Rule on Hospital Payments

Column 5 in Table 6 represents the full impact on each hospital group of all the changes for 2002. Columns 2 through 4 in the table reflect the independent effects of the change in the wage index, the APC reclassification and recalibration changes (including the incorporation of pass-through device

costs), and the change in outlier method, respectively.

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 the Pacific Region, a decrease of 0.1 percent. Conversely, the urban hospitals are generally negatively affected by these changes, with the largest effect on those with 500 or more beds (a 0.5 percent decrease) and those in the Middle Atlantic (a 0.5 percent decrease) and West South Central (a 0.9 percent decrease) Regions.

We estimate that the APC reclassification and recalibration changes have generally an opposite impact from the wage index, causing increases in payments for all urban hospitals except those with fewer than 200 beds and volumes of fewer than 21,000 services per year and those located in the New England (a 0.6 percent decrease), Middle Atlantic (a 0.8 percent decrease), and Puerto Rico (an 8.1 percent decrease) Regions.

The incorporation of 75 percent of the estimated costs of pass-through devices into the base APC rates has a relatively large negative effect on rural hospitals. In the proposed rule, the estimated impact of the APC reclassification and recalibration changes on rural hospitals was a 1.5 percent decrease in payments. With the incorporation of the device costs, the impact is now estimated to be a 3.8 percent decrease. This impact does not include the effects of any additional transitional corridor payments to rural hospitals. The negative effect is particularly pronounced for rural hospitals with fewer than 100 beds (a decrease of 5.6 percent for hospitals with fewer than 50 beds and a 4.9 percent decrease for hospitals with 50–99 beds). This impact is due to the large increase in payment rates for device-related APCs and the corresponding decrease in nondevice-related APCs, as discussed in more detail above in section II.C. of this preamble. The decrease in the payment rates for clinic visits and diagnostic and preventive services affect rural hospitals disproportionately because they perform far more of these services as compared to the device-related APCs for which payment rates have increased. These impact estimates do not reflect the effects of the hold harmless transitional corridor payments in 2002 for the smallest rural hospitals.

We also note that it is not the large academic medical centers that are most positively affected by the incorporation of pass-through device costs. While the group of hospitals that receives the largest increase in payments is hospitals with 500 or more beds (a 3.4 percent increase), minor teaching hospitals will receive an increase of only 2.0 percent and major teaching hospitals, an increase of 0.5 percent.

Although teaching hospitals perform many device-related procedures, they also provide a very large number of clinic and emergency room visits, both of which will experience a projected decrease in payment rates of approximately 8 percent. In fact, teaching hospitals that do not also receive disproportionate share payments will experience a projected decrease of 2.1 percent. The largest negative impact for urban hospitals is for those with no teaching adjustment that also do not serve a disproportionate share of low-income patients. Even though this is a relatively small group of hospitals, their payments are projected to decrease by 15.5 percent.

The change in outlier policy to an APC-specific payment has a slight negative effect on rural hospitals as a group (a 0.1 percent decrease), no effect on urban hospitals as a group, and slight negative effects on all small hospitals (fewer than 100 beds) as well as those with lower volumes of services. For urban hospitals, other than a projected increase in payments of 0.3 percent for hospitals in the Middle Atlantic Region, no geographic group of hospitals is affected by more than 0.1 percent. For rural hospitals, the Middle Atlantic Region will also experience a positive impact, a 0.2 percent increase. For the rest of the regions, rural hospitals will experience no more than a 0.2 percent decrease, except for hospitals in the Pacific Region, where there is no impact.

The overall projected increase in payments for urban hospitals (3.0 percent) is greater than the average increase for all hospitals (2.3 percent). However, due to the large decrease in payments attributable to the APC changes, rural hospitals will experience an average decrease in payments of 0.7 percent. While rural hospitals gain 1.0 percent from the wage index change, they lose a combined 3.9 percent from the APC changes (–3.8 percent) and the change in method of determining outlier payments (a slight decrease of 0.1 percent). These impacts do not include the effects of any additional transitional corridor payments to rural hospitals. Rural hospitals with 100 or more beds will experience an overall increase in payments, however, those with fewer than 100 beds are projected to receive large decreases in payments (–3.5 percent for hospitals with fewer than 50 beds and –2.4 percent for those with 50 to 99 beds). We note that these smallest rural hospitals will be protected by the hold harmless transitional corridor payments for 2002. That is, their Medicare payment margin for services furnished under the OPPS cannot be less than their margin for the services in 1996.

In both urban and rural areas, hospitals that provide a higher volume of outpatient services are projected to receive a larger increase in payments than lower volume hospitals. In rural areas, hospitals with volumes of fewer than 5,000 services are projected to experience a relatively large decline in payments (–3.6 percent). The less favorable impact for the low volume hospitals is attributable to the APC changes and the change in outlier method. For example, rural hospitals providing fewer than 5000 services are projected to lose a combined 6 percent due to these changes.

Urban hospitals in all regions except Puerto Rico (with a decrease of 5.1 percent) receive an increase on overall payments. The lowest increase is in the Middle Atlantic Region, where hospitals are projected to receive a 1.2 percent increase in payments. Except for increases for hospitals in the South Atlantic (0.3 percent) and West South Central (0.5) Regions and no change in the Mountain Region, rural hospitals experience an overall loss in payments. Again, this is due to the decrease in payments as a result of the APC changes.

Major teaching hospitals are projected to experience a smaller increase in overall payments (2.4 percent) than do hospitals with the less intensive teaching programs due to the negative impacts of the wage index (–0.4 percent), a relatively small increase due to the APC recalibration (0.5 percent), and outlier changes (–0.2 percent). Among hospitals with varying shares of low-income patients, those with a DSH patient percentage of zero experience a large decrease in payments because of the APC changes (–7.6 percent) and the outlier changes (–0.3 percent). For hospitals with a greater than 0 percent of low-income patients, the impact on all hospitals is positive, with the lowest increase of 0.3 percent attributable to hospitals with the highest share.

E. Estimated Impacts of This Final Rule on Beneficiary Copayments

In general, the increase in the APC rates for procedures that use pass-through devices results in increased copayments for beneficiaries who receive those procedures. Many of the device-related APC rates (approximately 50 APCs) have increased by over 100

percent and a small number by over 750 percent. Under the statute, the copayment amount for an APC cannot be less than 20 percent of the payment rate. Therefore, beneficiaries will experience an increase in copayments for most of the device-related APCs. This increase is countered by small decreases in the copayments for some other APCs, particularly clinic and emergency room visits.

One important thing to note is that beneficiaries receive far more clinic and emergency visits in a year than they do device-related procedures. For example, in the 1999–2000 claims data base, there are almost 7 million low-level clinic visits, over 3 million mid-level clinic visits, and almost 2 million high-level clinic visits. However, for APC 0084, Level I Electrophysiologic Evaluation (the device-related APC with the largest increase), there were only about 7,000 procedures performed. Thus, the number of services received by beneficiaries with small decreases in copayments far outweighs the number of services for which they will incur some incremental costs.

In addition, we note that section 1833(t)(8)(C)(i) of the Act places a limit on the copayment amount for any procedure; that is, the copayment may not be more than the applicable inpatient hospital deductible for the year in which the procedure is performed. For CY 2002, the inpatient deductible is $812. We further note that the complete incorporation of the costs of the current pass-through devices into the base APCs must be done in CY 2003. Therefore, any increase in copayments that occur in 2002 are a transition to increases that must, by statute, occur in 2003. Finally, as discussed in section IV. C above, we have minimized the effects of changes in APC groupings on beneficiary coinsurance and copayments.

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1] (1)	New wage index [2] (2)	APC/WGTS/ 75% fold in [3] (3)	New outlier policy [4] (4)	All CY2002 changes [5] (5)
All Hospitals	5,084	0.0	0.0	0.0	2.3
Non-Tefra Hospitals	4,671	0.0	0.0	0.0	2.3
Urban Hosps	2,550	-0.2	1.0	0.0	3.0
Large Urban (GT 1 Mill.)	1,459	-0.4	0.8	0.1	2.7
Other Urban (LE 1 Mill.)	1,091	0.0	1.3	0.0	3.5
Rural Hosps	2,121	1.0	-3.8	-0.1	-0.7
Beds (Urban):					
0–99 Beds	646	-0.1	-3.2	-0.1	-1.2
100–199 Beds	908	-0.2	-1.2	0.0	0.9
200–299 Beds	490	-0.2	0.8	0.0	2.8
300–499 Beds	363	-0.2	2.9	0.0	5.0
500 + Beds	143	-0.5	3.4	0.1	5.3
Beds (Rural):					
0–49 Beds	1,278	0.2	-5.6	-0.2	-3.5
50–99 Beds	508	0.4	-4.9	-0.1	-2.4
100–149 Beds	196	1.5	-3.0	-0.1	0.6
150–199 Beds	73	1.5	-1.6	-0.1	2.0
200 + Beds	66	2.3	-1.7	0.0	2.8
Volume (Urban)					
LT 5,000	307	-0.4	0.7	-0.2	2.3
5,000–10,999	445	-0.3	-2.4	0.0	-0.5
11,000–20,999	570	-0.3	-0.9	0.0	1.1
21,000–42,999	739	-0.3	1.0	0.0	3.0
GT 42,999	489	-0.2	1.8	0.0	4.0
Volume (Rural):					
LT 5,000	945	0.3	-5.6	-0.4	-3.6
5,000–10,999	602	0.2	-5.7	-0.2	-3.5
11,000–20,999	332	0.7	-3.9	-0.1	-1.2
21,000–42,999	198	1.4	-2.5	0.0	1.1
GT 42,999	44	2.3	-2.2	0.0	2.3
Region (Urban):					
New England	135	0.6	-0.6	0.0	2.2
Middle Atlantic	379	-0.5	-0.8	0.3	1.2
South Atlantic	386	-0.1	2.8	0.0	5.0
East North Cent	441	-0.4	0.1	0.0	1.9
East South Cent	154	1.2	2.1	-0.1	5.5
West North Cent	181	-0.4	1.5	0.0	3.3
West South Cent	321	-0.9	2.1	-0.1	3.4
Mountain	128	-0.1	2.4	0.0	4.5
Pacific	386	-0.4	1.6	-0.1	3.5
Puerto Rico	39	1.0	-8.1	-0.1	-5.1
Region (Rural):					
New England	52	0.0	-4.1	-0.1	-2.1
Middle Atlantic	74	0.5	-4.9	0.2	-2.0
South Atlantic	270	1.4	-3.2	-0.1	0.3
East North Cent	279	1.1	-4.6	-0.1	-1.5
East South Cent	250	1.3	-3.8	-0.1	-0.4

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1] (1)	New wage index [2] (2)	APC/WGTS/ 75% fold in [3] (3)	New outlier policy [4] (4)	All CY2002 changes [5] (5)
West North Cent	506	1.2	-3.9	-0.2	-0.9
West South Cent	328	1.5	-3.0	-0.1	0.5
Mountain	215	1.3	-3.2	-0.2	0.0
Pacific	142	-0.8	-2.8	0.0	-1.5
Puerto Rico	5	4.5	-6.8	-0.1	-0.5
Teaching Status:					
Non-Teaching	3,576	0.2	-1.4	0.0	0.9
Minor	803	0.0	2.0	0.0	4.4
Major	291	-0.4	0.5	0.0	2.4
DSH Patient Percent:					
0	32	0.7	-7.6	-1.3	-6.4
GT 0–0.10	1,261	0.0	0.2	0.0	2.5
0.10–0.16	1,035	0.1	-0.1	0.1	2.4
0.16–0.23	869	-0.1	0.6	0.0	2.7
0.23–0.35	786	0.1	0.3	-0.1	2.6
GE 0.35	688	-0.2	-1.6	-0.1	0.3
Urban IME/DSH:					
IME & DSH	1,000	-0.3	1.8	0.1	3.8
IME/No DSH	3	0.0	-2.1	-2.0	-2.3
No IME/DSH	1,531	-0.2	-0.1	0.0	2.0
No IME/No DSH	16	0.8	-15.5	-0.3	-13.2
Rural Hosp. Types:					
No Special Status	794	0.2	-4.8	-0.1	-2.6
RRC	172	2.1	-2.0	0.0	2.3
SCH/Each	666	0.4	-4.8	-0.1	-2.4
MDH	329	0.2	-6.2	-0.3	-4.2
SCH and RRC	71	2.0	-2.1	-0.1	2.0
Type of Ownership:					
Voluntary	2,774	0.0	0.2	0.0	2.4
Proprietary	757	0.0	1.0	0.0	3.3
Government	1,140	0.3	-1.7	-0.1	0.6
Specialty Hospitals:					
Eye and Ear	12	0.8	-4.8	0.0	-1.8
Trauma	151	-0.1	1.5	0.0	3.7
Cancer	10	-1.3	-0.4	0.4	0.7
Tefra Hospitals (Not Included on Other Lines):					
Rehab	169	0.3	7.5	-0.3	9.2
Psych	103	-0.7	-7.4	-1.7	-7.8
LTC	99	-0.7	-4.3	-0.4	-3.3
Children	42	-0.6	-0.9	-1.0	-0.5

Note: For CY 2002, under the OPPS transitional corridor policy cancer, children's, and rural hospitals with 100 or fewer beds are held harmless compared to their 1996 payment margin for these services. All other hospitals are protected to some extent when their payment margins are less than they were in 1996 (see § 419.70(b)). These additional payments are not reflected below.

[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 using the final FY 2002 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2002 was published in the **Federal Register** on September 1, 2001.

[3] This column shows the impact of recalibrating the APC weights based on the 1999–2000 hospital claims data and on the reassignment of some HCPCs to APCs as well as the incorporation of the device costs discussed in this rule.

[4] This column shows the difference in calculating outliers on an APC-specific rather than bill basis and with the final thresholds.

[5] This column shows changes in total payment from CY2001 to CY 2002. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of the CY 2002 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

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

List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare &

Medicaid Services amends 42 CFR chapter IV as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

A. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B—Accounting Records and Reports

2. In § 413.24, the heading to paragraph (d) is republished, paragraph (d)(6) is revised, and a new paragraph (d)(7) is added, to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Provider-based entities and departments: Preventing duplication of cost.* In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a contract must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC's management contract to the RHC cost center (for example, Form HCFA 2552–96, Worksheet A, Line 71). A full allocation of the hospital's administrative and general costs to the RHC cost center would duplicate most of the RHC's administrative and general costs. However, an allocation of the hospital's cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers, including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC's management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) *Costs of services furnished to free-standing entities.* The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

* * * * *

Subpart E—Payments to Providers

3. Section 413.65 is amended as follows:

A. Revising paragraph (a)(1).

B. Revising the definition of ''Provider-based entity'' in paragraph (a)(2).

C. Revising paragraph (b).

D. Revising paragraph (c).

E. Revising the introductory text to paragraph (d).

F. Revising paragraph (d)(7).

G. Revising paragraph (g)(7).

H. Revising the introductory text to paragraph (i)(1).

I. Revising paragraph (i)(1)(ii).

J. Revising paragraph (i)(2).

The revisions read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* (i) This section applies to all facilities for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) This section does not apply to the following facilities:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests.

(H) Facilities furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under § 413.174 of this chapter).

(2) *Definitions.* * * *

* * * * *

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

* * * * *

(b) *Provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply

because it or the main provider believe it is provider-based.

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of this section will not apply to that hospital or CAH for that facility until October 1, 2002. For purposes of this paragraph, a facility is considered as provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3) Except as specified in paragraphs (b)(2) and (b)(5) of this section, a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider based, or before it includes costs of those services on its cost report.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.

(5) A facility that has requested provider-based status in relation to a hospital or CAH on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) *Reporting.* A main provider that has had one or more facilities considered provider-based also must report to CMS any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that would affect the provider-based status of the facility.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by CMS to have provider-based status.

* * * * *

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except when the requirements in paragraphs (d)(7)(i), (d)(7)(ii), or (d)(7)(iii) of this section are met:

(i) The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider;

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization is not considered in the ''immediate vicinity'' of the main provider unless the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, or adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criteria in paragraphs (d)(7)(i) through (d)(7)(iv) of this section.

* * * * *

(g) *Obligations of hospital outpatient departments and hospital-based entities.* * * *

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based. The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

* * * * *

(i) *Inappropriate treatment of a facility or organization as provider-based*—(1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, CMS will—

* * * * *

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods before the beginning of the hospital's first cost reporting period beginning or or after January 10, 2001, the requirements in applicable program instructions) were met; and

* * * * *

(2) *Recovery of overpayments.* If CMS finds that payments for services at the facility or organization were made as if the facility or organization were provider-based, even though CMS had not previously determined that the facility or organization qualified for provider-based status—

(i) CMS will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates would have been made in the absence of a determination of provider-based status.

(ii) CMS will not make recovery payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001 if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

B. Part 419 is amended as set forth below:

1. The authority citation for part 419 continues to read as follows:

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

Subpart A—General Provisions

2. In § 419.2, paragraph (c) is revised to read as follows:

§ 419.2 Basis of payment.

* * * * *

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in § 413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in § 413.85 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in § 415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under § 415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in § 413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

Subpart B—Categories of Hospitals and Services Subject to and Excluded from the Hospital Outpatient Prospective Payment System

3. In § 419.20, paragraph (a) is revised, and paragraphs (b)(3) and (b)(4) are added to read as follows:

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after August 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.*

* * * * *

(3) A hospital located outside one of the 50 States, the District of Columbia, and Puerto Rico is excluded from the hospital outpatient prospective payment system.

(4) A hospital of the Indian Health Service.

4. In § 419.22, the introductory text is republished, and paragraph (r) is added to read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

* * * * *

(r) Services defined in § 419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

5. In § 419.32, paragraph (b)(1) is revised to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001—

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For calendar year 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

* * * * *

Subpart D—Payments to Hospitals

6. In § 419.40, the word ''coinsurance'' is removed and the word ''copayment'' is added in its place as follows. As revised, § 419.40 reads as follows:

§ 419.40 Payment concepts.

(a) In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare program payment amount for each APC group is calculated by applying the

program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the greater of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) Program payment percentage is calculated as the lower of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

(3) Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of copayment amount to inpatient hospital deductible amount.* The copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

7. Amend § 419.41 as follows:

A. The section heading is revised.

B. The word ''coinsurance'' is removed each time it appears, and the word ''copayment'' is added in its place.

C. Paragraph (c)(4)(ii) is redesignated as paragraph (c)(4)(iv).

D. Paragraphs (c)(4)(ii) and (c)(4)(iii) are added as follows:

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

* * * * *

(c) * * *

(4) * * *

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

* * * * *

8. In § 419.42 paragraph (a), (c), and (e) are revised to read as follows:

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

* * * * *

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

* * * * *

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

* * * * *

§ 419.43 [Amended]

9. Section 419.43 is amended by removing the word ''coinsurance'' from the section heading and from paragraph (a), and adding the word ''copayment'' in its place.

Subpart H—Transitional Corridors

10. In § 419.70, paragraph (d)(2) is revised to read as follows:

§ 419.70 Transitional adjustment to limit decline in payment.

* * * * *

(d) *Hold harmless provisions* * * *

* * * * *

(2) *Permanent treatment for cancer hospitals and children's hospitals.* In the case of a hospital described in § 412.23(d) or § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

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

Subpart B—Essentials of Provider Agreements

2. In § 489.24, paragraphs (i)(2) introductory text and (i)(2)(ii) are revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(i) *Off-campus departments.* * * *

(2) *Protocols for off-campus departments.* The hospital must establish protocols for the handling of individuals with potential emergency conditions at off-campus departments. These protocols must provide for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services. Any contact with emergency personnel at the main hospital campus should either be made after or concurrently with the actions needed to arrange an appropriate transfer under paragraph (i)(3)(ii) of this section if contacting the main hospital campus prior to transfer would significantly jeopardize the life or health of the individual.

* * * * *

(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section.

* * * * *

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

Dated: November 20, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 23, 2001.

Tommy G. Thompson,

Secretary.

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

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Photochemotherapy	S	0.43	$21.89	$7.88	$4.38
0002	Fine needle Biopsy/Aspiration	T	0.42	$21.38	$11.76	$4.28
0003	Bone Marrow Biopsy/Aspiration	T	1.03	$52.43	$27.99	$10.49
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	2.47	$125.73	$32.57	$25.15
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	4.03	$205.14	$90.26	$41.03
0006	Level I Incision & Drainage	T	2.18	$110.97	$33.95	$22.19
0007	Level II Incision & Drainage	T	6.75	$343.60	$72.03	$68.72
0008	Level III Incision and Drainage	T	10.93	$556.38	$113.67	$111.28
0009	Nail Procedures	T	0.63	$32.07	$8.34	$6.41
0010	Level I Destruction of Lesion	T	0.66	$33.60	$9.86	$6.72
0011	Level II Destruction of Lesion	T	1.47	$74.83	$27.69	$14.97
0012	Level I Debridement & Destruction	T	0.66	$33.60	$9.18	$6.72
0013	Level II Debridement & Destruction	T	1.36	$69.23	$17.66	$13.85
0015	Level IV Debridement & Destruction	T	2.07	$105.37	$31.20	$21.07
0016	Level V Debridement & Destruction	T	3.02	$153.73	$64.57	$30.75
0017	Level VI Debridement & Destruction	T	9.68	$492.75	$226.67	$98.55
0018	Biopsy of Skin/Puncture of Lesion	T	1.05	$53.45	$17.66	$10.69
0019	Level I Excision/ Biopsy	T	4.22	$214.81	$78.91	$42.96
0020	Level II Excision/ Biopsy	T	8.44	$429.63	$130.53	$85.93
0021	Level IV Excision/ Biopsy	T	11.82	$601.69	$236.51	$120.34
0022	Level V Excision/ Biopsy	T	13.91	$708.07	$292.94	$141.61
0023	Exploration Penetrating Wound	T	2.08	$105.88	$40.37	$21.18
0024	Level I Skin Repair	T	2.28	$116.06	$41.78	$23.21
0025	Level II Skin Repair	T	3.39	$172.56	$65.57	$34.51
0026	Level III Skin Repair	T	12.62	$642.41	$277.92	$128.48
0027	Level IV Skin Repair	T	18.02	$917.29	$383.10	$183.46
0028	Level I Breast Surgery	T	14.00	$712.66	$303.74	$142.53
0029	Level II Breast Surgery	T	23.76	$1,209.48	$628.93	$241.90
0030	Level III Breast Surgery	T	34.20	$1,740.92	$763.55	$348.18
0032	Insertion of Central Venous/Arterial Catheter	T	12.64	$643.43	.....	$128.69
0033	Partial Hospitalization	P	4.17	$212.27	$48.17	$42.45
0035	Placement of Arterial or Central Venous Catheter	T	0.12	$6.11	$2.69	$1.22
0041	Level I Arthroscopy	T	23.61	$1,201.84	$576.88	$240.37
0042	Level II Arthroscopy	T	35.76	$1,820.33	$804.74	$364.07
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	4.05	$206.16	.....	$41.23
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.52	$128.28	$38.08	$25.66
0045	Bone/Joint Manipulation Under Anesthesia	T	11.67	$594.05	$277.12	$118.81
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	27.69	$1,409.53	$535.76	$281.91
0047	Arthroplasty without Prosthesis	T	26.36	$1,341.83	$537.03	$268.37
0048	Arthroplasty with Prosthesis	T	43.19	$2,198.54	$725.94	$439.71
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.84	$806.32	$356.95	$161.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	20.63	$1,050.15	$504.07	$210.03
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	28.56	$1,453.82	$675.24	$290.76
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	35.94	$1,829.49	$930.91	$365.90
0053	Level I Hand Musculoskeletal Procedures	T	11.69	$595.07	$253.49	$119.01
0054	Level II Hand Musculoskeletal Procedures	T	19.83	$1,009.43	$472.33	$201.89
0055	Level I Foot Musculoskeletal Procedures	T	15.44	$785.96	$355.34	$157.19
0056	Level II Foot Musculoskeletal Procedures	T	18.85	$959.54	$405.81	$191.91
0057	Bunion Procedures	T	24.35	$1,239.51	$496.65	$247.90
0058	Level I Strapping and Cast Application	S	1.28	$65.16	$19.27	$13.03
0059	Level II Strapping and Cast Application	S	2.22	$113.01	$29.59	$22.60
0060	Manipulation Therapy	S	0.23	$11.71	.....	$2.34
0068	CPAP Initiation	S	3.02	$153.73	$84.55	$30.75
0069	Thoracoscopy	T	23.57	$1,199.81	.....	$239.96
0070	Thoracentesis/Lavage Procedures	T	4.58	$233.14	$79.60	$46.63
0071	Level I Endoscopy Upper Airway	T	1.03	$52.43	$14.22	$10.49
0072	Level II Endoscopy Upper Airway	T	1.21	$61.59	$33.87	$12.32
0073	Level III Endoscopy Upper Airway	T	3.29	$167.47	$73.69	$33.49
0074	Level IV Endoscopy Upper Airway	T	11.32	$576.23	$293.88	$115.25
0075	Level V Endoscopy Upper Airway	T	17.42	$886.75	$443.38	$177.35
0076	Endoscopy Lower Airway	T	7.56	$384.83	$188.57	$76.97
0077	Level I Pulmonary Treatment	S	0.39	$19.85	$10.92	$3.97
0078	Level II Pulmonary Treatment	S	0.86	$43.78	$18.83	$8.76
0079	Ventilation Initiation and Management	S	0.60	$30.54	$16.80	$6.11
0080	Diagnostic Cardiac Catheterization	T	34.73	$1,767.90	$838.92	$353.58
0081	Non-Coronary Angioplasty or Atherectomy	T	29.24	$1,488.43	$710.91	$297.69
0082	Coronary Atherectomy	T	92.00	$4,683.17	$1,351.74	$936.63

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

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty	T	59.49	$3,028.28	$794.30	$605.66
0084	Level I Electrophysiologic Evaluation	S	199.65	$10,162.98	.....	$2,032.60
0085	Level II Electrophysiologic Evaluation	T	38.69	$1,969.48	$654.48	$393.90
0086	Ablate Heart Dysrhythm Focus	T	72.72	$3,701.74	$1,265.37	$740.35
0087	Cardiac Electrophysiologic Recording/Mapping	T	52.46	$2,670.42	.....	$534.08
0088	Thrombectomy	T	34.38	$1,750.08	$678.68	$350.02
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	149.52	$7,611.17	$2,246.59	$1,522.23
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	117.54	$5,983.26	$2,133.88	$1,196.65
0091	Level I Vascular Ligation	T	20.34	$1,035.39	$348.23	$207.08
0092	Level II Vascular Ligation	T	19.91	$1,013.50	$503.71	$202.70
0093	Vascular Repair/Fistula Construction	T	14.16	$720.80	$277.34	$144.16
0094	Resuscitation and Cardioversion	S	6.08	$309.50	$105.29	$61.90
0095	Cardiac Rehabilitation	S	0.61	$31.05	$16.46	$6.21
0096	Non-Invasive Vascular Studies	S	1.71	$87.05	$47.88	$17.41
0097	Cardiac Monitoring for 30 days	X	0.84	$42.76	$23.52	$8.55
0098	Injection of Sclerosing Solution	T	1.24	$63.12	$20.88	$12.62
0099	Electrocardiograms	S	0.35	$17.82	$9.80	$3.56
0100	Stress Tests and Continuous ECG	X	1.47	$74.83	$41.16	$14.97
0101	Tilt Table Evaluation	S	3.74	$190.38	$104.71	$38.08
0103	Miscellaneous Vascular Procedures	T	15.95	$811.92	$295.70	$162.38
0104	Transcatheter Placement of Intracoronary Stents	T	87.98	$4,478.53	.....	$895.71
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	14.76	$751.34	$368.16	$150.27
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	36.64	$1,865.12	$503.07	$373.02
0107	Insertion of Cardioverter-Defibrillator	T	379.46	$19,316.03	$4,224.27	$3,863.21
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	573.46	$29,191.41	.....	$5,838.28
0109	Removal of Implanted Devices	T	6.27	$319.17	$130.86	$63.83
0110	Transfusion	S	5.30	$269.79	$113.31	$53.96
0111	Blood Product Exchange	S	21.08	$1,073.06	$300.74	$214.61
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.25	$1,845.27	$608.94	$369.05
0113	Excision Lymphatic System	T	15.53	$790.54	$326.55	$158.11
0114	Thyroid/Lymphadenectomy Procedures	T	29.28	$1,490.47	$493.78	$298.09
0115	Cannula/Access Device Procedures	T	21.35	$1,086.80	$506.74	$217.36
0116	Chemotherapy Administration by Other Technique Except Infusion	S	0.91	$46.32	.....	$9.26
0117	Chemotherapy Administration by Infusion Only	S	4.01	$204.13	$52.69	$40.83
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	4.20	$213.80	$72.03	$42.76
0119	Implantation of Devices	T	79.67	$4,055.52	.....	$811.10
0120	Infusion Therapy Except Chemotherapy	T	3.08	$156.78	$42.67	$31.36
0121	Level I Tube changes and Repositioning	T	2.54	$129.30	$52.53	$25.86
0122	Level II Tube changes and Repositioning	T	9.89	$503.44	$114.93	$100.69
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	8.56	$435.74	.....	$87.15
0124	Revision of Implanted Infusion Pump	T	89.07	$4,534.02	.....	$906.80
0125	Refilling of Infusion Pump	T	3.00	$152.71	.....	$30.54
0130	Level I Laparoscopy	T	25.91	$1,318.92	$659.53	$263.78
0131	Level II Laparoscopy	T	37.63	$1,915.52	$996.07	$383.10
0132	Level III Laparoscopy	T	56.06	$2,853.68	$1,239.22	$570.74
0140	Esophageal Dilation without Endoscopy	T	5.65	$287.61	$107.24	$57.52
0141	Upper GI Procedures	T	7.21	$367.02	$184.67	$73.40
0142	Small Intestine Endoscopy	T	6.94	$353.27	$151.91	$70.65
0143	Lower GI Endoscopy	T	7.27	$370.07	$185.04	$74.01
0144	Diagnostic Anoscopy	T	4.43	$225.50	$49.32	$45.10
0145	Therapeutic Anoscopy	T	10.81	$550.27	$179.39	$110.05
0146	Level I Sigmoidoscopy	T	2.73	$138.97	$63.93	$27.79
0147	Level II Sigmoidoscopy	T	5.71	$290.66	$136.61	$58.13
0148	Level I Anal/Rectal Procedure	T	2.40	$122.17	$43.59	$24.43
0149	Level III Anal/Rectal Procedure	T	13.53	$688.73	$293.06	$137.75
0150	Level IV Anal/Rectal Procedure	T	18.08	$920.34	$437.12	$184.07
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	15.29	$778.32	$245.46	$155.66
0152	Percutaneous Biliary Endoscopic Procedures	T	16.13	$821.08	$207.38	$164.22
0153	Peritoneal and Abdominal Procedures	T	23.55	$1,198.79	$496.31	$239.76
0154	Hernia/Hydrocele Procedures	T	31.40	$1,598.39	$556.98	$319.68
0155	Level II Anal/Rectal Procedure	T	5.26	$267.76	.....	$53.55
0156	Level II Urinary and Anal Procedures	T	2.45	$124.71	$37.41	$24.94
0157	Colorectal Cancer Screening: Barium Enema	S	1.98	$100.79	$22.19	$20.16
0158	Colorectal Cancer Screening: Colonoscopy	T	6.55	$333.42	$83.36	$66.68
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.33	$118.61	$29.65	$23.72
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.13	$261.14	$104.46	$52.23
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	13.72	$698.40	$249.36	$139.68
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.09	$1,277.18	$427.49	$255.44
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	40.40	$2,056.52	$792.58	$411.30
0164	Level I Urinary and Anal Procedures	T	1.01	$51.41	$15.42	$10.28
0165	Level III Urinary and Anal Procedures	T	5.22	$265.72	$91.76	$53.14
0166	Level I Urethral Procedures	T	12.20	$621.03	$218.73	$124.21
0167	Level II Urethral Procedures	T	22.28	$1,134.14	$555.84	$226.83
0168	Level III Urethral Procedures	T	18.42	$937.65	$403.19	$187.53
0169	Lithotripsy	T	39.62	$2,016.82	$1,109.25	$403.36
0170	Dialysis for Other Than ESRD Patients	S	0.28	$14.25	$3.14	$2.85
0179	Urinary Incontinence Procedures	T	139.33	$7,092.45	$2,340.51	$1,418.49

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0180	Circumcision	T	15.02	$764.58	$304.87	$152.92
0181	Penile Procedures	T	22.09	$1,124.47	$618.46	$224.89
0182	Insertion of Penile Prosthesis	T	87.54	$4,456.14	$1,492.28	$891.23
0183	Testes/Epididymis Procedures	T	18.87	$960.56	$448.94	$192.11
0184	Prostate Biopsy	T	4.83	$245.87	$122.94	$49.17
0187	Miscellaneous Placement/Repositioning	X	4.22	$214.81	.....	$42.96
0188	Level II Female Reproductive Proc	T	0.80	$40.72	$11.81	$8.14
0189	Level III Female Reproductive Proc	T	1.26	$64.14	$17.96	$12.83
0190	Surgical Hysteroscopy	T	16.91	$860.79	$421.79	$172.16
0191	Level I Female Reproductive Proc	T	0.23	$11.71	$3.40	$2.34
0192	Level IV Female Reproductive Proc	T	2.50	$127.26	$35.33	$25.45
0193	Level V Female Reproductive Proc	T	11.16	$568.09	$171.13	$113.62
0194	Level VI Female Reproductive Proc	T	15.86	$807.34	$395.60	$161.47
0195	Level VII Female Reproductive Proc	T	20.62	$1,049.64	$483.80	$209.93
0196	Dilation and Curettage	T	13.48	$686.19	$336.23	$137.24
0197	Infertility Procedures	T	2.40	$122.17	$49.55	$24.43
0198	Pregnancy and Neonatal Care Procedures	T	1.31	$66.68	$32.67	$13.34
0199	Vaginal Delivery	T	5.09	$259.10	$72.55	$51.82
0200	Therapeutic Abortion	T	11.34	$577.25	$305.94	$115.45
0201	Spontaneous Abortion	T	14.33	$729.45	$329.65	$145.89
0202	Level VIII Female Reproductive Proc	T	63.54	$3,234.44	$1,487.84	$646.89
0203	Level V Nerve Injections	T	15.79	$803.77	$369.73	$160.75
0204	Level VI Nerve Injections	T	2.24	$114.02	$43.33	$22.80
0206	Level III Nerve Injections	T	3.59	$182.75	$74.93	$36.55
0207	Level IV Nerve Injections	T	5.36	$272.85	$122.78	$54.57
0208	Laminotomies and Laminectomies	T	29.12	$1,482.32	.....	$296.46
0209	Extended EEG Studies and Sleep Studies, Level II	S	10.54	$536.53	$279.00	$107.31
0212	Level II Nervous System Injections	T	3.77	$191.91	$88.78	$38.38
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.65	$134.90	$70.15	$26.98
0214	Electroencephalogram	S	2.10	$106.90	$53.45	$21.38
0215	Level I Nerve and Muscle Tests	S	0.66	$33.60	$17.47	$6.72
0216	Level III Nerve and Muscle Tests	S	2.61	$132.86	$59.79	$26.57
0218	Level II Nerve and Muscle Tests	S	1.03	$52.43	$23.59	$10.49
0220	Level I Nerve Procedures	T	13.60	$692.29	$325.38	$138.46
0221	Level II Nerve Procedures	T	21.43	$1,090.87	$463.62	$218.17
0222	Implantation of Neurological Device	T	302.53	$15,399.99	.....	$3,080.00
0223	Implantation of Pain Management Device	T	75.39	$3,837.65	.....	$767.53
0224	Implantation of Reservoir/Pump/Shunt	T	28.48	$1,449.75	$453.41	$289.95
0225	Implantation of Neurostimulator Electrodes	T	267.56	$13,619.87	.....	$2,723.97
0226	Implantation of Drug Infusion Reservoir	T	75.81	$3,859.03	.....	$771.81
0227	Implantation of Drug Infusion Device	T	139.55	$7,103.65	.....	$1,420.73
0228	Creation of Lumbar Subarachnoid Shunt	T	53.77	$2,737.11	$696.46	$547.42
0229	Transcatherter Placement of Intravascular Shunts	T	67.22	$3,421.77	$996.86	$684.35
0230	Level I Eye Tests & Treatments	S	0.61	$31.05	$14.28	$6.21
0231	Level III Eye Tests & Treatments	S	2.03	$103.34	$46.50	$20.67
0232	Level I Anterior Segment Eye Procedures	T	3.50	$178.16	$78.39	$35.63
0233	Level II Anterior Segment Eye Procedures	T	10.83	$551.29	$264.62	$110.26
0234	Level III Anterior Segment Eye Procedures	T	19.08	$971.25	$466.20	$194.25
0235	Level I Posterior Segment Eye Procedures	T	5.57	$283.54	$78.91	$56.71
0236	Level II Posterior Segment Eye Procedures	T	16.21	$825.15	.....	$165.03
0237	Level III Posterior Segment Eye Procedures	T	36.32	$1,848.83	.....	$369.77
0238	Level I Repair and Plastic Eye Procedures	T	3.01	$153.22	$58.96	$30.64
0239	Level II Repair and Plastic Eye Procedures	T	5.80	$295.24	$115.14	$59.05
0240	Level III Repair and Plastic Eye Procedures	T	13.83	$704.00	$315.34	$140.80
0241	Level IV Repair and Plastic Eye Procedures	T	18.12	$922.38	$384.47	$184.48
0242	Level V Repair and Plastic Eye Procedures	T	23.72	$1,207.44	$597.36	$241.49
0243	Strabismus/Muscle Procedures	T	17.70	$901.00	$429.78	$180.20
0244	Corneal Transplant	T	38.46	$1,957.77	$851.42	$391.55
0245	Level I Cataract Procedures without IOL Insert	T	10.44	$531.44	$249.78	$106.29
0246	Cataract Procedures with IOL Insert	T	21.20	$1,079.16	$507.21	$215.83
0247	Laser Eye Procedures Except Retinal	T	4.03	$205.14	$94.36	$41.03
0248	Laser Retinal Procedures	T	29.51	$1,502.18	.....	$300.44
0249	Level II Cataract Procedures without IOL Insert	T	21.80	$1,109.71	$521.56	$221.94
0250	Nasal Cauterization/Packing	T	2.10	$106.90	$37.42	$21.38
0251	Level I ENT Procedures	T	2.43	$123.70	$27.99	$24.74
0252	Level II ENT Procedures	T	5.95	$302.88	$114.24	$60.58
0253	Level III ENT Procedures	T	12.33	$627.65	$284.00	$125.53
0254	Level IV ENT Procedures	T	17.37	$884.20	$272.41	$176.84
0256	Level V ENT Procedures	T	26.61	$1,354.56	$623.05	$270.91
0258	Tonsil and Adenoid Procedures	T	17.43	$887.26	$434.76	$177.45
0259	Level VI ENT Procedures	T	376.56	$19,168.41	$8,798.30	$3,833.68
0260	Level I Plain Film Except Teeth	X	0.70	$35.63	$19.60	$7.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.21	$61.59	$33.87	$12.32
0262	Plain Film of Teeth	X	0.65	$33.09	$10.90	$6.62
0263	Level I Miscellaneous Radiology Procedures	X	1.61	$81.96	$44.26	$16.39
0264	Level II Miscellaneous Radiology Procedures	X	3.71	$188.85	$103.87	$37.77
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.95	$48.36	$26.60	$9.67

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.54	$78.39	$43.11	$15.68
0267	Vascular Ultrasound	S	2.33	$118.61	$65.24	$23.72
0269	Level I Echocardiogram Except Transesophageal	S	3.85	$195.98	$101.91	$39.20
0270	Transesophageal Echocardiogram	S	5.30	$269.79	$145.69	$53.96
0271	Mammography	S	0.60	$30.54	$16.80	$6.11
0272	Level I Fluoroscopy	X	1.38	$70.25	$38.64	$14.05
0274	Myelography	S	5.24	$266.74	$128.12	$53.35
0275	Arthrography	S	2.59	$131.84	$68.56	$26.37
0276	Level I Digestive Radiology	S	1.48	$75.34	$41.44	$15.07
0277	Level II Digestive Radiology	S	2.16	$109.95	$60.47	$21.99
0278	Diagnostic Urography	S	2.34	$119.12	$65.52	$23.82
0279	Level I Angiography and Venography except Extremity	S	7.72	$392.98	$174.57	$78.60
0280	Level II Angiography and Venography except Extremity	S	13.54	$689.24	$351.51	$137.85
0281	Venography of Extremity	S	4.32	$219.91	$114.35	$43.98
0282	Miscellaneous Computerized Axial Tomography	S	1.58	$80.43	$44.24	$16.09
0283	Computerized Axial Tomography with Contrast Material	S	4.48	$228.05	$125.43	$45.61
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.15	$363.96	$200.18	$72.79
0285	Positron Emission Tomography (PET)	S	18.72	$952.92	$415.21	$190.58
0286	Myocardial Scans	S	5.41	$275.39	$151.46	$55.08
0287	Complex Venography	S	4.06	$206.67	$90.93	$41.33
0288	CT, Bone Density	S	1.17	$59.56	$32.76	$11.91
0289	Needle Localization for Breast Biopsy	X	1.63	$82.97	$44.80	$16.59
0290	Standard Non-Imaging Nuclear Medicine	S	1.75	$89.08	$48.99	$17.82
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.50	$178.16	$90.20	$35.63
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.20	$213.80	$117.59	$42.76
0294	Level I Therapeutic Nuclear Medicine	S	5.01	$255.03	$140.27	$51.01
0295	Level II Therapeutic Nuclear Medicine	S	12.10	$615.94	$338.77	$123.19
0296	Level I Therapeutic Radiologic Procedures	S	3.39	$172.56	$94.91	$34.51
0297	Level II Therapeutic Radiologic Procedures	S	7.07	$359.89	$172.51	$71.98
0299	Miscellaneous Radiation Treatment	S	0.21	$10.69	$4.06	$2.14
0300	Level I Radiation Therapy	S	2.07	$105.37	$47.72	$21.07
0301	Level II Radiation Therapy	S	5.15	$262.16	$52.53	$52.43
0302	Level III Radiation Therapy	S	11.16	$568.09	$216.55	$113.62
0303	Treatment Device Construction	X	3.00	$152.71	$69.28	$30.54
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.63	$82.97	$41.52	$16.59
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.71	$188.85	$90.65	$37.77
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.51	$738.62	$339.05	$147.72
0312	Radioelement Applications	S	32.40	$1,649.29	.....	$329.86
0313	Brachytherapy	S	14.84	$755.42	$164.02	$151.08
0314	Hyperthermic Therapies	S	3.90	$198.53	$101.25	$39.71
0320	Electroconvulsive Therapy	S	3.88	$197.51	$80.06	$39.50
0321	Biofeedback and Other Training	S	0.93	$47.34	$21.78	$9.47
0322	Brief Individual Psychotherapy	S	1.15	$58.54	$12.29	$11.71
0323	Extended Individual Psychotherapy	S	1.73	$88.06	$21.13	$17.61
0324	Family Psychotherapy	S	2.69	$136.93	$20.19	$27.39
0325	Group Psychotherapy	S	1.38	$70.25	$18.27	$14.05
0330	Dental Procedures	S	10.97	$558.42	.....	$111.68
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.24	$164.93	$90.71	$32.99
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.22	$265.72	$146.15	$53.14
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.39	$274.37	$150.90	$54.87
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.29	$320.19	$176.10	$64.04
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	8.54	$434.72	$239.10	$86.94
0339	Observation	X	6.85	$348.69	.....	$69.74
0340	Minor Ancillary Procedures	X	0.84	$42.76	$10.69	$8.55
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.10	$5.09	$2.80	$1.02
0342	Level I Pathology	X	0.21	$10.69	$5.88	$2.14
0343	Level II Pathology	X	0.39	$19.85	$10.72	$3.97
0344	Level III Pathology	X	0.56	$28.51	$15.68	$5.70
0345	Level I Transfusion Laboratory Procedures	X	0.26	$13.24	$5.37	$2.65
0346	Level II Transfusion Laboratory Procedures	X	0.77	$39.20	$12.03	$7.84
0347	Level III Transfusion Laboratory Procedures	X	1.56	$79.41	$20.13	$15.88
0348	Fertility Laboratory Procedures	X	0.77	$39.20	.....	$7.84
0352	Level II Injections	X	0.41	$20.87	.....	$4.17
0353	Level II Allergy Injections	X	0.25	$12.73	.....	$2.55
0354	Administration of Influenza/Pneumonia Vaccine	K	0.10	$5.09	.....	.....
0355	Level I Immunizations	K	0.19	$9.67	.....	$1.93
0356	Level II Immunizations	K	1.11	$56.50	.....	$11.30
0359	Level II Injections	X	1.79	$91.12	.....	$18.22
0360	Level I Alimentary Tests	X	1.35	$68.72	$34.36	$13.74
0361	Level II Alimentary Tests	X	3.25	$165.44	$82.72	$33.09
0362	Fitting of Vision Aids	X	0.86	$43.78	$9.63	$8.76
0363	Otorhinolaryngologic Function Tests	X	1.73	$88.06	$32.58	$17.61

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0364	Level I Audiometry	X	0.58	$29.52	$11.51	$5.90
0365	Level II Audiometry	X	1.31	$66.68	$20.00	$13.34
0367	Level I Pulmonary Test	X	0.70	$35.63	$17.82	$7.13
0368	Level II Pulmonary Tests	X	1.47	$74.83	$38.16	$14.97
0369	Level III Pulmonary Tests	X	3.49	$177.65	$58.50	$35.53
0370	Allergy Tests	X	0.80	$40.72	$11.81	$8.14
0371	Level I Allergy Injections	X	0.70	$35.63	.....	$7.13
0372	Therapeutic Phlebotomy	X	0.53	$26.98	$10.09	$5.40
0373	Neuropsychological Testing	X	1.00	$50.90	$14.25	$10.18
0374	Monitoring Psychiatric Drugs	X	0.89	$45.30	$9.97	$9.06
0600	Low Level Clinic Visits	V	0.86	$43.78	.....	$8.76
0601	Mid Level Clinic Visits	V	0.95	$48.36	.....	$9.67
0602	High Level Clinic Visits	V	1.38	$70.25	.....	$14.05
0610	Low Level Emergency Visits	V	1.23	$62.61	$19.41	$12.52
0611	Mid Level Emergency Visits	V	2.16	$109.95	$36.47	$21.99
0612	High Level Emergency Visits	V	3.49	$177.65	$54.14	$35.53
0620	Critical Care	S	8.40	$427.59	$149.66	$85.52
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.16	$466.28	$205.16	$93.26
0686	Level V Skin Repair	T	24.01	$1,222.21	$277.92	$244.44
0687	Revision/Removal of Neurostimulator Electrodes	T	42.34	$2,155.28	.....	$431.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	145.27	$7,394.82	.....	$1,478.96
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.43	$21.89	$12.04	$4.38
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.37	$18.83	$10.36	$3.77
0691	Electronic Analysis of Programmable Shunts/Pumps	S	3.17	$161.37	$88.75	$32.27
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	14.34	$729.96	$401.48	$145.99
0693	Level II Breast Reconstruction	T	31.81	$1,619.26	$712.47	$323.85
0694	Level III Excision/Biopsy	T	3.99	$203.11	$60.93	$40.62
0695	Level VII Debridement & Destruction	T	15.78	$803.27	$369.50	$160.65
0697	Level II Echocardiogram Except Transesophageal	S	2.08	$105.88	$55.06	$21.18
0698	Level II Eye Tests & Treatments	S	1.03	$52.43	$19.92	$10.49
0699	Level IV Eye Tests & Treatment	T	6.46	$328.84	$147.98	$65.77
0701	SR 89 chloride, per mCi	G	.....	$963.42	.....	$137.92
0702	SM 153 lexidronam, 50 mCi	G	.....	$1,020.00	.....	$146.02
0704	IN 111 Satumomab pendetide per dose	G	.....	$1,591.25	.....	$227.80
0705	TC 99M tetrofosmin, per dose	G	.....	$114.00	.....	$16.32
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
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
0725	Leucovorin calcium inj, 50 mg	G	.....	$4.15	.....	$.38
0726	Dexrazoxane hcl injection, 250 mg	G	.....	$194.52	.....	$24.98
0727	Etidronate disodium inj 300 mg	G	.....	$63.65	.....	$9.11
0728	Filgrastim 300 mcg injection	G	.....	$179.08	.....	$23.00
0730	Pamidronate disodium , 30 mg	G	.....	$265.87	.....	$38.06
0731	Sargramostim injection 50 mcg	G	.....	$29.06	.....	$4.16
0732	Mesna injection 200 mg	G	.....	$36.48	.....	$3.30
0733	Non esrd epoetin alpha inj, 1000 u	G	.....	$12.26	.....	$1.57
0750	Dolasetron mesylate, 10 mg	G	.....	$16.45	.....	$2.11
0754	Metoclopramide hcl injection up to 10 mg	G	.....	$1.17	.....	$.11
0755	Thiethylperazine maleate inj up to 10 mg	G	.....	$4.60	.....	$.66
0762	Dronabinol 2.5mg oral	G	.....	$3.28	.....	$.42
0763	Dolasetron mesylate oral, 100 mg	G	.....	$69.64	.....	$8.94
0764	Granisetron hcl injection 10 mcg	G	.....	$18.54	.....	$2.65
0765	Granisetron hcl 1 mg oral	G	.....	$44.69	.....	$6.40
0768	Ondansetron hcl injection 1 mg	G	.....	$6.09	.....	$.78
0769	Ondansetron hcl 8mg oral	G	.....	$26.41	.....	$3.39
0800	Leuprolide acetate, 3.75 mg	G	.....	$93.47	.....	$12.00
0801	Cyclophosphamide oral 25 mg	G	.....	$2.03	.....	$.18
0802	Etoposide oral 50 mg	G	.....	$52.43	.....	$6.73
0803	Melphalan oral 2 mg	G	.....	$2.29	.....	$.33
0807	Aldesleukin/single use vial	G	.....	$672.60	.....	$96.29
0809	Bcg live intravesical vac	G	.....	$166.49	.....	$21.38
0810	Goserelin acetate implant 3.6 mg	G	.....	$446.49	.....	$63.92
0811	Carboplatin injection 50 mg	G	.....	$114.46	.....	$16.39
0812	Carmus bischl nitro inj 100 mg	G	.....	$117.84	.....	$16.87

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0813	Cisplatin 10 mg injection	G		$42.18		$3.82
0814	Asparaginase injection 10,000 u	G		$62.61		$8.96
0815	Cyclophosphamide 100 mg inj	G		$5.82		$.75
0816	Cyclophosphamide lyophilized 100 mg	G		$4.89		$.63
0817	Cytarabine hcl 100 mg inj	G		$6.10		$.55
0818	Dactinomycin 0.5 mg	G		$13.87		$1.99
0819	Dacarbazine 100 mg inj	G		$12.68		$1.15
0820	Daunorubicin 10 mg	G		$76.62		$6.94
0821	Daunorubicin citrate liposom 10 mg	G		$64.60		$9.25
0822	Diethylstilbestrol injection 250 mg	G		$14.41		$1.30
0823	Docetaxel, 20 mg	G		$297.83		$42.64
0824	Etoposide 10 mg inj	G		$10.45		$.95
0826	Methotrexate Oral 2.5 mg	G		$3.45		$.31
0827	Floxuridine injection 500 mg	G		$129.56		$16.64
0828	Gemcitabine HCL 200 mg	G		$106.72		$15.28
0830	Irinotecan injection 20 mg	G		$134.25		$19.22
0831	Ifosfomide injection 1 gm	G		$156.64		$22.42
0832	Idarubicin hcl injection 5 mg	G		$412.21		$59.01
0833	Interferon alfacon-1, 1 mcg	G		$4.10		$.59
0834	Interferon alfa-2a inj recombinant 3 million u	G		$34.86		$4.99
0836	Interferon alfa-2b inj recombinant, 1 million	G		$11.28		$1.45
0838	Interferon gamma 1–b inj, 3 million u	G		$285.65		$40.89
0839	Mechlorethamine hcl inj 10 mg	G		$12.01		$1.72
0840	Melphalan hydrochl 50 mg	G		$400.74		$57.37
0841	Methotrexate sodium inj 5 mg	G		$.45		$.04
0842	Fludarabine phosphate inj 50 mg	G		$271.82		$38.91
0844	Pentostatin injection, 10 mg	G		$1,654.14		$236.80
0847	Doxorubicin hcl 10 mg vl chemo	G		$37.46		$4.81
0849	Rituximab, 100 mg	G		$454.55		$65.07
0850	Streptozocin injection, 1 gm	G		$117.64		$16.84
0851	Thiotepa injection, 15 mg	G		$116.97		$10.59
0852	Topotecan, 4 mg	G		$664.19		$95.08
0853	Vinblastine sulfate inj, 1 mg	G		$4.11		$.37
0854	Vincristine sulfate 1 mg inj	G		$30.16		$3.87
0855	Vinorelbine tartrate, 10 mg	G		$88.83		$12.72
0856	Porfimer sodium, 75 mg	G		$2,603.67		$372.74
0857	Bleomycin sulfate injection 15 u	G		$289.37		$37.16
0858	Cladribine, 1mg	G		$53.39		$4.83
0859	Fluorouracil injection 500 mg	G		$2.73		$.25
0860	Plicamycin (mithramycin) inj 2.5 mg	G		$93.80		$13.43
0861	Leuprolide acetate injection 1 mg	G		$69.79		$6.32
0862	Mitomycin 5 mg inj	G		$121.65		$11.01
0863	Paclitaxel injection, 30 mg	G		$173.50		$22.28
0864	Mitoxantrone hcl, 5 mg	G		$244.21		$34.96
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	G		$7.86		$1.12
0884	Rho d immune globulin inj, 1 dose pkg	G		$34.11		$4.38
0886	Azathioprine oral 50mg	G		$1.25		$.11
0887	Azathioprine parenteral 100 mg	G		$1.06		$.10
0888	Cyclosporine oral 100 mg	G		$5.22		$.67
0889	Cyclosporin parenteral 250mg	G		$25.08		$3.22
0890	Lymphocyte immune globulin 250 mg	G		$269.06		$38.52
0891	Tacrolimus oral per 1 mg	G		$2.91		$.42
0900	Alglucerase injection, per 10 u	G		$37.53		$5.37
0901	Alpha 1 proteinase inhibitor, 10 mg	G		$2.09		$.30
0902	Botulinum toxin a, per unit	G		$4.39		$.63
0903	Cytomegalovirus imm IV/vial	G		$370.50		$47.58
0905	Immune globulin 500 mg	G		$35.63		$3.23
0906	RSV-ivig, 50 mg	G		$15.51		$1.99
0907	Ganciclovir Sodium 500 mg injection	K	0.42	$21.38		$4.28
0908	Tetanus immune globulin inj up to 250 u	G		$102.60		$13.18
0909	Interferon beta-1a, 33 mcg	G		$225.22		$32.24
0910	Interferon beta-1b /0.25 mg	G		$68.40		$9.79
0911	Streptokinase per 250,000 iu	K	1.66	$84.50		$16.90
0913	Ganciclovir long act implant 4.5 mg	G		$4,750.00		$680.00
0916	Injection imiglucerase /unit	G		$3.75		$.54
0917	Pharmacologic stressors	K	0.34	$17.31		$3.46
0925	Factor viii per iu	G		$.87		$.08
0926	Factor VIII (porcine) per iu	G		$2.09		$.30
0927	Factor viii recombinant per iu	G		$1.12		$.14
0928	Factor ix complex per iu	G		$.48		$.04
0929	Anti-inhibitor per iu	G		$1.43		$.18
0930	Antithrombin iii injection per iu	G		$1.05		$.15
0931	Factor IX non-recombinant, per iu	G		$26.13		$3.74
0932	Factor IX recombinant, per iu	G		$1.12		$.16
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.78	$141.51		$28.30
0950	Blood (Whole) For Transfusion	K	1.97	$100.28		$20.06
0952	Cryoprecipitate	K	0.66	$33.60		$6.72

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0954	RBC leukocytes reduced	K	2.67	$135.91	.....	$27.18
0955	Plasma, Fresh Frozen	K	2.13	$108.43	.....	$21.69
0956	Plasma Protein Fraction	K	1.19	$60.58	.....	$12.12
0957	Platelet Concentrate	K	0.93	$47.34	.....	$9.47
0958	Platelet Rich Plasma	K	1.10	$55.99	.....	$11.20
0959	Red Blood Cells	K	1.93	$98.24	.....	$19.65
0960	Washed Red Blood Cells	K	3.60	$183.25	.....	$36.65
0961	Infusion, Albumin (Human) 5%, 50 ml	K	2.07	$105.37	.....	$21.07
0962	Infusion, Albumin (Human) 25%, 50 ml	K	1.04	$52.94	.....	$10.59
0963	Albumin (human), 5%, 250 ml	K	10.35	$526.86	.....	$105.37
0964	Albumin (human), 25%, 20 ml	K	2.08	$105.88	.....	$21.18
0965	Albumin (human), 25%, 50ml	K	5.20	$264.70	.....	$52.94
0966	Plasmaprotein fract,5%,250ml	K	5.95	$302.88	.....	$60.58
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	0.82	$41.74	.....	$8.35
1010	Blood, L/R, CMV-neg	K	2.72	$138.46	.....	$27.69
1011	Platelets, HLA-m, L/R, unit	K	11.21	$570.63	.....	$114.13
1012	Platelet concentrate, L/R, irradiated, unit	K	1.81	$92.14	.....	$18.43
1013	Platelet concentrate, L/R, unit	K	1.11	$56.50	.....	$11.30
1014	Platelets, aph/pher, L/R, unit	K	8.45	$430.14	.....	$86.03
1016	Blood, L/R, froz/deglycerol/washed	K	6.76	$344.11	.....	$68.82
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.82	$448.97	.....	$89.79
1018	Blood, L/R, irradiated	K	2.96	$150.68	.....	$30.14
1019	Platelets, aph/pher, L/R, irradiated, unit	K	9.11	$463.74	.....	$92.75
1024	Quinupristin/dalfopristin 500 mg (150/350)	G	.....	$102.05	.....	$13.11
1045	Iobenguane sulfate I–131	G	.....	$495.65	.....	$70.96
1058	TC 99M oxidronate, per vial	G	.....	$36.74	.....	$5.26
1059	Cultured chondrocytes implnt	G	.....	$14,250.00	.....	$2,040.00
1064	I–131 cap, each add mCi	G	.....	$5.86	.....	$.75
1065	I–131 sol, each add mCi	G	.....	$15.81	.....	$2.03
1066	IN 111 satumomab pendetide	G	.....	$1,591.25	.....	$227.80
1079	CO 57/58 0.5 mCi	G	.....	$253.84	.....	$36.34
1084	Denileukin diftitox, 300 MCG	G	.....	$999.88	.....	$143.14
1086	Temozolomide,oral 5 mg	G	.....	$6.05	.....	$.87
1087	I–123 per 100 uci	G	.....	$.65	.....	$.06
1089	Coo 57, 0.5 Mci	G	.....	$81.10	.....	$10.41
1091	IN 111 Oxyquinoline, per .5 mCi	G	.....	$427.50	.....	$61.20
1092	IN 111 Pentetate, per 0.5 mCi	G	.....	$256.50	.....	$23.22
1094	TC 99M Albumin aggr,1.0 cmCi	G	.....	$33.09	.....	$4.25
1095	Technetium TC 99M Depreotide	G	.....	$38.00	.....	$5.44
1096	TC 99M Exametazime, per dose	G	.....	$445.31	.....	$63.75
1097	TC 99M Mebrofenin, per vial	G	.....	$51.44	.....	$7.36
1098	TC 99M Pentetate, per vial	G	.....	$22.43	.....	$2.88
1099	TC 99M Pyrophosphate, per vial	G	.....	$39.11	.....	$5.60
1122	TC 99M arcitumomab, per vial	G	.....	$1,235.00	.....	$176.80
1166	Cytarabine liposomal, 10 mg	G	.....	$371.45	.....	$53.18
1167	Epirubicin hcl, 2 mg	G	.....	$24.94	.....	$3.57
1178	Busulfan IV, 6 mg	G	.....	$26.48	.....	$3.79
1188	I–131 cap, per 1–5 mCi	G	.....	$117.25	.....	$15.06
1200	TC 99M Sodium Glucoheptonate	G	.....	$22.61	.....	$3.24
1201	TC 99M succimer, per vial	G	.....	$135.66	.....	$19.42
1202	TC 99M Sulfur Colloid, per dose	G	.....	$76.00	.....	$9.76
1203	Verteporfin for injection	G	.....	$1,458.25	.....	$208.76
1205	Technetium Tc 99m disofenin	G	.....	$79.17	.....	$11.33
1207	Octreotide acetate depot 1mg	G	.....	$138.08	.....	$19.77
1305	Apligraf	G	.....	$1,157.81	.....	$165.75
1348	I–131 sol, per 1–6 mCi	G	.....	$146.57	.....	$18.82
1400	Diphenhydramine hcl 50mg	G	.....	$.23	.....	$.02
1401	Prochlorperazine maleate 5mg	G	.....	$.65	.....	$.06
1402	Promethazine hcl 12.5mg oral	G	.....	$.01	.....	$.00
1403	Chlorpromazine hcl 10mg oral	G	.....	$.27	.....	$.02
1404	Trimethobenzamide hcl 250mg	G	.....	$.38	.....	$.03

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1405	Thiethylperazine maleate10mg	G		$.56		$.08
1406	Perphenazine 4mg oral	G		$.62		$.06
1407	Hydroxyzine pamoate 25mg	G		$.28		$.03
1409	Factor viia recombinant, per 1.2 mg	G		$1,596.00		$228.48
1600	Technetium TC 99M sestamibi	G		$121.70		$17.42
1601	Technetium TC 99M medronate	G		$42.18		$5.42
1602	Technetium TC 99M apcitide	G		$475.00		$68.00
1603	Thallous chloride TL 201, per mCi	G		$78.16		$7.08
1604	IN 111 capromab pendetide, per dose	G		$2,192.13		$313.82
1605	Abciximab injection, 10 mg	G		$513.02		$73.44
1606	Anistreplase, 30 u	G		$2,693.80		$385.64
1607	Eptifibatide injection, 5 mg	G		$11.31		$1.45
1608	Etanercept injection, 25 mg	G		$141.01		$20.19
1609	Rho(D) immune globulin h, sd, 100 iu	G		$20.55		$2.64
1611	Hylan G–F 20 injection, 16 mg	G		$213.87		$27.47
1612	Daclizumab, parenteral, 25 mg	G		$397.29		$56.88
1613	Trastuzumab, 10 mg	G		$52.83		$7.56
1614	Valrubicin, 200 mg	G		$423.23		$60.59
1615	Basiliximab, 20 mg	G		$1,437.78		$205.83
1617	Lepirudin	G		$131.96		$18.89
1618	Vonwillebrandfactrcmplx, per iu	G		$.95		$.14
1619	Ga 67, per mCi	G		$25.62		$2.32
1620	Technetium tc99m bicisate	G		$403.99		$57.83
1621	Xenin xe 133	G		$29.93		$2.71
1622	Technetium tc99m mertiatide	G		$137.75		$19.72
1623	Technetium tc99m glucepatate	G		$22.61		$3.24
1624	Sodium phosphate p32	G		$54.34		$7.78
1625	Indium 111-in pentetreotide	G		$935.75		$133.96
1626	Technetium tc99m oxidronate	G		$1.47		$.21
1627	Technetium tc99mlabeled rbcs	G		$40.90		$5.85
1628	Chromic phosphate p32	G		$150.86		$21.60
1713	Anchor/screw bn/bn,tis/bn	H				
1714	Cath, trans atherectomy, dir	H				
1715	Brachytherapy needle	H				
1716	Brachytx seed, Gold 198	H				
1717	Brachytx seed, HDR Ir-192	H				
1718	Brachytx seed, Iodine 125	H				
1719	Brachytxseed, Non-HDR Ir-192	H				
1720	Brachytx seed, Palladium 103	H				
1721	AICD, dual chamber	H				
1722	AICD, single chamber	H				
1724	Cath, trans atherec,rotation	H				
1725	Cath, translumin non-laser	H				
1726	Cath, bal dil, non-vascular	H				
1727	Cath, bal tis dis, non-vas	H				
1728	Cath, brachytx seed adm	H				
1729	Cath, drainage	H				
1730	Cath, EP, 19 or fewer elect	H				
1731	Cath, EP, 20 or more elec	H				
1732	Cath, EP, diag/abl, 3D/vect	H				
1733	Cath, EP, othr than cool-tip	H				
1750	Cath, hemodialysis,long-term	H				
1751	Cath, inf, per/cent/midline	H				
1752	Cath, hemodialysis,short-term	H				
1753	Cath, intravas ultrasound	H				
1754	Catheter, intradiscal	H				
1755	Catheter, intraspinal	H				
1756	Cath, pacing, transesoph	H				
1757	Cath, thrombectomy/embolect	H				
1758	Cath, ureteral	H				
1759	Cath, intra echocardiography	H				
1760	Closure dev, vasc, imp/insert	H				
1762	Conn tiss, human (inc fascia)	H				
1763	Conn tiss, non-human	H				
1764	Event recorder, cardiac	H				
1765	Adhesion barrier	H				
1766	Intro/sheath,strble,non-peel	H				
1767	Generator, neurostim, imp	H				
1768	Graft, vascular	H				
1769	Guide wire	H				
1770	Imaging coil, MR, insertable	H				
1771	Rep dev, urinary, w/sling	H				
1772	Infusion pump, programmable	H				
1773	Retrieval dev, insert	H				
1776	Joint device (implantable)	H				
1777	Lead, AICD, endo single coil	H				
1778	Lead, neurostimulator	H				

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

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1779	Lead, pmkr, transvenous VDD	H				
1780	Lens, intraocular	H				
1781	Mesh (implantable)	H				
1782	Morcellator	H				
1784	Ocular dev, intraop, det ret	H				
1785	Pmkr, dual, rate-resp	H				
1786	Pmkr, single, rate-resp	H				
1787	Patient progr, neurostim	H				
1788	Port, indwelling, imp	H				
1789	Prosthesis, breast, imp	H				
1813	Prosthesis, penile, inflatab	H				
1815	Pros, urinary sph, imp	H				
1816	Receiver/transmitter, neuro	H				
1817	Septal defect imp sys	H				
1874	Stent, coated/cov w/del sys	H				
1875	Stent, coated/cov w/o del sy	H				
1876	Stent, non-coa/no-cov w/del	H				
1877	Stent, non-coat/cov w/o del	H				
1878	Matrl for vocal cord	H				
1879	Tissue marker, imp	H				
1880	Vena cava filter	H				
1881	Dialysis access system	H				
1882	AICD, other than sing/dual	H				
1883	Adapt/ext, pacing/neuro lead	H				
1885	Cath, translumin angio laser	H				
1887	Catheter, guiding	H				
1891	Infusion pump,non-prog,perm	H				
1892	Intro/sheath,fixed,peel-away	H				
1893	Intro/sheath,fixed,non-peel	H				
1894	Intro/sheath, non-laser	H				
1895	Lead, AICD, endo dual coil	H				
1896	Lead, AICD, non sing/dual	H				
1897	Lead, neurostim test kit	H				
1898	Lead, pmkr, other than trans	H				
1899	Lead, pmkr/AICD combination	H				
2615	Sealant, pulmonary, liquid	H				
2616	Brachytx seed, Yttrium-90	H				
2617	Stent, non-cor, tem w/o del	H				
2618	Probe, cryoablation	H				
2619	Pmkr, dual, non rate-resp	H				
2620	Pmkr, single, non rate-resp	H				
2621	Pmkr, other than sing/dual	H				
2622	Prosthesis, penile, non-inf	H				
2625	Stent, non-cor, tem w/del sys	H				
2626	Infusion pump, non-prog,temp	H				
2627	Cath, suprapubic/cystoscopic	H				
2628	Catheter, occlusion	H				
2629	Intro/sheath, laser	H				
2630	Cath, EP, cool-tip	H				
2631	Rep dev, urinary, w/o sling	H				
7000	Amifostine, 500 mg	G		$392.06		$56.13
7001	Amphotericin B lipid complex, 50 mg	G		$109.25		$15.64
7003	Epoprostenol injection 0.5 mg	G		$12.04		$1.72
7005	Gonadorelin hydroch, 100 mcg	G		$192.37		$27.54
7007	Milrinone lactate, per 5 ml, inj	K	0.44	$22.40		$4.48
7010	Morphine sulfate (preservative free) 10 mg	G		$1.02		$.09
7011	Oprelvekin injection, 5 mg	G		$245.81		$35.19
7014	Fentanyl citrate injection	G		$1.23		$.11
7015	Busulfan, oral, 2 mg	G		$1.91		$.27
7019	Aprotinin, 10,000 kiu	G		$2.16		$.31
7022	Elliot's B solution, per ml	G		$1.43		$.20
7023	Bladder calculi irrig sol	G		$24.70		$3.54
7024	Corticorelin ovine triflutat	G		$368.03		$52.69
7025	Digoxin immune FAB (ovine)	G		$551.66		$78.97
7026	Ethanolamine oleate, 100 mg	G		$39.73		$5.69
7027	Fomepizole, 15 mg	G		$10.93		$1.56
7028	Fosphenytoin, 50 mg	G		$5.73		$.82
7029	Glatiramer acetate, per dose	G		$30.07		$4.30
7030	Hemin, per 1 mg	G		$.99		$.14
7031	Octreotide acetate injection	G		$138.08		$19.77
7032	Sermorelin acetate, 0.5 mg	G		$13.60		$1.95
7033	Somatrem, 5mg	G		$209.48		$29.99
7034	Somatropin injection	G		$39.90		$5.12
7035	Teniposide, 50 mg	G		$222.80		$31.90
7036	Urokinase 250,000 iu inj	K	6.41	$326.29		$65.26
7037	Urofollitropin, 75 iu	G		$73.29		$10.49
7038	Muromonab-CD3, 5 mg	G		$269.06		$38.52

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

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7039	Pegademase bovine inj 25 I.U	G		$139.33		$19.95
7040	Pentastarch 10% solution	G		$15.11		$2.16
7041	Tirofiban hydrochloride 12.5 mg	G		$436.41		$62.48
7042	Capecitabine, oral, 150 mg	G		$2.43		$.35
7043	Infliximab injection 10 mg	G		$63.24		$9.05
7045	Trimetrexate glucoronate	G		$118.75		$17.00
7046	Doxorubicin hcl liposome inj 10 mg	G		$358.95		$51.39
7048	Alteplase recombinant	K	0.36	$18.33		$3.67
7049	Filgrastim 480 mcg injection	G		$285.38		$36.65
7050	Prednisone oral	G		$.07		$.01
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$773.02
7315	Sodium hyaluronate injection, 5mg	G		$26.13		$3.74
9000	Na chromate Cr51, per 0.25mCi	G		$.52		$.07
9001	Linezolid inj, 200mg	G		$24.13		$3.45
9002	Tenecteplase, 50mg/vial	G		$2,612.50		$374.00
9003	Palivizumab, per 50mg	G		$664.49		$95.13
9004	Gemtuzumab ozogamicin inj,5mg	G		$1,929.69		$276.25
9005	Reteplase injection	G		$1,306.25		$187.00
9006	Tacrolimus inj	G		$113.15		$16.20
9007	Baclofen Intrathecal kit-1amp	G		$79.80		$11.42
9008	Baclofen refill kit—per 500 mcg	G		$11.69		$1.67
9009	Baclofen refill kit—per 2000 mcg	G		$49.12		$7.03
9010	Baclofen refill kit—per 4000 mcg	G		$43.08		$6.17
9011	Caffeine Citrate, inj,	G		$3.05		$.44
9012	Arsenic Trioxide	G		$23.75		$3.40
9013	Co 57 Cobaltous Cl	G		$81.10		$10.41
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	G		$6.51		$.93
9100	Iodinated I–131 albumin	G		$10.34		$1.48
9102	51 na chromate, per 50mCi	G		$64.84		$9.28
9103	Na iothalamate I–125, per 10 uci	G		$17.18		$2.46
9104	Anti-thymocyte globulin rabbit	G		$325.09		$46.54
9105	Hep B imm glob, per 1 ml	G		$133.00		$17.08
9106	Sirolimus, 1 mg	G		$6.51		$.93
9108	Thyrotropin alfa, per 1.1 mg	G		$531.05		$76.02
9109	Tirofliban hcl, per 6.25 mg	G		$207.81		$29.75
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	G		$592.60		$84.84
9500	Platelets, irradiated	K	1.68	$85.52		$17.10
9501	Platelets, pheresis	K	9.16	$466.28		$93.26
9502	Platelet pheresis irradiated	K	9.94	$505.99		$101.20
9503	Fresh frozen plasma, ea unit	K	1.56	$79.41		$15.88
9504	RBC deglycerolized	K	4.11	$209.22		$41.84
9505	RBC irradiated	K	2.44	$124.21		$24.84
9506	Granulocytes, pheresis	K	27.75	$1,412.59		$282.52

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*0001T	C	Endovas repr abdo ao aneurys					
*0002T	C	Endovas repr abdo ao aneurys					
*0003T	N	Cervicography					
*0005T	C	Perc cath stent/brain cv art					
*0006T	C	Perc cath stent/brain cv art					
*0007T	C	Perc cath stent/brain cv art					
*0008T	E	Upper gi endoscopy w/suture					
*0009T	T	Endometrial cryoablation	0193	11.16	$568.09	$171.13	$113.62

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	23.61	$1,201.84	$576.88	$240.37
*0013T	T	Osteochondral knee allograft	0041	23.61	$1,201.84	$576.88	$240.37
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	23.61	$1,201.84	$576.88	$240.37
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	0.66	$33.60	$17.47	$6.72
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, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
*0023T	A	Phenotype drug test, hiv 1					
*0024T	C	Transcath cardiac reduction					
*0025T	S	Ultrasonic pachymetry	0230	0.61	$31.05	$14.28	$6.21
*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					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
00850	D	Anesth, cesarean section					
*00851	N	Anesth, tubal ligation					
00855	D	Anesth, hysterectomy					
00857	D	Analgesia, labor & c-section					
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					
00884	D	Anesth, major vein revision					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					
00906	N	Anesth, removal of vulva					
00908	C	Anesth, removal of prostate					
00910	N	Anesth, bladder surgery					
00912	N	Anesth, bladder tumor surg					
00914	N	Anesth, removal of prostate					
00916	N	Anesth, bleeding control					
00918	N	Anesth, stone removal					
00920	N	Anesth, genitalia surgery					
00922	N	Anesth, sperm duct surgery					
00924	N	Anesth, testis exploration					
00926	N	Anesth, removal of testis					
00928	C	Anesth, removal of testis					
00930	N	Anesth, testis suspension					
00932	C	Anesth, amputation of penis					
00934	C	Anesth, penis, nodes removal					
00936	C	Anesth, penis, nodes removal					
00938	N	Anesth, insert penis device					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surg on vag/urethal					
00944	C	Anesth, vaginal hysterectomy					
00946	D	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
00955	D	Analgesia, vaginal delivery					
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, replacement of hip					
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, replacement of knee					
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					
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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
01904	D	Anesth, skull x-ray inject					
*01905	N	Anes, spine inject, x-ray/re					
01906	D	Anesth, lumbar myelography					
01908	D	Anesth, cervical myelography					
01910	D	Anesth, skull myelography					
01912	D	Anesth, lumbar diskography					
01914	D	Anesth, cervical diskography					
01916	N	Anesth, head arteriogram					
01918	D	Anesth, limb arteriogram					
01920	N	Anesth, catheterize heart					
01921	D	Anesth, vessel surgery					
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 1 percent					
01952	N	Anesth, burn, 1–9 percent					
01953	N	Anesth, burn, each 9 percent					
*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	0.42	$21.38	$11.75	$4.28
*10022	T	Fna w/image	0002	0.42	$21.38	$11.75	$4.28
10040	T	Acne surgery of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10060	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10061	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10080	T	Drainage of pilonidal cyst	0006	2.18	$110.97	$33.95	$22.19
10081	T	Drainage of pilonidal cyst	0007	6.75	$343.60	$72.03	$68.72
10120	T	Remove foreign body	0006	2.18	$110.97	$33.95	$22.19
10121	T	Remove foreign body	0020	8.44	$429.63	$130.53	$85.93
10140	T	Drainage of hematoma/fluid	0007	6.75	$343.60	$72.03	$68.72
10160	T	Puncture drainage of lesion	0018	1.05	$53.45	$17.66	$10.69
10180	T	Complex drainage, wound	0007	6.75	$343.60	$72.03	$68.72
11000	T	Debride infected skin	0015	2.07	$105.37	$31.20	$21.07

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	T	Debride infected skin add-on	0013	1.36	$69.23	$17.66	$13.85
11010	T	Debride skin, fx	0022	13.91	$708.07	$292.94	$141.61
11011	T	Debride skin/muscle, fx	0022	13.91	$708.07	$292.94	$141.61
11012	T	Debride skin/muscle/bone, fx	0022	13.91	$708.07	$292.94	$141.61
11040	T	Debride skin, partial	0015	2.07	$105.37	$31.20	$21.07
11041	T	Debride skin, full	0015	2.07	$105.37	$31.20	$21.07
11042	T	Debride skin/tissue	0016	3.02	$153.73	$64.57	$30.75
11043	T	Debride tissue/muscle	0016	3.02	$153.73	$64.57	$30.75
11044	T	Debride tissue/muscle/bone	0017	9.68	$492.75	$226.67	$98.55
11055	T	Trim skin lesion	0012	0.66	$33.60	$9.18	$6.72
11056	T	Trim skin lesions, 2 to 4	0012	0.66	$33.60	$9.18	$6.72
11057	T	Trim skin lesions, over 4	0012	0.66	$33.60	$9.18	$6.72
11100	T	Biopsy of skin lesion	0018	1.05	$53.45	$17.66	$10.69
11101	T	Biopsy, skin add-on	0018	1.05	$53.45	$17.66	$10.69
11200	T	Removal of skin tags	0013	1.36	$69.23	$17.66	$13.85
11201	T	Remove skin tags add-on	0015	2.07	$105.37	$31.20	$21.07
11300	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11301	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11302	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11303	T	Shave skin lesion	0015	2.07	$105.37	$31.20	$21.07
11305	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11306	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11307	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11308	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11310	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11311	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11312	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11313	T	Shave skin lesion	0016	3.02	$153.73	$64.57	$30.75
11400	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11401	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11402	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11403	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11404	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11406	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11420	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11421	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11422	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11423	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11424	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11426	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11440	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11441	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11442	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11443	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11444	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11446	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11450	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11451	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11462	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11463	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11470	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11471	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11600	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11601	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11602	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11603	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11604	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11606	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11620	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11621	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11622	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11623	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11624	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11626	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11640	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11641	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11642	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11643	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11644	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11646	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11719	T	Trim nail(s)	0009	0.63	$32.07	$8.34	$6.41
11720	T	Debride nail, 1–5	0009	0.63	$32.07	$8.34	$6.41
11721	T	Debride nail, 6 or more	0009	0.63	$32.07	$8.34	$6.41
11730	T	Removal of nail plate	0013	1.36	$69.23	$17.66	$13.85
11732	T	Remove nail plate, add-on	0012	0.66	$33.60	$9.18	$6.72

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11740	T	Drain blood from under nail	0009	0.63	$32.07	$8.34	$6.41
11750	T	Removal of nail bed	0019	4.22	$214.81	$78.91	$42.96
11752	T	Remove nail bed/finger tip	0022	13.91	$708.07	$292.94	$141.61
11755	T	Biopsy, nail unit	0019	4.22	$214.81	$78.91	$42.96
11760	T	Repair of nail bed	0024	2.28	$116.06	$41.78	$23.21
11762	T	Reconstruction of nail bed	0024	2.28	$116.06	$41.78	$23.21
11765	T	Excision of nail fold, toe	0015	2.07	$105.37	$31.20	$21.07
11770	T	Removal of pilonidal lesion	0021	11.82	$601.69	$236.51	$120.34
11771	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11772	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11900	T	Injection into skin lesions	0012	0.66	$33.60	$9.18	$6.72
11901	T	Added skin lesions injection	0012	0.66	$33.60	$9.18	$6.72
11920	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11921	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11922	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11950	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11951	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11952	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11954	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11960	T	Insert tissue expander(s)	0026	12.62	$642.41	$277.92	$128.48
11970	T	Replace tissue expander	0026	12.62	$642.41	$277.92	$128.48
11971	T	Remove tissue expander(s)	0022	13.91	$708.07	$292.94	$141.61
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	0019	4.22	$214.81	$78.91	$42.96
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
11980	X	Implant hormone pellet(s)	0340	0.84	$42.76	$10.69	$8.55
*11981	X	Insert drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11982	X	Remove drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11983	X	Remove/insert drug implant	0340	0.84	$42.76	$10.69	$8.55
12001	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12002	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12004	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12005	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12006	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12007	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12011	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12013	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12014	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12015	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12016	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12017	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12018	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12020	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12021	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12031	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12032	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12034	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12035	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12036	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12037	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12041	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12042	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12044	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12045	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12046	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12047	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12051	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12052	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12053	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12054	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12055	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12056	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12057	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
13100	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13101	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13102	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13120	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13121	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13122	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13131	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13132	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13133	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13150	T	Repair of wound or lesion	0026	12.62	$642.41	$277.92	$128.48
13151	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13152	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13153	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13160	T	Late closure of wound	0026	12.62	$642.41	$277.92	$128.48
14000	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14001	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14020	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14021	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14040	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14041	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14060	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14061	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14300	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14350	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
15000	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15001	T	Skin graft add-on	0026	12.62	$642.41	$277.92	$128.48
15050	T	Skin pinch graft	0026	12.62	$642.41	$277.92	$128.48
15100	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15101	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15120	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15121	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15200	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15201	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15220	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15221	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15240	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15241	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15260	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15261	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15342	T	Cultured skin graft, 25 cm	0025	3.39	$172.56	$65.57	$34.51
15343	T	Culture skn graft addl 25 cm	0025	3.39	$172.56	$65.57	$34.51
15350	T	Skin homograft	0686	24.01	$1,222.21	$277.92	$244.44
15351	T	Skin homograft add-on	0026	12.62	$642.41	$277.92	$128.48
15400	T	Skin heterograft	0026	12.62	$642.41	$277.92	$128.48
15401	T	Skin heterograft add-on	0026	12.62	$642.41	$277.92	$128.48
15570	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15572	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15574	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15576	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15600	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15610	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15620	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15630	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15650	T	Transfer skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15732	T	Muscle-skin graft, head/neck	0027	18.02	$917.29	$383.10	$183.46
15734	T	Muscle-skin graft, trunk	0027	18.02	$917.29	$383.10	$183.46
15736	T	Muscle-skin graft, arm	0027	18.02	$917.29	$383.10	$183.46
15738	T	Muscle-skin graft, leg	0027	18.02	$917.29	$383.10	$183.46
15740	T	Island pedicle flap graft	0027	18.02	$917.29	$383.10	$183.46
15750	T	Neurovascular pedicle graft	0027	18.02	$917.29	$383.10	$183.46
15756	C	Free muscle flap, microvasc					
15757	C	Free skin flap, microvasc					
15758	C	Free fascial flap, microvasc					
15760	T	Composite skin graft	0027	18.02	$917.29	$383.10	$183.46
15770	T	Derma-fat-fascia graft	0027	18.02	$917.29	$383.10	$183.46
15775	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15776	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15780	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15781	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15782	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15783	T	Abrasion treatment of skin	0016	3.02	$153.73	$64.57	$30.75
15786	T	Abrasion, lesion, single	0013	1.36	$69.23	$17.66	$13.85
15787	T	Abrasion, lesions, add-on	0013	1.36	$69.23	$17.66	$13.85
15788	T	Chemical peel, face, epiderm	0012	0.66	$33.60	$9.18	$6.72
15789	T	Chemical peel, face, dermal	0015	2.07	$105.37	$31.20	$21.07
15792	T	Chemical peel, nonfacial	0012	0.66	$33.60	$9.18	$6.72
15793	T	Chemical peel, nonfacial	0013	1.36	$69.23	$17.66	$13.85
15810	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15811	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15819	T	Plastic surgery, neck	0026	12.62	$642.41	$277.92	$128.48
15820	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15821	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15822	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15823	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15824	T	Removal of forehead wrinkles	0027	18.02	$917.29	$383.10	$183.46
15825	T	Removal of neck wrinkles	0026	12.62	$642.41	$277.92	$128.48
15826	T	Removal of brow wrinkles	0026	12.62	$642.41	$277.92	$128.48

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15828	T	Removal of face wrinkles	0027	18.02	$917.29	$383.10	$183.46
15829	T	Removal of skin wrinkles	0026	12.62	$642.41	$277.92	$128.48
15831	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15832	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15833	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15834	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15835	T	Excise excessive skin tissue	0026	12.62	$642.41	$277.92	$128.48
15836	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15837	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15838	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15839	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15840	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15841	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15842	T	Flap for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15845	T	Skin and muscle repair, face	0027	18.02	$917.29	$383.10	$183.46
15850	T	Removal of sutures	0016	3.02	$153.73	$64.57	$30.75
15851	T	Removal of sutures	0013	1.36	$69.23	$17.66	$13.85
15852	T	Dressing change, not for burn	0013	1.36	$69.23	$17.66	$13.85
15860	N	Test for blood flow in graft	.....	.....	.....	.....	.....
15876	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15877	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15878	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15879	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15920	T	Removal of tail bone ulcer	0022	13.91	$708.07	$292.94	$141.61
15922	T	Removal of tail bone ulcer	0027	18.02	$917.29	$383.10	$183.46
15931	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15933	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15934	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15935	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15936	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15937	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15940	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15941	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15944	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15945	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15946	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15950	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15951	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15952	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15953	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15956	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15958	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15999	T	Removal of pressure sore	0022	13.91	$708.07	$292.94	$141.61
16000	T	Initial treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16010	T	Treatment of burn(s)	0016	3.02	$153.73	$64.57	$30.75
16015	T	Treatment of burn(s)	0017	9.68	$492.75	$226.67	$98.55
16020	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16025	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16030	T	Treatment of burn(s)	0015	2.07	$105.37	$31.20	$21.07
16035	C	Incision of burn scab, initi	.....	.....	.....	.....	.....
16036	C	Incise burn scab, addl incis	.....	.....	.....	.....	.....
17000	T	Destroy benign/premal lesion	0010	0.66	$33.60	$9.86	$6.72
17003	T	Destroy lesions, 2–14	0010	0.66	$33.60	$9.86	$6.72
17004	T	Destroy lesions, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17106	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17107	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17108	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17110	T	Destruct lesion, 1–14	0010	0.66	$33.60	$9.86	$6.72
17111	T	Destruct lesion, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17250	T	Chemical cautery, tissue	0013	1.36	$69.23	$17.66	$13.85
17260	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17261	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17262	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17263	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17264	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17266	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17270	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17271	T	Destruction of skin lesions	0012	0.66	$33.60	$9.18	$6.72
17272	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17273	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17274	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17276	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17280	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17281	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17282	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17283	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17284	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17286	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17304	T	Chemosurgery of skin lesion	0694	3.99	$203.11	$60.93	$40.62
17305	T	2nd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17306	T	3rd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17307	T	Followup skin lesion therapy	0694	3.99	$203.11	$60.93	$40.62
17310	T	Extensive skin chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17340	T	Cryotherapy of skin	0012	0.66	$33.60	$9.18	$6.72
17360	T	Skin peel therapy	0012	0.66	$33.60	$9.18	$6.72
17380	T	Hair removal by electrolysis	0017	9.68	$492.75	$226.67	$98.55
17999	T	Skin tissue procedure	0004	2.47	$125.73	$32.57	$25.15
19000	T	Drainage of breast lesion	0004	2.47	$125.73	$32.57	$25.15
19001	T	Drain breast lesion add-on	0004	2.47	$125.73	$32.57	$25.15
19020	T	Incision of breast lesion	0008	10.93	$556.38	$113.67	$111.28
19030	N	Injection for breast x-ray					
19100	T	Bx breast percut w/o image	0005	4.03	$205.14	$90.26	$41.03
19101	T	Biopsy of breast, open	0028	14.00	$712.66	$303.74	$142.53
19102	T	Bx breast percut w/image	0005	4.03	$205.14	$90.26	$41.03
19103	S	Bx breast percut w/device	0710		$400.00		$80.00
19110	T	Nipple exploration	0028	14.00	$712.66	$303.74	$142.53
19112	T	Excise breast duct fistula	0028	14.00	$712.66	$303.74	$142.53
19120	T	Removal of breast lesion	0028	14.00	$712.66	$303.74	$142.53
19125	T	Excision, breast lesion	0028	14.00	$712.66	$303.74	$142.53
19126	T	Excision, addl breast lesion	0028	14.00	$712.66	$303.74	$142.53
19140	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19160	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19162	T	Remove breast tissue, nodes	0693	31.81	$1,619.26	$712.47	$323.85
19180	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19182	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	T	Removal of breast	0030	34.20	$1,740.92	$763.55	$348.18
19260	T	Removal of chest wall lesion	0021	11.82	$601.69	$236.51	$120.34
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	N	Place breast clip, percut					
19316	T	Suspension of breast	0029	23.76	$1,209.48	$628.93	$241.90
19318	T	Reduction of large breast	0693	31.81	$1,619.26	$712.47	$323.85
19324	T	Enlarge breast	0693	31.81	$1,619.26	$712.47	$323.85
19325	T	Enlarge breast with implant	0693	31.81	$1,619.26	$712.47	$323.85
19328	T	Removal of breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19330	T	Removal of implant material	0029	23.76	$1,209.48	$628.93	$241.90
19340	T	Immediate breast prosthesis	0030	34.20	$1,740.92	$763.55	$348.18
19342	T	Delayed breast prosthesis	0693	31.81	$1,619.26	$712.47	$323.85
19350	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19355	T	Correct inverted nipple(s)	0029	23.76	$1,209.48	$628.93	$241.90
19357	T	Breast reconstruction	0693	31.81	$1,619.26	$712.47	$323.85
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19371	T	Removal of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19380	T	Revise breast reconstruction	0030	34.20	$1,740.92	$763.55	$348.18
19396	T	Design custom breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19499	T	Breast surgery procedure	0028	14.00	$712.66	$303.74	$142.53
20000	T	Incision of abscess	0006	2.18	$110.97	$33.95	$22.19
20005	T	Incision of deep abscess	0049	15.84	$806.32	$356.95	$161.26
20100	T	Explore wound, neck	0023	2.08	$105.88	$40.37	$21.18
20101	T	Explore wound, chest	0026	12.62	$642.41	$277.92	$128.48
20102	T	Explore wound, abdomen	0026	12.62	$642.41	$277.92	$128.48
20103	T	Explore wound, extremity	0023	2.08	$105.88	$40.37	$21.18
20150	T	Excise epiphyseal bar	0051	28.56	$1,453.82	$675.24	$290.76
20200	T	Muscle biopsy	0020	8.44	$429.63	$130.53	$85.93
20205	T	Deep muscle biopsy	0021	11.82	$601.69	$236.51	$120.34
20206	T	Needle biopsy, muscle	0005	4.03	$205.14	$90.26	$41.03
20220	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20225	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20240	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61
20245	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20250	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20251	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20500	T	Injection of sinus tract	0251	2.43	$123.70	$27.99	$24.74
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	4.22	$214.81	$78.91	$42.96
20525	T	Removal of foreign body	0022	13.91	$708.07	$292.94	$141.61
*20526	T	Ther injection carpal tunnel	0204	2.24	$114.02	$43.33	$22.80
20550	T	Inject tendon/ligament/cyst	0204	2.24	$114.02	$43.33	$22.80
*20551	T	Inject tendon origin/insert	0204	2.24	$114.02	$43.33	$22.80
*20552	T	Inject trigger point, 1 or 2	0204	2.24	$114.02	$43.33	$22.80
*20553	T	Inject trigger points, > 3	0204	2.24	$114.02	$43.33	$22.80
20600	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20605	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20610	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20615	T	Treatment of bone cyst	0004	2.47	$125.73	$32.57	$25.15
20650	T	Insert and remove bone pin	0049	15.84	$806.32	$356.95	$161.26
20660	C	Apply,remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	0021	11.82	$601.69	$236.51	$120.34
20680	T	Removal of support implant	0022	13.91	$708.07	$292.94	$141.61
20690	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20692	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20693	T	Adjust bone fixation device	0049	15.84	$806.32	$356.95	$161.26
20694	T	Remove bone fixation device	0049	15.84	$806.32	$356.95	$161.26
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	20.63	$1,050.15	$504.07	$210.03
20902	T	Removal of bone for graft	0050	20.63	$1,050.15	$504.07	$210.03
20910	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20912	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20920	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20922	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20924	T	Removal of tendon for graft	0050	20.63	$1,050.15	$504.07	$210.03
20926	T	Removal of tissue for graft	0026	12.62	$642.41	$277.92	$128.48
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	2.18	$110.97	$33.95	$22.19
20955	C	Fibula bone graft, microvasc					
20956	C	Iliac bone graft, microvasc					
20957	C	Mt bone graft, microvasc					
20962	C	Other bone graft, microvasc					
20969	C	Bone/skin graft, microvasc					
20970	C	Bone/skin graft, iliac crest					
20972	C	Bone/skin graft, metatarsal					
20973	C	Bone/skin graft, great toe					
20974	A	Electrical bone stimulation					
20975	T	Electrical bone stimulation	0049	15.84	$806.32	$356.95	$161.26
20979	A	Us bone stimulation					
20999	N	Musculoskeletal surgery					
21010	T	Incision of jaw joint	0254	17.37	$884.20	$272.41	$176.84
21015	T	Resection of facial tumor	0252	5.95	$302.88	$114.24	$60.58
21025	T	Excision of bone, lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21026	T	Excision of facial bone(s)	0256	26.61	$1,354.56	$623.05	$270.91
21029	T	Contour of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21030	T	Removal of face bone lesion	0254	17.37	$884.20	$272.41	$176.84
21031	T	Remove exostosis, mandible	0254	17.37	$884.20	$272.41	$176.84
21032	T	Remove exostosis, maxilla	0254	17.37	$884.20	$272.41	$176.84
21034	T	Removal of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21040	T	Removal of jaw bone lesion	0254	17.37	$884.20	$272.41	$176.84
21041	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21044	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21045	C	Extensive jaw surgery					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21050	T	Removal of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21060	T	Remove jaw joint cartilage	0256	26.61	$1,354.56	$623.05	$270.91
21070	T	Remove coronoid process	0256	26.61	$1,354.56	$623.05	$270.91
21076	T	Prepare face/oral prosthesis	0254	17.37	$884.20	$272.41	$176.84
21077	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21079	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21080	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21081	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21082	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21083	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21084	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21085	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21086	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21087	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21088	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21089	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21100	T	Maxillofacial fixation	0256	26.61	$1,354.56	$623.05	$270.91
21110	T	Interdental fixation	0252	5.95	$302.88	$114.24	$60.58
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21121	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21122	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21123	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21125	T	Augmentation, lower jaw bone	0254	17.37	$884.20	$272.41	$176.84
21127	T	Augmentation, lower jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21137	T	Reduction of forehead	0254	17.37	$884.20	$272.41	$176.84
21138	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
21139	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
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	17.37	$884.20	$272.41	$176.84
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					
21198	T	Reconstr lwr jaw segment	0256	26.61	$1,354.56	$623.05	$270.91
21199	T	Reconstr lwr jaw w/advance	0256	26.61	$1,354.56	$623.05	$270.91
21206	T	Reconstruct upper jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21208	T	Augmentation of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21209	T	Reduction of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21210	T	Face bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21215	T	Lower jaw bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21230	T	Rib cartilage graft	0256	26.61	$1,354.56	$623.05	$270.91
21235	T	Ear cartilage graft	0254	17.37	$884.20	$272.41	$176.84
21240	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21242	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21243	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21244	T	Reconstruction of lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21245	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21246	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21249	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21261	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21263	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21267	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	26.61	$1,354.56	$623.05	$270.91
21275	T	Revision, orbitofacial bones	0256	26.61	$1,354.56	$623.05	$270.91
21280	T	Revision of eyelid	0256	26.61	$1,354.56	$623.05	$270.91
21282	T	Revision of eyelid	0253	12.33	$627.65	$284.00	$125.53
21295	T	Revision of jaw muscle/bone	0252	5.95	$302.88	$114.24	$60.58
21296	T	Revision of jaw muscle/bone	0254	17.37	$884.20	$272.41	$176.84
21299	T	Cranio/maxillofacial surgery	0253	12.33	$627.65	$284.00	$125.53
21300	T	Treatment of skull fracture	0253	12.33	$627.65	$284.00	$125.53
21310	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21315	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21320	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21325	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21330	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21335	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21336	T	Treat nasal septal fracture	0046	27.69	$1,409.53	$535.76	$281.91
21337	T	Treat nasal septal fracture	0253	12.33	$627.65	$284.00	$125.53
21338	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21339	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21340	T	Treatment of nose fracture	0256	26.61	$1,354.56	$623.05	$270.91
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	17.37	$884.20	$272.41	$176.84
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	26.61	$1,354.56	$623.05	$270.91
21356	C	Treat cheek bone fracture					
21360	C	Treat cheek bone fracture					
21365	C	Treat cheek bone fracture					
21366	C	Treat cheek bone fracture					
21385	C	Treat eye socket fracture					
21386	C	Treat eye socket fracture					
21387	C	Treat eye socket fracture					
21390	C	Treat eye socket fracture					
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	5.95	$302.88	$114.24	$60.58
21401	T	Treat eye socket fracture	0253	12.33	$627.65	$284.00	$125.53
21406	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21407	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	17.37	$884.20	$272.41	$176.84
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	17.37	$884.20	$272.41	$176.84
21445	T	Treat dental ridge fracture	0254	17.37	$884.20	$272.41	$176.84
21450	T	Treat lower jaw fracture	0251	2.43	$123.70	$27.99	$24.74
21451	T	Treat lower jaw fracture	0252	5.95	$302.88	$114.24	$60.58
21452	T	Treat lower jaw fracture	0253	12.33	$627.65	$284.00	$125.53
21453	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21454	T	Treat lower jaw fracture	0254	17.37	$884.20	$272.41	$176.84
21461	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21462	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21465	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21470	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21480	T	Reset dislocated jaw	0251	2.43	$123.70	$27.99	$24.74
21485	T	Reset dislocated jaw	0253	12.33	$627.65	$284.00	$125.53
21490	T	Repair dislocated jaw	0256	26.61	$1,354.56	$623.05	$270.91
21493	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21494	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	12.33	$627.65	$284.00	$125.53
21499	T	Head surgery procedure	0253	12.33	$627.65	$284.00	$125.53
21501	T	Drain neck/chest lesion	0008	10.93	$556.38	$113.67	$111.28
21502	T	Drain chest lesion	0049	15.84	$806.32	$356.95	$161.26
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0019	4.22	$214.81	$78.91	$42.96
21555	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21556	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
21610	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
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	0006	2.18	$110.97	$33.95	$22.19
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0008	10.93	$556.38	$113.67	$111.28
21725	T	Revision of neck muscle	0006	2.18	$110.97	$33.95	$22.19
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	4.05	$206.16		$41.23
21805	T	Treatment of rib fracture	0046	27.69	$1,409.53	$535.76	$281.91
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0044	2.52	$128.28	$38.08	$25.66
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	5.95	$302.88	$114.24	$60.58
21920	T	Biopsy soft tissue of back	0019	4.22	$214.81	$78.91	$42.96
21925	T	Biopsy soft tissue of back	0022	13.91	$708.07	$292.94	$141.61
21930	T	Remove lesion, back or flank	0022	13.91	$708.07	$292.94	$141.61
21935	T	Remove tumor, back	0022	13.91	$708.07	$292.94	$141.61
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
22110	C	Remove part of neck vertebra					
22112	C	Remove part, thorax vertebra					
22114	C	Remove part, lumbar vertebra					
22116	C	Remove extra spine segment					
22210	C	Revision of neck spine					
22212	C	Revision of thorax spine					
22214	C	Revision of lumbar spine					
22216	C	Revise, extra spine segment					
22220	C	Revision of neck spine					
22222	C	Revision of thorax spine					
22224	C	Revision of lumbar spine					
22226	C	Revise, extra spine segment					
22305	T	Treat spine process fracture	0043	4.05	$206.16		$41.23
22310	T	Treat spine fracture	0043	4.05	$206.16		$41.23
22315	T	Treat spine fracture	0043	4.05	$206.16		$41.23
22318	C	Treat odontoid fx w/o graft					
22319	C	Treat odontoid fx w/graft					
22325	C	Treat spine fracture					
22326	C	Treat neck spine fracture					
22327	C	Treat thorax spine fracture					
22328	C	Treat each add spine fx					
22505	T	Manipulation of spine	0045	11.67	$594.05	$277.12	$118.81
22520	T	Percut vertebroplasty thor	0050	20.63	$1,050.15	$504.07	$210.03
22521	T	Percut vertebroplasty lumb	0050	20.63	$1,050.15	$504.07	$210.03
22522	T	Percut vertebroplasty addl	0050	20.63	$1,050.15	$504.07	$210.03
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	4.05	$206.16		$41.23
22900	T	Remove abdominal wall lesion	0022	13.91	$708.07	$292.94	$141.61
22999	T	Abdomen surgery procedure	0022	13.91	$708.07	$292.94	$141.61
23000	T	Removal of calcium deposits	0021	11.82	$601.69	$236.51	$120.34
23020	T	Release shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23030	T	Drain shoulder lesion	0008	10.93	$556.38	$113.67	$111.28
23031	T	Drain shoulder bursa	0008	10.93	$556.38	$113.67	$111.28
23035	C	Drain shoulder bone lesion					
23040	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23044	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23065	T	Biopsy shoulder tissues	0021	11.82	$601.69	$236.51	$120.34
23066	T	Biopsy shoulder tissues	0022	13.91	$708.07	$292.94	$141.61
23075	T	Removal of shoulder lesion	0021	11.82	$601.69	$236.51	$120.34
23076	T	Removal of shoulder lesion	0022	13.91	$708.07	$292.94	$141.61
23077	T	Remove tumor of shoulder	0022	13.91	$708.07	$292.94	$141.61
23100	T	Biopsy of shoulder joint	0049	15.84	$806.32	$356.95	$161.26
23101	T	Shoulder joint surgery	0050	20.63	$1,050.15	$504.07	$210.03
23105	T	Remove shoulder joint lining	0050	20.63	$1,050.15	$504.07	$210.03
23106	T	Incision of collarbone joint	0050	20.63	$1,050.15	$504.07	$210.03
23107	T	Explore treat shoulder joint	0050	20.63	$1,050.15	$504.07	$210.03
23120	T	Partial removal, collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23125	C	Removal of collar bone					
23130	T	Remove shoulder bone, part	0051	28.56	$1,453.82	$675.24	$290.76
23140	T	Removal of bone lesion	0049	15.84	$806.32	$356.95	$161.26
23145	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23146	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23150	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23155	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23156	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23170	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23172	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23174	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23180	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23182	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23184	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23190	T	Partial removal of scapula	0050	20.63	$1,050.15	$504.07	$210.03
23195	C	Removal of head of humerus					
23200	C	Removal of collar bone					
23210	C	Removal of shoulder blade					
23220	C	Partial removal of humerus					
23221	C	Partial removal of humerus					
23222	C	Partial removal of humerus					
23330	T	Remove shoulder foreign body	0019	4.22	$214.81	$78.91	$42.96
23331	T	Remove shoulder foreign body	0022	13.91	$708.07	$292.94	$141.61
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	C	Muscle transfer,shoulder/arm					
23397	C	Muscle transfers					
23400	C	Fixation of shoulder blade					
23405	T	Incision of tendon & muscle	0050	20.63	$1,050.15	$504.07	$210.03
23406	T	Incise tendon(s) & muscle(s)	0050	20.63	$1,050.15	$504.07	$210.03
23410	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23412	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23415	T	Release of shoulder ligament	0051	28.56	$1,453.82	$675.24	$290.76
23420	T	Repair of shoulder	0052	35.94	$1,829.49	$930.91	$365.90
23430	T	Repair biceps tendon	0052	35.94	$1,829.49	$930.91	$365.90
23440	T	Remove/transplant tendon	0052	35.94	$1,829.49	$930.91	$365.90
23450	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23455	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23460	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23462	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23465	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23466	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23470	T	Reconstruct shoulder joint	0048	43.19	$2,198.54	$725.94	$439.71
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23485	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23490	T	Reinforce clavicle	0051	28.56	$1,453.82	$675.24	$290.76
23491	T	Reinforce shoulder bones	0051	28.56	$1,453.82	$675.24	$290.76
23500	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23505	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23515	T	Treat clavicle fracture	0046	27.69	$1,409.53	$535.76	$281.91
23520	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23525	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23530	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23532	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23540	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23545	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23550	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23552	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23570	T	Treat shoulder blade fx	0043	4.05	$206.16		$41.23
23575	T	Treat shoulder blade fx	0044	2.52	$128.28	$38.08	$25.66
23585	T	Treat scapula fracture	0046	27.69	$1,409.53	$535.76	$281.91
23600	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23605	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23615	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23616	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23620	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23625	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23630	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23650	T	Treat shoulder dislocation	0043	4.05	$206.16		$41.23
23655	T	Treat shoulder dislocation	0045	11.67	$594.05	$277.12	$118.81
23660	T	Treat shoulder dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23665	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23670	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23675	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23680	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23700	T	Fixation of shoulder	0045	11.67	$594.05	$277.12	$118.81
23800	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23802	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
23929	T	Shoulder surgery procedure	0043	4.05	$206.16		$41.23
23930	T	Drainage of arm lesion	0008	10.93	$556.38	$113.67	$111.28
23931	T	Drainage of arm bursa	0006	2.18	$110.97	$33.95	$22.19
23935	T	Drain arm/elbow bone lesion	0049	15.84	$806.32	$356.95	$161.26
24000	T	Exploratory elbow surgery	0050	20.63	$1,050.15	$504.07	$210.03
24006	T	Release elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24065	T	Biopsy arm/elbow soft tissue	0020	8.44	$429.63	$130.53	$85.93
24066	T	Biopsy arm/elbow soft tissue	0021	11.82	$601.69	$236.51	$120.34
24075	T	Remove arm/elbow lesion	0021	11.82	$601.69	$236.51	$120.34
24076	T	Remove arm/elbow lesion	0022	13.91	$708.07	$292.94	$141.61
24077	T	Remove tumor of arm/elbow	0022	13.91	$708.07	$292.94	$141.61
24100	T	Biopsy elbow joint lining	0049	15.84	$806.32	$356.95	$161.26
24101	T	Explore/treat elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24102	T	Remove elbow joint lining	0050	20.63	$1,050.15	$504.07	$210.03
24105	T	Removal of elbow bursa	0049	15.84	$806.32	$356.95	$161.26
24110	T	Remove humerus lesion	0049	15.84	$806.32	$356.95	$161.26
24115	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24116	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24120	T	Remove elbow lesion	0049	15.84	$806.32	$356.95	$161.26
24125	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24126	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24130	T	Removal of head of radius	0050	20.63	$1,050.15	$504.07	$210.03
24134	T	Removal of arm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24136	T	Remove radius bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24138	T	Remove elbow bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24140	T	Partial removal of arm bone	0050	20.63	$1,050.15	$504.07	$210.03
24145	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
24147	T	Partial removal of elbow	0050	20.63	$1,050.15	$504.07	$210.03
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24152	C	Extensive radius surgery	.....	.....	.....	.....	.....
24153	C	Extensive radius surgery	.....	.....	.....	.....	.....
24155	T	Removal of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24160	T	Remove elbow joint implant	0050	20.63	$1,050.15	$504.07	$210.03
24164	T	Remove radius head implant	0050	20.63	$1,050.15	$504.07	$210.03
24200	T	Removal of arm foreign body	0019	4.22	$214.81	$78.91	$42.96
24201	T	Removal of arm foreign body	0021	11.82	$601.69	$236.51	$120.34
24220	N	Injection for elbow x-ray	.....	.....	.....	.....	.....
*24300	T	Manipulate elbow w/anesth	0045	11.67	$594.05	$277.12	$118.81
24301	T	Muscle/tendon transfer	0050	20.63	$1,050.15	$504.07	$210.03
24305	T	Arm tendon lengthening	0050	20.63	$1,050.15	$504.07	$210.03
24310	T	Revision of arm tendon	0049	15.84	$806.32	$356.95	$161.26
24320	T	Repair of arm tendon	0051	28.56	$1,453.82	$675.24	$290.76
24330	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
24331	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
*24332	T	Tenolysis, triceps	0049	15.84	$806.32	$356.95	$161.26
24340	T	Repair of biceps tendon	0051	28.56	$1,453.82	$675.24	$290.76
24341	T	Repair arm tendon/muscle	0051	28.56	$1,453.82	$675.24	$290.76
24342	T	Repair of ruptured tendon	0051	28.56	$1,453.82	$675.24	$290.76
*24343	T	Repr elbow lat ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24344	T	Reconstruct elbow lat ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
*24345	T	Repr elbw med ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24346	T	Reconstruct elbow med ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
24350	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24351	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24352	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24354	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24356	T	Revision of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24360	T	Reconstruct elbow joint	0047	26.36	$1,341.83	$537.03	$268.37
24361	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24362	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24363	T	Replace elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24365	T	Reconstruct head of radius	0047	26.36	$1,341.83	$537.03	$268.37
24366	T	Reconstruct head of radius	0048	43.19	$2,198.54	$725.94	$439.71
24400	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24410	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24420	T	Revision of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24430	T	Repair of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24435	T	Repair humerus with graft	0051	28.56	$1,453.82	$675.24	$290.76
24470	T	Revision of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24495	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
24498	T	Reinforce humerus	0051	28.56	$1,453.82	$675.24	$290.76
24500	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24505	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24515	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24516	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24530	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24535	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24538	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24545	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24546	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24560	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24565	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24566	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24575	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24576	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24577	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24579	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24582	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24586	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24587	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24600	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24605	T	Treat elbow dislocation	0045	11.67	$594.05	$277.12	$118.81
24615	T	Treat elbow dislocation	0046	27.69	$1,409.53	$535.76	$281.91
24620	T	Treat elbow fracture	0044	2.52	$128.28	$38.08	$25.66
24635	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24640	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24650	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24655	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24665	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24666	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24670	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24675	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24685	T	Treat ulnar fracture	0046	27.69	$1,409.53	$535.76	$281.91
24800	T	Fusion of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24802	T	Fusion/graft of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24900	C	Amputation of upper arm	.....	.....	.....	.....	.....
24920	C	Amputation of upper arm	.....	.....	.....	.....	.....
24925	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
24930	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
24931	C	Amputate upper arm & implant	.....	.....	.....	.....	.....
24935	T	Revision of amputation	0052	35.94	$1,829.49	$930.91	$365.90
24940	C	Revision of upper arm	.....	.....	.....	.....	.....
24999	T	Upper arm/elbow surgery	0044	2.52	$128.28	$38.08	$25.66
25000	T	Incision of tendon sheath	0049	15.84	$806.32	$356.95	$161.26
*25001	T	Incise flexor carpi radialis	0049	15.84	$806.32	$356.95	$161.26
25020	T	Decompression of forearm	0049	15.84	$806.32	$356.95	$161.26
25023	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
*25024	T	Decompress forearm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
*25025	T	Decompress forarm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
25028	T	Drainage of forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25031	T	Drainage of forearm bursa	0049	15.84	$806.32	$356.95	$161.26
25035	T	Treat forearm bone lesion	0049	15.84	$806.32	$356.95	$161.26
25040	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25065	T	Biopsy forearm soft tissues	0021	11.82	$601.69	$236.51	$120.34
25066	T	Biopsy forearm soft tissues	0022	13.91	$708.07	$292.94	$141.61
25075	T	Removal of forearm lesion	0020	8.44	$429.63	$130.53	$85.93
25076	T	Removal of forearm lesion	0022	13.91	$708.07	$292.94	$141.61
25077	T	Remove tumor, forearm/wrist	0022	13.91	$708.07	$292.94	$141.61
25085	T	Incision of wrist capsule	0049	15.84	$806.32	$356.95	$161.26
25100	T	Biopsy of wrist joint	0049	15.84	$806.32	$356.95	$161.26
25101	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25105	T	Remove wrist joint lining	0050	20.63	$1,050.15	$504.07	$210.03
25107	T	Remove wrist joint cartilage	0050	20.63	$1,050.15	$504.07	$210.03
25110	T	Remove wrist tendon lesion	0049	15.84	$806.32	$356.95	$161.26
25111	T	Remove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25112	T	Reremove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25115	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25116	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25118	T	Excise wrist tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25119	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25120	T	Removal of forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25125	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25126	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25130	T	Removal of wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25135	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25136	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25145	T	Remove forearm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
25150	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25151	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25170	C	Extensive forearm surgery	.....	.....	.....	.....	.....
25210	T	Removal of wrist bone	0054	19.83	$1,009.43	$472.33	$201.89
25215	T	Removal of wrist bones	0054	19.83	$1,009.43	$472.33	$201.89
25230	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25240	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25246	N	Injection for wrist x-ray	.....	.....	.....	.....	.....
25248	T	Remove forearm foreign body	0049	15.84	$806.32	$356.95	$161.26
25250	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
25251	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
*25259	T	Manipulate wrist w/anesthes	0044	2.52	$128.28	$38.08	$25.66
25260	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25263	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25265	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25270	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25272	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25274	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
*25275	T	Repair forearm tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25280	T	Revise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25290	T	Incise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25295	T	Release wrist/forearm tendon	0049	15.84	$806.32	$356.95	$161.26
25300	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25301	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25310	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25312	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25315	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25316	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25320	T	Repair/revise wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25332	T	Revise wrist joint	0047	26.36	$1,341.83	$537.03	$268.37
25335	T	Realignment of hand	0051	28.56	$1,453.82	$675.24	$290.76
25337	T	Reconstruct ulna/radioulnar	0051	28.56	$1,453.82	$675.24	$290.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25350	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25355	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25360	T	Revision of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25365	T	Revise radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25370	T	Revise radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25375	T	Revise radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
25390	C	Shorten radius or ulna					
25391	C	Lengthen radius or ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
*25394	T	Repair carpal bone, shorten	0053	11.69	$595.07	$253.49	$119.01
25400	T	Repair radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25405	T	Repair/graft radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25415	T	Repair radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25426	T	Repair/graft radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
*25430	T	Vasc graft into carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
*25431	T	Repair nonunion carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
25440	T	Repair/graft wrist bone	0051	28.56	$1,453.82	$675.24	$290.76
25441	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25442	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25443	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25444	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25445	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25446	T	Wrist replacement	0048	43.19	$2,198.54	$725.94	$439.71
25447	T	Repair wrist joint(s)	0047	26.36	$1,341.83	$537.03	$268.37
25449	T	Remove wrist joint implant	0047	26.36	$1,341.83	$537.03	$268.37
25450	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25455	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25490	T	Reinforce radius	0051	28.56	$1,453.82	$675.24	$290.76
25491	T	Reinforce ulna	0051	28.56	$1,453.82	$675.24	$290.76
25492	T	Reinforce radius and ulna	0051	28.56	$1,453.82	$675.24	$290.76
25500	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25505	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25515	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25520	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25525	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25526	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25530	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25535	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25545	T	Treat fracture of ulna	0046	27.69	$1,409.53	$535.76	$281.91
25560	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25565	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25574	T	Treat fracture radius & ulna	0046	27.69	$1,409.53	$535.76	$281.91
25575	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25600	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25605	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25611	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25620	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25622	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25624	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25628	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25630	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25635	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25645	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25650	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
*25651	T	Pin ulnar styloid fracture	0046	27.69	$1,409.53	$535.76	$281.91
*25652	T	Treat fracture ulnar styloid	0046	27.69	$1,409.53	$535.76	$281.91
25660	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25670	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
*25671	T	Pin radioulnar dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25675	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25676	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25680	T	Treat wrist fracture	0044	2.52	$128.28	$38.08	$25.66
25685	T	Treat wrist fracture	0046	27.69	$1,409.53	$535.76	$281.91
25690	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25695	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25800	T	Fusion of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25805	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25810	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25820	T	Fusion of hand bones	0053	11.69	$595.07	$253.49	$119.01
25825	T	Fuse hand bones with graft	0054	19.83	$1,009.43	$472.33	$201.89
25830	T	Fusion, radioulnar jnt/ulna	0051	28.56	$1,453.82	$675.24	$290.76
25900	C	Amputation of forearm					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25905	C	Amputation of forearm	.....	.....	.....	.....	.....
25907	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
25909	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25915	C	Amputation of forearm	.....	.....	.....	.....	.....
25920	C	Amputate hand at wrist	.....	.....	.....	.....	.....
25922	T	Amputate hand at wrist	0049	15.84	$806.32	$356.95	$161.26
25924	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25927	C	Amputation of hand	.....	.....	.....	.....	.....
25929	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
25931	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25999	T	Forearm or wrist surgery	0044	2.52	$128.28	$38.08	$25.66
26010	T	Drainage of finger abscess	0006	2.18	$110.97	$33.95	$22.19
26011	T	Drainage of finger abscess	0007	6.75	$343.60	$72.03	$68.72
26020	T	Drain hand tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26025	T	Drainage of palm bursa	0053	11.69	$595.07	$253.49	$119.01
26030	T	Drainage of palm bursa(s)	0053	11.69	$595.07	$253.49	$119.01
26034	T	Treat hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26035	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26037	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26040	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26045	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26055	T	Incise finger tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26060	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26070	T	Explore/treat hand joint	0053	11.69	$595.07	$253.49	$119.01
26075	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26080	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26100	T	Biopsy hand joint lining	0053	11.69	$595.07	$253.49	$119.01
26105	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26110	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26115	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26116	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26117	T	Remove tumor, hand/finger	0022	13.91	$708.07	$292.94	$141.61
26121	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26123	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26125	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26130	T	Remove wrist joint lining	0053	11.69	$595.07	$253.49	$119.01
26135	T	Revise finger joint, each	0054	19.83	$1,009.43	$472.33	$201.89
26140	T	Revise finger joint, each	0053	11.69	$595.07	$253.49	$119.01
26145	T	Tendon excision, palm/finger	0053	11.69	$595.07	$253.49	$119.01
26160	T	Remove tendon sheath lesion	0053	11.69	$595.07	$253.49	$119.01
26170	T	Removal of palm tendon, each	0053	11.69	$595.07	$253.49	$119.01
26180	T	Removal of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26185	T	Remove finger bone	0053	11.69	$595.07	$253.49	$119.01
26200	T	Remove hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26205	T	Remove/graft bone lesion	0054	19.83	$1,009.43	$472.33	$201.89
26210	T	Removal of finger lesion	0053	11.69	$595.07	$253.49	$119.01
26215	T	Remove/graft finger lesion	0053	11.69	$595.07	$253.49	$119.01
26230	T	Partial removal of hand bone	0053	11.69	$595.07	$253.49	$119.01
26235	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26236	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26250	T	Extensive hand surgery	0053	11.69	$595.07	$253.49	$119.01
26255	T	Extensive hand surgery	0054	19.83	$1,009.43	$472.33	$201.89
26260	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26261	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26262	T	Partial removal of finger	0053	11.69	$595.07	$253.49	$119.01
26320	T	Removal of implant from hand	0020	8.44	$429.63	$130.53	$85.93
*26340	T	Manipulate finger w/anesth	0043	4.05	$206.16	.....	$41.23
26350	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26352	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26356	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26357	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26358	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26370	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26372	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26373	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26390	T	Revise hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26392	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26410	T	Repair hand tendon	0053	11.69	$595.07	$253.49	$119.01
26412	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26415	T	Excision, hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26416	T	Graft hand or finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26418	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26420	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26426	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26428	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26432	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26433	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26434	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26437	T	Realignment of tendons	0053	11.69	$595.07	$253.49	$119.01
26440	T	Release palm/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26442	T	Release palm & finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26445	T	Release hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26449	T	Release forearm/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26450	T	Incision of palm tendon	0053	11.69	$595.07	$253.49	$119.01
26455	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26460	T	Incise hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26471	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26474	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26476	T	Tendon lengthening	0053	11.69	$595.07	$253.49	$119.01
26477	T	Tendon shortening	0053	11.69	$595.07	$253.49	$119.01
26478	T	Lengthening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26479	T	Shortening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26480	T	Transplant hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26483	T	Transplant/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26485	T	Transplant palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26489	T	Transplant/graft palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26490	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26492	T	Tendon transfer with graft	0054	19.83	$1,009.43	$472.33	$201.89
26494	T	Hand tendon/muscle transfer	0054	19.83	$1,009.43	$472.33	$201.89
26496	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26497	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26498	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26499	T	Revision of finger	0054	19.83	$1,009.43	$472.33	$201.89
26500	T	Hand tendon reconstruction	0053	11.69	$595.07	$253.49	$119.01
26502	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26504	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26508	T	Release thumb contracture	0053	11.69	$595.07	$253.49	$119.01
26510	T	Thumb tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26516	T	Fusion of knuckle joint	0054	19.83	$1,009.43	$472.33	$201.89
26517	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26518	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26520	T	Release knuckle contracture	0053	11.69	$595.07	$253.49	$119.01
26525	T	Release finger contracture	0053	11.69	$595.07	$253.49	$119.01
26530	T	Revise knuckle joint	0047	26.36	$1,341.83	$537.03	$268.37
26531	T	Revise knuckle with implant	0048	43.19	$2,198.54	$725.94	$439.71
26535	T	Revise finger joint	0047	26.36	$1,341.83	$537.03	$268.37
26536	T	Revise/implant finger joint	0048	43.19	$2,198.54	$725.94	$439.71
26540	T	Repair hand joint	0053	11.69	$595.07	$253.49	$119.01
26541	T	Repair hand joint with graft	0054	19.83	$1,009.43	$472.33	$201.89
26542	T	Repair hand joint with graft	0053	11.69	$595.07	$253.49	$119.01
26545	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26546	T	Repair nonunion hand	0054	19.83	$1,009.43	$472.33	$201.89
26548	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26550	T	Construct thumb replacement	0054	19.83	$1,009.43	$472.33	$201.89
26551	C	Great toe-hand transfer	.....	.....	.....	.....	.....
26553	C	Single transfer, toe-hand	.....	.....	.....	.....	.....
26554	C	Double transfer, toe-hand	.....	.....	.....	.....	.....
26555	T	Positional change of finger	0054	19.83	$1,009.43	$472.33	$201.89
26556	C	Toe joint transfer	.....	.....	.....	.....	.....
26560	T	Repair of web finger	0053	11.69	$595.07	$253.49	$119.01
26561	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26562	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26565	T	Correct metacarpal flaw	0054	19.83	$1,009.43	$472.33	$201.89
26567	T	Correct finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26568	T	Lengthen metacarpal/finger	0054	19.83	$1,009.43	$472.33	$201.89
26580	T	Repair hand deformity	0054	19.83	$1,009.43	$472.33	$201.89
26585	D	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26587	T	Reconstruct extra finger	0053	11.69	$595.07	$253.49	$119.01
26590	T	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26591	T	Repair muscles of hand	0054	19.83	$1,009.43	$472.33	$201.89
26593	T	Release muscles of hand	0053	11.69	$595.07	$253.49	$119.01
26596	T	Excision constricting tissue	0054	19.83	$1,009.43	$472.33	$201.89
26597	D	Release of scar contracture	0054	19.83	$1,009.43	$472.33	$201.89
26600	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26605	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26607	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26608	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26615	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26641	T	Treat thumb dislocation	0044	2.52	$128.28	$38.08	$25.66
26645	T	Treat thumb fracture	0044	2.52	$128.28	$38.08	$25.66

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26650	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26665	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26670	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26675	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26676	T	Pin hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26685	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26686	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26700	T	Treat knuckle dislocation	0043	4.05	$206.16	.....	$41.23
26705	T	Treat knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26706	T	Pin knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26715	T	Treat knuckle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26720	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26725	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26727	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26735	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26740	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26742	T	Treat finger fracture, each	0044	2.52	$128.28	$38.08	$25.66
26746	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26750	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26755	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26756	T	Pin finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26765	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26770	T	Treat finger dislocation	0043	4.05	$206.16	.....	$41.23
26775	T	Treat finger dislocation	0045	11.67	$594.05	$277.12	$118.81
26776	T	Pin finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26785	T	Treat finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26820	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26841	T	Fusion of thumb	0054	19.83	$1,009.43	$472.33	$201.89
26842	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26843	T	Fusion of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26844	T	Fusion/graft of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26850	T	Fusion of knuckle	0054	19.83	$1,009.43	$472.33	$201.89
26852	T	Fusion of knuckle with graft	0054	19.83	$1,009.43	$472.33	$201.89
26860	T	Fusion of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26861	T	Fusion of finger jnt, add-on	0054	19.83	$1,009.43	$472.33	$201.89
26862	T	Fusion/graft of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26863	T	Fuse/graft added joint	0054	19.83	$1,009.43	$472.33	$201.89
26910	T	Amputate metacarpal bone	0054	19.83	$1,009.43	$472.33	$201.89
26951	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26952	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26989	T	Hand/finger surgery	0043	4.05	$206.16	.....	$41.23
26990	T	Drainage of pelvis lesion	0049	15.84	$806.32	$356.95	$161.26
26991	T	Drainage of pelvis bursa	0049	15.84	$806.32	$356.95	$161.26
26992	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	0049	15.84	$806.32	$356.95	$161.26
27001	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
27003	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
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	28.56	$1,453.82	$675.24	$290.76
27035	C	Denervation of hip joint	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	0021	11.82	$601.69	$236.51	$120.34
27041	T	Biopsy of soft tissues	0022	13.91	$708.07	$292.94	$141.61
27047	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27048	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27049	T	Remove tumor, hip/pelvis	0022	13.91	$708.07	$292.94	$141.61
27050	T	Biopsy of sacroiliac joint	0049	15.84	$806.32	$356.95	$161.26
27052	T	Biopsy of hip joint	0049	15.84	$806.32	$356.95	$161.26
27054	C	Removal of hip joint lining	.....	.....	.....	.....	.....
27060	T	Removal of ischial bursa	0049	15.84	$806.32	$356.95	$161.26
27062	T	Remove femur lesion/bursa	0049	15.84	$806.32	$356.95	$161.26
27065	T	Removal of hip bone lesion	0049	15.84	$806.32	$356.95	$161.26
27066	T	Removal of hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27067	T	Remove/graft hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
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	20.63	$1,050.15	$504.07	$210.03

* Code is new in 2002.