DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410, 411, 413, 414, 415, 423, 424, 485, 486, and 489

[CMS–1403–FC] [CMS–1270–F2]

RINs 0938–AP18, 0938–AN14

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period implements changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also finalizes the calendar year (CY) 2008 interim relative value units (RVUs) and issues interim RVUs for new and revised codes for CY 2009. In addition, as required by the statute, it announces that the physician fee schedule update is 1.1 percent for CY 2009, the preliminary estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is $36.0666. This final rule with comment period also implements or discusses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). (See the Table of Contents for a listing of the specific issues addressed in this rule.)

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2009 except for amendments to § 410.62 and § 411.351 which are effective July 1, 2009.

Comment Date: Comments will be considered if we receive them at one of the addresses provided below, no later than 5 p.m. e.s.t. on December 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1403–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the filecode to find the document accepting comments.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1403–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1403–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

7500 Security Boulevard, Baltimore, MD 21244–1850; or

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

Pam West, (410) 786–2302, for issues related to practice expense.

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

Stephanie Monroe, (410) 786–6864, for issues related to malpractice RVUs.

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

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

Ken Marsalek, (410) 786–4502, for issues related to the multiple procedure payment reduction for diagnostic imaging.

Catherine Jansto, (410) 786–7762, or Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

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

Corinne Axelrod, (410) 786–5620, for issues related to Health Professional Shortage Area Bonus Payments.

Henry Richter, (410) 786–4562, for issues related to payments for end-stage renal disease facilities.

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

August Nemec, (410) 786–0612, for issues related to independent diagnostic testing facilities; enrollment issues; and the revision to the ''Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges'' final rule.

Lisa Ohrin, (410) 786–4565, Kristin Bohl, (410) 786–8680, or Don Romano, (410) 786–1401, for issues related to anti-markup provisions and physician self-referral (incentive payment and shared savings programs).

Diane Stern, (410) 786–1133, for issues related to the quality reporting system for physician payment for CY 2009.

Andrew Morgan, (410) 786–2543, for issues related to the e-prescribing exemption for computer-generated fax transmissions.

Terri Harris, (410) 786–6830, for issues related to payment for comprehensive outpatient rehabilitation facilities (CORFs).

Lauren Oviatt, (410) 786–4683, for issues related to CORF conditions of coverage.

Trisha Brooks, (410) 786–4561, for issues related to personnel standards for portable x-ray suppliers.

David Walczak, (410) 786–4475, for issues related to beneficiary signature for nonemergency ambulance transport services.

Jean Stiller, (410) 786–0708, for issues related to the prohibition concerning providers of sleep tests

Mark Horney, (410) 786–4554, for issues related to the solicitation for comments and data pertaining to physician organ retrieval services.

Regina Walker-Wren, (410) 786–9160, for information concerning educational

requirements for nurse practitioners and clinical nurse specialists.

Randy Throndset, (410) 786–0131, for information concerning physician certification and recertification for Medicare home health services.

William Larson, (410) 786–4639, for coverage issues related to the initial preventive physical examination.

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

Dorothy Shannon, (410) 786–3396, for issues related to speech language pathology.

Kendra Hedgebeth, (410) 786–4644, or Gina Longus, (410) 786–1287, for issues related to low vision aids.

Christopher Molling, (410) 786–6399, or Anita Greenberg, (410) 786–4601, for issues related to the repeal to transfer of title for oxygen equipment.

Karen Jacobs, (410) 786–2173, or Hafsa Bora, (410) 786–7899, for issues related to the therapeutic shoes fee schedule.

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

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues:

- The Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x)) in section II.N.1. of this final rule with comment period;
- Sections 131(c), 144(b), and 149 of the MIPPA as described in sections III.C., III.J., and III.M. of this final rule with comment period.
- Interim Relative Value Units (RVUs) for selected codes identified in Addendum C;
- Information on pricing for items in Tables 2 through 5;
- Issues related to the Physician Resource Use Feedback Program described in section II.S.6. of this final rule with comment period; and
- The physician self-referral designated health services (DHS) codes listed in Tables 29, 30, and 31. You can assist us by referencing the file code [CMS–1403–FC] and the section heading on which you choose to comment.

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

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

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section XVI. of this final rule with comment period.

I. Background
A. Development of the Relative Value System
1. Work RVUs
2. Practice Expense Relative Value Units (PE RVUs)
3. Resource-Based Malpractice RVUs
4. Refinements to the RVUs
5. Adjustments to RVUs are Budget Neutral
B. Components of the Fee Schedule Payment Amounts
C. Most Recent Changes to Fee Schedule
II. Provisions of the Proposed Regulation
A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
1. Current Methodology
2. PE Proposals for CY 2009
B. Geographic Practice Cost Indices (GPCIs): Locality Discussion
C. Malpractice RVUs (TC/PC issue)
D. Medicare Telehealth Services
E. Specific Coding Issues Related to Physician Fee Schedule
1. Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin
2. Multiple Procedure Payment Reduction for Diagnostic Imaging
3. HCPCS Code for Prostate Saturation Biopsies
F. Part B Drug Payment
1. Average Sales Price (ASP) Issues
2. Competitive Acquisition Program (CAP) Issues
G. Application of the HPSA Bonus Payment
H. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities
I. Independent Diagnostic Testing Facility (IDTF) Issues
J. Physician and Nonphysician Practitioner (NPP) Enrollment Issues
K. Amendment to the Exemption for Computer-Generated Facsimile (FAX) Transmissions From the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Covered Drugs Prescribed for Part D Eligible Individuals
L. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues
M. Technical Corrections for Therapy-Related Issues
N. Physician Self-Referral and Anti-Markup Issues
1. Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x))
2. Changes to Reassignment Rules Related to Diagnostic Tests (Anti-Markup Provisions)
O1. Physician Quality Reporting Initiative
O2. Electronic Prescribing (E-Prescribing) Incentive Program
P. Discussion of Chiropractic Services Demonstration
Q. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists
R. Portable X-Ray Issue
S. Other Issues
1. Physician Certification (G0180) and Recertification (G0179) for Medicare-Covered Home Health Services Under a Home Health Plan of Care (POC) in the Home Health Prospective Payment System (HH PPS)
2. Prohibition Concerning Payment of Continuous Positive Airway Pressure (CPAP) Devices
3. Beneficiary Signature for Nonemergency Ambulance Transport Services
4. Solicitation of Comments and Data Pertaining to Physician Organ Retrieval Services
5. Revision to the ''Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges'' Final Rule
6. Physician Resource Use Feedback Program
T. Electronic Prescribing (E-Prescribing) Incentive Program
III. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Provisions
A. Section 101: Improvements to Coverage of Preventive Services
B. Section 131: Physician Payment, Efficiency, and Quality Improvements
C. Section 131(c): Physician Resource Use Feedback Program
D. Section 132: Incentives for Electronic Prescribing
E. Section 133(b): Expanding Access to Primary Care Services
F. Section 134: Extension of Floor on Medicare Work Geographic Adjustment Under the Medicare Physician Fee Schedule
G. Section 136: Extension of Treatment of Certain Physician Pathology Services Under Medicare
H. Section 141: Extension of Exceptions Process for Medicare Therapy Caps

I. Section 143: Speech-Language Pathology Services
J. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment
K. Section 145: Clinical Laboratory Tests
L. Section 146: Improved Access to Ambulance Services
M. Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth Services
N. Section 153: Renal Dialysis Provisions
IV. Potentially Misvalued Codes Under PFS
A. Valuing Services Under the Physician Fee Schedule
B. Requested Approaches for the AMA RUC To Utilize
C. AMA RUC Review of Potentially Misvalued Codes
V. Refinement of Relative Value Units for Calendar Year 2009 and Response to Public Comments on Interim Relative Value Units for 2008
A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units
B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule
C. Interim 2008 Codes
D. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2009 (Includes Table Titled ''AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes'')
E. Discussion of Codes and AMA RUC Recommendations
F. Additional Coding Issues
G. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2009
VI. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes
A. General
B. Speech-Language Pathology Services
C. Annual Update to the Code List
VII. Physician Fee Schedule Update for CY 2009
A. Physician Fee Schedule Update
B. The Percentage Change in the Medicare Economic Index (MEI)
C. The Update Adjustment Factor (UAF)
VIII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate (SGR)
A. Medicare Sustainable Growth Rate
B. Physicians' Services
C. Preliminary Estimate of the SGR for 2009
D. Revised Sustainable Growth Rate for 2008
E. Calculation of 2009, 2008, and 2007 Sustainable Growth Rates
IX. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2009
A. Physician Fee Schedule Conversion Factor
B. Anesthesia Conversion Factor
X. Telehealth Originating Site Facility Fee Payment Amount Update
XI. Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)—Services Excluded From Coverage
A. Low Vision Aid Exclusion
B. Replacement of Reasonable Charge Methodology by Fee Schedules for Therapeutic Shoes
XII. Provisions of the Final Rule
XIII. Waiver of Proposed Rulemaking and Delay in Effective Date
XIV. Collection of Information Requirements
XV. Response to Comments
XVI. Regulatory Impact Analysis
Regulation Text
Addendum A—Explanation and Use of Addendum B
Addendum B—Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2009
Addendum C—Codes With Interim RVUs
Addendum D—2009 Geographic Adjustment Factors (GAFs)
Addendum E—2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality
Addendum F—Multiple Procedure Payment Reduction Code List
Addendum G—CY 2009 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas
Addendum H—CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas
Addendum I—CPT/HCPCS Imaging Codes Defined by Section 5102(b) of the DRA
Addendum J—List of CPT/HCPCS Codes Used To Define Certain Designated Health Services Under Section 1877 of the Social Security Act

Acronyms

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

ACC American College of Cardiology
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHRQ [HHS] Agency for Healthcare Research and Quality
AIDS Acquired immune deficiency syndrome
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Bureau of Labor Statistics
BN Budget neutrality
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBSA Core-Based Statistical Area
CCHIT Certification Commission for Healthcare Information Technology
CEAMA Council on Education of the American Medical Association
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
CORF Comprehensive Outpatient Rehabilitation Facility
CPAP Continuous positive air pressure
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DNP Doctor of Nursing Practice
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythopoeitin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FFS Fee-for-service
FMS [Department of the Treasury's] Financial Management Service
FPLP Federal Payment Levy Program
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System

HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
ICF Intermediate care facilities
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
MA Medicare Advantage
MA–PD Medicare Advantage-Prescription Drug Plans
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MS–DRG Medicare Severity-Diagnosis related group
MSA Metropolitan statistical area
NCD National Coverage Determination
NCPDP National Council for Prescription Drug Programs
NDC National drug code
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPDB National Practitioner Data Bank
NPI National Provider Identifier
NPP Nonphysician practitioner
NPPES National Plan and Provider Enumeration System
NQF National Quality Forum
NRC Nuclear Regulatory Commission
NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)
NUBC National Uniform Billing Committee
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator for Health Information Technology
OPPS Outpatient prospective payment system
OSA Obstructive Sleep Apnea
OSCAR Online Survey and Certification and Reporting
P4P Pay for performance
PA Physician assistant
PC Professional component
PCF Patient compensation fund
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PECOS Provider Enrollment, Chain, and Ownership System
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PSG Polysomnography
PT Physical therapy
ResDAC Research Data Assistance Center
RFA Regulatory Flexibility Act
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
VBP Value-based purchasing
WAMP Widely available market price

I. Background

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

A. Development of the Relative Value System

1. Work RVUs

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

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

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

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

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432),

enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

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

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

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

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

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

In CY 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology. We will continue to evaluate this policy and proposed necessary revisions through future rulemaking.

3. Resource-Based Malpractice (MP) RVUs

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

4. Refinements to the RVUs

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

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

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263).

5. Adjustments to RVUs are Budget Neutral

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

As explained in the CY 2007 PFS final rule with comment period (71 FR 69624), due to the increase in work RVUs resulting from the third 5-Year Review of physician work RVUs, we applied a separate budget neutrality (BN) adjustor to the work RVUs for services furnished during 2007 and 2008. This approach is consistent with the method we used to make BN adjustments to reflect the changes in the PE RVUs.

Section 133(b) of the MIPPA amends section 1848(c)(2)(B) of the Act to specify that, instead of continuing to apply the BN adjustor for the 5-Year Review to work RVUs, the BN adjustment must be applied to the CF for years beginning with CY 2009. Further discussion of this MIPPA provision as it relates to the CY 2009 PFS can be found in sections III. and IX. of this final rule with comment period.

B. Components of the Fee Schedule Payment Amounts

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

RVUs are converted to dollar amounts through the application of a CF, which

is calculated by CMS' Office of the Actuary (OACT).

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

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

C. Most Recent Changes to the Fee Schedule

The CY 2008 PFS final rule with comment period (72 FR 66222) addressed certain provisions of Division B of the Tax Relief and Health Care Act of 2006—Medicare Improvements and Extension Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), and made other changes to Medicare Part B payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. The CY 2008 PFS final rule with comment period also discussed refinements to resource-based PE RVUs; GPCI changes; malpractice RVUs; requests for additions to the list of telehealth services; several coding issues including additional codes from the 5–Year Review; payment for covered outpatient drugs and biologicals; the competitive acquisition program (CAP); clinical lab fee schedule issues; payment for end-stage renal dialysis (ESRD) services; performance standards for facilities; expiration of the physician scarcity area (PSA) bonus payment; conforming and clarifying changes for comprehensive outpatient rehabilitation facilities (CORFs); a process for updating the drug compendia; physician self-referral issues; beneficiary signature for ambulance transport services; durable medical equipment (DME) update; the chiropractic services demonstration; a Medicare economic index (MEI) data change; technical corrections; standards and requirements related to therapy services under Medicare Parts A and B; revisions to the ambulance fee schedule; the ambulance inflation factor for CY 2008; and an amendment to the e-prescribing exemption for computer-generated facsimile transmissions.

We also finalized the calendar year (CY) 2007 interim RVUs and issued interim RVUs for new and revised procedure codes for CY 2008.

In accordance with section 1848(d)(1)(E)(i) of the Act, we also announced that the PFS update for CY 2008 is −10.1 percent, the preliminary estimate for the sustainable growth rate (SGR) for CY 2008 is −0.1 percent and the CF for CY 2008 is $34.0682. However, subsequent to publication of the CY 2008 PFS final rule with comment period, section 101(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA) was enacted on December 29, 2007 and provided for a 0.5 percent update to the conversion factor for the period beginning January 1, 2008 and ending June 30, 2008. For the first half of 2008 (that is, January through June), the Medicare PFS conversion factor was $38.0870. In the absence of legislation, the PFS conversion factor for the second half of 2008 would have been $34.0682, as announced in the PFS final rule with comment period for CY 2008. However, as a result of the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) (MIPPA), the Medicare PFS conversion factor remained at $38.0870 for the remaining portion of 2008 (July through December).

II. Provisions of the Final Rule With Comment Period

In response to the CY 2009 PFS proposed rule (73 FR 38502) we received approximately 4,100 timely public comments. These included comments from individual physicians, health care workers, professional associations and societies, manufacturers and Congressmen. The majority of the comments addressed proposals related to independent diagnostic testing facilities, anti-markup, prohibition concerning providers of sleep tests, and the general impact of the proposed rule on specific specialties. To the extent that comments were outside the scope of the proposed rule, they are not addressed in this final rule with comment period.

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

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

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

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

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

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

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the ''top-down'' approach to calculate the direct PE RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a ''bottom-up'' approach to calculate the direct costs. Under the ''bottom up'' approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The

costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed explanation of the PE methodology see the June 29, 2006 proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

1. Current Methodology

a. Data Sources for Calculating Practice Expense

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

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

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

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

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

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting. The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment.

In 1999, the AMA's RUC established the PEAC. From 1999 to March 2004, the PEAC, a multi-specialty committee, reviewed the original CPEP inputs and provided us with recommendations for refining these direct PE inputs for existing CPT codes. Through its last meeting in March 2004, the PEAC provided recommendations for over 7,600 codes which we have reviewed and in most instances have accepted. As a result, the current PE inputs differ markedly from those originally recommended by the CPEPs. The PEAC was replaced by the Practice Expense Review Committee (PERC) and now these PE-related activities are addressed by the AMA RUC PE subcommittee.

b. Allocation of PE to Services

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

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

(ii) *Indirect costs.* The SMS and supplementary survey data are the source for the specialty-specific aggregate indirect costs used in our PE calculations. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the maximum of either the clinical labor costs or the physician work RVUs. For calculation of the 2009 PE RVUs, we use the 2007 procedure-specific utilization data crosswalked to 2009 services. To arrive at the indirect PE costs—

- We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.
- We use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (*Note:* For radiation oncology, the data represent

the combined survey data from the American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.

- When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility/Nonfacility Costs

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

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

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

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), we are implementing the change in the methodology for calculating PE RVUs over a 4-year period. During this transition period, the PE RVUs will be calculated on the basis of a blend of RVUs calculated using our methodology described previously in this section (weighted by 25 percent during CY 2007, 50 percent during CY 2008, 75 percent during CY 2009, and 100 percent thereafter), and the CY 2006 PE RVUs for each existing code. PE RVUs for codes that are new during this period will be calculated using only the current PE methodology and will be paid at the fully transitioned rate.

f. PE RVU Methodology

The following is a description of the PE RVU methodology.

(i) Setup File

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

(ii) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

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

Apply a BN adjustment to the direct inputs.

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

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

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

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

(iii) Create the Indirect PE RVUs

Create indirect allocators.

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

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

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

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

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.*

• If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU.*

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

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

Apply a BN adjustment to the indirect allocators.

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

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

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

Calculate the Indirect Practice Cost Index.

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

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

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

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

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service. (*Note:* For services with TCs and PCs, we calculate the indirect practice cost index across the global components, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC and global component.)

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

(iv) Calculate the Final PE RVUs

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

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

(v) Setup File Information

• *Specialties excluded from rate-setting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties *are* included for the purposes of calculating the BN adjustment.

• *Crosswalk certain low volume physician specialties:* Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.

• *Physical therapy utilization:* Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.

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

• *Payment modifiers:* Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier.

• *Work RVUs:* The setup file contains the work RVUs from this final rule.

(vi) Equipment Cost per Minute

The equipment cost per minute is calculated as:

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

Where:

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

usage = equipment utilization assumption; 0.5.

price = price of the particular piece of equipment.

interest rate = 0.11.

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

maintenance = factor for maintenance; 0.05.

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

TABLE 1—CALCULATION OF PE RVUS UNDER METHODOLOGY FOR SELECTED CODES

	Step	Source	Formula	99213 Office visit, est nonfacility	33533 CABG, arterial single facility	71020 Chest x-ray non-facility	71020TC Chest x-ray non-facility	7102026 Chest x-ray non-facility	93000 ECG, complete nonfacility	93005 ECG, tracing nonfacility	93010 ECG, report non-facility
(1) Labor cost (Lab)	Step 1	AMA		$13.32	$77.52	$5.74	$5.74	$—	$6.12	$6.12	$—
(2) Suppy cost (Sup)	Step 1	AMA		$2.98	$7.34	$3.39	$3.39	$—	$1.19	$1.19	$—
(3) Equipment cost (Eqp).	Step 1	AMA		$0.19	$0.65	$8.17	$8.17	$—	$0.12	$0.12	$—
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	$16.50	$85.51	$17.31	$17.31	$—	$7.43	$7.43	$—
(5) Direct adjustment (Dir Adj).	Steps 2–4	See footnote*		0.625	0.625	0.625	0.625	0.625	0.625	0.625	0.625
(6) Adjusted labor	Steps 2–4	=Lab*Dir Adj	=(1)*(5)	$8.33	$48.48	$3.59	$3.59	$—	$3.83	$3.83	$—
(7) Adjusted supplies	Steps 2–4	=Sup*Dir Adj	=(2)*(5)	$1.87	$4.59	$2.12	$2.12	$—	$0.75	$0.75	$—
(8) Adjusted equipment	Steps 2–4	=Eqp*Dir Adj	=(3)*(5)	$0.12	$0.41	$5.11	$5.11	$—	$0.07	$0.07	$—
(9) Adjusted direct	Steps 2–4		=(6)+(7)+(8)	$10.32	$53.48	$10.82	$10.82	$—	$4.65	$4.65	$—
(10) Conversion Factor (CF).	Step 5	MFS		36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666
(11) Adj. labor cost converted.	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.23	1.34	0.10	0.10	—	0.11	0.11	—
(12) Adj. supply cost converted.	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.05	0.13	0.06	0.06	—	0.02	0.02	—
(13) Adj. equip cost converted.	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.14	0.14	—	0.00	0.00	—
(14) Adj. direct cost converted.	Step 5		=(11)+(12)+(13)	0.29	1.48	0.30	0.30	—	0.13	0.13	—
(15) Wrk RVU	Setup File	MFS		0.92	33.64	0.22	—	0.22	0.17	—	0.17
(16) Dir_pct	Steps 6, 7	Surveys		33.8%	32.6%	40.7%	40.7%	40.7%	37.7%	37.7%	37.7%
(17) Ind_pct	Steps 6, 7	Surveys		66.2%	67.4%	59.3%	59.3%	59.3%	62.3%	62.3%	62.3%
(18) Ind. Alloc. formula (1st part).	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
(19) Ind. Alloc. (1st part)	Step 8		See (18)	0.56	3.06	0.44	0.44	—	0.21	0.21	—
(20) Ind. Alloc. formulas (2nd part).	Step 8		See Step 8	(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21) Ind. Alloc. (2nd part).	Step 8		See (20)	0.92	33.64	0.32	0.10	0.22	0.28	0.11	0.17
(22) Indirect Allocator (1st+2nd).	Step 8		=(19)+(21)	1.48	36.70	0.76	0.54	0.22	0.49	0.32	0.17
(23) Indirect Adjustment (Ind Adj).	Steps 9–11	See footnote**		0.337	0.337	0.337	0.337	0.337	0.337	0.337	0.337
(24) Adjusted Indirect Allocator.	Steps 9–11	=Ind Alloc * Ind Adj		0.50	12.37	0.26	0.18	0.07	0.16	0.11	0.06
(25) Ind.Practice Cost Index (PCI).	Steps 12–16	See Steps 12–16 = Adj. Ind.		0.973	0.976	1.087	1.087	1.087	1.237	1.237	1.237
(26) Adjusted Indirect	Step 17	Alloc*PCI	=(24)*(25)	0.49	12.07	0.28	0.20	0.08	0.20	0.13	0.07
(27) PE RVU	Steps 18–19	=(Adj Dir+Adj Ind) *budn.	=((14)+(26)) *budn	0.77	13.44	0.57	0.49	0.08	0.33	0.26	0.07

2. PE Proposals for CY 2009

a. RUC Recommendations for Direct PE Inputs

In the CY 2009 PFS proposed rule, we agreed with the AMA RUC PE recommendations for 23 codes except for the inclusion of the clinical staff for quality-related activities for 8 immunization injection services (73 FR 38512). The AMA RUC recommendations and other PE issues are addressed below.

Immunization Services

We did not accept the AMA RUC-recommended inclusion of 4 minutes of clinical staff time related to quality activities (QA) for the 4 immunization codes for the initial injection: CPT codes 90465, 90467, 90471, and 90473; nor did we accept the recommended 1 minute of QA time for the 4 ''each additional'' subsequent injection for CPT codes 90466, 90468, 90472 and 90474. As we explained, unlike the clinical staff time related to quality activities that is included for mammography services as required by the Mammography Quality Standards Act of 1992 (Pub. L. 102–539) (MQSA), there is no statutory requirement for quality-related clinical staff time inputs for these services.

Comment: We received comments from individuals and group practice physicians, specialty societies, the AMA RUC, the AMA, two State medical societies, a vaccine manufacturer, a pharmaceutical research association, and the National Vaccine Advisory Committee regarding our omission of the QA clinical labor time for the immunization injection codes. These commenters requested that we add back the QA clinical time as recommended by the AMA RUC.

Response: Based on the commenters' requests, we reexamined the issue. We have identified clinical QA time included in other services that is not based on a statutory requirement. For many cardiac and vascular ultrasound services, for example, QA time is included because it is directly related to compliance with accreditation requirements. After our review, we believe there was evidence to support the inclusion of this QA time in this case in order to comply with State and Federal regulatory guidelines. We have revised the PE database to reflect QA time for these immunization services.

Comment: Other commenters representing specialty societies supported our acceptance of the AMA RUC recommendations for the 15 other services identified in Table 2 of the proposed rule.

Response: We have finalized the AMA RUC PE recommendations for these services.

b. Equipment Time-in-Use

The formula for estimating the cost per minute for equipment is based upon a variety of factors, including the cost of the equipment, useful life, interest rate, maintenance cost, and utilization. The purpose of this formula is to identify an estimated cost per minute for the equipment that can be multiplied by the time the equipment is in use to obtain an estimated per use equipment cost to develop the resource-based PE RVU.

In calculating the estimated cost per minute for services that are in use 24 hours per day for 7 days per week, we have assumed that the maximum amount of time that the equipment can be in use is approximately 525,000 minutes (that is, 525,000 minutes = (24 hours per day) × (7 days per week) × (52 weeks per year) × (60 minutes per hour)).

For CY 2008, we used 525,000 minutes to calculate the per minute equipment cost for the equipment used in CPT code 93012, *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; tracing only* and CPT code 93271, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis.* Based on information presented to us by a provider group suggesting that the equipment was in use continuously, we determined that this equipment is used 24 hours a day, 7 days a week. Thus, we assigned the equipment a 100 percent usage rate. However, in subsequent discussions with a provider group, we determined that, although there may be a 100 percent usage rate for a particular month, this does not correspond to a 100 percent usage rate for a year. Therefore, for CY 2009 we proposed to apply our standard utilization rate of 50 percent to the 525,000 maximum minutes of use, consistent with our utilization rate assumption for other equipment. This results in 262,500 minutes (that is, 262,500 = 525,000 × 0.50) of average use over the course of the year.

In the CY 2008 PFS rule, we used 43,200 minutes (60 minutes per hour × 24 hours per day × 30 days per month) to estimate the per use cost of the equipment in these monthly services. We are continuing to use 43,200 minutes in determining the equipment cost per use for these codes.

Comment: The majority of comments received supported our proposal to assign the standard 50 percent utilization rate to CPT codes 93012 and 93271. Other comments disagreed with our proposal and described it as an arbitrary method for changing equipment utilization rates. Many commenters suggested that we should develop a survey process that would obtain service specific utilization rates for all PFS services.

Response: We agree with the commenters that support assigning the standard 50 percent equipment utilization rate to CPT codes 93012 and 93271 and we will finalize our proposal to use the standard 50 percent utilization rate for CPT codes 93012 and 93271. Although we did not make any proposals related to a comprehensive survey of services specific equipment costs, we plan to continue to work with interested parties to analyze the possibilities for potential inclusion in a future rulemaking cycle.

c. Change to PE Database Inputs for Certain Cardiac Stress Tests

In the CY 2009 PFS proposed rule, we proposed to change the PE database for CPT code 93025, *Microvolt T-wave alternans for assessment of ventricular arrhythmias*, to make the clinical labor staff type consistent with the other cardiac stress tests, CPT codes 93015 and 93017. In addition, we proposed to add the specific Microvolt T-wave testing equipment in place of the cardiac stress testing treadmill devices, as well as to revise the time-in-use for the equipment in CPT 93025 to reflect the service period. We also proposed to apply similar revisions to the equipment time-in-use to the other 2 CPT codes, CPT codes 93015 and 93017.

Comment: The manufacturer of the equipment technology and the specialty society were supportive of these proposed changes. In addition, the AMA RUC noted that it would address this issue at the 2008 October AMA RUC meeting.

Response: We have received and accepted the AMA RUC recommendations for CPT 93025, 93015 and 93017 which support all of the changes in our proposal. The PE database is revised to reflect these changes.

d. Revisions to § 414.22(b)(5)(i) Concerning Practice Expense

Current regulations at § 414.22(b)(5)(i) provide an explanation of the two levels of PE RVUs for the facility and nonfacility settings that are used in determining payment under the PFS. Section 414.22(b)(5)(i)(A) discusses

facility PE RVUs and § 414.22(b)(5)(i)(B) discusses nonfacility PE RVUs. Language in each of these sections incorrectly implies that the facility PE RVU is lower than or equal to the nonfacility PE RVUs. However, there are some instances where the facility PE RVUs may actually be greater than the nonfacility PE RVUs. In order to address this inaccuracy, we proposed to revise § 414.22(b)(5)(i)(A) and (B) to remove this language.

We received no comments on our proposed technical change and have revised the regulations at § 414.22(b)(5)(i)(A) and (B) as proposed.

e. Other PE Direct Input Issues

(i) *Removal of Conscious Sedation (CS) PE Inputs for Services in Which CS is not Inherent—Technical Correction*

In reviewing the PE database, we noted that the conscious sedation (CS) PE inputs for 12 CPT codes in which CS is not inherent had not been removed after CPT 2005 began identifying these codes in a separate Addendum. The CS inputs for CPT codes 19300, 22520, 22521, 31717, 62263, 62264, 62268, 62269, 63610, 64585, 64590, and 64595 had been added by the AMA RUC's PEAC prior to CY 2005. At that time, the AMA RUC recommended deletion of the CS PE inputs for all procedures that were not identified in the CPT 2005 manual Addendum which lists the services in which CS is inherent; and thus include the associated direct PE inputs. Due to a technical error, these inputs were not removed for CY 2005. We have removed the CS PE inputs for the 12 CPT codes noted above. We ask that the AMA RUC permit specialty societies to bring any CPT codes forward to either the February or April 2009 AMA RUC meetings should any other discrepancies between the CPT Addendum and the PE database be identified.

(ii) Jejunostomy Tube Price

A comment received on the CY 2009 PFS proposed rule stated that we had mistakenly entered the price for a set of 2, rather than just 1, jejunostomy tube in each of the following CPT codes 49441, 49446, 49451, and 49452. So that the price of this PE supply can be properly valued as part of the PE RVUs for each of the four services in which it is found, we have changed the price of this supply from $198 to $97.50 in CPT codes 49441, 49446, 49451, and 49452. In addition, because it's correct price is less than $150, this item was erroneously placed on the list for re-pricing of higher-cost supplies on Table 29 in the proposed rule; and, as a result of this price correction, it has been removed from the list of supply items in need of repricing.

(iii) Supply Code SH079, Collagen, Dermal Implant (2.5ml uou) (Contigen)

We received comments from a specialty society representing urologists noting that the dermal collagen implant, priced at $317, was an inappropriate supply input for CPT 52330. The specialty society asked that we remove this supply from this service. We agree that inclusion of the dermal collagen implant as a supply input for CPT code 52330 is not appropriate. The PE RVUs for CPT 52330 reflect the removal of this supply item.

(iv) Contractor Pricing of CPT 77371 for Stereotactic Radiosurgery (SRS) Treatment Delivery

CPT code 77371, *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based*, (more commonly known as Gamma Knife) was a new CPT code for CY 2007. At that time, we accepted nearly all of the AMA RUC PE recommendations for this procedure (we did not accept the Cobalt 60 radiation source as a direct PE input) during CY 2007 rulemaking, and these recommendations are reflected in the PE RVUs for CPT 77371. The PE inputs for CPT 77371 had been proposed by the sitting AMA RUC specialty society representing therapeutic radiation oncology physicians. The AMA RUC discussed and amended the specialty's proposal for direct PE inputs (particularly the amount of clinical labor time) prior to agreeing on the final AMA RUC recommendation that was forwarded to CMS for CY 2007. Due to the equipment expense (nearly $4 million) along with the many Nuclear Regulatory Commission (NRC) requirements for construction of the facility required to furnish these procedures, all but one of these facilities is connected with a hospital setting, leaving a single free-standing nonfacility provider.

Comment: We received 3 comments stating that the PE RVUs listed in Addendum B for CPT 77371 are exceptionally inadequate. All commenters, including the single freestanding nonfacility based provider, noted the difference in payments between those made under OPPS and the PFS for CPT 77371. For CY 2009, the commenters noted that the proposed OPPS payment is $7,608 and the PFS payment under the proposed rule would be $1,260. A freestanding nonfacility provider noted that it had worked with the Medicare contractor but was unsuccessful in securing a higher payment because the contractor could not deviate from the established PE RVUs. Two commenters also stated that they believe the direct PE inputs are incorrect since the cost data they had gathered from other facility providers of this stereotactic radiosurgery (SRS) service included extra clinical labor time due to Nuclear Regulatory Commission (NRC) requirements for both the physicist and the registered nurse. In addition, they disagreed with our decision to treat the Cobalt 60 radiation source (recommended by the AMA RUC as a 1-month renewable equipment item) as an indirect PE cost in the CY 2007 PFS final rule with comment period. The commenters have asked us to contractor-price CPT 77371 for CY 2009 if a payment correction cannot be made in the final rule.

Response: We will ask the AMA RUC to review the direct PE inputs for this code in light of these comments. In the interim, we believe the commenters have raised sufficient questions regarding the propriety of the direct PE inputs and PE RVUs established for this new code in 2007 to warrant contractor-pricing for CPT 77371 for CY 2009.

f. Supply and Equipment Items Needing Specialty Input

We have identified some supply and equipment items from the CY 2008 final rule with comment period for which we were unable to verify the pricing information (see Table 2: Items Needing Specialty Input for Pricing and Table 3: Equipment Items Needing Specialty Input for Pricing). For the items listed in Tables 2 and 3, we are requesting that commenters provide pricing information. In addition, we are requesting acceptable documentation, as described in the footnote to each table, to support the recommended prices. For supplies or equipment that previously appeared on these lists, we may propose to delete these items unless we receive adequate information to support current pricing by the conclusion of the comment period for this final rule.

In Tables 4 and 5, we have listed specific supplies and equipment items related to new CY 2009 CPT codes that are discussed in section V. of this final rule with comment period. We have added these items to the PE database along with the associated prices (on an interim basis). We plan to propose finalized pricing information in the CY 2010 PFS proposed rule. Item prices identified in these tables are also reflected in the PE RVUs in Addendum B. In addition, we have asked commenters to submit specific information in response to the

discussion of the supply and equipment items for some each of the new CPT codes in section V. of this final rule with comment period. We have also specifically asked for public comment about the direct cost inputs for the 3 new 2009 CPT codes which we contractor-priced for CY 2009 (CPT codes 93229, 93299, and 95803).

TABLE 2—SUPPLY ITEMS NEEDING SPECIALTY INPUT FOR PRICING

Code	2008/9 Description	Unit	Unit price	Primary Associated Specialties	Associated * CPT code(s)	Prior item status on table	Commenter response and CMS action	2009 Item status refer to note(s)
	Gas, argon, cryoablation.	.....	.....	Urology, Radiology, Interventional Radiology.	50395	YES	New item 2008	A, D.
	Gas, helium, cryoablation.	.....	.....	Urology, Radiology, Interventional Radiology.	50395	YES	New item 2008	A, D.
SL119	Sealant spray	oz	.....	Radiation Oncology	77333	YES	No comments received.	B.
	Catheter, Kumpe ...	Item	.....	Radiology, Interventional Radiology.	50385, 50386	YES	New item 2008	A, D.
	Disposable aspirating syringe.	.....	.....	Oral and Maxillofacial Surgery.	21073	YES	New item 2008	A, D.
	Guidewire, angle tip (Terumo), 180 cm.[1]	.....	.....	Radiology, Interventional Radiology.	50385, 50386	YES	New item 2008	A, D.
	Snare, Nitinol (Amplatz).	Item	.....	Radiology, Interventional Radiology.	50385, 50386	YES	New item 2008	A, D.
NA	Agent, neurolytic ...	ml	.....	Orthopedic Surgery, Podiatry.	64632	NO	New item 2009	A.
NA	Strut, replacement, dynamic external.	Item	1151	.....	20697	NO	New item 2009	A.
NA	Tube, anaerobic culture.	Item	.....	62267	Lab	NO	New item 2009	A, B.
NA	Tube, jejunsostomy	Item	97.50	49441, 49446, 49451 and 49452.	Accessory	NO	Price changed/ CMS error. $195 price for 2 J-tubes. $97.50 accepted.	C.

* CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

Note: Acceptable documentation includes detailed description (including system, kit or product components), source (multiple sources requested), and current pricing information. For most items, there will be multiple sources of documentation available—multiple products/models that can be used as acceptable substitutes in performing a procedure. We ask that documentation from multiple sources be submitted with verified prices of the various products which represent the price range. In these instances, only one specific item/model/product is available on the market for use in a given procedure, one source of documentation is required. However, CMS expects that all documentation reflect the market price for each product reflecting the manufacturer or vendor discounts, rebates, etc. Invoices from physician purchases are the preferred documentation. In cases where this is not possible, CMS may accept other documentation such as copies of catalog pages, hard copy from specific Web pages, physician invoices, and typical or average sales price ''quotes'' (letter format okay) from manufacturers, vendors, or distributors. Unacceptable documentation includes phone numbers and addresses of manufacturer, vendors or distributors, Web site links without pricing information, etc.

A. Additional documentation required. Need detailed description (including ''kit'', system, or product contents and component parts), source, and current pricing information (including pricing per specified unit of measure in database).

B. No/Insufficient information received. Where applicable, retained price in database on an interim basis. Forward acceptable documentation promptly.

C. Submitted price accepted.

D. 2008/9 price retained on an interim basis. Forward acceptable documentation promptly.

TABLE 3—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING

Code	2008/9 Description	2008/9 Price	Primary specialties associated with item	* CPT code(s) associated with item	Prior status on table	Commenter response and CMS action	2009 Item status refer to note(s)
	Camera mount-floor.	2300	Dermatology	96904	Yes	Specialty to submit, asap.	A and D.
	Cross slide attachment.	500	Dermatology	96904	Yes	Specialty to submit, asap.	A and D.
	Plasma pheresis machine.	37,900	Radiology, Dermatology.	36481, G0341	Yes	Revised description based on comments received that light source was not part of item. Documentation requested.	B.
ED039	Psychology Testing Equipment.	.....	Psychology	96101, 96102	Yes	Specialty to submit, asap.	B.
	Strobe, 400 watts (Studio)(2).	1500	Dermatology	96904	Yes	Documentation requested.	B.
	Cryosurgery system (for tumor ablation).[1]	.....	Urology, Radiology, Interventional Radiology.	50593	Yes	New item 2008	A and D.

TABLE 3—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING—Continued

Code	2008/9 Description	2008/9 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status on table	Commenter response and CMS action	2009 Item status refer to note(s)
	Workstation, dual, echocardiography.	85000	Cardiology	93351	No	New item 2009, Specialty submitted $173,509—CMS accept $85,000.	E.
EQ136	Infrared Coagulator (with hand applicator, includes light guide).	3659.50	.....	46606, 46608, 46610, 46612, 46930	No	New price for 2009 with addition of light guide, Supply code, Eq136, descriptor changed to include the light guide.	E.

*CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

Note: Acceptable documentation includes detailed description (including system, kit or product components), source (multiple sources requested), and current pricing information. For most items, there will be multiple sources of documentation available—multiple products/models that can be used as acceptable substitutes in performing a procedure. We ask that documentation from multiple sources be submitted with verified prices of the various products which represent the price range. In these instances, only one specific item/model/product is available on the market for use in a given procedure, one source of documentation is required. However, CMS expects that all documentation reflect the market price for each product reflecting the manufacturer or vendor discounts, rebates, etc. Invoices from physician purchases are the preferred documentation. In cases where this is not possible, CMS may accept other documentation such as copies of catalog pages, hard copy from specific Web pages, physician invoices, and typical or average sales price ''quotes'' (letter format okay) from manufacturers, vendors, or distributors. Unacceptable documentation includes phone numbers and addresses of manufacturer, vendors or distributors, Web site links without pricing information, etc.

A. Additional documentation required. Need detailed description (including kit contents), source, and current pricing information (including pricing per specified unit of measure in database). Accept copies of catalog pages or hard copy from specific Web pages. Phone numbers or addresses of manufacturer, vendors, or distributors are not acceptable documentation.

B. No/Insufficient received. Retained price in database on an interim basis. Forward acceptable documentation promptly.

C. Submitted price accepted.

D. 2008/9 price, where specified, retained on an interim basis. Forward acceptable documentation promptly.

E. See discussion in section V. of this final rule with comment period. Forward requested documentation promptly, for example, whether item is typical.

TABLE 4—PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR CY 2009

Equip code	Supply description	Unit	Unit price	*CPT code(s) associated with item	Supply category	Comments
NA	Agent, neurolytic	ml	.....	64632	Pharmacy, Rx	A, B and D.
NA	IV infusion set, Sof-set (Minimed)	Item	11.5	96369 and 96371	Hypodermic, IV ..	B.
NA	Strut, replacement, dynamic external.	Item	1151	20697	Accessory	A.
NA	Swab, patient prep, 1.5 ml (chloraprep).	Item	1.04	93352	Pharmacy, NonRx.	B.
NA	Tube, anaerobic culture	Item	.....	62267	Lab	A.
NA	Tube, jejunsostomy	Item	97.50	49441, 49446, 49451 and 49452.	Accessory	A and C.

*CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

A. Price verification needed. Item(s) added to table of supplies requiring specialty input.

B. Request explanation/rationale as to why specific supply is necessary, how it differs from current PE database item, and why current PE item(s) cannot be used for procedure(s).

C. CMS price correction.

D. Also, see discussion in section V. of this final rule with comment period. Proxy in use on an interim basis: SH062 Sclerosing solution, inj.

TABLE 5—PRACTICE EXPENSE EQUIPMENT ITEM ADDITIONS FOR CY 2009

Item code	Equipment description	Equip life	Unit price	*CPT code(s) associated with item	Supply or equipment category	Comments
NA	Workstation, dual, echocardiography.	5	85000	93351	DOCUMENTATION	A and D.
NA	Pacemaker, Interrogation, System (CMS used Pacemaker, Monitoring, System as proxy for price).	5	123250	93693 and 93696	OTHER EQUIPMENT	B and D.

TABLE 5—PRACTICE EXPENSE EQUIPMENT ITEM ADDITIONS FOR CY 2009—Continued

Item code	Equipment description	Equip life	Unit price	*CPT code(s) associated with item	Supply or equipment category	Comments
EQ198	Pacemaker follow-up system (incl software and hardware) (Paceart).	7	23507	93279, 93280, 93281, 93282, 93284, 93285, 93286, 93287, 93288, 93289, 93290, 93291, 93292, 93724.	OTHER EQUIPMENT	C and D.
EQ136	Infrared Coagulator (with hand applicator, includes light guide).	10	3659.50	46606, 46608, 46610, 46612, 46930.	OTHER EQUIPMENT	A and D.

*CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

A. Price verification needed. Item(s) added to table of equipment requiring specialty input.

B. Interim value, CY 2009 only. CMS assigned the pacemaker monitoring system to these two CPT codes that the specialty association requested a pacemaker ''interrogation'' system. Since the CMS PE database does not contain such an item, we assigned, on an interim basis, the pacemaker monitoring system that was assigned to these 2 codes previously. Although we remain uncertain as to the appropriate equipment that should be assigned, we will work with the specialty as they provide us with more information and documentation for the typical equipment needed for these 2 services when provided in the physician's office.

C. Interim value, CY 2009 only. CMS assigned EQ198 to all new cardiac monitoring codes for CY 2009 because the crosswalked codes (for CY 2008) each contained the equipment item EQ198. While the specialty requested the ''pacemaker monitoring system'' for these services, CMS was not provided any information to support the change in technology for these services provided in the physician's office setting.

D. Also, see discussion in Section V. of this final rule with comment period.

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

1. Update

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (work, PE and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2008 PFS final rule with comment period (72 FR 66243), we established new GPCIs for each Medicare locality in CY 2008 and implemented them. The CY 2008 adjustment to the GPCIs reflected the first year of the 2-year phase-in.

We noted in the CY 2009 PFS proposed rule (73 FR 38513), that the physician work GPCIs we calculated did not reflect the 1.000 floor that was in place during CY 2006 through June 30, 2008. However, as discussed in section III. of this preamble, section 134 of the MIPPA of 2008 extended the 1.000 work GPCI floor from July 1, 2008, through December 31, 2009. Additionally, section 134(b) of the MIPPA sets a permanent 1.500 work GPCI floor in Alaska for services furnished beginning January 1, 2009. As such, the CY 2009 GPCIs and summarized GAFs reflect these statutorily mandated work GPCI floors.

See Addenda D and E for the CY 2009 GPCIs and summarized geographic adjustment factors (GAFs).

For a detailed explanation of how the GPCI update was developed, see the CY 2008 PFS final rule with comment period (72 FR 66244).

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (work, PE, and malpractice). Payments under the PFS are based on the relative resources required to provide services, and are adjusted for differences in resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities. Although the PFS payment for a particular service is actually adjusted by applying a GPCI to each fee schedule component, for purposes of discussion and comparison, we calculate a geographic adjustment factor (GAF) for each locality. These GAFs reflect a weighted average of the GPCIs within the locality and can be used as a general proxy for area practice costs. A GAF is calculated to reflect a summarization of the GPCIs, (which is used only to make comparisons across localities). The GAFs are not an absolute measure of actual costs, nor are they used to calculate PFS payments. Rather, they are a tool that can be used as a proxy for differences in the cost of operating a medical practice among various geographic areas (for example counties) for the purpose of assessing the potential impact of alternative locality configurations.

Prior to 1992, Medicare payments for physicians' services were made on the basis of reasonable charges. Payment localities were established under the reasonable charge system by local Medicare carriers based on their knowledge of local physician charging patterns and economic conditions. A total of 210 localities were developed; including 22 ''Statewide'' localities where all areas within a State (whether urban or rural) received the same payment amount for a given service. These localities changed little between the inception of Medicare in 1966 and the beginning of the PFS in 1992. Following the inception of the PFS, we acknowledged that there was no consistent geographic basis for these localities and that they did not reflect the significant economic and demographic changes that had taken place since 1966. As a result, a study was begun in 1994 which culminated in a comprehensive locality revision which was implemented in 1997.

The 1997 payment locality revision was based and built upon the prior locality structure. The 22 previously existing Statewide localities remained Statewide localities. New localities were established in the remaining 28 States by comparing the area cost differences (using the GAFs as a proxy for costs) of the localities within these States. We ranked the existing localities within these States by GAFs in descending order. The GAF of the highest locality

within a State was compared to the weighted average GAF of other localities. If the differences between these GAFs exceeded 5 percent, the highest locality remained a distinct locality. If the GAFs associated with all the localities in a State did not vary by at least 5 percent, the State became a Statewide locality. If the highest locality remained a distinct locality, the process was repeated for the second highest locality and so on until the variation among remaining localities fell below the 5 percent threshold. The rest of the localities within the State were combined into a single rest-of-State locality as their costs were relatively homogeneous. The revised locality structure (which is the one currently in use) reduced the number of localities from 210 to 89. The number of Statewide localities increased from 22 to 34. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

Although there have been no changes to the locality structure since 1997, we have proposed changes in recent years, although we did not finalize them. As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner. Therefore, changes in localities can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State Medical Association, which we believed would demonstrate consensus for the change among the professionals who would be affected. However, we recognize that over time changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities, and consideration of potential alternatives.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

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

After evaluating the comments on these options, which included MedPAC's two suggestions for developing changes in payment localities for the entire country (not just California), other States expressing interest in having their payment localities reconfigured, and the California Medical Association's decision not to endorse any option, we decided not to proceed with any of the alternatives we presented. We explained in the CY 2008 final rule with comment period (72 FR 66248) that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking. We also noted that some commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time.

b. Alternative Payment Locality Approaches

In the CY 2009 PFS proposed rule, we explained that as a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC to conduct a preliminary study of several options for revising the payment localities. To that end, we are currently reviewing several alternative approaches for reconfiguring payment localities on a nationwide basis. However, our study of possible alternative payment locality configurations is in the early stages of development. We also stated that we are not making any changes to our payment localities at this time. For a discussion of the alternative payment locality configurations currently under consideration, see the CY 2009 PFS proposed rule (73 FR 38514).

Our preliminary study of several options for revising the payment localities was posted on the CMS Web site on August 21, 2008. The report entitled, ''Review of Alternative GPCI Payment Locality Structures'', which was produced by Acumen, LLC under contract to CMS, is accessible from the PFS Federal regulation notices Web page under the download section of the CY 2009 PFS proposed rule (CMS–1403–P). The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/ReviewOfAltGPCIs.pdf*. Comments on the interim report were accepted through November 3, 2008.

In the CY 2009 PFS proposed rule and on the CMS Web site, we encouraged interested parties to submit comments on the options presented in the proposed rule and in our interim report. We also requested comments on the administrative and operational issues associated with each option, as well as suggestions for other options.

Comment: We received comments on the options discussed in the proposed rule from various specialty groups and medical societies, as well as a few group practices and individual practitioners. Generally, commenters commended us for acknowledging the need for intermittent reconfiguration of PFS payment localities and expressed support for our study of alternative locality configurations. Some commenters urged us to expedite changes in our payment localities and suggested that we do so as part of the CY 2009 final rule. Other commenters requested that, in any locality reconfiguration, we minimize the payment discrepancy between urban and rural areas to ensure continued access to care.

Response: We would like to thank the public for the comments submitted on the options presented in the proposed rule and in the interim report posted on the CMS Web site. We will summarize all comments received in future rulemaking. As we have stated previously, we will provide extensive opportunities for public comment (for example, town hall meetings or open door forums, as well as a proposed rule) on any specific proposals for changes to the locality configuration before implementing any changes.

C. Malpractice RVUs (PC/TC Issue)

In the CY 1992 PFS final rule (56 FR 59527), we described in detail how malpractice (MP) RVUs are calculated for each physicians' service and, when professional liability insurance (PLI) premium data are not available, how we crosswalk or assign RVUs to services. Following the initial calculation of resource-based MP RVUs, the MP RVUs are then subject to review by CMS at 5-year intervals. Reviewing the MP RVUs every 5 years ensures that the MP relative values reflect any marketplace changes in the physician community's ability to acquire PLI. However, there are codes that define certain radiologic services that have never been part of the MP RVU review process. The MP RVUs initially assigned to these codes have not been revised because there is a lack of suitable data on the cost of PLI for technical staff or imaging centers (where most of these services are performed).

In the CY 2008 PFS proposed rule (72 FR 38143), we noted that the PLI workgroup, a subset of the Relative Value Update Committee (RUC) of the AMA, brought to our attention the fact that there are approximately 600 services that have TC MP RVUs that are

greater than the PC MP RVUs. The PLI workgroup requested that we make changes to these MP RVUs and suggested that it is illogical for the MP RVUs for the TC of a service to be higher than the MP RVUs for the PC.

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

In the CY 2008 PFS final rule with comment period (72 FR 66248), one commenter suggested that we ''flip'' the MP RVUs between the PCs and TCs, or make them equal. Reversing the RVUs would reduce the MP RVUs for the TC and increase the MP RVUs for the PC. The AMA's PLI workgroup recommended that we reduce the MP RVUs for the TC for these codes to zero. The workgroup suggested that there are no identifiable separate costs for professional liability for the TC. The workgroup also recommended that the MP RVUs removed from the TC for these codes be redistributed across all physicians' services.

We responded that we did not believe it would be appropriate to ''flip'' the PC and TC MP RVU values because the professional part of the MP RVUs has undergone a resource-based review, is derived from actual data, and is consistent with the resource-based methodology for PFS payments. We stated that we would not simply equalize the PC and TC RVU values because we had no data to demonstrate that the MP costs for the technical portion of these services are the same as the professional portion.

We also noted that we have received several comments supporting the decision to examine the possibility of developing a resource-based methodology for the technical portion of the MP RVUs. The commenters supported the collection and analysis of appropriate MP premium data before making any changes to the MP RVU distribution.

We stated that we would continue to solicit, collect, and analyze appropriate data on this subject. We noted that when we had sufficient information we would be better able to make a determination as to what, if any, changes should be made and that we would propose any changes in future rulemaking.

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

The following is a summary of the comments we received on the CY 2009 PFS proposed rule and our responses.

Comment: Most commenters opposed any change to the MP RVUs that would make the TC MP RVUs zero. The commenters stated that there are identifiable MP expenses associated with allied health professionals and that for many radiation oncology centers there are separate MP insurance policies for the radiation oncologists and the nonphysician clinical personnel. The commenters requested that we ensure that the liability insurance associated with the nonphysician personnel is reflected in the MP RVUs for technical services. The commenters also stated that these expenses do not represent general insurance liability premiums which are part of the PE RVUs. The commenters were supportive of our plan for researching data sources for MP premium data for the TC of these codes. One commenter provided the name of a company that provides liability insurance to imaging facilities.

Other commenters, including the AMA, proposed that CMS reduce to zero the TC MP RVUs associated with the codes identified as having higher TC MP RVUs than PC MP RVUs. The commenters stated that any premium data received would represent general liability insurance, not liability insurance premium data related to nonphysician clinical personnel. The commenters suggested that premium data does not exist to support a resource-based computation of the MP RVUs for the TC and stated that general liability insurance premiums are included in the PE component and should not be part of the MP RVU calculation.

Response: We appreciate the comments in support of our proposal to instruct our contractor to research available data sources for the MP costs associated with the TC portions of these codes. As we stated in the CY 2008 PFS final rule with comment period (72 FR 66248), we are not able to evaluate whether sufficient data exists or to make a judgment on the RUC's assertion that such data are not available. It is possible that the contractor responsible for collecting the data for the 5-year MP RVU update will identify providers of professional liability insurance for nonphysician clinical personnel. We plan to share the information received on a potential source of such data with our contractor. If such premium data can be identified, it will be incorporated into the MP RVU update. In the event that we adopt such data, we will ensure there is no duplication of costs between the PE and the MP RVUs. As noted in the CY 2009 PFS proposed rule, and discussed above in this section, we will be addressing this issue as part of the update to the malpractice RVUs for CY 2010.

D. Medicare Telehealth Services

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

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. In addition, the statute required us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis.

In the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- Category #1: Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the proposed and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site

and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.

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

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

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2007 are considered for the CY 2009 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to directly mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/.*

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

We received the following requests in CY 2007 for additional approved services to become effective for CY 2009: (1) Diabetes self-management training (DSMT); and (2) critical care services. In addition, in the CY 2008 PFS final rule with comment period (72 FR 66250), we committed to continuing to evaluate last year's request to add subsequent hospital care to the list of approved telehealth services. In the CY 2009 PFS proposed rule (73 FR 38515), we responded to these requests. We did not propose to add DSMT or critical care services to the list of Medicare telehealth services. We proposed to create HCPCS codes specific to follow-up inpatient consultations delivered via telehealth, and we proposed to revise § 410.78 and § 414.65 to revise our regulations accordingly. The following is a summary of the discussion from the proposed rule and a summary of the comments we received and our responses.

a. Diabetes Self-Management Training (DSMT)

The American Telemedicine Association (ATA) and the Marshfield Clinic submitted a request to add individual and group diabetes self management training (DSMT) (as represented by Healthcare Common Procedure Coding System (HCPCS) codes G0108 and G0109) to the list of approved telehealth services. The requesters believe that DSMT services can be considered and approved for telehealth as Category 1 services because they are comparable to medical nutrition therapy (MNT) services approved for telehealth.

As discussed in the CY 2009 PFS proposed rule (73 FR 38516), § 414.65 provides for the payment of individual MNT furnished via telehealth. Group MNT is not an approved telehealth service, so it cannot be used as a point of comparison for group DSMT (as represented by HCPCS code G0109). In addition, group counseling services have a different interactive dynamic between the physician or practitioner at the distant site and beneficiary at the originating site as compared to services on the current list of Medicare telehealth services. (See 70 FR 45787 and 70 FR 70157 for a previous discussion of group services.) Since the interactive dynamic of group DSMT is not similar to individual MNT or any other service currently approved for telehealth, we believe that group DSMT must be evaluated as a category 2 service.

Section 1861(qq) of the Act provides that DSMT (which can be either a group or individual service) involves educational and training services to ensure therapy compliance or to provide necessary skills and knowledge to participate in managing the condition, including the skills necessary for the self administration of injectable drugs. We believe individual DSMT is not analogous to individual MNT because of the element of skill based training that is encompassed within individual DSMT, but is not an aspect of individual MNT (or any other services currently approved for telehealth). Due to the statutory requirement that DSMT services include teaching beneficiaries the skills necessary for the self administration of injectable drugs, we believe that DSMT, whether provided to an individual or a group, must be evaluated as a category 2 service.

Because we consider individual and group DSMT to be category 2 services, we needed to evaluate whether these are services for which telehealth can be an adequate substitute for a face to face encounter. After reviewing studies submitted with the request, we determined that we do not have sufficient comparative analysis that either individual or group DSMT delivered via telecommunications is equivalent to DSMT delivered face to face. We did not find evidence that providing DSMT via telehealth is an adequate substitute for providing DSMT in person. Therefore, we proposed not to add individual and group DSMT (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services.

Comment: Some commenters disagreed with our proposal and noted that adding DSMT to the list of approved telehealth services would provide a physician or practitioner with an additional tool for supporting patient compliance with management of diabetes. One commenter acknowledged that training patients in the self-administration of injectable drugs, a required component of DSMT programs, would be difficult to perform via telehealth. However, the commenter disagreed that this concern should prevent diabetes patients from accessing the DSMT benefit through telehealth. The commenter believes that educating a patient on diet, exercise, medications, managing stress and illness, and managing blood sugar can be taught via telehealth.

Another commenter agreed that telehealth should not serve as a substitute for initial DSMT training that may involve hands-on teaching of injectable medications or appropriate usage of glucose monitors. However, the commenter believes that follow-up telehealth encounters can help to quickly identify any potential problems or health concerns.

Response: The request we received was to add individual and group DSMT as described by HCPCS codes G0108 and G0109 to the list of Medicare

telehealth services. As discussed above, teaching beneficiaries the skills necessary for the self administration of injectable drugs is a statutorily required element of DSMT (and is typically provided as part of an individual DSMT session). This skill based training is typically not a component of any of the current Medicare telehealth services.

Group DSMT (which comprises the vast majority of DSMT; initial and follow up) is by definition furnished in a group setting and, therefore, the interactive dynamic is not similar to any existing telehealth service. No group services are approved for telehealth. For more information on our review of the use of telehealth to furnish group services, see the CY 2006 PFS proposed rule (70 FR 45787).

In order to consider addition of services for Medicare telehealth that are not similar to the existing list of telehealth services, we require comparative studies showing that the use of an interactive audio and video telecommunications system is an adequate substitute for the in person (face-to-face) delivery of the requested service. To date, requestors have not submitted sufficient comparative analyses supporting the approval of skill based training (such as teaching a patient how to administer self-injectable drugs) for telehealth. Likewise, requestors have not submitted comparative analyses showing that the use of a telecommunications system is an adequate substitute for group counseling services (DSMT or otherwise) furnished in person.

We agree with the commenters that skill-based training, such as teaching patients how to inject insulin, would be difficult to accomplish without the physical in person presence of the teaching practitioner. However, we disagree that this training element should be carved out of individual (or group) DSMT for purposes of providing Medicare telehealth services. The skill-based training involved in teaching beneficiaries the skills necessary for the self-administration of injectable drugs is a key component of this statutorily defined benefit (and therefore inherent in the codes that describe DSMT). We do not believe that it would be appropriate to carve out this statutorily required component of DSMT for purposes of telehealth.

b. Critical Care Services

The (UPMC) submitted a request to add critical care services (as defined by HCPCS codes 99291 and 99292) as a ''Category 1'' service. The requester draws similarities to the evaluation and management (E/M) consultation services currently approved for telehealth. The requester noted that the primary difference between critical care and other E/M services already approved for telehealth is that critical care is specific to patients with vital organ failure. Anecdotally, UPMC has found that the use of telecommunications systems and software gives stroke patients timely access to highly specialized physicians. According to the request, UPMC physicians are able to give ''an equally effective examination, spend the same amount of time with the patient and develop the same course of treatment just as if they were bedside.''

The acuity of a critical care patient is significantly greater than the acuity generally associated with patients receiving the E/M services approved for telehealth. Because of the acuity of critically ill patients, we do not consider critical care services similar to any services on the current list of Medicare telehealth services. Therefore, we believe critical care must be evaluated as a Category 2 service.

Because we consider critical care services to be Category 2, we needed to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. We had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care. As such, we did not propose to add critical care services (as defined by HCPCS codes 99291 and 99292) to the list of approved telehealth services.

Comment: UPMC submitted a detailed description of their experiences using telehealth to support the treatment of acute stroke patients and provided supporting studies describing the use of telemedicine in remote stroke assessment. Per their comment, remote stroke assessment has specific and unique clinical importance because an urgent decision, based in part on a neurological examination, must be made regarding the administration of thrombolytic therapy within 3 hours of the onset of stroke symptoms. The elements of remote stroke assessment involve discrete interactions between physicians and patients, and the consultative input of specialists experienced in acute stroke treatment is considered in directing the bedside care of the patient.

Some commenters were concerned that our proposal will not permit the use of telehealth to treat critically ill patients. We received comments and supporting documentation regarding the feasibility and value of providing consultations via telehealth to patients who are critically ill.

Response: Consultations are already included on the list of approved telehealth services. Our proposal not to add critical care services (as defined by 99291 and 99292) to the list of Medicare telehealth services does not preclude physicians or NPPs from providing medically necessary and clinically appropriate telehealth consultations to patients who are critically ill. We believe that permitting initial and follow up inpatient consultation via telehealth will help provide greater access to specialty care for critically ill patients (including stroke patients). If guidance or advice is needed regarding a critically ill patient, a consultation may be requested from an appropriate source and may be furnished as a telehealth service. (See the CMS Internet-Only Medicare Claims Processing Manual, Chapter 12, Section 30.6.10 for more information on Medicare policy regarding payment for consultation services.)

In support of the request to approve critical care services (as described by HCPCS codes 99291 through 99292), UPMC provided comparative analyses involving the use of an interactive audio and video telecommunications system as a substitute for an in-person (face-to-face) clinical assessment. However, the focus of these studies was limited to stroke patients (critical care services include a broad range of disease categories). Additionally, one study recruited clinically stable patients. This study noted that ''because of the subacute nature of our test bed, the current data must be considered preliminary in determining their potential impact on actual clinical decision making.'' The same study also noted that although the use of telehealth ''may expedite stroke-related decision making, it cannot and should not be thought of as a substitute for the comprehensive clinical evaluation of the acute stroke patient, including thorough medical and cardiac evaluations.'' In another study submitted, the patients selected were not randomized.

Comment: A few commenters supported our proposal not to add critical care services to the list of Medicare approved telehealth services. The commenters believe that, within the current standards of practice, critical care services require the physical presence of the physician rendering the critical care services.

We received approximately 20 comments expressing opposition to our proposal not to add critical care services to the list of Medicare approved telehealth services which distinguished between their use of telehealth for

critical care services and the use of telehealth for remote stroke assessments, as described in the original request. Many of the commenters characterized our proposal as a ''non-coverage determination'' of remote critical care services and described an intensive care unit (ICU) model that integrates continuous surveillance of the ICU with an electronic medical records interface. This model is also programmed to automatically prompt the physician to rapidly respond and intervene in the event of certain changes in a patient's physiological status. Many of these commenters included documentation and references to studies that the adoption of this model reduced medical errors; enhanced patient safety; reduced complications; decreased overall length of stay in the ICU; and resulted in a statistically significant decrease in ICU mortality in comparison to the traditional ICU model. The commenters also noted that patient outcomes have been equivalent if not superior to patient outcomes prior to adopting this model of care.

The American Medical Association (AMA) recently developed Category III tracking codes for remote critical care services (0188T–0189T). Two specialty societies commented that they are working with other critical care organizations to collect and analyze data on remote critical care services, as requested by the CPT editorial panel.

Response: In the CY 2009 PFS proposed rule, we explained that we have no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of critical care services, as defined by HCPCS codes 99291 and 99292. We agree with the comments that, within the current standards of practice, critical care services require the physical presence of the physician rendering the critical care services.

Our proposal not to add critical care services to the list of approved telehealth services for Medicare was in no way a ''non-coverage determination'' for remote critical care services described by the AMA's Category III tracking codes, 0188T–0189T. Consistent with the AMA's creation of those tracking codes, we believe that remote critical care services are different from the telehealth delivery of critical care services (as defined by CPT codes 99291 through 99292). Category III CPT codes track utilization of a service, facilitating data collection on, and assessment of new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future. However, at the present time, we do not have sufficient evidence that the provision of critical care services (as represented by HCPCS codes 99291 and 99292) via telehealth is an adequate substitute for an in person (face-to-face) encounter.

c. Subsequent Hospital Care

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved for telehealth. CPT 2006 deleted the follow-up inpatient consultation codes and advised practitioners instead to bill for these services using the codes for subsequent hospital care (as described by CPT codes 99231 through 99233). For CY 2006, we removed the deleted codes for follow-up inpatient consultations from the list of approved telehealth services.

In the CY 2008 PFS proposed rule (72 FR 38144) and subsequent final rule with comment period (72 FR 66250), we discussed a request we received from the ATA to add subsequent hospital care to the list of approved telehealth services. Because there is currently no method for practitioners to bill for follow-up inpatient consultations delivered via telehealth, the ATA requested that we approve use of the subsequent hospital care codes to bill follow-up inpatient consultations furnished via telehealth, as well as to bill for subsequent hospital care services furnished via telehealth that are related to the ongoing E/M of the hospital inpatient (72 FR 66250). Since the subsequent hospital care codes describe a broader range of services than follow-up inpatient consultation, including some services that may not be appropriate for addition to the list of telehealth services, we did not add subsequent hospital care to the list of approved telehealth services. Instead, we committed to continue to evaluate whether, and if so, by what mechanism subsequent hospital care could be approved for telehealth when used for follow-up inpatient consultations (72 FR 66249).

In the CY 2009 PFS proposed rule, we proposed to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. Practitioners would use these codes to submit claims to their Medicare contractors for payment of follow-up inpatient consultations provided via telehealth. We proposed that the new HCPCS codes would be limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these services as follow-up inpatient consultations provided via telehealth, and not subsequent hospital care used for inpatient visits. Utilization of these codes would allow for payment for these services, as well as enable us to monitor whether the codes are used appropriately. We also proposed to establish the RVUs for these services at the same level as the RVUs established for subsequent hospital care (as described by CPT codes 99231 through 99233). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing follow-up inpatient consultations in a face-to-face encounter must continue to utilize subsequent hospital care codes (as described by CPT codes 99231 through 99233), we believe it is appropriate to set the RVUs for the new telehealth G codes at the same level as for the subsequent hospital care codes.

Comment: Several commenters enthusiastically supported our proposal to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. Some commenters were concerned that our proposed definition of the new HCPCS codes did not clearly distinguish these consultations from subsequent hospital care, and they believed it would not preclude the use of telehealth for the ongoing E/M of an inpatient. Other commenters supported our effort to reinstitute follow-up inpatient consultations delivered via telehealth, but discouraged us from creating new HCPCS codes for the long-term. A few commenters recommended that instead we approve subsequent hospital care for telehealth. The AMA and others urged us to implement the proposed G codes as an interim measure, while working expeditiously with the CPT Editorial Panel and the RUC to develop appropriate codes and RVUs for the long-term.

Response: We are pleased that the majority of commenters supported our proposal to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. As discussed in the CY 2009 PFS proposed rule, we considered other approaches to provide and bill for follow-up inpatient consultations delivered via telehealth. In response to the comments requesting that we approve subsequent hospital care for telehealth only when the codes are used for follow-up inpatient consultations, we were concerned that

the other approaches under consideration would lead to a misuse of the service, and practitioners would provide a broader range of services via telehealth than was formerly approved, including the ongoing, day-to-day E/M of a hospital inpatient. We were also concerned that it could be difficult to implement sufficient controls and monitoring to ensure that whatever mechanism we created would be limited to the delivery of services that were formerly described as follow-up inpatient consultations. We continue to believe that creating HCPCS codes specific to the telehealth delivery of follow-up inpatient consultations allows us to provide payment for these services, as well as enables us to best monitor whether the codes are used appropriately.

As noted previously, CPT deleted the follow-up inpatient consultation codes. We determined that there was a need to establish a method by which practitioners could provide and bill Medicare for follow-up inpatient consultations delivered via telehealth, without allowing the ongoing E/M of a hospital inpatient via telehealth. Physicians and NPPs furnishing follow-up inpatient consultations in a face-to-face encounter must continue to utilize subsequent hospital care codes (as described by CPT codes 99231 through 99233).

In response to commenters concerns that the new HCPCS codes will not prevent the use of telehealth for the ongoing E/M of an inpatient, we have modified the definition of follow-up inpatient telehealth consultations. We clarified that the criteria for these services will be subject to and consistent with Medicare policy for consultation services, including criteria that would distinguish a follow-up consultation from a subsequent E/M visit.

Result of Evaluation of 2009 Requests

We will finalize our proposal not to add DSMT (as defined by HCPCS codes G0108 and G0109) and not to add critical care services (as defined by HCPCS codes 99291 and 99292) to the list of Medicare telehealth services.

We will finalize our proposal to add follow-up inpatient telehealth consultation, as represented by HCPCS codes G0406 through G0408, to the list of Medicare telehealth services. We will also finalize our proposal to add follow-up inpatient telehealth consultations to the list of Medicare services at § 410.78 and § 414.65.

Practitioners would use the new HCPCS codes to submit claims to their Medicare contractors for payment of follow-up inpatient consultations provided via telehealth. These new HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth. The HCPCS codes clearly designate these services as follow-up inpatient consultations provided via telehealth, and not subsequent hospital care used for inpatient visits. Utilization of these codes will allow for payment for these services, as well as enable us to monitor whether the codes are used appropriately.

We also will finalize our proposal to establish the RVUs for these services at the same level as the RVUs established for subsequent hospital care (as described by CPT codes 99231 through 99233). Physicians and NPPs furnishing follow-up inpatient consultations in a face-to-face encounter must continue to utilize subsequent hospital care codes (as described by CPT codes 99231 through 99233).

We are finalizing our proposal to create HCPCS codes specific to the telehealth delivery of follow-up inpatient consultations solely to re-establish the ability for practitioners to provide and bill for follow-up inpatient consultations delivered via telehealth. These codes are intended for use by practitioners serving beneficiaries located at qualifying originating sites (as defined in § 410.78) requiring the consultative input of physicians who are not available for an in person (face-to-face) encounter. These codes are not intended to include the ongoing E/M of a hospital inpatient.

Claims for follow-up inpatient telehealth consultations will be submitted to the Medicare contractors that process claims for the area where the physician or practitioner who furnishes the service is located. Physicians/practitioners must submit the appropriate HCPCS procedure code for follow-up inpatient telehealth consultations along with the ''GT'' modifier (''via interactive audio and video telecommunications system''). By coding and billing the ''GT'' modifier with the inpatient follow-up inpatient telehealth consultation codes, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, § 190.6.1 for instructions for submission of interactive telehealth claims.)

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

Follow-Up Inpatient Telehealth Consultations Defined

Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in person or via telehealth. The conditions of payment for follow-up inpatient telehealth consultations, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of § 410.78. Payment for these services is subject to the provisions of § 414.65.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for consultation services, as

described in the CMS Internet-Only Medicare Claims Processing Manual, Pub 100–04, Chapter 12, § 30.6.10.

Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim lab work) and communicating with other professionals or family members. Intra-service activities must include at least two of the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to a follow-up inpatient telehealth consultation.

Follow-up inpatient telehealth consultations could be provided at various levels of complexity. To reflect this, we are establishing three codes.

Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406. At this level of service, practitioners would typically spend 15 minutes communicating with the patient via telehealth.

Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code G0407. At this level of service, practitioners would typically spend 25 minutes communicating with the patient via telehealth.

Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408. At this level of service, practitioners would typically spend 35 minutes or more communicating with the patient via telehealth.

We are establishing the following HCPCS codes to describe follow-up inpatient consultations approved for telehealth:

- G0406, *Follow-up inpatient telehealth consultation, limited, typically 15 minutes communicating with the patient via telehealth.*
- G0407, *Follow-up inpatient telehealth consultation, intermediate, typically 25 minutes communicating with the patient via telehealth.*
- G0408, *Follow-up inpatient telehealth consultation, complex, typically 35 minutes or more communicating with the patient via telehealth.*

3. Other Issues

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

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

Response: Section 149 of the MIPPA did not add any services to the approved telehealth list. Currently, telehealth may substitute for a face-to-face, ''hands on'' encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that we have determined to be appropriate for telehealth. We will continue to review requests for additions to this list using our existing criteria.

Telehealth is a delivery mechanism for otherwise payable Part B services. Although the requested nursing facility services are not on the approved telehealth list, we will pay eligible distant site physicians or practitioners for eligible Medicare telehealth services if the service is separately payable under the PFS when furnished in a face-to-face encounter at a SNF effective January 1, 2009.

Since we believed it was not relevant to add these codes when SNFs were not eligible originating sites, we did not include a full review of these codes in the CY 2007 PFS proposed rule or final rule with comment period. We also note that in considering nursing facility care for telehealth, we would need to carefully evaluate the use of telehealth for the personal visits that are currently required under § 483.40, (which are billed using procedure codes included in this request). Overall, we believe that it would be more appropriate to consider the addition of nursing facility care services for telehealth through full notice and comment procedures.

In the CY 2010 PFS proposed rule, we will address the request to add nursing facility care services to the list of approved telehealth services, as received in 2005. In light of the previous request to add these services and the new legislation adding SNFs as permissible telehealth originating sites, we will accept additional information in support of this request for consideration in the CY 2010 proposed rule if received prior to December 31, 2008.

Comment: We received a request to add health and behavior assessment and intervention codes (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services.

Response: Requests submitted before the end of CY 2008 will be considered for the CY 2010 proposed rule. Requestors should be advised that each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requestor wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to directly mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/.*

E. Specific Coding Issues Related to the Physician Fee Schedule

1. Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin

In the CY 2009 PFS proposed rule (73 FR 38518), we proposed to discontinue payment for HCPCS code G0332, *Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin),* for services furnished after December 31, 2008.

Immune globulin is a complicated biological product that is purified from human plasma obtained from human plasma donors. In past years, there have been issues reported with the supply of intravenous immune globulin (IVIG) due to numerous factors including decreased manufacturing capacity, increased usage, more sophisticated

processing steps, and low demand for byproducts from IVIG fractionation.

When IVIG is furnished to a patient in a physician's office, three different payments are usually recognized: payment for the IVIG product itself (described by a HCPCS J code); payment for the administration of the IVIG product (described by one or more CPT codes); and similar payment for the preadministration-related services (HCPCS code G0332). The Medicare payment rates for IVIG products are established through the Part B average sales price (ASP) drug payment methodology.

As explained in detail in the CY 2006, CY 2007 and CY 2008 PFS final rules with comment period (70 FR 70218 to 70221, 71 FR 69678 to 69679, and 72 FR 66254 to 66255, respectively), we created, in 2006, a temporary code in order to pay separately for the IVIG preadministration-related services in order to assist in ensuring appropriate access to IVIG during a period of market instability. Part of this instability was due to the implementation of the new ASP payment methodology for IVIG drugs which began in 2005. The payment for preadministration-related services was continued in 2007 and 2008 because of continued reported instability in the IVIG marketplace. The preadministration-related payment was designed to pay the physician practice for the added costs of obtaining adequate supplies of the appropriate IVIG product and scheduling the patient infusion during a period of market uncertainty.

The PFS rates for the pre-administration service codes were $72, $75, and $75 respectively in 2006, 2007, and 2008.

In the CY 2009 PFS proposed rule, we noted that the Office of the Inspector General's (OIG) study on the availability and pricing of IVIG published in a April 2007 report entitled, ''Intravenous Immune Globulin: Medicare Payment and Availability (OEI–03–05–00404),'' found that for the third quarter of CY 2006, just over half of IVIG sales to hospitals and physicians were at prices below Medicare payment amounts. Relative to the previous three quarters, this represented a substantial increase of the percentage of sales with prices below Medicare amounts. During the third quarter of 2006, 56 percent of IVIG sales to hospitals and over 59 percent of IVIG sales to physicians by the largest 3 distributors occurred at prices below the Medicare payment amounts. We reviewed national claims data for IVIG drug utilization as well as utilization of the preadministration-related services HCPCS code. The data show modest increases in the utilization of IVIG drugs and the preadministration-related services code, which suggest that IVIG pricing and access may be improving.

In the CY 2009 PFS proposed rule, we noted that these factors, taken as a whole, suggested a lessening of the instability of the IVIG market. As a result of these developments, we proposed to discontinue the preadministration-related service payment in 2009 for HCPCS code G0332. For CY 2009, under the Outpatient Prospective Payment System (OPPS), a proposal was made to package payment for HCPCS code G0332 (73 FR 41457).

The following is a summary of the comments received and our responses.

Comment: We received several comments from beneficiaries, patient advocate groups, manufacturers, and physicians. Most commenters opposed the elimination of the preadministration-related services payment. A few commenters requested that the preadministration-related services payment become permanent for both the PFS and the OPPS. Some commenters stated that the market conditions for IVIG are not fundamentally different than they were when CMS initially instituted the preadministration-related services payment in CY 2006. The commenters requested that CMS continue the separate payment until there is more stability in the IVIG market. Several commenters stated that the information CMS presented in the CY 2009 PFS proposed rule did not conclusively prove that the IVIG market was stabilizing. The commenters stated that significant access problems remain.

In response to the findings of the OIG report, some commenters stated that the lag inherent in the ASP pricing system may have played a role in substantially increasing the percentage of IVIG sales at prices below the Medicare payment amounts in the third quarter of 2006. The preadministration-related service fee was cited as providing some assistance to physicians and hospitals that are experiencing problems obtaining IVIG. Several commenters noted that the OIG report could be interpreted as leaving a large percent of hospitals and physicians unable to acquire IVIG at prices below Medicare's payment amounts. Many commenters stated that they do not believe the introduction of new brand-specific reporting codes for IVIG will result in a more stable marketplace.

One commenter presented patient surveys conducted in CYs 2006, 2007 and 2008 which described access limitations and shifts in the site of service. These surveys were limited in size and surveyed only patients receiving IVIG for primary immune deficiency. Another commenter referred to a report on IVIG issued in February 2007 titled, *''Analysis of Supply, Distribution, Demand and Access Issues Associated with Immune Globulin Intravenous''* prepared by the Eastern Research Group under contract (Contract No. HHSP23320045012XI) to the Assistant Secretary of Planning and Evaluation in the U.S. Department of Health and Human Services and cited this report as an important source of information on IVIG usage and patient access.

Response: The separate payment for IVIG preadministration-related service was designed to compensate the physician practice for the additional, unusual, and temporary costs associated with obtaining IVIG products and scheduling patient infusions during a temporary period of market instability. This payment was never intended to subsidize payment for drugs made under the ASP system.

In the CY 2009 PFS proposed rule, we referred to data from the OIG study that indicated that for the third quarter of 2006, just over half of IVIG sales to hospitals and physicians were at prices below Medicare payment amounts. Relative to the previous three quarters, this represented a substantial increase of the percentage of sales with prices below Medicare amounts. We agree with the commenters that it is likely that increased ASP payments were the result of previous price increases from past quarters influencing future ASP data. Furthermore, the new HCPCS codes for IVIG products allow the physician to report and receive payment for the specific product furnished to the patient. We stated clearly in the CY 2006 PFS final rule with comment period that the preadministration-related services payment policy was a temporary measure to pay physicians for the unusual and temporary costs associated with procuring IVIG. We expected that these costs would decline over time as practices became more familiar with the nuances of the IVIG market and the availability of the limited primary and secondary suppliers in their areas.

We did not reference the report conducted by the Eastern Research Group (Contract No. HHSP23320045012XI) in the proposed rule. As the commenter noted, this report provides important comprehensive background on the IVIG marketplace. For example, it provides an analysis of IVIG supply and distribution, and an analysis of the

demand for and utilization of IVIG products. This report describes how IVIG is administered and paid and includes information from the industry and others on physician and patient problems with access to IVIG. The study is a collection of multi-source information that provides an understanding of the IVIG marketplace. One limitation of the study is it depicts the market only up through the first quarter of 2006 and it does not have detailed information on IVIG pricing as the OIG report did. The OIG report also contains data from a later time period because it includes data through the third quarter of 2006.

We note, based on the information that follows, that the IVIG market today appears more stable than it was in CY 2006. We have reviewed national claims data for IVIG drug utilization, as well as the utilization of the preadministration-related services HCPCS code. These data show a modest increase in the utilization of IVIG and the preadministration-related services code in both physicians' offices and hospital outpatient departments from CY 2006 to CY 2007, after a period of decreased IVIG utilization in physicians' offices with a shift of IVIG infusions to the hospital outpatient department in the previous year, which suggests that IVIG pricing and access may be improving.

National Medicare claims history data show that there were about 3.1 million units of IVIG administered in physicians' offices in CY 2006, and 7.3 million units in hospital outpatient departments. In CY 2007, those numbers rose to estimates of 3.3 million units and 8.1 million units in the office and hospital outpatient department settings, respectively. Under the OPPS, the total number of days of IVIG administration increased modestly from CY 2006 to CY 2007, from 113,000 to 119,000. Aggregate allowed IVIG charges in the physician's office setting for CY 2006 were $82 million, while total payments (including beneficiary copayments) under the OPPS were $184 million for the same time period. In CY 2007, aggregate allowed charges in the physician's office setting are estimated at $8 million, while total OPPS payments are estimated at $246 million.

In summary, beginning in CY 2007, IVIG utilization increased modestly in both the physician's office setting and the hospital outpatient department, after a prior shift to the hospital and away from the physicians' offices, presumably reflecting increasing availability of IVIG and appropriate payment for the drug in both settings.

According to information on the Plasma Protein Therapeutics Association (PPTA) Web site regarding the supply of IVIG, in the past year, while the supply has spiked at various times throughout the year, the supply has remained above or near the 12-month moving average. While we acknowledge that the supply is only one of several factors that influence the market, we believe that an adequate supply is one significant factor that contributes to better access to IVIG for patients.

Therefore, because we believe that the reported transient market conditions that led us to adopt the separate payment for IVIG preadministration-related services have improved, we believe that continuation of the separate payment for preadministration services beyond CY 2008 is not warranted.

After consideration of the public comments received, we are finalizing our CY 2009 proposal, without modification, to discontinue separate payment under the PFS for IVIG preadministration-related services described by HCPCS code G0332. The treatment of payment for preadministration-related services under the OPPS will be addressed separately in that final rule. We will continue to work with IVIG stakeholders to understand their concerns regarding the pricing of IVIG and Medicare beneficiary access to this important therapy.

2. Multiple Procedure Payment Reduction for Diagnostic Imaging

In general, we price diagnostic imaging procedures in the following three ways:

- The PC represents the physician's interpretation (PC-only services are billed with the 26 modifier).
- The TC represents PE and includes clinical staff, supplies, and equipment (TC-only services are billed with the TC modifier).
- The global service represents both PC and TC.

Effective January 1, 2006, we implemented a multiple procedure payment reduction (MPPR) on certain diagnostic imaging procedures (71 FR 48982 through 49252 and 71 FR 69624 through 70251). When two or more procedures within one of 11 imaging code families are furnished on the same patient in a single session, the TC of the highest priced procedure is paid at 100 percent and the TC of each subsequent procedure is paid at 75 percent (a 25-percent reduction). The reduction does not apply to the PC.

It is necessary to periodically update the list of codes subject to the MPPR to reflect new and deleted codes. In the CY 2009 PFS proposed rule, we proposed to subject several additional procedures to the MPPR (73 FR 38519). Six procedures represent codes newly created since the MPPR list was established. Four additional procedures have been identified as similar to procedures currently subject to the MPPR. We also proposed to remove CPT code 76778, a deleted code, from the list. Table 6 contains the proposed additions to the list. After we adopted the MPPR, section 5102 of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) exempted the expenditure reductions resulting from this policy from the statutory BN requirement. Therefore, we proposed that expenditure reductions resulting from these changes be exempt from BN. (See the Regulatory Impact Analysis in section XVI. of this final rule with comment period for a discussion of BN.) The complete list of procedures subject to the MPPR is in Addendum F of this final rule with comment period.

TABLE 6—PROCEDURES PROPOSED FOR MULTIPLE PROCEDURE PAYMENT REDUCTION

CPT code	Short descriptor	Code family
70336	mri, temporomandibular joint(s)	Family 5 MRI and MRA (Head/Brain/Neck).
70554	Fmri brain by tech	Family 5 MRI and MRA (Head/Brain/Neck).
75557	Cardiac mri for morph	Family 4 MRI and MRA (Chest/Abd/Pelvis).
75559	Cardiac mri w/stress img	Family 4 MRI and MRA (Chest/Abd/Pelvis).
75561	Cardiac mri for morph w/dye	Family 4 MRI and MRA (Chest/Abd/Pelvis).
75563	Cardiac mri w/stress img & dye	Family 4 MRI and MRA (Chest/Abd/Pelvis).
76776	Us exam k transpl w/doppler	Family 1 Ultrasound (Chest/Abdomen/Pelvis—Non-Obstetrical).
76870	Us exam, scrotum	Family 1 Ultrasound (Chest/Abdomen/Pelvis—Non-Obstetrical).
77058	Mri, one breast	Family 4 MRI and MRA (Chest/Abd/Pelvis).

TABLE 6—PROCEDURES PROPOSED FOR MULTIPLE PROCEDURE PAYMENT REDUCTION—Continued

CPT code	Short descriptor	Code family
77059	Mri, broth breasts	Family 4 MRI and MRA (Chest/Abd/Pelvis).

The following is a summary of the comments we received and our responses.

Comment: Some commenters indicated that the MPPR should not be extended to additional procedures without providing data supporting the appropriateness of a 25-percent payment reduction for the additional procedures. A commenter expressed concern that the MPPR was being extended to include breast MRIs, but the commenter provided no other information.

Response: As stated in the CY 2006 PFS final rule with comment period (70 FR 70261), when multiple images are taken in a single session, most of the clinical labor activities and supplies are not duplicated for subsequent procedures. Specifically, the following activities are not duplicated for subsequent procedures:

- Greeting the patient.
- Positioning and escorting the patient.
- Providing education and obtaining consent.
- Retrieving prior exams.
- Setting up the IV.
- Preparing and cleaning the room.

In addition, we considered that supplies, with the exception of film, are not duplicated for subsequent procedures.

To determine the appropriate level of the payment reduction for multiple procedures, we examined multiple pairs of procedure codes from the families representing all modalities (that is, ultrasound, CT/CTA, and MRI/MRA studies) that were frequently performed on a single day based on historical claims data. Using PE input data provided by the RUC, we factored out the clinical staff minutes for the activities we indicated are not duplicated for subsequent procedures, and the supplies, other than film, which we considered are not duplicated for subsequent procedures. We did not assume any reduction in procedure (scanning) time or equipment for subsequent procedures. However, equipment time and indirect costs are allocated based on clinical labor time; therefore, these inputs were reduced accordingly. Removing the PE inputs for activities that are not duplicated, and adjusting the equipment time and indirect costs for the individual pairs of procedures studied, supported payment reductions ranging from 40 to 59 percent for the subsequent services. Because we found a relatively narrow range of percentage payment reductions across modalities and families, and taking into consideration that we did not eliminate any duplicative image acquisition time for subsequent procedures in our analysis, we originally proposed an across-the-board MPPR for all 11 families of 50 percent (which is approximately the midpoint of the range established through our analysis). We believe this level of reduction was both justified and conservative (70 FR 45849). To allow for a transition of the changes in payments for these services attributable to this policy, we implemented a 25 percent payment reduction for all code families in CY 2006 which was scheduled to increase to a 50 percent reduction in CY 2007.

Subsequent to the publication of the CY 2006 PFS final rule with comment period, section 5102 (b) of the DRA capped the PFS payment for most imaging services at the amount paid under the hospital outpatient prospective payment system (OPPS). In addition, in response to our request for data on the appropriateness of the 50 percent reduction in the CY 2006 PFS final rule with comment period, the American College of Radiology (ACR) provided information for 25 code combinations supporting a reduction of between 21 and 44 percent. Given the expected interaction between the MPPR policy and the further imaging payment reductions mandated by section 5102(b) of the DRA, along with the information we received from the ACR on the MPPR as it applies to common combinations of imaging services, we decided it was prudent to maintain the MPPR at its current 25 percent level while we continue to examine the appropriate payment levels. Therefore, we have maintained the MPPR at the 25 percent level.

In establishing the MPPR, we elected to use a single reduction percentage for all code pairs. We adopted a percentage reduction that is considerably lower than the range supported by our prior analysis, and slightly higher than the lowest percentage supported by ACR's analysis. We do not believe it is necessary to conduct another analysis for the additional codes because we adopted a conservative reduction percentage and are continuing use of a single reduction percentage for all code pairs. We believe the payment reduction policy, described above, represents an appropriate reduction for the typical delivery of multiple imaging services furnished in the same session.

Furthermore, in establishing the MPPR, we limited it to codes in the same family, that is, contiguous areas of the body that are commonly furnished on the same patient, in the same session, on the same day. We believe that the eight CPT codes that were newly created for 2007 or 2008, and proposed for inclusion in the MPPR beginning in CY 2009 (CPT codes 70554, 75557, 75559, 75561, 75563, 76776, 77058, and 77059), would have been included on the MPPR list when it was finalized in CY 2006, had they existed at the time. These CPT codes are similar to CPT codes that were selected for the list in CY 2006 and can be classified into the 11 contiguous body area families already in existence. For example, the procedure described by CPT code 76776 (Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation) is similar to the procedure described by CPT code 76705 (Ultrasound, abdominal, real time with image documentation; limited (for example, single organ, quadrant, follow-up), which has been subject to the MPPR since the creation of the policy in CY 2006. Similarly, we believe we should add CPT codes 70336 and 76870, which were in existence in CY 2006, to the list because they also share characteristics with other procedures subject to the MPPR.

In response to the commenter expressing concern that we were adding the breast MRI CPT codes 77058 and 77059 in particular, we are not certain of the reason for his or her concern because none was stated. However, we continue to believe it is appropriate to add these CPT codes because their addition is consistent with our policy for other procedures included in Family 4, which describe procedures involving MRI of the chest area.

To the extent that the newly added procedures do not meet the MPPR criteria (for example, if they are not performed in the same session), they will be unaffected by the MPPR.

Comment: Commenters noted that we proposed to establish new composite rates for certain multiple diagnostic imaging procedures performed at the same time in hospital outpatient settings. One commenter asked whether individual procedure payment rates, or the composite payment rates under hospital OPPS will be used for purposes of applying the OPPS cap to PFS services. The commenter also asked whether we will continue our policy of applying the MPPR before application of the OPPS cap.

Response: Under the PFS, services are paid based on the individual CPT or HCPCS code. Therefore, the OPPS cap will continue to be applied based on the hospital OPPS ambulatory payment classification (APC) rate for the individual procedure, and not the composite rate. The policy of applying the MPPR before applying the OPPS cap remains unchanged.

Comment: Several commenters expressed concern that the proposed MPPR undervalues the procedures and jeopardizes beneficiary access to care. One commenter indicated that we should examine any shifts in the site-of-service that may have resulted due to the MPPR.

Response: The Government Accountability Office (GAO) and the Office of the Inspector General (OIG) have been performing several reviews relating to the utilization of imaging procedures including the effects of the OPPS cap and the MPPR on utilization, payment, and access to care. We will continue to monitor the effects of the policies to ensure that beneficiaries have proper access to care.

After reviewing the public comments, we are proceeding with the policy as proposed. The ten additional procedures listed in Table 6 will be subject to the MPPR, effective January 1, 2009.

3. HCPCS Code for Prostate Saturation Biopsies

In the CY 2009 PFS proposed rule, we proposed to create four new G codes for prostate saturation biopsy as shown in Table 7, currently reported with CPT code 88305, *Surgical pathology, gross and microscopic examination*, which is separately billed by the physician for each core sample taken. We also proposed to have Medicare contractors price these codes.

TABLE 7—G CODES FOR PROSTATE BIOPSY

G code	Descriptor
G0416 ..	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens.
G0417 ..	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens.
G0418 ..	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens.
G0419 ..	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens.

The following is a summary of the comments we received and our responses.

Comment: Some commenters expressed opposition to this proposal, while others supported it but recommended modifications to the proposed G codes. All commenters were opposed to Medicare contractor pricing the G codes and stated that CMS, rather than the Medicare contractor, should assign an appropriate work value for each specimen level to capture the expertise, skill, time, and resources used to determine if prostate cancer is present.

Response: First, for CY 2009, the CPT Editorial Panel changed Category III code (0137T) to a Category I code, 55706, *Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance*, which the AMA RUC valued at 6.15 work RVUs. As discussed in the proposed rule, we currently pay $102.35 for CPT code 88305, which is the code used by pathologists when interpreting prostate biopsy samples. Patients requiring a prostate saturation biopsy generally have 30 to 60 specimens taken. The pathologist would bill CPT code 88305 for evaluation of each individual specimen. When CPT code 88305 is used to evaluate prostate saturation biopsies, the average total payment for the evaluation of samples from one prostate needle saturation biopsy ranges from $3000 to $6000, depending on the number of biopsies taken. We believe the use of CPT code 88305 to bill individually for the evaluation of each biopsy sample would result in overpayment for this service. Therefore, we are proceeding with the proposal to create four G codes for pathologic examination of prostate needle saturation tissue sampling for services furnished beginning in 2009.

However, we agree with commenters that, rather than having Medicare contractors price the new G codes, it would be preferable for us to specify the payment for these services. We generally use contractor pricing when we do not have sufficient information to set the price. Upon further reflection, we believe we can set prices for the new G-codes by analogy to the current RVUs for two existing codes: 88304 and 88305. We selected the mid-point of the range of samples for G0417, G0418, and G0419 to calculate the average number of samples for each code. We assumed 15 percent of the samples taken require considerable clinical expertise to differentiate and distinguish carcinoma from hyperplasia. We assigned the work and PE values of 88305 to the 15 percent of samples requiring this level of expertise. The remaining 85 percent of samples require confirmation of prostate tissue and interpretation indicating the presence of cancer or not since the diagnosis had been identified in the 15 percent of samples. We assigned the work and PE of 88304 to this group of samples. We assigned the full work and PE payment to the 15 percent sample component to reflect the skill, time, and effort required to identify and diagnose carcinoma. We applied the multiple surgical procedure discount (RVUs were reduced by 50 percent in accordance with current CMS policy) to the remaining 85 percent of samples reviewed for identification and confirmation of prostate tissue. We selected the 75th percentile of samples from G0416 to recognize the greater degree of skill, time, and effort required to review, identify, and interpret the initial biopsy specimens sampled. (See Addendum B for the values assigned to these G codes.)

Note: Under the PFS, CPT code 88305 will continue to be recognized for those surgical pathology services unrelated to prostate needle saturation biopsy sampling.

F. Part B Drug Payment

1. Average Sales Price (ASP) Issues

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this final rule with comment period, the term ''drugs'' will hereafter refer to both drugs and biologicals, unless otherwise specified. Medicare Part B covered drugs not paid on a cost or prospective payment basis generally fall into the following three categories:

- Drugs furnished incident to a physician's service.
- DME drugs.

• Drugs specifically covered by statute (certain immunosuppressive drugs, for example).

Beginning in CY 2005, the vast majority of Medicare Part B drugs not paid on a cost or prospective payment basis are paid under the ASP methodology. The ASP methodology is based on data submitted to us quarterly by manufacturers. In addition to the payment for the drug, Medicare currently pays a furnishing fee for blood clotting factors, a dispensing fee for inhalation drugs, and a supplying fee to pharmacies for certain Part B drugs.

In this section, we discuss recent statutory changes to the ASP methodology and other drug payment issues.

a. Determining the Payment Amount Based on ASP Data

The methodology for developing Medicare drug payment allowances based on the manufacturers' submitted ASP data is specified in 42 CFR part 414, subpart K. We initially established this regulatory text in the CY 2005 PFS final rule with comment period (69 FR 66424). We further described the formula we use to calculate the payment amount for each billing code in the CY 2006 PFS proposed rule (70 FR 45844) and final rule with comment period (70 FR 70217). With the enactment of the MMSEA, the formula we use changed beginning April 1, 2008. Section 112(a) of the MMSEA requires us to calculate payment amounts using a specified volume-weighting methodology. In addition, section 112(b) of the MMSEA sets forth a special rule for determining the payment amount for certain inhalation drugs.

For each billing code, we calculate a volume-weighted, ASP-based payment amount using the ASP data submitted by manufacturers. Manufacturers submit ASP data to us at the 11-digit National Drug Code (NDC) level, including the number of units of the 11-digit NDC sold and the ASP for those units. We determine the number of billing units in an NDC based on the amount of drug in the package. For example: a manufacturer sells a box of four vials of a drug. Each vial contains 20 milligrams (mg). The billing code is per 10 MG. The number of billing units in this NDC for this billing code is (4 vials × 20mg)/ 10mg = 8 billable units.

Prior to April 1, 2008, we used the following three-step formula to calculate the payment amount for each billing code. First, we converted the manufacturer's ASP for each NDC into the ASP per billing unit by dividing the manufacturer's ASP for that NDC by the number of billing units in that NDC. Then, we summed the product of the ASP per billing unit and the number of units of the 11-digit NDC sold for each NDC assigned to the billing code. Then, we divided this total by the sum of the number of units of the 11-digit NDC sold for each NDC assigned to the billing code.

Beginning April 1, 2008, we use a two-step formula to calculate the payment amount for each billing code. We sum the product of the manufacturer's ASP and the number of units of the 11-digit NDC sold for each NDC assigned to the billing and payment code, and then divide this total by the sum of the product of the number of units of the 11-digit NDC sold and the number of billing units in that NDC for each NDC assigned to the billing and payment code.

In addition to the formula change, the MMSEA established a special payment rule for certain inhalation drugs furnished through an item of durable medical equipment (DME). The ''grandfathering'' provision in section 1847A(c)(6)(C)(ii) of the Act requires that certain drugs be treated as multiple source drugs for purposes of calculating the payment allowance limits. Section 112(b) of the MMSEA requires that, effective April 1, 2008, the payment amount for inhalation drugs furnished through an item of DME is the lesser of the amount determined by applying the grandfathering provision or by not applying that provision. We reviewed our payment determinations effective January 1, 2008 to identify the drugs subject to this special rule, and implemented this new requirement in accordance with the statutory implementation date of April 1, 2008. We identified that albuterol and levalbuterol, in both the unit dose and concentrated forms, are subject to the special payment rule. At this time, we have not identified other inhalation drugs furnished through an item of DME to which section 112(b) of the MMSEA applies.

The provisions in section 112 of the MMSEA are self-implementing for services on and after April 1, 2008. Because of the limited time between enactment and the implementation date, it was not practical to undertake and complete rulemaking on this issue prior to implementing the required changes. As a result of the legislation, we proposed to revise § 414.904 to codify the changes to the determination of payment amounts as required by section 112 of the MMSEA. We solicited comments on the proposed regulatory text.

The following is a summary of the comments we received and our responses.

Comment: We received a number of comments regarding our proposed regulatory text. All of comments we received strongly supported our proposed regulatory text. Several comments strongly urged CMS to ensure that the methodology is properly applied to all drugs paid under the ASP methodology.

Response: We appreciate the support from the public with regard to the implementation of this statutory provision. We have been applying the revised methodology since April 2008 and are unaware of payment issues resulting from its usage. The new methodology is being applied consistently across all Part B drugs subject to the ASP methodology.

Comment: One commenter requested that we limit the application of the special payment rule, established by section 112(b) of MMSEA to only albuterol and levalbuterol.

Response: We disagree with this comment. While we currently believe that we have identified all of the drugs to which the special payment rule applies, it would be imprudent to expressly limit its application to albuterol and levalbuterol in the regulations text because the statute does not do so. The statute refers to certain drugs described in section 1842(o)(1)(G) of the Act. Thus, we believe the regulations text, as proposed, adequately specifies the drugs to which the special rule applies. We have committed, via postings on our web site, to proceeding transparently when making pricing determinations and have done so by posting our decisions on our web site. We will continue to do so in the future.

After review of the public comments, we are finalizing our proposed regulatory text at § 414.904.

b. Average Manufacturer Price (AMP)/ Widely Available Market Prices (WAMP)

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that, ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

• The WAMP for such drugs and biologicals (if any); and

• The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals.''

Section 1847A(d)(3)(A) of the Act states that, ''The Secretary may disregard the average sales price (ASP) for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold percentage is specified in section 1847A(d)(3)(B)(i) of the Act as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B)(ii) of the Act establishes that the applicable threshold percentage is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In CY 2006 through CY 2008, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP comparisons. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2009, we proposed to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP comparisons. As we stated in the proposed rule, the OIG is continuing its ongoing comparison of both the WAMP and the AMP. However, information on how recent changes to the ASP weighting methodology may affect the comparison of WAMP/AMP to ASP was not available in time for consideration prior to developing our proposal to maintain the applicable threshold percentage at 5 percent for CY 2009. Although we have recently received reports comparing ASP to AMP in which the OIG states it has applied the new volume-weighting methodology consistently, we have not had sufficient time to analyze these reports. Thus, we do not have data suggesting a more appropriate level for the threshold at this time. Therefore, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP comparisons is appropriate for CY 2009.

As we noted in the CY 2008 PFS final rule with comment period (72 FR 66259), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, particularly manufacturers of drugs impacted by potential price substitutions, with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. As part of our approach, we intend to develop a better understanding of the issues that may be related to certain drugs for which the WAMP and AMP may be lower than the ASP over time.

We solicited comments on our proposal to continue the applicable threshold at 5 percent for both the WAMP and AMP for CY 2009.

The following is a summary of the comments we received and our responses.

Comment: Most commenters supported maintaining the threshold at 5 percent. Other commenters suggested that we exercise caution in the determination of price substitutions and that we develop a formal process and criteria to determine when substitutions are necessary. Commenters also recommended that we provide adequate notice prior to making a price substitution.

Response: We appreciate the comments to maintain the threshold at 5 percent. As we noted in the CY 2008 PFS final rule with comment period (72 FR 66259), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, particularly manufacturers of drugs impacted by potential price substitutions, with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. As part of our approach, we intend to develop a better understanding of the issues that may be related to certain drugs for which the WAMP and AMP may be lower than the ASP over time.

After reviewing of the public comments, we are finalizing our proposal to establish the WAMP/AMP threshold at 5 percent for CY 2009.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, physicians agree to obtain all of the approximately 190 drugs on the CAP drug list from an approved CAP vendor. A vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The physician bills Medicare only for administering the drug to the beneficiary. The CAP currently operates with a single CAP drug category. CAP claims processing began on July 1, 2006.

After the CAP was implemented, section 108 of the MIEA–TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA–TRHCA requires the Secretary to establish (by program instruction or otherwise) a post-payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, since the publication of our proposed rule, we have announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 is not being held this Fall, and CAP drugs will not be available from an Approved CAP Vendor for dates of service after December 31, 2008.

Moreover, we are currently soliciting public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We are soliciting public comments

about a range of issues, including, but not limited to the following issues: the categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and physicians. Interested parties can submit feedback about the CAP electronically or request to meet with us in person. Feedback about the CAP and meeting requests can be submitted electronically to: *MMA303DDrugBid@cms.hhs.gov.*

We will also host a CAP Open Door Forum (ODF) this December for participating physicians, potential vendors, and other interested parties. Participants will have an opportunity to discuss the postponement and suggest changes to the program. Additional information about this event will be available on the CMS CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/.*

We will assess information from the public and consider implementing changes to the CAP before proceeding with another bid solicitation for Approved CAP Vendor contracts. Furthermore, in light of the postponement of the CAP, we believe it would be prudent to consider the additional information that is being collected before finalizing any further changes to the program. For this reason, we will not finalize the CAP items in the CY 2009 proposed rule at this time. We appreciate the comments that we have received and we will consider these comments as we assess potential changes to the program and future rulemaking.

G. Application of the HPSA Bonus Payment

Section 1833(m) of the Act provides for an additional 10-percent bonus payment for physicians' services furnished in a year to a covered individual in an area that is designated as a geographic Health Professional Shortage Area (HPSA) as identified by the Secretary prior to the beginning of such year. The statute indicates that the HPSA bonus payment will be made for services furnished during a year in areas that have been designated as HPSAs prior to the beginning of that year. As a result, the HPSA bonus payment is made for physicians' services furnished in an area designated as of December 31 of the prior year, even if the area's HPSA designation is removed during the current year. However, for physicians' services furnished in areas that are designated as geographic HPSAs after the beginning of a year, the HPSA bonus payment is not made until the following year, if the area is still designated as of December 31 of that year.

In the CY 2005 PFS final rule with comment period (69 FR 66297), we stated that determination of zip codes for automatic HPSA bonus payment will be made on an annual basis and that there would be no updates to the zip code file during the year. We also stated that physicians furnishing covered services in ''newly designated'' HPSAs may add a modifier to their Medicare claims to collect the HPSA bonus payment until our next annual posting of zip codes for which automatic payment of the bonus will be made.

In the CY 2009 PFS proposed rule, we proposed to revise § 414.67 to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

Comment: We received comments in support of using the AQ modifier to ensure that all physicians furnishing services in a geographic HPSA that is not included in the list of zip codes eligible for automatic bonus payments will still receive the 10-percent HPSA bonus payment. One commenter emphasized that this clarification would lessen the administrative burdens they experienced from the lack of a modifier in the past.

A few commenters expressed concern that many physicians may not be aware of the AQ modifier requirement for services furnished in areas that are not on the list of zip codes for automatic payment. One commenter urged us to use educational materials and outreach in order to ensure physicians are aware they may need to use the AQ modifier when submitting their Medicare claims. Another commenter requested that we develop a method to ensure payments are received automatically for all physicians that would qualify for the HPSA bonus payment.

One commenter suggested that we change the HPSA bonus payment program to include nonphysicians and work with the Congress to allow all persons who directly bill under Part B to be eligible for the 10-percent bonus for working in a designated HPSA.

Response: We appreciate the comments in support of our efforts to ensure all physicians furnishing services to Medicare beneficiaries in an area that is designated as a geographic HPSA on December 31 of the prior year receive the HPSA bonus payment.

As a result of refinements in our systems, we expect that more areas that are eligible for the bonus payment will be on the list of zip codes eligible for automatic payment of the HPSA bonus, thereby reducing the number of physicians who need to use the modifier. However, we acknowledge that some physicians may not be aware of the need to use the modifier if they are furnishing services in a geographic HPSA that was designated after the list of eligible zip codes was created but prior to December 31. We will continue to utilize our provider education resources to increase awareness of the appropriate application of the AQ modifier. We will also continue to refine our systems to include as many areas as possible to the list of zip codes that receive automatic HPSA bonus payments.

We recognize that there can be shortages of all types of healthcare practitioners and we indeed appreciate the value of these nonphysicians. However, section 1833(m) of the Act provides for the payment of an additional amount only to physicians and a change would require a statutory revision.

After careful consideration of all of the comments, we are adopting our proposal to add § 414.67(d) with minor revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

H. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

In the CY 2009 PFS proposed rule (73 FR 38527), we outlined for CY 2009 the proposed updates to the case-mix adjusted composite rate payment system established under section 1881(b)(12) of the Act, added by section 623 of the MMA. These included updates to the drug add-on component of the composite rate system, as well as the wage index values used to adjust the labor component of the composite rate.

Specifically, we proposed the following provisions which are described in more detail below in this section:

- A zero growth update to the proposed 15.5 percent drug add-on adjustment to the composite rates for 2009 required by section 1881(b)(12)(F) of the Act (resulting in a $20.33 per treatment drug add-on amount).
- An update to the wage index adjustment to reflect the latest available

wage data, including a revised BN adjustment factor of 1.056672;

• The completion of the 4-year transition from the previous wage-adjusted composite rates to the CBSA wage-adjusted rates, where payment will be based on 100 percent of the revised geographic adjustments; and

• A reduction of the wage index floor from 0.7500 to 0.7000.

A total of 56 comments were submitted under the caption ''ESRD PROVISIONS.'' Eight of these comments pertained to the proposed changes to ESRD payment related provisions listed above. The remaining 48 comments responded to the solicitation for public comment pertaining to the application of preventable hospital-acquired condition (HAC) payment provisions for IPPS hospitals in settings other than IPPS hospitals, including ESRD facilities. Please refer to section II.H.6. of this final rule with comment period for a discussion of the applicability of the HAC payment provision for IPPS hospitals in settings other than IPPS hospitals.

The ESRD payment related comments are discussed in detail below in this section. In addition, subsequent to the publication of the CY 2009 PFS proposed rule, section 153 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), enacted on July 15, 2008, mandates changes in ESRD payment effective January 1, 2009.

Section 153(a) of the MIPPA amends section 1881(b)(12)(G) of the Act to increase the composite rate component of the payment system and amends section 1881(b)(12)(A) to revise payments to ESRD facilities. The amendments that are effective January 1, 2009 include an update of 1 percent to the composite rate component of the payment system (for services furnished on or after January 1, 2009, and before January 1, 2010), and the establishment of a site neutral composite rate for both hospital-based and independent dialysis facilities which, when applying the geographic index, shall reflect the labor share based on the labor share otherwise applied for renal dialysis facilities. The labor share for both hospital-based and independent dialysis facilities is 53.711.

In addition, since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, the drug add-on percentage is decreased to account for the higher composite payment rate and will result in a 15.2 percent drug add-on adjustment for CY 2009. Since the statutory increase only applies to the composite rate, this adjustment to the drug add-on percentage is needed to ensure that the total drug add-on dollars remains constant.

Prior to the MIPPA provisions, effective for CY 2008, hospital-based dialysis facilities received a base composite rate of $136.68 and independent dialysis facilities received a base composite rate of $132.49, and so the CY 2009 base composite rate for independent dialysis facilities prior to the MIPPA was $132.49. The MIPPA mandates that payments for both the hospital-based dialysis facilities and independent dialysis facilities be based on the independent dialysis facilities rate. The 1 percent increase to the independent dialysis facility's 2008 composite rate of $132.49 results in a 2009 base composite rate for both hospital-based and independent dialysis facilities of $133.81. A drug add-on amount of $20.33 per treatment remains the same for 2009, which results in a 15.2 percent increase over the base independent composite rate of $133.81.

1. Growth Update to the Drug Add-On Adjustment to the Composite Rates

Section 623(d) of the MMA added section 1881(b)(12)(B)(ii) of the Act which requires us to establish an add-on to the composite rate to account for changes in the drug payment methodology stemming from enactment of the MMA. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the AWP payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus, the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to ASP pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that beginning in CY 2006, we establish an annual update to the drug add-on to reflect the estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system.

The CY 2008 drug add-on adjustment to the composite rate is 15.5 percent. The drug add-on adjustment for 2008 incorporates an inflation adjustment of 0.5 percent. This computation is explained in detail in the CY 2008 PFS final rule with comment period (72 FR 66280 through 66282).

a. Estimating Growth in Expenditures for Drugs and Biologicals for CY 2009

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that uses the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth, in conjunction with 2 years of ESRD drug data, to estimate per patient utilization growth. We indicated that this methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ESRD drug expenditure data to project the growth in ESRD drug expenditures beginning in CY 2010.

For CY 2009, we proposed revising the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing instead of the PPI to estimate the price component of the update calculation.

As detailed below in this section, we proposed for CY 2009 to estimate price growth using historical ASP pricing data for ESRD drugs for CY 2006 through CY 2008, and to estimate growth in per patient utilization of drugs by using ESRD facility historical drug expenditure data for CY 2006 and CY 2007.

b. Estimating Growth in ESRD Drug Prices

For CY 2009, we proposed to estimate price growth using ASP pricing data for the four quarters of CY 2006 and CY2007, and the two available quarters of CY 2008. For this final rule with comment period, we are using four quarters of ASP prices for CYs 2006, 2007, and 2008. We calculated the weighted price change, for the original top ten ESRD drugs for which we had acquisition pricing, plus Aranesp. In CY 2006 and CY 2007, we calculated a weighted average price reduction of 1.8 percent. We also calculated a weighted average price reduction of 2.1 percent between CY 2007 and CY 2008. The overall average price reduction is 1.9 percent over the 3-year period. Thus, the weighted average ESRD drug pricing change projected for CY 2009 is a reduction of 1.9 percent.

Comment: Commenters were generally opposed to the use of ASP prices to estimate the price component of the drug add-on adjustment. One commenter stated that although the price of EPO has declined in the past few years, it has now stabilized and will likely not decline again in CY 2009. Two commenters, including MedPAC, supported the use of ASP prices stating that it is more closely related to the

actual ESRD drug pricing than the use of the overall drug PPI. Another commenter stated that the PPI was a more accepted proxy for predicting drug price increases compared to ASP price trends which have never been used in forecasting drug price changes. Some suggested that we use a blend of ASP and PPI to soften the impact of the change in the methodology.

Response: Given that the statutory language mandates that we estimate the growth in ESRD drug expenditures in order to update the drug add-on adjustment, we believe we have an obligation to utilize the best data available to make those estimates. Although the PPI is a well recognized measure of overall drug price growth, it is not specific to ESRD drug prices. Given that ESRD drug pricing trends are very different from overall drug pricing trends, we do not believe it would be appropriate to continue using the PPI when more specific data are available. ASP pricing data that are specific to ESRD drugs provide the most accurate measure for estimating the price component of the total ESRD drug expenditure estimate for CY 2009. Therefore, for this final rule with comment period, we used ASP pricing data to estimate price growth in ESRD drugs.

c. Estimating Growth in per Patient Drug Utilization

To isolate and project the growth in per patient utilization of ESRD drugs for CY 2009, we removed the enrollment and price growth components from the historical drug expenditure data, and considered the residual to be utilization growth. As discussed previously in this section, we proposed to use ESRD facility drug expenditure data from CY 2006 and CY 2007 to estimate per patient utilization growth for CY 2009.

We first estimated total drug expenditures for all ESRD facilities. For the CY 2009 PFS proposed rule (73 FR 38528), we used the final CY 2006 ESRD claims data and the latest available CY 2007 ESRD facility claims, updated through December 31, 2007 (that is, claims with dates of service from January 1 through December 31, 2007, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2007). For this final rule with comment period, we are using additional updated CY 2007 claims with dates of service for the same time period. This updated CY 2007 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2008.

For the CY 2009 PFS proposed rule, we adjusted the December 2007 file to reflect our estimate of what total drug expenditures would be using the final June 30, 2008 bill file for CY 2007. The net adjustment we applied to the CY 2007 claims data was an increase of 12.6 percent to the December 2007 claims file. To calculate the proposed per patient utilization growth, we removed the enrollment component by using the growth in enrollment data between CY 2006 and CY 2007. This was approximately 3 percent. To remove the price effect, we calculated the weighted change between CY 2006 and CY 2007 ASP pricing for the top eleven ESRD drugs. We weighted the differences using 2007 ESRD facility drug expenditure data.

This process led to an overall 1.8 percent reduction in price between CY 2006 and CY 2007.

After removing the enrollment and price effects from the expenditure data, the residual growth would reflect the per patient utilization growth. To do this, we divided the product of the enrollment growth of 3 percent (1.03) and the price reduction of 1.8 percent (1.00 − 0.018 = 0.982) into the total drug expenditure change between 2006 and 2007 of 0 percent (1.00 − 0.00 = 1.00). The result is a utilization factor equal to 0.99 or 1.00/(1.03 * 0.982) = 0.99.

Since we observed a 1 percent drop in per patient utilization of drugs between CY 2006 and CY 2007, we projected a 1 percent drop in per patient utilization for ESRD facilities in CY 2009.

Comment: A few commenters suggested that the use of CY 2007 billing data to predict utilization change in CY 2009 is not accurate since the utilization change in CY 2007 was driven by a revision to the EPO monitoring policy which caused a one-time decline in utilization that has since leveled off.

Response: We agree that the revised monitoring policy for erythropoesis stimulating agents (ESAs) that took effect in CY 2007 could have contributed to the observed decrease in ESRD drug utilization between CY 2006 and CY 2007, especially given that EPO and Aranesp make up over 75 percent of all ESRD drug expenditures. Moreover, this effect could distort our estimate of per patient utilization growth in CY 2009. Since CY 2007, we have analyzed 2 years of historical claims data for estimating growth in utilization (CY 2005 and CY 2006). During that period, utilization based on an analysis of independent ESRD facility drug data has indicated no growth. We believe the use of CY 2005 and CY 2006 drug data is the best data available for use in projecting utilization in CY 2009. Therefore, for CY 2009, we will continue to use our estimate of growth in utilization based on CY 2005 and CY 2006 data (72 FR 66282). That is, we are finalizing an estimation of no growth in utilization for CY 2009.

2. Applying the Proposed Growth Update to the Drug Add-on Adjustment

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment (71 FR 69684). For CY 2008, the per treatment drug add-on amount was updated to $20.33.

For CY 2009, we proposed no update to the per treatment drug add-on amount of $20.33 established in CY 2008.

3. Update to the Drug Add-On Adjustment

In the CY 2009 PFS proposed rule (73 FR 38529), we estimated a 1 percent reduction in per patient utilization of ESRD drugs for CY 2009. Using the projected decline of the CY 2009 ASP pricing for ESRD drugs of 1.9 percent, we projected that the combined growth in per patient utilization and pricing for CY 2009 would result in a negative update equal to −2.9 percent (0.99 * 0.981 = 0.971). However, we proposed to apply a zero percent update to the drug add-on adjustment and maintain the $20.33 per treatment drug add-on amount for CY 2009 that reflects a 15.5 percent drug add-on adjustment to the composite rate for CY 2009.

In addition, for CY 2009 we presented an alternative approach to the zero percent update. The alternative approach would be to apply an adjustment of less than 1.0 to the drug add-on adjustment. For CY 2009, we would ''increase'' the drug add-on by 0.971. Applying the 0.971 increase to the $20.33 per treatment adjustment would yield a drug add-on amount of $19.74 per treatment, which represents a 0.4 percent decrease in the CY 2008 drug add-on percentage of 15.5 percent. As such, the drug add-on adjustment to the composite rate for CY 2009 would be equal to 1.155 * 0.996 = 1.15 or 15.0 percent.

We solicited public comment on our proposal of a zero update, as well as the alternative approach presented above, so that we could make an informed decision with respect to the final update

to the CY 2009 drug add-on adjustment to the composite rate.

Comment: Commenters were uniformly opposed to any decrease in the drug add-on adjustment, citing the plain reading of the statute which calls for an annual ''increase'' in the adjustment. As support for the reliance on the plain reading of the statute, several commenters cited case law examples in which courts have relied on dictionary definitions, biblical text, and common usage of terms for purposes of interpreting statutory text. One commenter disagreed with CMS' alternative reading of 1881(b)(12)(F) of the Act, under which an increase in the drug add-on could not be implemented when estimated drug growth is negative, pointing to MMA Conference Report language that referenced a payment update that would be based on a ''growth'' in drug spending and ''drug cost increases.'' Commenters further argued, citing case law the priority on plain language over policy arguments and cautioned against identifying gaps in statutes.

One commenter suggested that we should use the methodology to estimate growth in ESRD drug expenditures that yields a positive adjustment as required by the statute. Another commenter stated that if we believe ESRD drug expenditures will decline, this would indicate that the spread between AWP and ASP pricing will widen in CY 2009, thus justifying an increase in the drug add-on adjustment.

Response: We agree that the plain reading of the statute would preclude any decrease in the drug add-on adjustment and would not support a negative growth update. Specifically, section 1881(b)(12)(F) of the Act states in part that ''the Secretary shall annually increase'' the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. We interpret the statutory language ''annually increase'' to mean a positive or zero update to the drug add-on given that the statute also requires that the annual ''increase'' to the drug add-on adjustment reflect our estimate of the growth in ESRD drug expenditures. Since our analysis indicates a projected reduction in ESRD drug expenditures for CY 2009, we do not believe it would be appropriate to provide an increase that cannot be substantiated by the best data available.

Therefore, we are finalizing our proposal to provide a zero update to the drug add-on adjustment for CY 2009. If the statute had included, instead of the word ''increase,'' a broader term, we believe we would have had authority to decrease the rate to take into account the projected reduction.

4. Final Growth Update to the Drug Add-On Adjustment for 2009

As we indicated earlier, we have decided not to use CY 2007 expenditure data to estimate utilization growth for CY 2009, because of the potential distortion of our estimates due to the implementation of the ESA monitoring policy in 2007. Therefore, for this final rule with comment period, we are using the same data we use to estimate growth in utilization for CY 2008 as outlined in the CY 2008 PFS final rule with comment period (72 FR 66282). That is, for CY 2009, we estimate no growth in per patient utilization of ESRD drugs for CY 2009.

Similar to the CY 2009 PFS proposed rule, we estimated growth in ESRD drug prices using ASP pricing data for CYs 2006, 2007 and 2008. In the proposed rule, we had only 2 quarters of data for 2008, but for this final rule all four quarters of ASP pricing data are available. We calculated the weighted price change for the top eleven ESRD drugs. Tables 8 and 9 show the average ASP prices and the 2007 weights used. We note that the final CY 2007 weights are derived from the final CY 2007 ESRD facility claims file as of June 30, 2008. For CY 2006 and CY 2007, we calculated a weighted average price reduction of 1.8 percent. We also calculated a weighted average price reduction of 1.9 percent between CY 2007 and CY 2008. The overall average price reduction is 1.8 percent over the 3-year period. Thus, the weighted average ESRD drug pricing change projected for CY 2009 is a reduction of 1.8 percent.

We project that the combined growth in per patient utilization and pricing of ESRD drugs for CY 2009 would result in a negative update equal to −1.8 percent (1.00 * 0.982 = 0.982). If we implement this decrease in the update to the drug-on adjustment, the resulting savings would have been $14 million. However, as indicated above, for this final rule with comment period, we are applying no update to the drug add-on adjustment for CY 2009. Thus, we are applying a zero update to the $20.33 per treatment drug add-on amount for CY 2009. After adjusting for the MIPPA changes as discussed earlier in this section, the final drug add-on adjustment to the composite rate for CY 2009 is 15.2 percent.

TABLE 8—CY 2006, 2007 AND 2008 ESRD DRUG ASP PRICES

Independent drugs	CY 2006	CY 2007	CY 2008
EPO	$9.46	$9.17	$9.05
Paricalcitol	3.81	3.79	3.78
Sodium-ferric-glut	4.88	4.76	4.81
Iron-sucrose	0.36	0.37	0.36
Levocarnitine	9.44	8.07	6.31
Doxercalciferol	2.97	2.68	2.75
Calcitriol	0.55	0.54	0.40
Iron-dextran	11.94	11.69	11.69
Vancomycin	3.23	3.43	3.19
Alteplase	31.63	33.21	33.06
Aranesp	3.01	3.29	2.86

TABLE 9—CY 2007 DRUG WEIGHTS FOR ESRD FACILITIES

Independent drugs	CY 2007 weights (%)
EPO	69.1
Paricalcitol	11.9

TABLE 9—CY 2007 DRUG WEIGHTS FOR ESRD FACILITIES—Continued

Independent drugs	CY 2007 weights (%)
Sodium-ferric-glut	2.5
Iron-sucrose	6.1

TABLE 9—CY 2007 DRUG WEIGHTS FOR ESRD FACILITIES—Continued

Independent drugs	CY 2007 weights (%)
Levocarnitine	0.2
Doxercalciferol	2.8

TABLE 9—CY 2007 DRUG WEIGHTS FOR ESRD FACILITIES—Continued

Independent drugs	CY 2007 weights (%)
Calcitriol	0.1
Iron-dextran	0.0
Vancomycin	0.1
Alteplase	1.0
Aranesp	6.2

5. Update to the Geographic Adjustments to the Composite Rates

Section 1881(b)(12)(D) of the Act, as added by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rates. The wage indexes are calculated for each urban and rural area. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located.

a. Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. OMB's CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03–04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

b. Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The current ESRD wage index values for CY 2008 were developed from FY 2004 wage and employment data obtained from the Medicare hospital cost reports. The ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. To calculate the ESRD wage index, hospital wage index data for FY 2004 for all providers in each urban/rural geographic area are combined. The sum of the wages for all providers in each geographic area was divided by the total hours for all providers in each area. The result is the average hourly hospital wage for that geographic locale. The ESRD wage index was computed by dividing the average hourly hospital wage for each geographic area by the national average hourly hospital wage. The final step was to multiply each wage index value by the ESRD wage index budget neutrality factor (BNF).

We proposed to use the same methodology for CY 2009, with the exception that FY 2005 hospital data will be used to develop the CY 2009 wage index values. The CY 2009 ESRD wage index BNF is 1.056689. This figure differs slightly from the figure in the proposed rule (1.056672) because we used updated hospital wage data and treatment counts from the most current claims data. (See section II.H.5.c. of this final rule with comment period for details about this adjustment.) For a detailed description of the development of the CY 2009 wage index values based on FY 2005 hospital data, see the FY 2009 ''Hospital Inpatient Prospective Payment Systems (IPPS) and Final Fiscal Year 2009 Rates'' rule (73 FR 23630). Section III.G. of the preamble to the FY 2009 IPPS final rule, Computation of the Final FY 2009 Unadjusted Wage Index, describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting ESRD composite rates for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, ''FY 2009 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

i. Fourth Year of the Transition

In the CY 2006 PFS final rule with comment period (70 FR 70167 through 70169), we indicated that we would apply a 4-year transition period to mitigate the impact on the composite rates resulting from our adoption of CBSA-based geographic designations. Beginning January 1, 2006, during each year of the transition, an ESRD facility's wage-adjusted composite rate (that is, without regard to any case-mix adjustments) is a blend of its old MSA-based wage-adjusted payment rate and its new CBSA-based wage adjusted payment rate for the transition year involved. In CY 2006, the first year of the transition, we implemented a 75/25 blend. In CY 2007, the second year of the transition, we implemented a 50/50 blend. In CY 2008, the third year of the transition, we implemented a 25/75 blend. Consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), in CY 2009, each ESRD facility's composite payment rate will be based entirely on the CBSA-based wage index.

For CY 2009, we proposed to reduce the wage index floor from 0.75 to 0.70. For this final year of the transition (CY 2009), we believe that a reduction to 0.70 is appropriate as we continue to reassess the need for a wage index floor in future years. We believe that a gradual reduction in the floor is still needed to ensure patient access to dialysis in areas that have low wage index values, especially Puerto Rico, and to prevent sudden adverse effects to the payment system. However, we note that our goal is the eventual elimination of all wage index floors.

The wage index floor and blended share applicable for CY 2009 are shown in Table 10.

TABLE 10—WAGE INDEX TRANSITION BLEND

CY payment	Floor	Ceiling	Old MSA	New CBSA
2009	0.70*	None	0%	100%

*Each wage index floor is multiplied by a BN adjustment factor. For CY 2009 the BN adjustment is 1.056689 resulting in an actual wage index floor of 0.7397.

Because CY 2009 is the final year of the 4-year transition period, each ESRD facility's composite payment rate will be based entirely on its applicable new CBSA-based wage index value.

Comment: We received a few comments that commend CMS for its use of a transition policy in shifting the Medicare ESRD program into a new geographic wage index system. Commenters stressed that prior to the elimination to the floor, we should provide protection to facilities in areas that would otherwise not be able to support dialysis facilities, which will ensure that access to care for beneficiaries is not compromised.

Response: We note that our goal is the eventual elimination of all wage index floors. However, we believe that a gradual reduction in the floor is still needed to ensure patient access to dialysis in areas that have low wage index values, especially Puerto Rico, and to prevent sudden adverse effects to the payment system. We will continue to reassess the need for a wage index floor in future years.

ii. Wage Index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Massachusetts, rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980). For CY 2006, CY 2007, and CY 2008, we calculated the ESRD wage index values for those areas as follows:

- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. For CY 2008, we used an alternative methodology as explained below.
- For rural Puerto Rico, the situation was similar to rural Massachusetts. However, because all geographic areas in Puerto Rico were subject to the wage index floor in CY 2006, CY 2007, and CY 2008, we applied the ESRD wage index floor to rural Puerto Rico as well.
- For the urban area of Hinesville, GA, we calculated the CY 2006, CY 2007, and CY 2008 wage index value based on the average wage index value for all urban areas within the State of Georgia.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts), and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term ''contiguous'' to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with Barnstable and Bristol counties. We will continue to use the same methodology for CY 2009. Under this methodology, the CY 2009 wage index values for the counties of Barnstable (CBSA 12700, Barnstable Town, MA–1.2643) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI–MA–1.0696) were averaged resulting in an imputed proposed wage index value of 1.1670 for rural Massachusetts in CY 2009.

For rural Puerto Rico, we continued to apply the wage index floor in CY 2008. Because all areas in Puerto Rico that have a wage index were eligible for the ESRD wage index floor of 0.75, we applied that floor to ESRD facilities located in rural Puerto Rico. For CY 2009, all areas in Puerto Rico that have a wage index are eligible for the final ESRD wage index floor of 0.70. Therefore, we will apply the ESRD wage index floor of 0.70 to all ESRD facilities that are located in rural Puerto Rico.

For Hinesville, GA (CBSA 25980), which is an urban area without specific hospital wage data, we proposed to apply the same methodology in 2009 that we used to impute a wage index value in CY 2006, CY 2007, and CY 2008. Specifically, we proposed to use the average wage index value for all urban areas within the State of Georgia. We are finalizing our proposal, which results in a CY 2009 wage index value of 0.9110 for the Hinesville-Fort Stewart GA CBSA.

In the CY 2008 PFS final rule with comment period (72 FR 66283 through 66284), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2009 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index, have emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy. We received no comments on this section and are finalizing our policies for wage areas with no hospital data as proposed.

iii. Evaluation of Wage Index Policies Adopted in the FY 2008 IPPS Final Rule

We stated in the CY 2008 PFS final rule with comment period (72 FR 66284) that we planned to evaluate any policies adopted in the FY 2008 IPPS final rule (72 FR 47130, 47337 through 47338) that affect the wage index, including how we treat certain New England hospitals under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21). This is relevant for the ESRD composite payment system, because the ESRD wage index is calculated using the same urban/rural classification system and computation methodology applicable under the IPPS, except that it is not adjusted for occupational mix and does not reflect geographic classifications authorized under sections 1886(d)(8) and (d)(12) of the Act. We also proposed to use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005), to compute the ESRD composite payment rates effective beginning January 1, 2009.

(1) CY 2009 Classification of Certain New England Counties

We are addressing the change in the treatment of ''New England deemed counties'' (that is, those counties in New England listed in § 412.64(b)(1)(ii)(B) that were deemed to part of urban areas under section 601(g) of the Social Security Amendments of 1983), that were made in the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338). These counties include the following: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five ''New England deemed counties'', three (York County, Sagadahoc County, and Newport County) are also included in the MSAs defined by OMB, and therefore, used in the calculations of the urban hospital wage index values reflected in the ESRD composite payment rates. The remaining two counties, Litchfield County and Merrimack County, are geographically located in areas that are considered ''rural'' under the current IPPS and ESRD composite payment system labor market definitions, but have been previously deemed urban under the IPPS in certain circumstances as discussed below.

In the FY 2008 IPPS final rule with comment period, for purposes of IPPS, § 412.64(b)(1)(ii)(B) was amended such that the two ''New England deemed counties'' that are still considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH) are no longer considered urban effective for discharges occurring on or after October 1, 2007, and therefore, are considered rural in accordance with § 412.64(b)(1)(ii)(C). For purposes of the ESRD wage index, we have recognized OMB's CBSA designations, as well as generally followed the policies under the IPPS with regard to the definitions for ''urban'' and ''rural'' for the wage index, but we do not to take into account IPPS geographic reclassifications in determining payments under the composite payment system. Accordingly, to reflect our general policy for the ESRD wage index, these two counties will be considered ''rural'' under the ESRD composite payment system effective with the next update of the payment rates on January 1, 2009, and will no longer be included in urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively.

(2) Multi-Campus Hospital Wage Index Data

In the CY 2008 ESRD composite payment system final rule (72 FR 66280), we established ESRD wage index values for CY 2008 calculated from the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. However, the IPPS policy that apportions the wage data for multi-campus hospitals was not finalized before the ESRD composite payment system final rule. Therefore, the CY 2008 ESRD wage index values reflected the IPPS wage data that were based on a hospital's actual location without regard to the urban or rural designation of any related or affiliated provider. Accordingly, all wage data from different campuses of a multi-campus hospital were included in the calculation of the CBSA wage index of the main hospital. In the proposed rule, we noted that the IPPS wage data used to determine the proposed CY 2009 ESRD wage index values were computed from wage data submitted by hospitals for cost reporting periods beginning in FY 2005, and reflect our policy adopted under the IPPS beginning in FY 2008, which apportions the wage data for multi-campus hospitals located in different labor market areas, CBSAs, to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). Specifically, under the CY 2009 ESRD composite payment system, the wage index was computed using IPPS wage data (published by hospitals for cost reporting periods beginning in 2005, as with the FY 2009 IPPS wage index). This resulted in the allocation of salaries and hours to the campuses of two multi-campus hospitals, with campuses that are located in different labor areas, one in Massachusetts and the other is Illinois. The ESRD wage index values proposed for CY 2009 in the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI-MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974), and Lake County-Kenosha County, IL-WI (CBSA 29404). (Please refer to Addenda G and H of this final rule with comment period.)

For CY 2009, we will use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005) to compute the ESRD composite payment rates effective beginning January 1, 2009.

Although we solicited comments, we did not receive any comments on this section and are implementing these provisions in this final notice. (For a detailed explanation of the multi-campus and New England deemed counties policies, refer to the CY 2009 PFS proposed rule (73 FR 38531 through 38532)).

c. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, requires that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment), be made in a budget neutral manner. This means that aggregate payments to ESRD facilities in CY 2008 should be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments currently in effect. As we did not propose any changes to the case-mix measures for CY 2009, the current case-mix BN adjustment will remain in effect for CY 2009. As in CY 2008, for CY 2009, we again proposed to apply a BN adjustment factor directly to the ESRD wage index values. As explained in the CY 2007 PFS final rule with comment period (71 FR 69687 through 69688), we believe this is the simplest approach because it allows us to maintain our base composite rates during the transition from the current wage adjustments to the revised wage adjustments described previously in this section. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the final CY 2009 wage index BN adjustment factor (1.056689), we used the most current FY 2005 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, treatment counts from the most current 2007 outpatient claims (paid and processed as of June 30, 2008), and geographic location information for each facility which may be found on the Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/*. The FY 2005 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp*. The wage index data are located in the section entitled, ''FY 2009 Final Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Using treatment counts from the 2007 claims and facility-specific CY 2008 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2008 (the 3rd year of the 4-year transition). The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2009. Next, we computed the estimated dollar amount that would have been paid to the same ESRD facilities using the proposed ESRD wage index for CY 2009 (the 4th year of the 4-year transition). The total of these payments became the fourth year new amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA updated section 1881(b)(12)(G) of the Act and revised payments to ESRD facilities. The revisions that are effective January 1, 2009 include an update of 1 percent to the composite rate component of the payment system, and the establishment of a site neutral composite rate to hospital-based and independent dialysis facilities. We note that when computing the 4th year new amount, we did not

include the MIPPA provisions because they are not budget neutral.

After comparing these two dollar amounts (target amount divided by the 4th year new amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2009 ESRD wage index value, would result in aggregate payments to ESRD facilities that will remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.7000 is used whenever appropriate. The BN adjustment factor for the CY 2009 wage index is 1.056689. This figure differs slightly from the figure in the proposed rule (1.056672) because we have used updated hospital wage data and treatment counts from the most current claims data.

To ensure BN, we also must apply the BN adjustment factor to the wage index floor of 0.7000 which results in a adjusted wage index floor of 0.7397 (0.7000×1.056689) for CY 2009.

d. ESRD Wage Index Tables

The 2009 wage index tables are located in Addenda G and H of this final rule with comment period.

6. Application of the Hospital-Acquired Conditions Payment Policy for IPPS Hospitals to Other Settings

Value-based purchasing (VBP) ties payment to performance through the use of incentives based on measures of quality and cost of care. The implementation of VBP is rapidly transforming CMS from being a passive payer of claims to an active purchaser of higher quality, more efficient health care for Medicare beneficiaries. Our VBP initiatives include hospital pay for reporting (the Reporting Hospital Quality Data for the Annual Payment Update), physician pay for reporting (the Physician Quality Reporting Initiative), home health pay for reporting, the Hospital VBP Plan Report to Congress, and various VBP demonstration programs across payment settings, including the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration.

The preventable hospital-acquired conditions (HAC) payment provision for IPPS hospitals is another of our value-based purchasing initiatives. The principle behind the HAC payment provision (Medicare will not provide additional payments to IPPS hospitals to treat certain preventable conditions acquired during a beneficiary's IPPS hospital stay) could be applied to the Medicare payment systems for other settings of care. Section 1886(d)(4)(D) of the Act requires the Secretary to select for the HAC IPPS payment provision conditions that are: (1) High cost, high volume, or both; (2) assigned to a higher paying Medicare Severity-Diagnosis Related Group (MS–DRG) when present as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher paying MS–DRG if a selected HAC was not present, or could not be identified based on clinical judgment, on admission. That is, the case will be paid as though the secondary diagnosis related to the HAC was not present. Medicare will continue to assign a discharge to a higher paying Medicare Severity-Diagnosis Related Group (MS–DRG) if a selected condition was present on admission.

The broad principle articulated in the HAC payment provision for IPPS hospitals (that is, Medicare not paying more for certain reasonably preventable hospital-acquired conditions) could potentially be applied to other Medicare payment systems for conditions that occur in settings other than IPPS hospitals. Other possible settings of care include, but are not limited to: hospital outpatient departments, ambulatory surgical centers, SNFs, HHAs, ESRD facilities, and physician practices. Implementation would be different for each setting, as each payment system is different and the level of reasonable prevention through the application of evidence-based guidelines would vary for candidate conditions across different settings of care. However, alignment of incentives across settings of care is an important goal for all of our VBP initiatives, including the HAC payment provision.

A related application of the broad principle behind the HAC payment provision for IPPS hospitals could be considered through Medicare secondary payer policy by requiring the provider that failed to prevent the occurrence of a preventable condition in one setting to pay for all or part of the necessary follow up care in a second setting. This would help shield the Medicare program from inappropriately paying for the downstream effects of a reasonably preventable condition acquired in the first setting but treated in the second setting.

We note that we did not propose new Medicare policy in this discussion of the possible application of the HAC payment policy for IPPS hospitals to other settings, as some of these approaches may require new statutory authority. Instead of proposing policy, we solicited public comment on the application of the preventable HAC payment provision for IPPS hospitals to other Medicare payment systems. We also stated that we look forward to working with stakeholders in the fight against all healthcare-associated conditions.

The following is a summary of the comments we received and our responses.

Comment: Commenters recommended that CMS work with technical experts, such as physicians and hospitals, to determine the impact, burden, and accuracy of POA indicator reporting in the inpatient setting before it is expanded to other settings of care. Commenters specifically recommended that CMS consider issues of adverse selection and access to care for vulnerable populations. Many commenters had concerns with CMS' authority and ability to implement such a policy for the physician office setting.

Response: We agree that the HAC payment provision should be studied to determine its impact. We also recognize the importance of aligning VBP policy across all Medicare payment systems. We believe it is appropriate to consider policies of not paying more for medical care that harms patients or leads to complications that could have been prevented. For example, we note that CMS is currently considering National Coverage Determinations (NCDs) for three of the National Quality Forum's Serious Reportable Events: (1) Surgery on the wrong body part, (2) surgery on the wrong patient, and (3) wrong surgery performed on a patient. NCDs can address physician services as well as institutional services. We will work with stakeholders as we move forward in combating healthcare-associated conditions in all Medicare payment settings. Any additional policies, within statutory authority, addressing these issues would be proposed through notice and comment rulemaking.

Comment: Some commenters stated that CMS may need to implement a Present on Admission (POA)-type indicator to recognize healthcare-acquired conditions in the physician office and ESRD settings of care, similar to the IPPS POA indicator.

Response: We agree that a POA-type indicator would aid in determining the onset of a healthcare-acquired condition. We welcome the opportunity to work with stakeholders to consider expansion of a POA-type indicator to all Medicare settings of care. We look forward to working with entities such as the National Uniform Billing Committee (NUBC) on the implementation of a

POA-type indicator for all settings of care.

Comment: Many commenters identified attribution of a healthcare-acquired condition to an individual physician who is broadly managing the patient's care as a challenge in expanding the principle behind the HAC payment provision to the physician office setting. Some commenters noted that several physicians may be responsible for the care of a patient, therefore attribution of the adverse event to a single physician may be difficult.

Response: We recognize that because health care is delivered by a team of professionals, several providers could potentially share responsibility for the occurrence of a healthcare-associated condition. We have extensive experience in testing various attribution methodologies in our cost of care measurement initiative. We refer readers to section III.C. of this final rule with comment period (section 131(c) of the MIPPA) for further discussion of attribution.

Comment: Some commenters expressed concern regarding implementation of the Medicare secondary payer policy to hold the provider in which a health-care associated condition occurred liable for the cost of subsequent care required to treat the condition.

Response: We appreciate the comments regarding MSP policy and payment for health-care associated conditions in downstream care settings. We look forward to further exploring these issues with stakeholders.

Comment: A few commenters recognized that the HAC payment provision targets a portion of an MS-DRG payment and were unsure how this concept could be transferred to the physician office setting. Further, several commenters mentioned bundled or global payment as a more rational way to pay for Medicare services, which could obviate the need for a healthcare-acquired condition payment provision.

Response: As commenters noted, the HAC payment provision prohibits payment for a portion of the MS-DRG when a HAC occurs in the inpatient setting. In that the HAC payment provision results in payment being adjusted to a lower level of payment, the basic payment concept could be made applicable to other Medicare payment settings. Implementation of such policies would likely depend on the specific coding and payment systems used for each payment system.

Comment: Several commenters expressed the need to adjust for patient-specific factors like severity of illness and patient compliance. A few commenters stated that unlike the inpatient setting, the physician office setting does not lend itself to close monitoring of patient compliance.

Response: We recognize that certain beneficiaries may pose a greater risk of contracting a healthcare-acquired condition. We also note that providers must carefully consider those risk factors to avoid preventable conditions. We refer readers to the FY 2009 Inpatient Prospective Payment System final rule (73 FR 48487 through 48488 (*http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf*)) where we discussed risk-adjustment as a potential enhancement to the IPPS HAC provision.

Comment: Many commenters believe that it could be more effective to combat healthcare-acquired conditions by adjusting payments based on a provider's rates of healthcare-associated conditions rather than to directly adjust the payment for an individual service.

Response: We agree that capturing rates of healthcare-associated conditions and using those rates for performance-based payment may be a more sophisticated and effective way to adjust payment. Rates of healthcare-associated conditions may be good candidates as possible quality measures for VBP programs like the PQRI as discussed in more detail in section II.O. of this final rule with comment period. Further, the ESRD pay-for-performance program and the forthcoming Physician VBP Plan Report to Congress may also address healthcare-associated conditions.

Comment: Commenters raised concern regarding the use of financial incentives to combat healthcare-associated conditions. Many commenters suggested that CMS should encourage compliance with evidence-based guidelines rather than use direct payment adjustments to address healthcare-associated conditions in the physician office setting.

Response: We agree that it is important for Medicare providers to provide care that is consistent with evidence-based guidelines. We intend to consider all of our statutory and regulatory authorities, including the implementation of quality measures and payment adjustments, to encourage provision of care that is consistent with evidence-based guidelines. We look forward to working with stakeholders to further identify and apply available methods to combat healthcare-acquired conditions.

Comment: Many commenters supported the alignment of incentives across all Medicare settings of care.

Response: We appreciate the public's support of our efforts to align incentives across all Medicare payment settings. We look forward to working with stakeholders to expand VBP initiatives in all Medicare payment settings. Further, we intend to host a public listening session toward the end of CY 2008 to discuss the expansion of the HAC payment provision, specifically targeting both the inpatient and hospital outpatient department (HOPD) settings of care.

I. Independent Diagnostic Testing Facility (IDTF) Issues

In the CY 2007 and 2008 PFS final rules with comment period, we established performance standards for suppliers enrolled in the Medicare program as an IDTF (71 FR 69695 and 72 FR 66285). These standards were established to improve the quality of care for diagnostic testing furnished to Medicare beneficiaries by a Medicare-enrolled IDTF and to improve our ability to verify that these suppliers meet minimum enrollment criteria to enroll or maintain enrollment in the Medicare program. These performance standards were established at § 410.33. In the proposed rule, we proposed to expand on the quality and program safeguard activities that we implemented previously.

1. Improving Quality of Diagnostic Testing Services Furnished by Physician and Nonphysician Practitioner Organizations

During the CY 2008 PFS proposed rule comment period, we received comments requesting that we require that the IDTF performance standards adopted in § 410.33, including prohibitions regarding the sharing of space and leasing/sharing arrangements, apply to physicians and nonphysician practitioners (NPPs) who are furnishing diagnostic testing services for Medicare beneficiaries, and who have enrolled in the Medicare program as a clinic, group practice, or physician's office. The commenters stated that standards for imaging services were not applied consistently for all imaging centers and that two distinct compliance and regulatory standards would emerge depending on how the similarly situated imaging centers were enrolled. In addition, one commenter stated that we should not prohibit space sharing when done with an adjoining physician practice or radiology group that is an owner of an IDTF. Because these comments were outside of the scope of the provisions in the CY 2008 PFS proposed rule, we were not able to take action regarding these comments in the

CY 2008 PFS final rule with comment period.

In the CY 2009 PFS proposed rule, we stated that we are concerned that—

- Certain physician entities, including physician group practices, and clinics, can enroll as a group practice or clinic and furnish diagnostic testing services without the benefit of qualified nonphysician personnel, as defined in § 410.33(c), to conduct diagnostic testing.
- Some physician entities expect to furnish diagnostic testing services for their own patients and the general public and are making the decision to enroll as a group or clinic thereby circumventing the performance standards found in the IDTF requirements in § 410.33.
- Some physician organizations are furnishing diagnostic tests using mobile equipment provided by an entity that furnishes mobile diagnostic services.

Therefore, we proposed certain exceptions to the established performance standards found in § 410.33(g) because we believe that physician organizations already meet or exceed some of these standards. For example, their liability insurance coverage usually far exceeds the $300,000 per incident threshold, and there are a host of ways in which patients may make clinical complaints concerning their physicians. In addition, we believe that compliance with some of the performance standards would be costly and burdensome and possibly limit beneficiary access, particularly in rural or medically underserved areas. For these reasons, we proposed that physician entities do not need to comply with the following standards:

- Maintaining additional comprehensive liability insurance for each practice location as required under § 410.33(g)(6).
- Maintaining a formal clinical complaint process as required under § 410.33(g)(8).
- Posting IDTF standards as required under § 410.33(g)(9).
- Maintaining a visible sign posting business hours as required under § 410.33(g)(14)(ii).
- Separately enrolling each practice location as required under § 410.33(g)(15)(i).

Accordingly, we proposed to add § 410.33(j) which states that, ''A physician or NPP organization (as defined in § 424.502) furnishing diagnostic testing services, except diagnostic mammography services: (1) Must enroll as an independent diagnostic testing facility for each practice location furnishing these services; and (2) is subject to the provisions found in § 410.33, except for § 410.33(g)(6), § 410.33(g)(8), § 410.33(g)(9), § 410.33(g)(14)(ii), and § 410.33(g)(15)(i).'' As discussed in section II.J. of this preamble, we proposed to define a ''physician or nonphysician practitioner organization'' as any physician or NPP entity that enrolls in the Medicare program as a sole proprietorship or organizational entity such as a clinic or group practice.

We maintained that this enrollment requirement is necessary to ensure that beneficiaries are receiving the quality of care that can only be administered by appropriately licensed or credentialed nonphysician personnel as described in § 410.33(c). Moreover, we proposed that physician or NPP organizations that do not enroll as an IDTF and meet the provisions at § 410.33 may be subject to claims denial for diagnostic testing services or a revocation of their billing privileges.

We solicited comments on whether we should consider establishing additional exceptions to the established performance standards in § 410.33(g) for physician and NPP organizations furnishing diagnostic testing services. We stated in the proposed rule that while we believe that most physician and NPP organizations utilize nonphysician personnel described in § 410.33(c) to furnish diagnostic testing services, we also solicited comments on whether physician or NPPs conduct diagnostic tests without benefit of qualified nonphysician personnel and under what circumstances the testing occurs.

While we proposed to apply the IDTF requirement to all diagnostic testing services furnished in physicians' offices, we stated that we were considering whether to limit this enrollment requirement to less than the full range of diagnostic testing services, such as to procedures that generally involve more costly testing and equipment. We solicited comments about whether the policy should apply only to imaging services or whether it should also include other diagnostic testing services such as electrocardiograms or other diagnostic testing services frequently furnished by primary care physicians. Within the scope of imaging services, we solicited comments about whether the policy should be limited to advanced diagnostic testing procedures which could include diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography), and other such diagnostic testing procedures described in section 1848(b)(4)(B) of the Act (excluding X-ray, ultrasound, and fluoroscopy). We also solicited comments on what would be appropriate criteria to limit this provision.

Finally, since these changes, if adopted, would take time to implement for suppliers that have enrolled in the Medicare program, we proposed an effective date of September 30, 2009, rather than the effective date of the final rule with comment period. For newly enrolling suppliers, we proposed the effective date of this rule which is January 1, 2009.

With the enactment of section 135 of the MIPPA legislation and after reviewing public comments, we are deferring the implementation of these proposals while we continue to review the public comments received on this provision and we will consider finalizing this provision in a future rulemaking effort if we deem it necessary. Section 135 of the MIPPA requires that the Secretary establish an accreditation process for those entities furnishing advanced diagnostic testing procedures which include diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography), and other such diagnostic testing procedures described in section 1848(b)(4)(B) of the Act (excluding X-ray, ultrasound, and fluoroscopy) by January 1, 2012.

Accordingly, we are not adopting our proposal to require physicians and NPPs to meet certain quality and performance standards when providing diagnostic testing services, except mammography services, within their medical practice setting and have removed the paperwork burden and regulatory impact analysis associated with this provision in this final rule with comment period.

2. Mobile Entity Billing Requirements

To ensure that entities furnishing mobile services are providing quality services and are billing for the diagnostic testing services they furnish to Medicare beneficiaries, we proposed a new performance standard for mobile entities at § 410.33(g)(16), which would require that entities furnishing mobile diagnostic services enroll in Medicare and bill directly for the mobile diagnostic services that they furnish, regardless of where the services are furnished. We believe that entities furnishing mobile diagnostic services to Medicare beneficiaries must be enrolled in the Medicare program, comply with the IDTF performance standards, and directly bill Medicare for the services they furnish.

While we understand that a mobile entity can furnish diagnostic testing services in various types of locations, we stated that we believe that it is essential that mobile entities use qualified physicians or nonphysician personnel to furnish diagnostic testing procedures and that the enrolled mobile supplier bill for the services furnished. We maintain that it is essential to our program integrity and quality improvement efforts that an entity furnishing mobile diagnostic testing services complies with the performance standards for IDTFs and bill the Medicare program directly for the services furnished to Medicare beneficiaries.

Since we believe that most mobile entities are already billing for the services they furnish, whether the service was provided in a fixed-based location or in a mobile facility, we proposed that this provision would be effective with the effective date of this final rule with comment period.

Comment: Several commenters supported our proposal to require mobile diagnostic service providers to enroll in Medicare as IDTFs and to be required to bill Medicare directly for the TC services they furnish.

Another commenter stated that this provision creates a single, universal quality standard for outpatient imaging that eliminates any possible inequity in standards that could exist between office-based imaging and IDTF imaging.

Several other commenters support the concept that all providers and suppliers serving Medicare beneficiaries must be enrolled to be eligible to receive payments from Medicare, directly or indirectly.

Response: We agree with these comments and thank the commenters for their support.

Comment: One commenter stated that this provision would eliminate two distinct and unfair competitive advantages that mobile cardiac nuclear imaging providers enjoy under existing regulations. One advantage is the ability to operate under a ''mobile'' Nuclear Regulatory Commission Radioactive Materials license, which does not require the same regulatory filings as fixed-site cardiac nuclear medicine laboratories, and in the case of some state Radioactive Materials licenses, it does not subject the mobile provider to the same pre-opening inspections that the fixed sites are subject to. Second, some mobile providers are able to secure accreditation from certain accrediting agencies that furnish a global, or ''hub'', accreditation certification.

Response: We thank the commenter for its support.

Comment: One commenter stated that our proposal to require mobile providers to enroll in Medicare as IDTFs, be subject to all IDTF performance standards, and to bill Medicare directly, not only would it create a single, universal standard for quality among all imaging providers, but would also level the playing field in the competitive market for management services for companies which provide high quality fixed site programs for Medicare-enrolled physician practices and their Medicare enrollees.

Response: We appreciate the comments and thank the commenter for their support.

Comment: One commenter supports the proposal requiring these entities to enroll in Medicare and as such, for them to be required to abide by applicable Medicare policies. The commenter continued to state that they do not oppose the direct billing requirement but that if the proposal is finalized, CMS needs to provide a great amount of detail in how the provision will work and its impact on hospital billing practices.

Response: We have revised the provision at § 410.33(g)(17) for those IDTFs that are billing under arrangement with hospitals as described in section 1862(a)(14)of the Act and § 482.12(e).

Comment: Several commenters urged CMS to clarify that its proposal to require mobile testing entities to bill directly for services they furnish would not apply when such services are furnished ''under arrangement to hospital inpatients and outpatients.'' In addition, these commenters recommended that mobile diagnostic testing facilities that furnish these services to hospitals be excluded from the proposed IDTF performance standards.

Response: Although we are requiring all mobile entities that furnish diagnostic testing services to enroll in the Medicare program, we are not requiring mobile testing entities to bill directly for the services they furnish when such services are furnished under arrangement with hospitals as described in sections 1861(w)(1) and 1862(a)(14)of the Act and § 482.12(e).

Comment: One commenter urges CMS to exclude from the definition of entities furnishing mobile diagnostic testing services those entities that do the following: lease equipment and provide technicians who conduct diagnostic tests in the office of the billing physician or physician organization; and furnish testing under the supervision of a physician who shares an office with the billing physician or physician organization.

Response: We disagree with the commenter. We maintain that a mobile entity providing diagnostic testing services must enroll for any diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location so that CMS knows which entity is providing these diagnostic testing services.

Comment: One commenter stated that the proposed IDTF performance standard is contrary to the Medicare ''under arrangement'' provisions and if the IDTF performance standard were extended into the hospital setting, it would prohibit hospitals from providing diagnostic imaging services under arrangement and present significant administrative and operational challenges for hospitals and their patients.

Response: We agree and have revised the provision to account for mobile IDTFs billing under arrangement with hospitals as described in sections 1861(w)(1) and 1862(a)(14)of the Act and § 482.12(e).

Comment: Several commenters requested that we not require mobile units that furnish diagnostic testing services to enroll in Medicare or be required to bill for all of the services they furnish.

Response: We disagree with the commenters. In order to maintain program integrity and enable CMS to monitor services furnished by mobile units providing diagnostic testing services, we maintain that a mobile entity providing diagnostic testing services must enroll for diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location. We are requiring these mobile IDTFs to bill for the services that they furnish unless they are billing under arrangement with hospitals.

Comment: One commenter stated the contractual arrangement between mobile diagnostic imaging services companies and hospitals are commonplace throughout the United States health care industry and these long-standing arrangements, which can be short-term or long-term depending upon hospital demand, service a variety of important needs within the hospital and provider community, including a valuable means to address capacity, volume and equipment cost issue and limitations imposed by State Certificate of Need (CON) requirements.

Response: We understand the commenters' concerns and we are requiring these mobile IDTFs to bill for the services that they furnish unless they are billing under arrangement with hospitals.

Comment: One commenter suggested that we should provide clear and concise guidance on billing protocols that permit hospitals to continue billing for mobile diagnostic testing services furnished as inpatient and outpatient hospital services and allow informational billing (that is, no payment impact) by the mobile entities through the use of a billing modifier.

Response: We believe these comments are outside the scope of the rule.

Comment: One commenter does not support a restriction of an enrolled provider/supplier that would preclude them from arrangements that are allowed under the purchased diagnostic test or purchased interpretation rules due to their method of connecting a patient with testing equipment.

Response: We understand the commenters' concerns and we are requiring these mobile IDTFs to bill for the services they furnish unless they are billing under arrangement with hospitals.

Comment: One commenter states that they believe that the provision of diagnostic and other therapeutic services by a contracted provider to registered inpatients and outpatients is fully consistent with longstanding Medicare provisions expressly permitting hospitals to furnish services directly or ''under arrangements,'' and that the mobile entities that may furnish these services under arrangement would not bill directly for their services but would be under the control of another entity.

Response: We agree with the commenter and although we are requiring all mobile entities that provide diagnostic testing services to enroll in the Medicare program, we are not requiring mobile testing entities to bill directly for the services they furnish when such services are furnished under arrangement to hospitals.

After reviewing public comments, we are finalizing the provision at § 410.33(g)(16), which would require that entities furnishing mobile diagnostic services enroll in Medicare program as an IDTF regardless of where the services are furnished. By enrolling in the Medicare program, CMS or our contractor can determine if the mobile IDTF meets all of the performance standards found in § 410.33(g) and that its owners are not otherwise excluded or barred from participation in the Medicare program. We believe that requiring mobile IDTFs to enroll in order to furnish services to Medicare beneficiaries is consistent with the existing enrollment regulation found at § 424.505 which states that to receive payment for covered Medicare items or services from either Medicare or a Medicare beneficiary, a provider or supplier must be enrolled in the Medicare program. Moreover, by requiring mobile IDTFs to enroll in order to furnish services to Medicare beneficiaries, the Medicare contractor will be able to certify that mobile IDTFs are in compliance with the requirements for enrolling and maintaining enrollment set forth at § 424.520. Finally, the owner of a mobile IDTF is responsible for ensuring that the mobile IDTF meets all applicable regulatory requirements to maintain their enrollment in the Medicare program.

In addition, we are finalizing the provision at § 410.33(g)(17) requiring that mobile diagnostic services bill for the mobile diagnostic services that they furnish, unless the mobile diagnostic service is part of a hospital service and furnished under arrangement with that hospital as described in section 1862(a)(14)of the Act and § 482.12(e). To ensure that IDTFs are actually furnishing services under arrangement with a hospital, we will require that mobile IDTFs provide documentation of the arrangement with their initial or revalidation enrollment application, or change in enrollment application.

3. Revocation of Enrollment and Billing Privileges of IDTFs in the Medicare Program

Historically, we have allowed IDTFs whose Medicare billing numbers have been revoked to continue billing for services furnished prior to revocation for up to 27 months after the effective date of the revocation. Since we believe that permitting this extensive billing period poses a significant risk to the Medicare program, we proposed to limit the claims submission timeframe after revocation. In § 424.535(g) (redesignated as § 424.535(g)), we proposed that a revoked IDTF must submit all outstanding claims for not previously submitted items and services furnished within 30 calendar days of the revocation effective date. We stated that this change is necessary to limit the Medicare program's exposure to future vulnerabilities from physician and NPP organizations and individual practitioners that have had their billing privileges revoked. Accordingly, the proposed change would allow a Medicare contractor to conduct focused medical review on the claims submitted during the claims filing period to ensure that each claim is supported by medical documentation that the contractor can verify. We maintain that focused medical review of these claims will ensure that Medicare only pays for services furnished by a physician or NPP organization or individual practitioner and that these entities and individuals receive payment in a timely manner. In addition, we also proposed to add a new provision at § 424.44(a)(3) to account for this provision related to the requirements for the timely filing of claims. The timely filing requirements in § 424.44(a)(1) and (a)(2) will no longer apply to physician and NPP organizations, physicians, NPPs and IDTFs whose billing privileges have been revoked by CMS.

Comment: Several commenters recommended that we withdraw all of our proposed changes to the requirements for physician enrollment in Medicare, including changes to the effective date of billing privileges, eligibility to participate in the program, enrollment processing, reporting requirements, and revocation of billing privileges. Many of the commenters were concerned that it would be burdensome to add new requirements where they must submit all claims within 60 days of the effective date of revocation because of the time it takes to process claims and that it would be easier to leave the retrospective billing rules as they are.

Response: We are not adopting this recommendation. Instead, we will respond to the specific comments received in response to our specific proposals.

Comment: Several commenters requested that we make no revisions to current physician and NPP enrollment rules at this time.

Response: We are not adopting this recommendation. Instead, we will respond to the specific comments received in response to our specific proposals.

After reviewing public comments, we are finalizing the provisions found at § 424.535(h) (formerly § 424.535(g)) that require a revoked physician organization, a physician, a NPP, or an IDTF to submit all outstanding claims not previously submitted within 60 calendar days of the revocation effective date. Since IDTFs are already afforded approximately 30 days notification before the effective date of revocation (except for revocations identified in § 405.874(b)(2) and § 424.535(f) of this final rule), we believe that almost 90 days is more than sufficient time to file any outstanding claims.

In addition, we are finalizing the provisions found at § 424.44(a) related

to the requirements for the timely filing of claims. The timely filing requirements in § 424.44(a)(1) and (a)(2) will no longer apply to physician and NPP organizations, physicians, NPPs or IDTFs. We revised this provision so that it is consistent with § 424.521 which limits the ability of these suppliers to bill Medicare retrospectively.

J. Physician and Nonphysician Practitioner (NPP) Enrollment Issues

1. Effective Date of Medicare Billing Privileges

In accordance with § 424.510, physician and NPP organizations (that is, groups, clinics, and sole owners) and individual practitioners including physicians and NPPs, operating as sole proprietorships or reassigning their benefits to a physician and nonphysician organization may submit claims as specified in § 424.44 after they are enrolled in the Medicare program. This provision permits newly enrolled physician and NPP organizations and individual practitioners, as well as existing physicians and nonphysician organizations and individual practitioners to submit claims for services that were furnished prior to the date of filing or the date the applicant received billing privileges to participate in the Medicare program.

For the purposes of this final rule with comment period, we believe that an NPP includes, but is not limited to, the following individuals: anesthesiology assistants, audiologists, certified nurse midwives, certified registered nurse anesthetists (CRNA), clinical social workers, nurse practitioners (NPs), physician assistants (PAs), clinical psychologists, psychologists billing independently, speech language pathologists, and registered dieticians or nutrition professionals.

Once enrolled, physician and NPP organizations and individual physicians and NPPs, depending on their effective date of enrollment, may retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program. For example, if a supplier is enrolled in the Medicare program in December 2008 with an approval date back to October 2006, that supplier could retrospectively bill for services furnished to Medicare beneficiaries as early as October 1, 2006.

Currently, physician and NPP organizations and individual practitioners, including physicians and NPPs, are allowed to bill Medicare prior to their enrollment date. Therefore, it is possible that the physician and NPP organizations and individual practitioners who meet our program requirements on the date of enrollment may not have met those same requirements prior to the date of enrollment, even though that supplier could bill Medicare and receive payments for services furnished up to 27 months prior to their enrolling in the Medicare program. In the proposed rule, we stated our concern that some physician and NPP organizations and individual practitioners may bill Medicare for services when they are not meeting our other program requirements, including those related to providing beneficiary protections, such as Advance Beneficiary Notices.

We solicited public comment on two approaches for establishing an effective date for Medicare billing privileges for physician and NPP organizations and for individual practitioners.

The first approach would establish the initial enrollment date for physician and NPP organizations and for individual practitioners, including physician and NPPs, as the date of approval by a Medicare contractor. This approach would prohibit physician and NPP organizations and individual practitioners from billing for services furnished to a Medicare beneficiary before they are approved and enrolled by a designated Medicare contractor to participate in the Medicare program and Medicare billing privileges are conveyed to their National Provider Identifier (NPI). Physicians and NPPs are eligible for NPIs and may apply for their NPIs at any time. To enroll in Medicare, a physician or NPP must have an NPI. If an enrollment application is received that is absent the NPI, it will be rejected. The NPI regulation, at 45 CFR 162.410(a)(1), requires a health care provider who is a covered entity under HIPAA to obtain an NPI. At 45 CFR 162.410(b), the NPI regulation states that a health care provider who is not a covered entity under HIPAA may obtain an NPI. The definition of ''health care provider'' is found at 45 CFR 160.103. The preamble of the NPI final rule (69 FR 3450) states that HIPAA does not prohibit a health plan from requiring its enrolled health care providers to obtain NPIs if those health care providers are eligible for NPIs (that is, that they meet the definition of ''health care provider''). With exceptions for the two entities that are eligible to enroll in Medicare but are not eligible for NPIs, Medicare requires all providers, including physicians and NPPs, who apply for enrollment to have NPIs, and to report them on their Medicare enrollment applications. When applying for NPIs, providers indicate they are one of the following: An Entity type 1 (an individual person, such as a physician or an NPP, to include a sole proprietor/sole proprietorship); or an Entity type 2 (an organization, which is any legal entity other than an individual).

The date of approval is the date that a designated Medicare contractor determines that the physician or NPP organization or individual practitioner meets all Federal and State requirements for their supplier type

Given this first approach, in proposed § 424.520, we stated that we may implement regulations text that reads similar to: ''The effective date of billing privileges for physician and NPP organizations and individual practitioners, including physicians and NPPs, is the date a Medicare contractor conveys billing privileges to a NPI.''

We also stated in the CY 2009 PFS proposed rule that we believe that this approach—

- Prohibits physicians, NPP organizations, and individual practitioners from receiving payments before a Medicare contractor conveys Medicare billing privileges to an NPI (69 FR 3434);
- Is consistent with our requirements in § 489.13 for those providers and suppliers that require a State survey prior to being enrolled and the requirements for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers in § 424.57(b)(2);
- Is consistent with our requirements for providers identified in § 400.202 and surveyed suppliers that are allowed to bill for services only after they are approved to participate in the Medicare program. Surveyed suppliers are those suppliers who have been certified by either CMS or a State certification agency and are in compliance with Medicare requirements. Surveyed suppliers may include ASCs or portable x-ray suppliers; and
- Ensures that we are able to verify a supplier's qualifications, including meeting any performance standards before payment for services can occur.

The second approach would establish the initial enrollment date for physician and NPP organizations and individual practitioners, including physician and NPPs, as the later of: (1) The date of filing of a Medicare enrollment application that was subsequently approved by a fee-for-service (FFS) contractor; or (2) the date an enrolled supplier first started furnishing services at a new practice location. The date of filing the enrollment application is the date that the Medicare FFS contractor receives a signed Medicare enrollment application that the Medicare FFS

contractor is able to process to approval. This option would allow a supplier that is already seeing non-Medicare patients to start billing for Medicare patients beginning on the day they submit an enrollment application that can be fully processed. In contrast to the first option, newly enrolling physicians and NPP organizations, and individual practitioners or physician and NPP organizations and individual practitioners that are establishing or changing a practice location would be allowed to bill the Medicare program for services furnished to Medicare beneficiaries on or after the date of filing if a Medicare contractor approves Medicare billing privileges and conveys billing privileges to an NPI. It is also important to note that if a Medicare contractor rejects or denies an enrollment application, then the physician or NPP organization or individual practitioner is at risk of not receiving payment for any services furnished after the date of filing.

Given this second approach, in proposed § 424.520, we stated that we may implement regulations text that reads similar to: ''The effective date of billing privileges for physician and NPP organizations and for individual practitioners, physicians and NPPs, is the later of—(1) The filing date of the Medicare enrollment application that was subsequently approved by a FFS contractor; or (2) The date that the physician or NPP organization or individual practitioner first furnished services at a new practice location.''

We also stated in the CY 2009 PFS proposed rule that we believe that this approach—

- Prohibits physician and NPP organizations and individual practitioners, including physician and NPPs, from receiving payments before a Medicare contractor conveys Medicare billing privileges to an NPI (69 FR 3434);
- Is consistent with our requirements found at § 410.33(i) that limit the retrospective billing for IDTFs and ensures that Medicare billing privileges are conveyed to physician and NPP organizations and to individual physicians and NPPs in a similar manner similar to IDTFs; and
- Addresses the public's concern regarding contractor processing timeliness while appropriately ensuring that Medicare payments are made to physician and NPP organizations and to individual physicians and NPPs who have enrolled in a timely manner.

We maintain that it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application. Therefore, the Medicare program should not be billed for services before the later of the two dates that a physician or NPP organization, physician, or NPP has submitted an enrollment application that can be fully processed or when the enrolled supplier is open for business.

To assist physician and NPP organizations and individual practitioners in enrolling and updating their existing enrollment record, we established an Internet-based enrollment process known as the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) that is more streamlined and efficient than the traditional paper-application enrollment method.

By using Internet-based PECOS, we expect that physician and NPP organizations and individual practitioners will be able to reduce the time necessary to enroll in the Medicare program or to make a change in their Medicare enrollment record by reducing common errors in the application submission process. We expect that Medicare contractors will fully process most complete Internet-based PECOS enrollment applications within 30 to 45 calendar days compared to 60 to 90 calendar days in the current paper-based enrollment process. Thus, if physician and NPP organizations and individual practitioners enroll in the Medicare program or make a change in their existing Medicare enrollment using Internet-based PECOS and submit required supporting documentation, including a signed certification statement, licensing and education documentation, and, if necessary, the electronic funds transfer authorization agreement (CMS–588) 45 days before their effective date, a Medicare contractor should be able to process the enrollment application without a delay in payment.

The date of filing for Internet-based PECOS will be the date the Medicare FFS contractor receives all of the following: (1) A signed certification statement; (2) an electronic version of the enrollment application; and (3) a signature page that the Medicare FFS contractor processes to approval.

In § 424.502, we also proposed to define a physician and NPP organization to mean any physician or NPP entity that enrolls in the Medicare program as a sole proprietorship or organizational entity such as a clinic or a group practice. In addition to establishing an organizational structure as a sole proprietorship, physicians and NPPs are able to establish various organizational relationships including corporations, professional associations, partnerships, limited liability corporations, and subchapter S corporations. We believe that the proposed definition would include sole proprietorships that receive a type 1 NPI and any organizational entity that is required to obtain a type 2 NPI.

Comment: Several commenters urged CMS to adopt the proposal to limit retrospective billing to the later of the date of filing or date the practice location was established.

Response: We agree with these commenters and have finalized this approach in this final rule with comment period.

Comment: One commenter recommended that we should not implement the revised effective date for billing privileges until January 1, 2010.

Response: We disagree with the commenter because we believe that it is essential that Medicare only pay for services to eligible practitioners that are qualified to bill for services.

Comment: Several commenters recommended that we refrain from implementing any proposed changes to the effective date of Medicare billing privileges until the Provider Enrollment, Chain and Ownership System (PECOS) system is fully functional and a thorough discussion is held between all affected parties and/or all current National Provider Identifier (NPI) applications are processed.

Response: While we understand this comment, we disagree with these commenters. By establishing an effective date of billing for physicians, NPPs, and physician and NPP organizations, we believe that Medicare will only pay for services furnished by licensed practitioners that meet all of the Medicare program requirements. In addition, we implemented the NPI on May 23, 2008. Accordingly, we do not believe that there is a nexus between the implementation of the effective date for physicians, NPPs, and physician and NPP organizations and the implementation of the Internet-based PECOS or the implementation of the NPI.

Comment: One commenter suggested that payment not commence until the provider's application has been processed and approved and that if the approval date is after the date the provider first started to render services, then payments will be paid retroactive to the rendering date. The commenter also requested that CMS implement an electronic enrollment processing system.

Response: We are finalizing a provision that allows physicians, NPPs (including CRNAs), and physician or NPP organizations to retrospectively bill

for services up to 30 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1). Further, we are implementing Internet-based PECOS for physicians and NPPs by the end of CY 2008 to facilitate the electronic enrollment process.

Comment: One commenter suggested that the enrollment payment policy for CRNAs remain as it is.

Response: We are finalizing a provision that allows physicians, NPPs (including CRNAs), and physician or NPP organizations to retrospectively bill for services up to 30 days prior to their effective date of billing when the physician or nonphysician organization has met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances, such as, when a physician is called to work in a hospital emergency department which precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1).

Comment: One commenter would like to recommend that CMS not make the new Web-based enrollment system too cumbersome. Their concerns are based on current member experiences with the IACS for review of PQRI claims. The requirements for the practice to designate a security officer, submit old IRS documents, etc., are extremely time-consuming, burdensome and serve as disincentives to physician participation.

Response: This comment is outside the scope of the proposed rule and cannot be addressed within this final rule.

Comment: One commenter asked that if we adopt either of these enrollment strategies, we should consider an exemption for hospital-based emergency physicians and NPP organizations to allow a period of retroactive billing and payment once an enrollment application is approved by the contractor.

Response: We are finalizing a provision that allows physicians, NPPs, and physician or NPP organizations to retrospectively bill for services up to a 30 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, where services were furnished at the enrolled practice location prior to the date of filing and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1).

Comment: One commenter stated that they support our efforts to ensure participating providers and suppliers of services are complying with Medicare program requirements in a matter consistent with policy and are not attempting to ''game'' the system. However, should we move forward with this proposal, the commenter advises the drafting of policies to identify unusual activities beyond the control of the provider or supplier, such as hurricanes and other natural disasters, that necessitate a provider or supplier of services obtaining additional Medicare billing privileges in order to provide services.

Response: We are finalizing a provision that allows physicians, NPPs, physician or NPP organizations to retrospectively bill for services up to a 90 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, services were furnished at the enrolled practice location prior to the date of filing and a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121–5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(2).

Comment: A large number of commenters do not support either approach and go further to state that both proposals will negatively impact the ability of hospital emergency departments and their physicians to meet their statutory obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA). Many of these commenters stated that in these emergency department situations, physicians are hired in very short timeframes, sometimes just days before they begin working in a new location that they cannot submit an enrollment application in such a short timeframe. They also continued to state that if we adopted the enrollment provisions as proposed, these emergency department enrollment situations would cause the physicians to forgo payment because they would not be able to submit an enrollment application before they begin furnishing services. Other commenters were opposed to both proposed approaches to limit retrospective billing after enrolling in the Medicare program and asked that we withdraw any proposed changes to the enrollment process.

Response: We disagree with the commenters. We believe that we have adopted an approach that balances the need to strengthen the Medicare enrollment process, protect the Medicare Trust Funds, and ensure that individual practitioners and physician and NPP organizations receive payment for services furnished to Medicare beneficiaries. The revised provision allows up to 30 days after furnishing services to submit an enrollment application (and up to 90 days when a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act)) so the physician, NPP or physician or NPP organization has sufficient time to submit their enrollment application.

Comment: One commenter stated that they believe that it is unreasonable to expect physicians to furnish care to their patients without the ability to be paid for their services until they are officially enrolled in the Medicare program.

Response: While we agree that physicians should be reimbursed for the services furnished to Medicare beneficiaries, we also believe that physicians, NPPs and physician and NPP organizations are responsible for enrolling or making a change in their enrollment in a timely manner. In most cases, we believe that physicians and NPP practitioners can submit an enrollment application prior to providing Medicare services at a new practice location.

Comment: One commenter stated that in emergency room situations these enrollment scenarios will not work and gives the example using the second approach of when an emergency department is in desperate need of a provider. The department is able to obtain a physician almost immediately who is already employed within the organization and is also an approved provider in the Medicare program at their current practice location. Simply because the events in this example happened so quickly, the physician's CMS–855R was submitted to the Medicare contractor 1 week after he began providing services in the emergency department. If the second approach were in effect, 1 week of services the physician furnished to Medicare beneficiaries in the emergency department would be denied as his enrollment at this location was not in effect.

Response: We understand this commenter's concerns and are finalizing a provision that allows physicians, NPPs, physician or NPP organizations to retrospectively bill for services up to 30

days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, where services were furnished at the enrolled practice location prior to the date of filing and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1).

Comment: One commenter stated that should we adopt the second approach, they requested that a standard be established that defines what constitutes the receipt of a substantially complete application form for which the effective date under approach two may be established. This approach would address the situations where denial errors and clarifications can be corrected without delaying the effective date.

Response: As a general rule, applicants are given at least 30 days to cure any deficiencies/technicalities before a contractor rejects an enrollment application (see § 424.525). During the application review process, contractors notify applicants about missing information and documentation and afford the applicant at least 30 days to correct deficiencies. With the implementation of Internet-based PECOS, we expect that physicians and NPPs using the Web process will significantly decrease the number of incomplete applications and the need for contractors to request additional information. With the implementation of this final rule, we would require contactor to deny, rather than reject paper or Web applications when a physician, NPP, or physician or NPP organization fails to cure any deficiencies/technicalities.

Comment: One commenter urged CMS to adopt a standard establishing that the filing date for an enrollment application is when a signed application is first received by a contractor and not when the application is deemed complete and ready for approval by that contractor. Otherwise, delays associated with contractor processing could become a larger concern.

Response: We agree with this commenter and have adopted the ''date of filing'' as the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval.

Comment: Several commenters strongly opposed the approach where billing privileges would be conveyed based on the date of approval by the Medicare contractor and maintain that tying billing privileges to a contractor's approval of a practitioner's Medicare enrollment application could create unintended access problems for some patients. Other commenters added that in certain situations, the physicians would furnish services and would not be able to be compensated which they do believe is an unintended consequence by CMS.

Response: We agree with the commenters and have not adopted the proposed approach as it was proposed but revised it so that it would establish the effective date of billing for physicians, NPPs, and physician and NNP organizations as the later of date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date they first began furnishing services at a new practice location.

Comment: The suggestion to use the Medicare contractor's date of approval as the initial enrollment date would mean that an employer can expect to generate no revenue from a new hire for a minimum of 3 to 6 months, which is unacceptable.

Response: As stated above, we have not adopted the proposed approach but revised it so that it would establish the effective date of billing for physicians, NPPs, and physician and NNP organizations as the later of date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date they first began furnishing services at a new practice location.

Comment: One commenter supports the establishment of an effective billing date for physicians, NPPs, and physician and NPP organizations as the later of: (1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or NPP first started furnishing services at a new practice location. The commenter further urges the agency to tie enrollment and when billing privileges begins to offering services at a new practice location.

Response: We appreciate this comment and have adopted a modified approach where that date of filing is the effective date of billing for physicians, NPPs, and physician and NPP organizations.

Comment: One commenter requests that current procedures change and allow enrollment applications to be submitted 60 days prior to a change.

Response: We disagree with the commenter and maintain that permitting billing 30 days before the filing of an enrollment application will provide a sufficient amount of time in most cases.

Comment: One commenter stated that the establishment of an effective billing date for physicians, NPPs, and physician and NPP organizations as: (1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or NPP first started furnishing services at a new practice location will improve patient access to Medicare providers, since patients could be scheduled for appointments based on the date that a Medicare provider submits an enrollment application to the Medicare Administrative Contractor (MAC). This also allows new Medicare providers more flexibility when initiating services under Medicare.

Response: We thank the commenter for their support of this provision.

Comment: Several commenters recommend that providers should be able to submit enrollment applications with a requested effective date.

Response: We believe limiting retrospective payments will ensure that physicians, NPPs, and physician and NPP organizations will ensure that only qualified practitioners are able to bill for services furnished to Medicare beneficiaries. Moreover, we believe that establishing an effective date of Medicare billing privileges and establishing limited retrospective payments will encourage physicians, NPPs, and physician and NPP organizations to enroll and maintain their enrollment in with the Medicare program. However, the effective date of billing privileges is 30 days prior to the later of the date an enrollment application is filed or the date services were furnished at a new practice location.

Comment: Several commenters urged CMS to retain its current retrospective billing policy for physicians and NPPs. However, these commenters stated that if CMS revised its retrospective billing policy for physicians, NPPs, and NPP organizations that they preferred option 2 (establishment of an effective billing date for physicians, NPPs, and physician and NPPs as the later of: (1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or NPP first started furnishing services at a new practice location), which limited retrospective billing to the later of the date of filing or the date the practice location was established.

Response: We agree with these commenters and have adopted this approach in this final rule.

Comment: One commenter recommends allowing those physicians

who are about to complete their fellowship to submit an application to Medicare for a generic provider number which at a later date can be linked to an eventual employer.

Response: Since we do not establish a provisional enrollment status for physicians or other suppliers, but rather convey billing privileges to a NPI, we disagree with this commenter.

Comment: One commenter suggests that to improve the Medicare enrollment process, the processing of enrollment applications should take 30 to 45 days versus a 90 to 120 days activity. Medicare could follow the process employed by private payers and utilize one central repository for provider enrollment given that all processes basically require the same essential information.

Response: CMS already utilizes a single national repository of enrollment information. The national enrollment repository is known as the Provider Enrollment, Chain and Ownership System (PECOS).

Comment: Several commenters supported our proposed approach that would establish the initial enrollment date for individual practitioners and physician and NPP organizations as the date an enrolled supplier started furnishing services at the new practice location as it would be the fairest option for all enrollees.

Response: We appreciate this comment, and as stated above, we are finalizing this proposal with revisions so that it would establish the effective date of billing for physicians, NPPs, and physician and NNP organizations as the later of date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date they first began furnishing services at a new practice location.

Comment: One commenter stated that physician practices that allow new practitioners to treat Medicare patients before their applications are approved run the risk of submitting an application that is ultimately returned on a technicality, forcing them to begin the application process all over again.

Response: As stated above, to address the concern that enrollment applications are returned based on a technicality, we expect that physicians and NPPs using the Web process will significantly decrease the number of incomplete applications and the need for contractors to request additional information. With the implementation of this final rule, we would require contactor to deny, rather than reject paper or Web applications when a physician, NPP, or physician or NPP organization fails to cure any deficiencies/technicalities.

Comment: One commenter stated that new physicians' practices must begin paying rent, salaries and other expenses the minute they become operational, if not before. This commenter also stated that many of these physicians are already forced to take out loans to pay expenses in the early days of operation until they enroll and can bill for services furnished in the interim. Finally, this commenter stated that our proposal to limit retrospective billing to the later of the date of filing or the date the practice location is operational will inhibit the ability of physicians and NPPs to create their own organizations, and instead, it will force them to join already existing entities.

Response: We do not believe that the Medicare program pays for services rendered prior to the date a new practice location is established. As described above, the physician or NPP would be allowed to file his or her enrollment application 30 days prior to the opening of new practice location and receive payments for services provided from the day the practice location was established or opened assuming that the physician met State licensing requirements and other Medicare program requirements at the time of filing and subsequently thereafter.

Comment: One commenter urged CMS to withdraw any proposed changes to the enrollment process, but stated that they would consider supporting limiting retrospective billing to the later of the date of filing or the date the practice location is operational but only after Internet-based PECOS has been proven to facilitate timely enrollment processing (fewer than 30 days). Another commenter supported CMS implementing this requirement once the enrollment processing time is at a period of 30 to 45 days.

Response: We do not believe that a change to the effective date of Medicare billing privileges has a nexus to the implementation of the Internet-based PECOS.

Comment: One commenter suggested that we allow 30 to 60 days before submission of an application to serve as the date of approval because this timeline will allow for practices to obtain provider signatures, licenses, and certifications so that we can approve back to the date of licensure and/or the date the provider started furnishing services with a minimum of 30 to 60 days.

Response: We disagree with this commenter, because physicians, NPPs and physician and NPP organizations should have all the necessary licenses/certifications at the time of filing, not 30 or 60 days after filing an enrollment application.

Comment: Several commenters asked for clarification of the ''date of filing'' when submitting an application for enrollment.

Response: We have clarified the ''date of filing'' in the provision of the final rule as the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval.

Comment: One commenter recommends that we wait until the Internet-based PECOS system has been released and used by the physician population before making these changes.

Response: As stated above, we do not believe that a change to the effective date of Medicare billing privileges has a nexus to the implementation of the Internet-based PECOS.

Comment: Several commenters recommended that we shorten the period of time during which retrospective billing is permitted from 27 months to 12 months. Another commenter stated that reducing retrospective billing from 27 months to 12 months would provide sufficient time for enrollment to occur, reduce the possibility of improper billing and eliminate the unreasonable administrative burden that the our alternatives would place on all new physicians.

Response: We appreciate these comments, but continue to believe that allowing retrospective billing for 12 months prior to enrollment poses a significant risk to the Medicare program. Accordingly, with the implementation of this final rule, physician and NPPs and physician and NPP organizations will have a limited time period to submit claims before the effective date of their respective Medicare billing privileges.

Comment: Several commenters urged CMS to establish the new Web-based program and determine the accuracy and ease of the system before making new enrollment rules. This commenter also stated the new Web-based system should be far easier to use than the current process.

Response: We agree with these commenters and, as previously stated, we expect to implement Internet-based PECOS for individuals by the end of CY 2008.

Comment: One commenter stated that they have been advised by Medicare that this change means upon receiving notice that a graduate nurse anesthetist

had passed his or her certifying exam that the ''graduate'' now a CRNA can retain any Medicare claims from his or her certification date forward and then submit these held claims upon receiving his or her National Provider Identifier (NPI). Further, the commenter stated that Medicare carriers have allowed this payment practice with the understanding that graduate nurse anesthetists are qualified to bill Medicare for their services upon their certification date.

Response: While we understand this comment, we believe that physicians and NPPs must meet all State licensing requirements before Medicare can convey billing privileges. Moreover, with the implementation of this final rule, physician and NPPs and physician and NPP organizations will have a limited time period to submit claims before the effective date of their Medicare billing privileges.

Comment: One commenter stated that they understand that there have been Medicare Carriers that allow CRNAs to hold their claims and back bill for up to 1 year prior to the date they are certified, consistent with Medicare payment policy.

Response: We believe that physician and NPPs must meet all State licensing requirements before Medicare can convey billing privileges. Moreover, with the implementation of this final rule, physician and NPPs and physician and NPP organizations will have a limited time period to submit claims before their effective date of Medicare billing privileges.

Comment: One commenter urged CMS to adopt the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing Database (UCD) as its provider credentialing information gathering tool. This commenter stated that CAQH has over 600,000 providers and suppliers in its database and is working with hospitals and State Medicaid programs as well.

Response: While we appreciate this comment, this comment is outside the scope of this final rule. However, it is important to understand that CMS' national enrollment repository, PECOS, maintains Medicare enrollment records on more than 610,000 physicians, 280,000 NPPs, 75,000 single specialty clinics, and 130,000 multi-specialty clinics. In addition, PECOS maintains enrollment records for all other provider and supplier types, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. This means that we have collected and retained current enrollment information on approximately 80 percent of physicians and 98 percent of the NPPs enrolled in and billing the Medicare program. In addition, since the information obtained during the enrollment process for physician and NPP organizations updates our claims payment systems for Part B services, we are able to help ensure claims processing accuracy by utilizing its existing processes.

Comment: One commenter urged CMS to produce educational materials beyond the vague tip sheets located at the beginning of each application. In addition, this commenter recommends that we develop a series of frequently asked questions on Medicare provider enrollment.

Response: We already maintain a link to provider enrollment frequently asked questions at *http://www.cms.hhs.gov/MedicareProviderSupEnroll.* In addition, this Web site maintains more than 10 different provider enrollment outreach documents that the public can view online or download for future reference.

In an attempt to ensure that all physicians, NPPs, and NPP organizations are aware of and comply with their reporting responsibilities, we developed and posted reporting responsibilities for physicians, NPPs, and physician organizations on our provider enrollment Web page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on September 16, 2008. In addition, on September 17, 2008, we issued a listserv announcement to those individual physicians and NPPs who subscribe to the CMS Physician Open Door Forum and to more than 150 national and State-level organizations that subscribe to the CMS provider partnership network. We also expect that contractors will continue to notify physicians and NPP organizations about their reporting responsibilities by listserv, bulletin, and/or direct mail in FY 2009 and beyond. With the implementation of this final rule with comment period on January 1, 2009, we will revise the educational materials found on our Web site and distribute this information through our established communication channels. Finally, we will post educational material, including fact sheets and frequent asked questions, regarding Internet-based PECOS as soon as this system is available to the public.

Comment: One commenter asked that we create extensive educational programming on provider enrollment for both our contractors and providers to ensure that both sides thoroughly understand the process and expectations.

Response: We provide Medicare contractors with manual instructions and other directives to ensure consistent enrollment processing. In addition, as stated above, we are disseminating additional educational materials to ensure that the public understands their reporting responsibilities.

Comment: One commenter suggested a process for the Medicare Contractor to notify the provider that the application has been received and it is being processed to ensure the approved billing date is the same between the provider and the Medicare contractor.

Response: Due to cost constraints, most Medicare contractors can not notify an applicant when their paper enrollment application is received; however, Medicare contractors are required to notify an applicant when the application is missing information or if additional supporting documentation is needed to process the enrollment request.

Comment: One commenter stated that the NPP nomenclature is ambiguous because CMS lists all suppliers as NPPs (including audiologists and physical and occupational therapists) on page 38535 of the proposed rule, rather than limiting this term to physician assistants, nurse practitioners, and clinical nurse specialists as defined in Medicare policy manuals.

Response: We have revised this rule to refer to individual physicians and NPPs and physician and NPP organizations.

Comment: One commenter urges CMS to require contractors to provide accurate and complete information to applicants, allowing their practices to complete their enrollment applications in an easy and efficient manner.

Response: While we appreciate this comment, this comment is outside the scope of this proposed rule and can not be addressed in this final rule.

Comment: One commenter urged CMS to require Medicare contractors to communicate requests for additional information in such a manner that the communications can be easily tracked.

Response: We believe that this issue is outside the scope of the proposed rule and can not be addressed in this final rule.

Comment: One commenter urged a ''timeout'' on the release of new rules and regulations surrounding the Medicare provider enrollment process.

Response: We recognize that we have published several regulations within the last 3 years and a number of program integrity manual instructions designed to strengthen the enrollment process. However, we continue to believe that CMS must maintain the flexibility to issue regulations in accordance with the Administrative Procedures Act.

Comment: One commenter urged CMS to clarify the apparent inconsistent policies on revalidation as set forth in the April 21, 2006 provider enrollment rule titled, ''Medicare Program: Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment (CMS–6002–F)'' and the June 27, 2008 provider enrollment rule titled, ''Medicare Program: Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS–6003–F).''

Response: In response to comment in the April 21, 2006 final rule (71 FR 20754), we stated, ''We expect that a fee-for-service contractor would notify the provider or supplier in writing regarding the need to revalidate its enrollment information. Once notified, providers and suppliers would be expected to review, update, and submit any changes and supporting documentation regarding the enrollment record within 60 days. If no changes have occurred, a provider or supplier would simply sign, date, and return the revalidation application.'' In addition, we stated in the provisions of the final rule that, ''We will contact all providers and suppliers directly as to when their 5-year revalidation cycle starts beginning with those providers and suppliers currently enrolled in the Medicare program but that have not submitted a completed enrollment application. The revalidation process would ensure that we collect and maintain complete and current information on all Medicare providers and suppliers and ensure continued compliance with Medicare requirements. In addition, this process further ensures that Medicare beneficiaries are receiving items or services furnished only by legitimate providers and suppliers, and strengthens our ability to protect the Medicare Trust Funds.''

In response to a comment in the June 27, 2008 final rule (73 FR 36448), we stated, ''Therefore, providers and suppliers that enrolled in the Medicare program prior to 2003, but who have not completed a Medicare enrollment application since then, have had more than 2 years to come into voluntary compliance with our enrollment criteria by submitting a complete enrollment application. With this final rule, we are again notifying physicians, providers, and suppliers that they may voluntarily complete and submit a Medicare enrollment application and the necessary supporting documentation prior to our formal request for revalidation. Accordingly, providers and suppliers who choose not to come into voluntary compliance or fail to respond to a revalidation request in a complete and timely manner fail to satisfy our enrollment criteria and may be subject to revocation of their billing privileges.'' Accordingly, we do not believe that these policies are inconsistent. We continue to encourage all physicians, providers, and suppliers to update their enrollment records when a reportable change occurs, and absent a reportable change we encourage all physicians, providers, and suppliers who have not updated their enrollment record within the last 5 years to do so in advance of contractor's revalidation request. Once we initiate revalidation efforts, physicians and other providers and suppliers will only be provided 60 days to respond to a contractor's request.

Comment: One commenter stated that we should monitor, track, and make publicly available the average length of time from submission of an enrollment application for new procedures to the time the Medicare contractors actually process and notify the providers of acceptance of that enrollment application.

Response: While we monitor contractor provider enrollment processing timeliness using PECOS, we do not currently calculate an average length of time for initial enrollments, changes, and reassignments. We will consider calculating the average length of time for initial enrollment applications, changes of information, and reassignments and making this information available to the public.

Comment: One commenter requests that if we finalize these provisions, a notice of onsite review should be provided 14 days in advance to allow the pharmacy to appropriately schedule for the onsite review.

Response: We disagree with this commenter. We believe that onsite reviews provide CMS and our contractors a valuable tool to ensure that providers and suppliers are in compliance.

Comment: Several commenters remain concerned about the failure of CMS to permit the use of electronic signatures and electronic documents which would provide practitioners and practices the opportunity to complete and submit the entire application package online.

Response: This comment is outside the scope of this proposed rule and can not be addressed in this final rule.

Comment: One commenter recommended that we hold an open and thorough dialogue with its contractors and the provider community regarding the enrollment process as it currently stands and the problems encountered by all.

Response: We believe that this issue is outside the scope of the proposed rule and can not be addressed in this final rule.

Comment: One commenter stated that they support CMS and the establishment of an electronic enrollment process but they do not believe it will address the provisions in the rule.

Response: While we do not expect that Internet-based PECOS will remedy all provider enrollment processing issues, we do believe that an Internet-based enrollment process will allow physicians and other providers and suppliers to reduce the time necessary to enroll or make a change in enrollment in the Medicare program.

Comment: One commenter recommended that we establish streamlined and user-friendly procedures that will encourage high rates of physician participation in the Medicare program.

Response: We appreciate this comment and believe that Internet-based PECOS will allow physicians and NPPs the ability to enroll or make changes in their enrollment records faster and more accurately than the paper-based enrollment process.

Comment: One commenter commended CMS for PECOS as it will provide timely ease of use for enrollment as well as updating the enrollment record.

Response: We appreciate this comment.

Comment: One commenter requested that we consider modifying existing provider enrollment applications to include an attestation statement for which an applicant would attest to those certain requisite program requirements having been met prior to the filing of the application.

Response: This recommendation is outside the scope of the proposed rule and can not be addressed in this final rule.

Comment: One commenter stated that we should provide notice 14 days in advance of conducting an onsite review and that reviews on Mondays should be avoided.

Response: This comment is outside the scope of this proposed rule and can not be addressed in this final rule.

Comment: One commenter urged that CMS and the NSC coordinate so that only a single onsite review would be required and the least disruptive to an operation.

Response: This comment is outside the scope of the proposed rule and can not be addressed in this final rule.

After reviewing public comments, we are finalizing the definition of ''physician or nonphysician practitioner (NPP) organization'' at § 424.502 as ''any physician or NPP organization that enrolls in the Medicare program as a sole proprietorship or any organizational entity.'' Organizational entities include, but are not limited to, limited liability corporations, Subchapter S corporations, partnerships, professional limited liability corporations, professional corporations, and professional associations.

After reviewing public comments, we are finalizing the provision at § 424.520(d) to state that we will establish an effective date of billing for physicians, NPPs and physician and NPP organizations that would be the later of: (1) The date of filing of a Medicare enrollment application that was subsequently approved by Medicare contractor (that is, carrier, fiscal intermediary or A/B Medicare Administrative Contractor); or (2) the date a physician, NPP or physician and NPP organization first started furnishing services at its new practice location.

In § 424.521, Request for Payment by Physicians, Nonphysician Practitioners, Physician or Nonphysician Organizations, we are finalizing the proposals.

In § 424.521(a)(1), we are finalizing a provision that allows physicians, NPPs, physician or NPP organizations to retrospectively bill for services up to 30 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, services were furnished at the enrolled practice location prior to the date of filing and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries. Thus, physicians, NPPs, and physician or NPP organizations would be limited to receiving reimbursement for services for a maximum of 30 days prior to filing an enrollment application that was subsequently approved by a Medicare contractor.

In § 424.521(a)(2), we are finalizing a provision that allows a physician, NPP, and physician or NPP organization to retrospectively bill for services up to 90 days prior to their effective date of billing privileges when the physician or NPP organization met all program requirements, including State licensure requirements, services were furnished at the enrolled practice location prior to the date of filing, and a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121–5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

While these changes limit the retrospective payments that a physician, NPP, or physician and NPP organization may obtain from the Medicare program, we believe that this approach will ensure that a Medicare contractor is able to verify that a physician, NPP or physician and NPP organization meets all program requirements at the time of filing, including State licensure. In addition, this approach will afford Medicare beneficiaries the appropriate protections under the statute, regulations, and CMS policy.

To ensure that eligible physicians, NPPs or physician and NPP organizations receive reimbursement for services furnished, we will require that Medicare contractors deny Medicare billing privileges when a Medicare contractor is not able to process an incomplete enrollment application that is submitted by a physician, NPP or physician and NPP organization. This is a change from our earlier final rule, ''Medicare Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment,'' (CMS–6002–F) which was published on April 21, 2006. In this earlier rulemaking effort, we stated that we would reject an incomplete enrollment application. In order to provide physician and NPP organizations and individual practitioners with the opportunity to preserve an initial application filing date, we will deny incomplete applications for these supplier types. We believe that § 424.530(a)(1) permit a Medicare contractor to deny an incomplete enrollment application.

By denying billing privileges for enrollment in the Medicare program or to establish a new practice location, rather than rejecting an enrollment application, physicians, NPPs or physician and NPP organizations will be afforded appeal rights which will preserve the original date of filing the application. Reimbursement for services furnished back to the effective date of billing will be permitted as long as the applicant submits a corrective action plan or appeal in accordance with § 405.874 and submits the necessary information to cure any application deficiencies. However, if the applicant does not submit a corrective action plan or appeal within the timeframe established in § 405.874, then the applicant would not preserve the right to bill the Medicare program for services furnished from the date of the initial filing of the application or the date the practitioner or organization first started furnishing services at its new practice location.

We are also adopting the ''date of filing'' as the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval. If the Medicare contractor denies an enrollment application that is not later overturned during the appeals process, the new date of filing would be established when a physician or NPP organization submits a new enrollment application that the contractor is able to process to approval.

PECOS is the system that supports the Medicare provider and supplier enrollment process by collecting and storing provider and supplier information obtained from the Medicare enrollment application (that is, the CMS–855). The PECOS database retains enrollment information on Part A providers that bill fiscal intermediaries (FIs) or A/B Medicare Administrative Contractors (A/B MAC) and Part B providers, including physicians and NPPs that bill carriers or A/B MACs.

Medicare contractors use PECOS to establish new enrollment records for providers and suppliers, update provider and supplier information, and process requests from individual health care practitioners for assignment of benefits. PECOS standardized the Medicare enrollment process and supplies enrollment data to the Part A and Part B claims processing systems.

In June 2002 and November 2003, we implemented PECOS for fiscal intermediaries (FIs) and carriers respectively. Today, PECOS is used by carriers, FIs, and A/B MACs to enter data submitted on the Medicare enrollment application. However, by establishing an Internet-based enrollment process, we will allow providers and suppliers (except suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) suppliers, the option of enrolling or making a change in their Medicare enrollment information via the Internet.

Internet-based PECOS will allow Medicare providers and suppliers to enroll or make a change in their Medicare enrollment record. The primary objectives for the Web enablement of PECOS are to: (1) Reduce the time necessary for providers and suppliers to enroll or make a change in their Medicare information; (2) streamline the enrollment process for providers and suppliers; (3) allow

physicians and NPPs to manage their enrollment information and verify their reassignments of benefits; and (4) reduce the administrative burden associated with completing and submitting enrollment information to Medicare.

Additional information regarding Internet-based PECOS will be made available later this year. This information will be posted on the Medicare provider/supplier enrollment Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll.*

With the implementation of an Internet enrollment process referred to as the Internet-based PECOS, the date of filing for individual practitioners submitted through Internet-based PECOS is the date the Medicare contractor receives both: (1) An electronic version of the enrollment application; and (2) a signature page containing an original signature that the Medicare contractor processes to approval. The date of filing for organizational entities submitted through Internet-based PECOS is the date the Medicare contractor receives all of the following: (1) An electronic version of the enrollment application; (2) a signature page containing an original signature that the Medicare contractor processes to approval.

To address public concerns regarding the burden and complexity associated with the Medicare enrollment process, we will implement Internet-based PECOS in three distinct phases. We will implement Internet-based PECOS for all individual physicians and NPPs enrolling or making a change to an existing enrollment record in Phase I. In Phase II, we will implement Internet-based PECOS for all organizational providers and suppliers, except DMEPOS suppliers, enrolling or making a change to an existing enrollment record. In Phase III, we will implement Internet-based PECOS for DMEPOS suppliers.

Based on current operating assumptions, we expect to begin implementation of Phase I by the end of CY 2008, with full implementation scheduled for completion in January 2009. We also expect to make Internet-based PECOS available to physicians and NPPs in all States, including California, Missouri, and New York.

Phase II is tentatively scheduled for implementation beginning in Spring 2009, with full implementation scheduled for completion by June 30, 2009. Phase III is tentatively scheduled for implementation in CY 2010.

Since Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens, we believe that this new enrollment application process will significantly simplify and streamline the enrollment process for physicians, providers and suppliers, reduce the time necessary to enroll or make a change to a Medicare enrollment record, reduce the administrative burden associated with completing and submitting enrollment information to Medicare, decrease the errors during the application submission process, and allow physicians and NPPs to take personal responsibility for their Medicare enrollment in a timely manner. Moreover, unlike the paper-based enrollment process, Internet-based PECOS' scenario-driven application process will ensure that prospective providers and suppliers or enrolled providers and suppliers only complete and submit the information necessary to apply or make a change in their Medicare enrollment record. Physicians and NPPs will no longer see questions that are not applicable for their supplier-type.

While we will encourage all physicians, NPPs, physicians and NPP organizations and other providers and suppliers to utilize Internet-based PECOS when it is made available for their provider/supplier type and their State, all providers and suppliers will continue to have the option of submitting an enrollment application by paper.

In order to use Internet-based PECOS to enroll or make a change in an enrollment record, physicians and NPPs will be required to use the User ID and user password obtained when applying for or updating their National Provider Identifier (NPI) with the National Plan and Provider Enumeration System (NPPES). Accordingly, physicians and NPPs will need to know their NPPES User ID/password information before trying to enroll or change their enrollment record with Medicare via Internet-based PECOS. To ensure privacy and security for these individual practitioners, we encourage that physicians and NPPs to reset their user password prior to initiating their first enrollment action via Internet-based PECOS, reset their user password at least once a year thereafter, and that physicians and NPPs not share their NPPES User ID/password with billing agents, clearinghouses, academic medical institutions, or staff within their practice.

Physicians and NPPs choosing to use billing agents, clearinghouses, academic medical institutions, etc. will be required to submit a paper enrollment application to enroll or make a change in their Medicare enrollment record.

In order to use Internet-based PECOS to enroll or make a change in an organizational enrollment record, we will verify that the authorized official associated with the Medicare enrollment record is employed by the organization and is authorized by the organization to submit or make changes to the organization enrollment record.

Over the last 2 years, we have stressed the importance of filing a complete application at the time of filing or in response to a contractor's request for additional information. However, Medicare contractors continue to report that a significant number of applications are incomplete at the time of filing or that applicants do not respond timely and completely to a contractor's request for additional information.

Finally, in the April 21, 2006 final rule, physicians, NPPs, and physician and NPP organizations learned about our intent to begin a revalidation process.

Specifically, § 424.515 states that a provider or supplier (other than a DMEPOS supplier), must resubmit and recertify the accuracy of its enrollment information every 5 years. Therefore, physicians, NPPs and physician and NPP organizations that enrolled in the Medicare program prior to 2003, but who have not completed a Medicare enrollment application since then, have had more than 2 years to come into voluntary compliance with our enrollment criteria by submitting a complete enrollment application. To date, approximately 80 percent of the enrolled physicians and 98 percent of NPPs have updated their Medicare enrollment record within the last 5 years.

To ensure that Medicare only pays eligible physicians and NPPs, we are again notifying physicians and NPPs that they may voluntarily complete and submit a Medicare enrollment application and the necessary supporting documentation prior to our formal request for revalidation. In accordance with the existing provision at § 424.535(a)(1)(ii), providers and suppliers who choose not to come into voluntary compliance or fail to respond to a revalidation request within 60 days of the Medicare contractor's request may be subject to the revocation of their billing privileges.

2. Medicare Billing Privileges and Existing Tax Delinquency

The Government Accountability Office (GAO) found that over 21,000 of the physicians, health professionals, and suppliers paid under Medicare Part B during the first 9 months of CY 2005 had tax debts totaling over $1 billion.

The GAO report titled, ''Medicare, Thousands of Medicare Part B Providers Abuse the Federal Tax System (GAO–07–587T)'' found abusive and potentially criminal activity, including failure to remit to IRS individual income taxes or payroll taxes or both withheld from their employees.

While we do not currently consider whether an individual physician, NPP currently enrolled in the Medicare program has delinquent tax debts with the Internal Revenue Service (IRS), we do consider whether a physician or NPP was convicted of a Federal or State felony offense, including income tax evasion, that we have determined to be detrimental to the best interest of the Medicare program. Moreover, if a physician or NPP was convicted of Federal or State felony offense within the 10 years preceding enrollment or revalidation of enrollment that we determined to be detrimental to the best interest of the Medicare program, we could deny or revoke the Medicare billing privileges of the physician or NPP.

The Financial Management Service (FMS), a bureau of the Department of Treasury, initiated the Federal Payment Levy Program (FPLP) portion of the Continuous Levy Program in July 2000 to recover delinquent Federal tax debts. The FPLP is a program whereby delinquent Federal income tax debts are collected by levying non-tax payments, as authorized by the Taxpayer Relief Act of 1997 (Pub. L. 105–34). The FPLP includes vendor and Social Security benefit payments, and Medicare payments. It is accomplished through a process of matching delinquent debtor data with payment record data. This automated collection of debt at the time of payment occurs after the delinquent taxpayer has been afforded due process, in accordance with the Internal Revenue Code.

In July 2000, the IRS in conjunction with the Department of Treasury's FMS started the FPLP which is authorized by section 6331(h) of the Internal Revenue Code as prescribed by section 1024 of the Taxpayer Relief Act of 1997. Through this program, the IRS can collect overdue taxes through a continuous levy on certain Federal payments disbursed by FMS; it generally allows Medicare to match a claim to a delinquent taxpayer, offset the payment, and recover a percentage of the amount due.

The FPLP is a collection and enforcement tool used by the IRS for individuals that have received all requisite notification of tax delinquency and who have either exhausted or neglected to use their respective appeal rights; therefore, the FPLP is only applied after all previous IRS collections efforts have failed. Accordingly, the FPLP is an automated levy program where certain delinquent taxpayers are systematically matched and levied on their Federal payments disbursed by Treasury's FMS.

In 2001, we implemented the FPLP process for Medicare Part C and vendor payments, and in FY 2009, we will implement the FPLP process for payments made to providers and suppliers reimbursed under Part A and Part B of the Medicare program. However, the FPLP does not allow CMS to offset a payment when an individual reassigns his or her benefits to a third-party, such as a group practice where an existing Federal tax delinquency exists.

Consistent with statutory authority found under sections 1866(j)(1)(A) and 1871 of the Act, we believe that we have the authority to establish and make changes to the enrollment process for providers and suppliers of service. Accordingly, to ensure that the Federal government is able to recoup delinquent Federal tax debts from physicians and NPPs who are enrolled in the Medicare program and are receiving payments, we are considering revoking the billing privileges for those individuals for whom a tax delinquency exists and we are unable to directly levy future payments through the FPLP. While we did not propose this change in this year's PFS proposed rule, we will consider proposing this type of change in a future rulemaking effort after we have implemented the FPLP process, monitored and evaluated the implementation of FPLP process, and analyzed the potential impact of this change on physician and NPPs who are subject to the FPLP but for whom we are unable to directly levy future payments through the FPLP. In addition, we expect to conduct outreach regarding our implementation of the FPLP in FY 2009.

We believe that this change, if proposed and adopted, would prohibit an individual with a tax delinquency from shielding their future payments through reassignment of benefits to a third party. Finally, since the tax delinquency would be incurred by an individual who has reassigned his or her benefits to a third party, we do not believe that it is appropriate to take action against the third-party. We believe that this is consistent with the protections already afforded to an individual by the IRS but ensures that Medicare does not enroll or allow continued enrollment to an individual with a serious tax delinquency.

We maintain that it is essential that a physician or NPP resolve any existing Federal tax delinquency before entering the Medicare program. This will ensure that the Medicare program is not making payments to an individual who has not met his or her obligation to pay their tax debts.

Finally, we solicited comments on whether we should consider revoking a physician's billing privileges or taking some other type of administrative action when a physician or NPP has a Federal tax delinquency that can not be levied through the FPLP process. We also solicited comments on whether we should consider revoking the billing privileges of an organizational entity or taking some other type of administrative action against organizational entities when the owners of an organizational entity have a Federal tax delinquency that can not be levied through the FPLP process.

Comment: One commenter recommends an alternative to payment denial where an individual with a tax delinquency has reassigned their benefits to a group. The commenter suggested that the government garnish a portion of the individual practitioner's salary directly, as appropriate. Another commenter does not believe it is appropriate to penalize all of the partners in a practice, when only one individual is guilty of tax evasion. One commenter requests that we define, in greater detail, the term ''reliable information,'' and also that we assure some formal type of appeals process apart from a simple rebuttal. Another commenter questions if there is a mechanism in place whereby a potential new hire can be held harmless should his or her potential employer find itself in a delinquent status within a 12-month period. One commenter questions whether the burden of reporting an adverse legal action would be placed upon the individual saddled with the action rather than his or her group managing partners, for sometimes the principals are not aware of the actions of their employees. Another commenter stated that at a minimum, the third party involved should be sent notification of the provider's revoked billing privileges 18 months before the date of revocation. One commenter believes that this provision is not logistically possible because it raises too many issues, including taxpayer privacy, equal opportunity employment concerns, and perhaps even whistleblower triggers regarding noncompliance.

Response: Section 189 of the MIPPA requires that CMS take all necessary steps to participate in the Federal

Payment Levy Program (FPLP) under section 6331(h) of the Internal Revenue Code of 1986. The FPLP process allows CMS to levy current and future payments until the tax delinquency is eliminated.

After reviewing comments received in response to our solicitation for comments regarding whether we should consider revoking billing privileges or taking some other administrative action when a physician or NPP has a Federal tax delinquency that cannot be levied through the FPLP process, we are considering whether future rulemaking or administrative action is needed in this area. We appreciate the public insight regarding our solicitation for comments and will consider these comments in developing any future rulemaking proposals; however, we continue to maintain that physicians and NPPs should resolve any existing Federal tax delinquency before enrolling in the Medicare program or as soon as practical if the physician is enrolled in Medicare.

3. Denial of Enrollment in the Medicare Program (proposed § 424.530(a)(6) and (a)(7))

Currently, owners, authorized officials, and delegated officials of physician and NPP organizations and individual practitioners, including physicians and NPPs, can obtain additional billing privileges by establishing a new tax identification number (TIN), reassigning benefits to another entity, or by submitting an enrollment application as another provider or supplier type even though the entity for which the provider or supplier furnished services and has had its billing privileges revoked, suspended, or has an outstanding Medicare overpayment. Absent a reason to reject or deny a Medicare enrollment application, the Medicare FFS contractor is required to approve the enrollment application for a provider or supplier who meets all other Federal and State enrollment requirements for their provider or supplier type.

By submitting and having an enrollment application (for example, an initial application or a change of ownership) with a new TIN, some physician and NPP organizations and individual practitioners are able to circumvent existing Medicare revocation, payment suspension, overpayment recovery, and medical review processes by obtaining additional Medicare billing privileges. By obtaining additional billing privileges for multiple locations, these providers and suppliers are able to discontinue the use of the NPI that has an administrative action against it and bill and receive payment under another NPI.

Consistent with existing § 405.371, we will impose a payment suspension when we possess reliable information that an overpayment or fraud, or willful misrepresentation exists, or that payments to be made may not be correct. Suspension procedures give providers and suppliers an opportunity to submit a rebuttal to CMS' payment suspension determination. We believe that it is essential that we resolve the payment suspension determination before we grant additional billing privileges to these providers or suppliers. In concert with § 405.372(c), once a payment suspension has been terminated, providers and suppliers may then apply for billing privileges.

Moreover, we are obligated to recover Medicare overpayments as expeditiously as possible. Providers and suppliers can pay the debt or Medicare can reduce present or future Medicare payments and apply the amount withheld to the indebtedness. When we identify an overpayment and provide notice of the overpayment, physician and NPP organizations and individual practitioners are given an opportunity to appeal the determination. Under certain conditions, the overpayment collection process is suspended during the appeals process. However, if the physician and NPP organization or individual practitioner does not appeal the overpayment determination, or if the overpayment determination is upheld on appeal, we will initiate a recovery action.

Accordingly, we proposed to add a new § 424.530(a)(6) and (a)(7) to deny enrollment applications for additional Medicare billing privileges if the physician or NPP organization or individual practitioner has an active payment suspension or has an existing overpayment that has not been repaid. We proposed to allow a Medicare FFS contractor to deny enrollment applications from those authorized officials, delegated officials, owners, and individual practitioners that own a supplier or provider at the time of filing until such time as the suspension has been terminated or the Medicare overpayment has been repaid in full. Specifically, we proposed to deny enrollment to any current owner (as defined in § 424.502), physician, or NPP, who is participating in the Medicare program and is under a current Medicare payment suspension.

We stated that we believe that the change to our denial policy would help protect the Medicare program from unscrupulous or problematic physician and NPP organizations and individual practitioners. Moreover, we believe this change would: (1) Allow Medicare FFS contractors to improve customer service to all providers and suppliers that are already enrolled in the Medicare program; (2) facilitate the enrollment of all providers and suppliers seeking to enroll in the Medicare program for the first time; and (3) expand on existing efforts to process changes in a timely manner and provide better customer service.

Comment: Several commenters stated that our proposal to deny additional billing privileges to a physician or an NPP when the physician or NPP is suspended or has an outstanding overpayment is a denial of due process and is in conflict with the principle of innocent until proven guilty.

Response: We believe that we have an obligation to protect the Medicare program from inappropriate payments. Conversely, physicians and NPPs have an obligation to the Medicare program to resolve payment suspensions and overpayment actions in a timely manner. Finally, as a payer of health care, we believe that additional billing privileges should not be conveyed to a physician, NPP or owners, authorized and delegated officials who have an existing payment suspension or overpayment. To grant additional billing privileges to individuals with an existing payment suspension or overpayment exposes the Medicare Trust Funds to additional risks.

With Medicare's implementation of the NPI on May 23, 2008, Medicare contractors no longer issue billing numbers to providers and suppliers participating in the Medicare program. However, Medicare contractors do convey billing privileges to providers and suppliers that have an NPI and meet all of the program requirements for their provider or supplier type. Once enrolled, providers and suppliers are required to use their NPI to submit claims to Medicare, and based on the NPI final rule, organizations may obtain one or more NPIs.

After reviewing public comments, we are finalizing the provisions at § 424.530(a)(6) and (a)(7) to deny enrollment applications for additional Medicare billing privileges if a physician, NPP, physician or NPP organization has an existing payment suspension or has an existing overpayment that has not been repaid. We believe that permitting a Medicare contractor to deny enrollment applications submitted by individual practitioners, authorized officials, delegated officials, and owners until such time as the Medicare overpayment

has been repaid in full will require providers and suppliers to resolve overpayments in a timely manner. Once CMS has imposed a payment suspension, a provider or supplier may submit a rebuttal to CMS for the purpose of reducing or terminating the payment suspension. As long as the payment suspension is effective, the contractor has the task of making an overpayment determination. Specifically, we are adopting the provision to deny enrollment to any physician, or NPP current owner (as defined in § 424.502), authorized or delegated official who is participating in the Medicare program and is under an existing Medicare payment suspension or has an outstanding overpayment that has not been repaid in full. As adopted, physicians and NPPs will not be allowed to enroll and reassigning payments to a third-party if the individual practitioner has an existing payment suspension or overpayment that have not been repaid.

4. Reporting Requirements for Providers and Suppliers (§ 424.516 and § 424.535(a)(10))

Currently, § 424.520(b) requires that providers and suppliers, except DMEPOS and IDTF suppliers, report to CMS most changes to the information furnished on the enrollment application and furnish supporting documentation within 90 calendar days of the change (changes in ownership must be reported within 30 days). As specified in § 424.57(c)(2), DMEPOS suppliers have only 30 calendar days to submit changes of information to CMS. As specified in § 410.33(g)(2), IDTFs, must report changes in ownership, changes in location, changes in general supervision, and final adverse actions within 30 calendar days. All other changes to the enrollment application must be reported within 90 days.

While physician and NPP organizations and individual practitioners are required to report changes within 90 days of the reportable event, in many cases, there is little or no incentive for them to report a change that may adversely affect their ability to continue to receive Medicare payments. For example, physician and NPP organizations and individual practitioners purposely may fail to report a felony conviction as described in § 424.535(a)(3), or other final adverse action, such as a revocation or suspension of a license to a provider of health care by any State licensing authority, or a revocation or suspension of accreditation, because reporting this action may result in the revocation of their Medicare billing privileges. Thus, unless CMS or our designated contractor becomes aware of the conviction or final adverse action through other means, the change may never be reported by a physician and NPP organization or individual practitioner. Alternatively, if CMS or our designated contractor becomes aware of the conviction or final adverse action after the fact, we have lacked the regulatory authority to collect overpayments for the period in which the physician and NPP organizations and individual practitioners should have had their billing privileges revoked.

Since we believe that physician and NPP organizations and individual practitioners must furnish updates to their Medicare enrollment information in a timely manner, we are adopting a new § 424.516(d) which would establish more stringent reporting requirements for physician NPP organizations and individual practitioners. (We proposed to redesignate § 424.520 as § 424.516 and amend the provisions in new § 424.516.) In addition to a change of ownership (as currently specified in redesignated § 424.516(d)(1)(i)), we proposed to add § 424.516(d)(1)(ii) requiring all physician and NPP organizations and individual practitioners to notify our designated contractor of any final adverse action within 30 days. We stated that final adverse actions include, but are not limited to, felonies, license suspensions, and the HHS Office of the Inspector General (OIG) exclusion or debarment. We believe that a physician and NPP organizations and individual practitioner's failure to comply with the reporting requirements within the time frames described above may result in the revocation of Medicare billing privileges and a Medicare overpayment from the date of the reportable change. Specifically, we believe that a final adverse action may preclude payment, and thus, establish an overpayment from the date of the adverse action. As such, we believe that physician and NPP organizations and individual practitioners should not be allowed to retain any reimbursement they receive after the final adverse action.

In addition, we added the word ''final'' to the beginning of the term ''adverse legal action'' in the regulation text in § 424.535 on overpayment. We define the term as a ''final adverse action'' in the definition section at § 424.502 and want to be consistent with that definition. Also, we want to be consistent with our definition of this term in the Durable medical Equipment prosthetics Orthotics and Supplies surety bond rule (CMS–6006–F). Moreover, we want this term to be consistent with the definition of ''final adverse action'' found in section 221(g)(1)(A) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Finally, we believe that a final adverse action has occurred when the sanction is imposed and not when a supplier has exhausted all of the appeal rights associated with the action itself.

We believe that it is essential that this type of change be reported in a timely manner (that is within 30 days). For example, if CMS or our designated contractor determines in February 2008 that a physician failed to notify Medicare about a final adverse action that occurred on June 30, 2007, that physician may be subject to an overpayment for all Medicare payments beginning June 30, 2007 and have their Medicare billing privileges revoked effective retroactively back to June 30, 2007 as well.

Additionally, we proposed to add a requirement for change in location at § 424.516(d)(1)(iii). Since a change in location may impact the amount of payment for services furnished by placing the physician and NPP organizations and individual practitioners into a new Core Based Statistical Area (CBSA). We believe that it is essential that physician and NPP organizations and individual practitioners report changes in practice location including those that impact the amount of payments they receive within a timely period (that is, 30 days). However, unlike a final adverse action, which may preclude all payments if reported, failure to report a change in practice location may impact the amount of payment, not whether a physician and NPP organizations and individual practitioners may be eligible to receive payments. Accordingly, we believe that failing to report changes in practice location would result in an overpayment for the difference in payment rates retroactive to the date the change in practice location occurred and may result in the revocation of Medicare billing privileges. For example, if a physician and NPP organization moves its practice location in New York, from urban Herkimer County to Hamilton County or Lewis County, which are both rural, but fails to update its provider enrollment information; then it would no longer be able to receive the higher payment rate associated with Herkimer County. We believe that reporting these types of changes is essential for making correct and appropriate payments.

We proposed to add § 424.535(a)(9) which would specify that failure to comply with the reporting requirements

specified in § 424.516(d) would be a basis for revocation. Additionally, we proposed in § 424.565, ''Failure to comply with the reporting requirements specified in § 424.516(d) would result in a Medicare overpayment from the date of a final adverse action or a change in practice location.'' In this situation, an overpayment for failure to timely report these changes would be calculated back to the date of the final adverse action or the date of the change in practice location. Once an overpayment has been assessed, we will follow the overpayment regulations established at 42 CFR part 405 subpart C. We previously addressed these procedures in Chapter 4 of the Medicare Financial Management Manual (IOM Manual 100–06). Lastly, collection of overpayments related to § 424.516(d)(1)(iii) would not begin until after the effective date of the final rule.

Since it is essential that physician and NPP organizations and individual practitioners notify their designated contractor of these types of reportable events in a timely manner and to ensure that the provider or supplier continues to be eligible for payment, we believe that it is essential that we establish an overpayment from the time of the reportable event. We believe that establishing an overpayment and revocation of billing privileges for noncompliance from the time of the reportable event would provide the supplier with a compelling incentive to report reportable changes in the 30-day reporting period.

In addition, if CMS or our designated contractor determines that a physician and NPP organization or an individual practitioner has moved and has not reported the reportable event within the 30-day reporting period, CMS or our designated contractor would impose an overpayment, if applicable, and revoke billing privileges for a period of not less than 1 year.

Comment: One commenter would like to laud CMS for expounding on reporting requirements for the updates regarding address changes, as well as reporting an adverse legal action in a manner to be complete within 30 days. The commenter continued to state that failure to report changes in location, leading to potential overpayment, and revocation of Medicare billing privileges needs to be highlighted for all providers.

Response: We appreciate this comment and will consider expanding this provision to all providers and suppliers in a future rulemaking effort.

Comment: One commenter stated that it disagrees with our assumption that all payments subsequent to an adverse legal action are collectable overpayments.

Response: Since final adverse actions such as Federal exclusion or debarment, felony convictions as described in § 424.535(a)(3) or license suspension or revocation that precluded continued enrollment in the Medicare program.

Comment: One commenter stated that while a CMS representative publicly stated that the proposed rule should have referenced adverse legal actions that have been finally adjudicated, the commenter recommends that CMS clarify this language in the final rule. Several commenters recommended that only adverse legal actions that are relevant to the practice of medicine should be required to be reported to CMS.

Response: Based on these comments, we are adding a definition of a final adverse action to § 424.502(a). Specifically, we have defined a final adverse action to mean one or more of the following actions: (1) A Medicare-imposed revocation of any Medicare billing privileges; (2) Suspension or revocation of a license to provide health care by any State licensing authority; (3) Revocation or suspension by an accreditation organization; (4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or (5) An exclusion or debarment from participation in a Federal or State health care program.

Comment: One commenter suggested that we should clarify in the final rule that with regard to adverse legal actions, the requirements should apply only to notification within 30 days of ''final'' legal actions that are relevant to or otherwise impact the practice of medicine.

Response: While we understand that physicians and NPPs are afforded different appeal rights depending on the type of final adverse action, we do not believe that it is appropriate to allow physicians and NPPs to continue to furnish services to Medicare beneficiaries if their State medical license has been suspended or revoked, a Federal exclusion or debarment or Medicare revocation has been imposed, or the physician or NPP was found guilty or pled to felony conviction as described in § 424.535(a)(3).

Comment: One commenter believes that if CMS wants to collect alleged overpayments for services paid during the 90 days as if they were performed in a higher-paying locale, then they should also pay the difference for underpayments when a physician provides services for up to 90 days in a higher paying locality prior to notifying CMS of the change in location.

Response: We maintain that it is the responsibility of the physician, NPP or physician or NPP organization to update their enrollment information within the appropriate timeframes. Further, note that CMS will not reprocess claims for the services provided when there has been a failure to report a change in practice location.

Comment: Several commenters stated that a State licensing board is the proper authority to weigh the significance of legal actions against a physician. Another commenter stated that State licensing and other requirements already protect beneficiaries from the most important kinds of issues that could arise in medical care.

Response: While we agree that State licensing boards are responsible for determining whether an individual meets or continues to meet the qualifications for a specific State medical license, we do not agree that a State license is the only criteria that an individual must maintain in order to receive billing privileges from the Medicare program.

Comment: One commenter stated that they do not oppose changing the time period for reporting adverse legal actions from 90 days to 30 days, as generally payments should not be made under these circumstances.

Response: We appreciate this comment.

Comment: One commenter stated that they did not agree that a change in practice location should be treated as an urgent matter that would support a retroactive revocation of billing authority.

Response: We disagree with this commenter. Since physicians and NPPs receive payments in part on locality adjustments based on the place of service, we believe that physicians, NPPs, and physician and NPP organizations are responsible for updating their enrollment record within 30 days of a change in practice location. It is also important to note that we already have existing authority to revoke the billing privileges of a Part B supplier, including physicians and NPPs, if CMS or our contractor determines that upon an on-site review or other reliable evidence that the supplier is not operational (see § 424.535(b)(5)).

Comment: One commenter stated that they oppose changing the time period for reporting a change in location from 90 days to 30 days because the physician is still eligible for payment and Medicare's vulnerability to overpayments is limited.

Response: While we agree that a physician may still be eligible to receive

payment, the issue in question is the amount of payment. Moreover, as a payer of health care, we believe that physicians and all other providers and suppliers have a responsibility to update their enrollment record when a change in practice location occurs. This will allow CMS or our contractor to verify that services are actually furnished at the practice locations identified by the medical practices.

Comment: One commenter stated that if we finalize our reporting requirements, a better option would be to limit the types of actions that are reportable to similar actions that are required to be reported to the National Practitioner Data Bank (NPDB) which was established by the Congress to address the need to improve the quality of medical care by encouraging State licensing boards, health care entities such as hospitals, and professional societies to identify and discipline those who engage in unprofessional behavior, as well as restrict a practitioner's ability to move from State to State without disclosure of previous adverse action history.

Response: We disagree with this commenter. In considering the types of events that should be reported within 30 days of the reportable event, with this final rule with comment period, we have limited the types of reportable events to three specific types of events: (1) Change in ownership, (2) final adverse actions, and (3) change in practice location. We believe that the failure to report any of these types of reportable events may result in payments to the wrong organization, erroneous payments if the physician or NPP payment no longer meets State licensure requirements, or payments in the wrong amount when a change in practice location impacts the payment to a physician, NPP or physician or NPP organization.

Comment: One commenter stated that our proposal to revoke billing privileges for a period of not less than 1 year for failure to comply with the proposed 30-day reporting period is a harsh and unjust penalty for a minor paperwork offense.

Response: While we understand this commenter's concern, we believe that physicians, NPPs, physician and NPP organizations have an obligation to report certain changes, including State license suspensions and revocations, felony convictions as described in § 424.535(a)(3), Federal debarments and exclusions, within 30 days since these adverse actions may affect a physician, NPP or physician or NPP organization's ability to continue to participate in the Medicare program.

Comment: One commenter urged CMS to consider that the failure to notify Medicare contractors of a change in location is an oversight rather than a true attempt to defraud the Medicare program.

Response: Since physicians, NPPs, and physician and NPP organizations routinely notify State medical societies, vendors, employees, utility companies, leasing companies, and others prior to a change in practice location, we disagree with this commenter that change in location is an oversight.

Comment: One commenter stated that that while there is a need to maintain timely provider records and track Medicare payments, proposed penalties for failure to report an address change promptly are so out of proportion to the offense as to be draconian.

Response: We disagree with this commenter. As stated above, we understand that physicians, NPPs, and physician and NPP organizations routinely notify other payers and affiliated business partners about a change of practice location in advance of the change. In addition, to ensure payment accuracy, it is essential that physicians, NPPs, and physician and NPP organizations report changes in practice locations prior to change, but not later than 30 days after the reportable event.

Comment: One commenter stated that it seemed sufficient to collect any overpayment from providers that file their change of address notice within the traditional 90-day window for updating enrollment records.

Response: As a payer of health care, it is essential that we make every attempt to make correct payments for services furnished by qualified providers and suppliers. To help ensure that we are making the correct payments the first time, we believe that it is necessary that physicians, NPPs, and physician and NPP organizations update their enrollment records when a change in practice location occurs.

Comment: One commenter urges CMS to withdraw the proposal to establish authority to require that physicians report a change in ownership, ''any'' adverse legal action, or change in practice location within 30 days since these events may be unrelated to the Medicare program and the reporting time frame is unduly burdensome to physicians.

Response: We disagree with this commenter. Since June 20, 2006, physicians and NPP organizations have been required to report a change in ownership within 30 days and changes in practice locations and final adverse actions within 90 days (see § 424.516(d)). Since we are aware of situations where physicians and NPPs have not reported State license suspensions/revocations or final adverse actions which may affect a physician or NPPs eligibility to participate in the Medicare program, we believe that it is essential to establish more stringent reporting requirements than in the past. We believe that these requirements along with corresponding enforcement procedures will encourage physicians, NPPs and physician and NPP organizations to report changes in ownership, final adverse actions, and changes in practice location in a timely manner (that is, 30 days.)

Comment: One commenter stated that ''any adverse legal action'' is not defined; therefore a 30-day reporting requirement is unreasonable as are the other proposed requirements. The commenter also stated that we should save our severe penalties for proven fraudulent behavior, not minor clerical oversights.

Response: We disagree with this commenter that failure to report a final adverse action is a minor clerical oversight. Since reporting a final adverse action may affect a physician or NPP's ability to continue to participate in the Medicare program, we understand why these actions may not be reported to a Medicare contractor; however, we believe that final adverse actions, including State licensing suspensions and revocations, should be reported within 30 days of the reportable event, even if the physician or NPP plans on appealing the final adverse action. By reporting the final adverse action within 30 days, the Medicare program will carefully review any revocation action and exercise its discretion as to whether to impose a revocation and the length of time of the reenrollment bar.

Comment: One commenter stated that a revocation of billing privileges seems to be a disproportionately severe penalty for infractions such as: (1) Failure to report changes in ownership, adverse legal actions, and changes in practice location, or (2) not maintaining ordering and referring documentation for a 10-year period.

Response: We disagree with this commenter. As stated above, we believe reporting changes in ownership, final adverse actions, and changes in practice locations are essential to ensuring that the Medicare program makes correct payments to eligible practitioners and organizations. We also believe that it is essential that physicians and NPPs maintain ordering and referring documentation to support the claims submissions.

Comment: One commenter stated that levying an overpayment for failure to report a ''reportable event,'' within 30 days is excessive for what is likely an honest oversight.

Response: We disagree with this commenter that establishing an overpayment is excessive when a physician, NPP or physician and NPP organization fails to report a final adverse action, such as a State license suspension or revocation or adverse legal action, that may preclude participation in the continued participation in the Medicare program in a timely manner (that is, 30 days).

Comment: One commenter stated that Federal regulations regarding overpayments are already established at 42 CFR part 405, therefore, changing the provider enrollment requirements to prevent overpayments is not necessary.

Response: We disagree with this commenter because the existing overpayment regulations do not allow us to assess an overpayment based on the failure of a physician, NPP, or physician or NPP organizations to report certain reportable enrollment events.

Comment: One commenter stated that they were concerned over inconsistency in the verbiage of this section where we state in the CY 2009 PFS proposed rule (73 FR 38538 through 38539) that billing privileges *may* be revoked in one place and in the other place state that they *would* be revoked.

Response: We appreciate this comment and have clarified in this final rule to use the word, ''may'' when referring to the revocation of Medicare billing privileges.

Comment: One commenter recommends that a 60-day limit be imposed rather than the proposed 30 days for notifying CMS about a ''reportable event.''

Response: We believe that changes of ownership, adverse legal actions, and changes in practice locations can and should be reported within 30 days of the reportable event. By reporting these types of reportable events within 30 days, the Medicare program can take the necessary steps to ensure that we are paying physicians and NPPs correctly and ensure that only eligible physicians and NPPs are enrolled in the Medicare program.

After reviewing public comments, we are finalizing the provision at proposed § 424.516(d) which would require physicians, NPPs or physician and NPP organizations to notify its Medicare contractor of a change of ownership, change in practice location or any final adverse action within 30 days of the reportable event. In addition, we believe that physician and NPP organizations' and individual practitioners' failure to comply with the reporting requirements within the time frame described above may result in the revocation of Medicare billing privileges and the imposition of a Medicare overpayment from the date of the reportable change. Specifically, we believe that a final adverse action may preclude payment, and thus, establish an overpayment from the date of the adverse legal action. As such, we believe that physician and NPP organizations and individual practitioners should not be allowed to retain any reimbursement they receive after the date of the adverse legal action. In addition, physicians, NPPs, or physician and NPP organizations who voluntarily report a final adverse action that prohibits further payment will have their Medicare billing privileges revoked and have an overpayment assessed back to the date of the reportable event. CMS has the discretion to revoke the supplier's billing privileges. Moreover, revocation affords the supplier appeal rights and by reporting an adverse legal action within 30 days of the reportable event, a physician or NPP or physician or NPP organization may regain billing privileges if the final adverse action no longer impedes the applicant's reenrollment into the Medicare program.

We are also finalizing the provision at § 424.516(d)(1)(iii) which requires physicians, NPPs and physician and NPP organizations to report a change of practice location within 30 days. While we may not revoke the billing privileges of physicians, NPPs and physician and NPP organizations if a change of practice location is reported by the practitioner or organization after the prescribed 30-day timeframe, we will assess an overpayment, if applicable, for the difference in payment rates retroactive to the date the change in practice location occurred. In addition, with limited exceptions such as a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act), physicians, NPPs, and physician and NPP organizations can report a change of practice location in advance of the reportable event. We note that individual practitioners and physician and NPP organizations routinely notify staff, the U.S. Post Office, telephone and electric companies, suppliers, vendors, State medical associations and other practitioner partners prior to a change in practice location. Accordingly, we believe that it is appropriate that physicians and NPP organizations notify the Medicare contractor in advance of any pending change of practice location, but no later than 30 days after the reportable event.

As such, we will not reprocess claims for those individual practitioners and physician and NPP organizations that do not report a change of practice location prior to a change in practice location where the reported change would result in an underpayment, unless the change of location was the direct result of a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act). We believe that this change will create an incentive for physicians, NPPs, and physician and NPP organizations to report changes in practice locations prior to the change of practice location or, at a minimum, within the 30 days of the reportable event.

Moreover, if we determine that a change of practice location occurred and it has not been reported within the 30 days of the reportable event, we may revoke billing privileges and assess any applicable overpayment for the difference in payment rates retroactive to the date the change in practice location occurred. We believe that the authority to revoke billing privileges has already been established in § 424.535(a)(5)(ii).

We are finalizing the provision at proposed § 424.535(a)(9) which would specify that failure to comply with the reporting requirements specified in § 424.516(d) would be a basis for revocation. Additionally, we are also finalizing the provision we proposed in § 424.565(a), ''Failure to comply with the reporting requirements specified in § 424.516(d) would result in a Medicare overpayment from the date of a final adverse action or a change in practice location.'' In this situation, an overpayment for failure to timely report these changes would be calculated back to the date of the final adverse action or the date of the change in practice location. Once an overpayment has been assessed, we will follow the overpayment regulations established at 42 CFR Part 405 subpart C.

Based on public comments, we are adding a definition of final adverse action to § 424.502(a). A final adverse action means one or more of the following actions: (1) A Medicare-imposed revocation of any Medicare billing privileges; (2) Suspension or revocation of a license to furnish health care by any State licensing authority; (3) Revocation or suspension by an accreditation organization; (4) A conviction of a Federal or State felony

offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or (5) An exclusion or debarment from participation in a Federal or State health care program.

5. Maintaining Ordering and Referring Documentation

We proposed to add a new § 424.516(f) that would specify, ''A provider or supplier is required to maintain ordering and referring documentation, including the NPI, received from a physician or eligible NPP. Physicians and NPPs are required to maintain written ordering and referring documentation for 10 years from the date of service.'' We believe that it is essential that providers and suppliers maintain documentation regarding the specific service ordered or referred to a Medicare beneficiary by a physician or NPP as defined in section 1842(b)(18)(c) of the Act, (which includes but is not limited to nurse practitioners and physician assistants). We believe that ordering and referring documentation maintained by a provider or supplier must match the information on the Medicare claims form. Additionally, we proposed to add § 424.535(a)(10) that would state that failure to comply with the documentation requirements specified in § 424.516(f) would serve as a reason for revocation. For example, a lab submits a claim with Dr. Smith's NPI (1234512345) in the ordering and referring section of the claim form. The number submitted on the claim form should match the documentation in the provider or supplier's records. In addition, we proposed to codify the requirement to maintain ordering and referring documentation as required in the Medicare Program Integrity Manual (PIM) Publication 100–08, Chapter 5. While the PIM currently requires that providers and suppliers maintain ordering and referring documentation for 7 years from the date of payment, we believe that the industry generally maintains documentation from the date of service. Accordingly, since there may be a delay in claims submission and subsequent payment for up to 27 months from the date of service, we believe that it would be administratively less burdensome for providers and suppliers to maintain ordering and referring documentation for 7 years from the date of service, rather than requiring providers and suppliers to maintain ordering and referring documentation associated with the date of payment.

We maintain that a provider or supplier should retain the necessary ordering and referring documentation received from physicians and NPPs as defined in section 1842(b)(18)(C) of the Act to assure themselves that coverage criterion for an item has been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier would be liable for the dollar amount involved unless a properly executed Advance Beneficiary Notice of possible denial has been obtained.

Comment: One commenter urged CMS to adopt its proposal that would specify that a provider or supplier is required to maintain ordering and referring documentation, including the NPI received from the physician or eligible NPP, for 10 years from the date of service, but that this provision only apply to services furnished on or after the effective date of this final rule with comment period.

Response: We agree with this commenter in that we are basing the ordering and referring record retention requirement based upon the date of service, however we are adopting the provision for 7 years from the date of service. We believe that this approach is administratively consistent with current manual record retention policy that requires that suppliers retain ordering and referring documentation for 7 years from the date of billing. We maintain that it is less burdensome for providers and suppliers to maintain ordering and referring documentation for 7 years from the date of service rather than requiring providers and suppliers to maintain ordering and referring documentation associated with the proposed provision for 10 years after the date of payment.

Comment: One commenter disagrees with increasing the retention of ordering and referring documentation beyond the current 7 years from the date of payment. The commenter continued to state that the provision as proposed may represent an additional cost for 3 years of additional record retention.

Response: As stated above, we are establishing an ordering and referring record retention period as 7 years from the date of service.

Comment: One commenter believes that CMS must understand that in virtually all cases, the only information the laboratory receives is the laboratory requisition submitted by the physician.

Response: We continue to believe that it is necessary that providers and suppliers retain ordering and referring documentation for services furnished 7 years from the date of service. However, we understand that the supplier may not maintain the NPI documentation for each service, but the provider or supplier must maintain sufficient documentation to identify the individual who ordered or referred the beneficiary for their services. In addition, upon review, CMS or our contractor may validate the ordering/referring documentation maintained by the billing provider or supplier with the individual practitioner who ordered/referred the beneficiary for these services.

Comment: One commenter recommends that CMS defer to the judgment of the State boards of pharmacy regarding the length of record retention, and also allow offsite electronic storage of ordering and referring records.

Response: We appreciate the importance of the requirements of State boards of pharmacy; however, we uphold that Medicare is a national program and it is necessary to establish national standards for maintaining the ordering and referring record retention period. We believe that this approach will lead to consistency. Further, the provisions of the final rule do not preclude offsite or electronic storage as long as these records are readily accessible and retrievable.

Comment: One commenter proposes CMS to abandon its proposal for the 10-year record retention period and allow pharmacies to follow record retention requirements under State law.

Response: We appreciate the importance of the requirements of State boards of pharmacy, however we uphold that Medicare is a national program and it is necessary to establish national standards for maintaining the ordering and referring record retention period. We believe that this approach will lead to CMS consistency. While we are not changing our record retention policy to account for different State pharmacy laws, we are revising the proposed 10-year record retention policy and establishing an ordering and referring record retention period as 7 years from the date of service

Comment: One commenter believes that pharmacies should be allowed to maintain their hard-copy records offsite electronically after a certain time.

Response: The provisions of the final rule do not preclude offsite or electronic storage as long as these records are readily accessible and retrievable.

Comment: Several commenters recommended that pharmacies should maintain the prescription record in written form for the greater of 3 years or the requirements in State law, and then allow the prescription to be stored electronically for the remaining years. The commenter continued to state that this would bring consistency to the Medicare Parts B and D programs, and

reduce the need to create new storage capacity for paper prescription records.

Response: Since Medicare is a Federal program that already requires a 7-year retention period from the date of billing, we disagree that this change will create a significant burden.

Comment: One commenter stated that the extension from 7 to 10 years would add a substantial recordkeeping burden.

Response: We agree with this commenter and have revised this final rule with comment period to establish an ordering and referring record retention period as 7 years from the date of service.

Comment: One commenter urged CMS to reconsider our position regarding maintaining ordering and referring documentation. In addition, this commenter stated that this change would constitute an unfunded mandate.

Response: We disagree with this commenter that this change is an unfunded mandate because providers and suppliers are already required by CMS' manual instructions to maintain ordering and referring documentation for 7 years from the date of billing.

Comment: One commenter stated that we should allow offsite and electronic storage of ordering and referring records.

Response: The provisions of the final rule do not preclude offsite or electronic storage as long as these records are readily accessible.

Comment: One commenter urged CMS to adopt the proposed requirement for record retention, but only with a provision that such record retention requirements became effective as of the effective date of the final rule. Further, the commenter states that those providers and suppliers that, until now, have not kept ordering and referring documentation for 10 years from the date of service (and were under no other statutory or regulatory requirement to do so) would not be liable and face possible revocation of billing privileges as long as the provider or supplier was in compliance with currently existing requirements.

Response: We agree with this commenter; however, we have revised this final rule to establish the ordering and referring record retention period as 7 years from the date of service.

After reviewing public comments, we are finalizing the provision at proposed § 424.516(f) that would require providers and suppliers to maintain ordering and referring documentation, including the NPI, received from a physician or eligible NPP. Physicians and NPPs are required to maintain written ordering and referring documentation for 7 years from the date of service. In addition, we are finalizing the provision found at § 424.535(a)(10) that states that failure to comply with the documentation requirements specified in § 424.516(f) is a reason for revocation.

Finally, the aforementioned provisions regarding ordering and referring documentation are effective with services furnished on or after the implementation date of this final rule.

6. Revocation of Enrollment and Billing Privileges in the Medicare Program (§ 424.535(h))

Historically, we have allowed providers and suppliers whose Medicare billing numbers have been revoked to continue billing for services furnished prior to revocation for up to 27 months after the effective date of the revocation. Since we believe this extensive billing period poses significant risk to the Medicare program, we proposed to limit the claims submission timeframe after revocation. In § 424.535(g) (Redesignated as § 424.535(h), we proposed that revoked physician and NPP organizations and individual practitioners, including physicians and NPPs, must submit all outstanding claims not previously submitted within 30 calendar days of the revocation effective date. We stated that this change is necessary to limit the Medicare program's exposure to future vulnerabilities from physician and NPP organizations and individual practitioners that have had their billing privileges revoked. We know that some physician and NPP organizations and individual practitioners are able to create false documentation to support claims payment. Accordingly, we stated that the proposed change would allow a Medicare contractor to conduct focused medical review on the claims submitted during the claims filing period to ensure that each claim is supported by medical documentation that the contractor can verify. We also stated that focused medical review of these claims will ensure that Medicare only pays for furnished services by a physician organization or individual practitioner and that these entities and individuals receive payment in a timely manner. Since a physician organization or individual practitioner generally submits claims on a nexus to the date of service, we stated that the proposed change will not impose a significant burden on physician organizations or individual practitioners. In addition, we also proposed to add § 424.44(a)(3) to account for this provision related to the requirements for the timely filing of claims.

Comment: One commenter supports our proposal to limit, to 30 days, the time frame in which a provider whose billing services have been revoked may continue to submit claims for services furnished prior to such revocation.

Response: We appreciate this comment.

Comment: One commenter appreciated our concern regarding the current period of up to 27 months but offered alternative time periods of 60 or 90 days rather than the proposed time period of 30 days.

Response: We are finalizing the provisions at § 424.535(h) (proposed as § 424.535(g)) that require a revoked physician, NPP or a physician or NPP organization to submit all outstanding claims not previously submitted within 60 calendar days of the effective date of the revocation, (except for revocations identified in § 405.874(b)(2) and § 424.535(f) of this final rule).

Comment: Several commenters encouraged CMS to reset the period of time a provider can submit claims after billing privileges have been revoked from up to 27 months to 6 months, instead of the proposed 30 days.

Response: As stated above, we are finalizing the provisions found at § 424.535(g) (Redesignated as § 424.535(h)) that require a revoked physician, NPP or a physician or NPP organization to submit all outstanding claims not previously submitted within 60 calendar days of the effective date of the revocation, (except for revocations identified in § 405.874(b)(2) and § 424.535(f) (redesignated as § 424.535(g)) of this final rule).

Comment: One commenter stated that 30 days is simply not enough time to wrap up all of the details of a practice, in addition to the other circumstances associated with a revocation of billing privileges.

Response: We are finalizing the provisions found at § 424.535(h) (proposed as § 424.535(g)) that require a revoked physician, NPP or a physician or NPP organization to submit all outstanding claims not previously submitted within 60 calendar days of the effective date of the revocation, (except for revocations identified in § 405.874(b)(2) and § 424.535(f) (redesignated as § 424.535(g)) of this final rule).

After reviewing public comments, we are finalizing the provisions found at § 424.535(h) (proposed as § 424.535(g)) that require a revoked physician, NPP or a physician or NPP organization to submit all outstanding claims not previously submitted within 60 calendar days of the effective date of the revocation. Since the physician, NPP or

a physician or NPP organization is already afforded approximately 30 days notification before the effective date of revocation (except for revocations identified in § 405.874(b)(2) and § 424.535(f) (redesignated as § 424.535(g)) of this final rule), we believe that almost 90 days is more than sufficient time to file any outstanding claims with the Medicare program.

In addition, we are amending § 424.44(a) to account for this provision related to the requirements for the timely filing of claims. We are revising the § 424.44(a) to clarify that this provision is consistent with § 424.521 which limits the ability of physicians, NPPs and physician and NPP organizations to bill retrospectively. The timely filing requirements in § 424.44(a)(1) and (a)(2) will no longer apply to physician, NPPs, or physician or NPP organizations or IDTFs.

7. Technical Changes to Regulations Text

We proposed to make the following technical changes:

- Existing § 424.510(d)(8) would be redesignated as § 424.517. This revision would separate our ability to conduct onsite reviews from the provider and supplier enrollment requirements.
- Existing § 424.520 would be revised and redesignated as § 424.516. This redesignation would move the additional provider and supplier enrollment requirements so that these requirements immediately follow the provider and supplier enrollment requirements.
- In new § 424.520, we proposed to specify the effective dates for Medicare billing privileges for the following entities: Surveyed, certified, or accredited providers and suppliers; IDTFs; and DMEPOS suppliers.
- In § 424.530, we proposed to add the phrase ''in the Medicare program'' to the section heading to remain consistent with other headings in the subpart.

After reviewing public comments, we are finalizing the following technical changes:

- Existing § 424.510(d)(8) has been redesignated as § 424.517. This revision would separate our ability to conduct onsite reviews from the provider and supplier enrollment requirements.
- Existing § 424.520 has been revised and redesignated as § 424.516. This redesignation would move the additional provider and supplier enrollment requirements so that these requirements immediately follow the provider and supplier enrollment requirements.
- In new § 424.520, we are adopting the effective dates for Medicare billing privileges for the following entities: Surveyed, certified, or accredited providers and suppliers; IDTFs; and DMEPOS suppliers.
- In § 424.530, we are adding the phrase ''in the Medicare program'' to the section heading to remain consistent with other headings in the subpart.

K. Amendment to the Exemption for Computer-Generated Facsimile (Fax) Transmissions From the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Covered Drugs Prescribed for Part D Eligible Individuals

1. Legislative History

Section 101 of the MMA amended title XVIII of the Act to establish a voluntary prescription drug benefit program. Prescription Drug Plan (PDP) sponsors and Medicare Advantage (MA) organizations offering Medicare Advantage-Prescription Drug Plans (MA–PDs) and other Medicare Part D sponsors are required to establish electronic prescription drug programs to provide for electronic transmittal of certain information to the prescribing provider and dispensing pharmacy and dispenser. This includes information about eligibility, benefits (including drugs included in the applicable formulary, any tiered formulary structure and any requirements for prior authorization), the drug being prescribed or dispensed and other drugs listed in the medication history, as well as the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed. Section 101 of the MMA established section 1860D–4(e)(4)(D) of the Act, which directed the Secretary to issue uniform standards for the electronic transmission of such data.

There is no requirement that prescribers or dispensers implement e-prescribing. However, prescribers and dispensers who electronically transmit prescription and certain other prescription-related information for covered drugs prescribed for Medicare Part D eligible individuals, directly or through an intermediary, are required to comply with any applicable final standards that are in effect. For a complete discussion of the statutory basis for the e-prescribing portions of this final rule with comment period and the statutory requirements at section 1860D–4(e) of the Act, please refer to the ''Background'' section of the E-Prescribing and the Prescription Drug Program proposed rule published in the February 4, 2005 **Federal Register** (70 FR 6256)

2. Regulatory History

a. Foundation Standards and Exemption for Computer-Generated Facsimiles (Facsimiles)

In the E-Prescribing and the Prescription Drug Program final rule (70 FR 67568, November 7, 2005), we adopted the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard, Implementation Guide, Version 5, Release 0 (Version 5.0), May 12, 2004, excluding the Prescription Fill Status Notification Transaction (and its three business cases which include the following: Prescription Fill Status Notification Transaction-Filled; Prescription Fill Status Notification Transaction-Not Filled; and Prescription Fill Status Notification Transaction-Partial Fill) hereafter referred to as ''NCPDP SCRIPT 5.0,'' as the standard for communicating prescriptions and prescription-related information between prescribers and dispensers. Subsequently, in the June 23, 2006 **Federal Register** (71 FR 36020), we published an interim final rule with comment period (IFC) that maintained NCPDP SCRIPT 5.0 as the adopted standard, but allowed for the voluntary use of a subsequent backward compatible version of the standard, NCPDP SCRIPT 8.1. In the April 7, 2008 **Federal Register**, we published a final rule (73 FR 18918) that finalized the June 23, 2006 IFC; effective April 1, 2009, we will retire the NCPDP SCRIPT 5.0 and adopt NCPDP SCRIPT 8.1 as the standard. Hereafter we refer to these standards as ''NCPDP SCRIPT.''

The November 7, 2005 final rule also established an exemption to the requirement to utilize the NCPDP SCRIPT standard for entities that transmit prescriptions or prescription-related information for Part D covered drugs prescribed for Part D eligible individuals by means of computer-generated facsimiles (facsimiles generated by one computer and electronically transmitted to another computer or facsimile machine which prints out or displays an image of the prescription or prescription-related information). Providers and dispensers who use this technology are not compliant with the NCPDP SCRIPT standard. The exemption was intended to allow such providers and dispensers time to upgrade to software that utilizes the NCPDP SCRIPT standard, rather than forcing them to revert to paper prescribing.

b. Amendment of Exemption

In the CY 2008 PFS proposed rule (72 FR 38194), we proposed to revise § 423.160(a)(3)(i) to eliminate the computer-generated facsimile exemption to the NCPDP SCRIPT standard for the communication of prescription or certain prescription-related information between prescribers and dispensers for the transactions specified in § 423.160(b)(1)(i) through (xii).

Since computer-generated facsimiles retain some of the disadvantages of paper prescribing (for example, the administrative cost of keying the prescription into the pharmacy system and the related potential for data entry errors that may impact patient safety), we believed it was important to take steps to encourage prescribers and dispensers to move toward use of NCPDP SCRIPT. We believed the elimination of the computer-generated facsimile exemption would encourage prescribers and dispensers using this computer-generated facsimile technology to, where available, utilize true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard) capabilities.

We proposed to eliminate the computer-generated facsimile exemption effective 1 year after the effective date of the CY 2008 PFS final rule (that is, January 1, 2009). We believed that this would provide sufficient notice to prescribers and dispensers who would need to implement or upgrade e-prescribing software to look for products and upgrades that are capable of generating and receiving transactions that utilize NCPDP SCRIPT. It would also afford current e-prescribers time to work with their trading partners to eventually eliminate computer-to-facsimile transactions.

We solicited comments on the impact of the proposed elimination of this exemption. Several commenters concurred with our proposal to eliminate the exemption for computer-generated facsimiles, indicating that eliminating the exemption for computer-generated facsimiles would act as an incentive to move prescribers and dispensers toward true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard), although many commenters suggested that we continue to allow for the use of computer-generated facsimiles in the case of transmission failure and network outages. Less than half of the commenters disagreed with our proposal to eliminate the exemptions for computer-generated facsimiles, citing concerns about increased hardware/software costs, transaction fees, certification, and other activation costs.

Several commenters indicated that the elimination of the exemption could be problematic in certain e-prescribing transactions, namely prescription refill requests, but only one of those commenters offered substantiation to support this assertion. Absent receipt of substantial industry data on the impact of the elimination of the computer-generated facsimile exemption on prescription refill requests, and not considering the industry's comments about prescription refill requests to constitute widespread concern regarding the prescription refill request function, in the CY 2008 PFS final rule with comment period (72 FR 66396), we amended the exemption to permit the use of computer-generated facsimiles only in cases of temporary/transient network transmission failures, effective January 1, 2009.

3. Proposal for CY 2009

Following the publication of the CY 2008 PFS final rule with comment period, we received additional information regarding how the modification of the exemption for computer-generated faxing to eliminate use of computer-generated faxing in all instances other than temporary/transient network transmission failures would adversely impact the electronic transmission of prescription refill requests. The submitted information offered additional support to the claim that in all instances other than temporary/transient network transmission problems, elimination of the use of computer-generated facsimiles would adversely impact the electronic transmission of prescription refill requests. These later materials substantiated the earlier claims that the elimination of the exemption in all instances other than temporary/transient network transmission failures would force dispensers who e-prescribe and use these transactions to revert to paper prescribing. These materials offered more specific information regarding the economic and workflow impacts associated with the elimination of the exemption for computer-generated facsimiles in all instances other than temporary/transient network transmission failures that was not forthcoming in the prior public comment period for the CY 2008 PFS proposed rule. We also received unsolicited comments on this issue during the comment period for the November 16, 2007 Part D e-prescribing proposed rule (proposing the adoption of certain final Part D e-prescribing standards and the use of NPI in Part D e-prescribing transactions) (72 FR 64900). As a result of the new information, we reexamined this issue and proposed additional modifications to the computer-generated facsimile exemption in the CY 2009 PFS proposed rule (73 FR 38502).

Dispensers have indicated that they use computer-generated facsimiles for the majority of prescription refill requests, in particular when communicating with prescribers that have not adopted e-prescribing. Currently, regardless of how the initial prescription was received by the pharmacy (that is, orally, via e-prescribing, telephone, paper, or facsimile) nearly all prescription refill requests from chain pharmacies to prescribers are sent electronically, either via an e-prescribing application or via computer-generated facsimile. When a prescription is received by a dispenser electronically, the prescription refill request is sent to the prescriber via the same technology. However, where the dispenser knows that the prescriber lacks e-prescribing capability or has not activated it, or where the prescriber does not respond to the request sent to his or her prescribing device, the prescription refill request is sent or resent via computer-generated facsimile. Commenters stated that the vast majority of computer-generated facsimiles sent today from prescribers to pharmacies are not electronic data interchange (EDI) transmissions, but usually prescription refill requests sent from pharmacies to prescribers who do not conduct true e-prescribing and, in many cases, do not engage in any electronic transactions at all. One national drug store chain estimates that it produces approximately 150,000 computer-generated facsimile prescription refill requests every day.

The workflow and process for filling prescriptions would be significantly disrupted if these computer-generated facsimile transmissions were prohibited. Dispensers and other staff would be forced to revert back to making phone calls or using a stand-alone facsimile machine to contact prescribers each time a refill is requested. Commenters indicated that not only would this be counterproductive to the advances and efficiencies made in pharmacy practice, it would impose an undue administrative burden on dispensing pharmacies and pharmacists.

As a result of this additional information regarding the larger than anticipated impact of the elimination of computer-generated facsimiles for the prescription refill request transaction, we proposed to further amend the

computer-generated facsimile exemption to also allow for an exemption from the NCPDP SCRIPT standards for electronic prescription refill request transactions that are conducted by computer-generated facsimiles when the prescriber is incapable of receiving electronic transmissions using the NCPDP SCRIPT standard. We proposed to retain the computer-generated facsimile exemption in instances of transient/temporary network transmission failures, effective January 1, 2009. We also proposed to revisit the computer-generated facsimile exemption for the purpose of ultimately eliminating it for the prescription refill request transaction found at § 423.160(b)(1)(vii), and specifically solicited industry and interested stakeholder comments regarding what would constitute an adequate time to allow the industry to transition to the use of the NCPDP SCRIPT standard.

We also solicited industry input on any other e-prescribing transaction that might be similarly adversely impacted by the elimination of computer-generated facsimiles in all instances other than transient/temporary network transmission failures.

We received 52 relevant and timely public comments on our proposal to further amend the exemption of computer-generated facsimiles from the NCPDP SCRIPT standard for Part D e-prescribing to include an exemption for refill request transactions with prescribers who are not capable of e-prescribing using the adopted NCPDP SCRIPT standard as detailed in the CY 2009 PFS proposed rule (73 FR 38600). While the comments were few in number, they tended to provide multiple detailed comments on what had been proposed.

Comment: Several commenters recommended that we reinstate the exemption for computer-generated facsimiles in its entirety. The commenters referenced the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and its potential to help drive e-prescribing adoption, stating that the e-prescribing incentives contained in the MIPPA provide a better, more transitional path towards that goal.

One commenter recommended that the elimination of the computer-generated facsimile exemption coincide with the incentive provisions contained in the MIPPA legislation. The commenter noted the eventual penalty for Medicare providers who do not adopt e-prescribing by the year 2012. The commenter also stated that structuring the elimination of the computer-generated facsimile exemption to coincide with this date would allow organizations the time needed to appropriately implement e-prescribing.

Other commenters recommended that we adopt a computer-generated facsimile exemption for pharmacies in areas where prescribers who do not e-prescribe fall under the ''significant hardship'' exception contained in the MIPPA. Commenters also recommended that the computer-generated facsimile exemption be further modified so as to allow for use of the computer-generated facsimile exemption that was adopted in the November 7, 2005 final rule (the ''original'' computer-generated facsimile exemption) until 2014, when provider disincentives/penalties are maximized under the MIPPA, at which time a study could be conducted to determine the number of prescriptions being e-prescribed. We assume that the commenters' intent would be to use the information gleaned from such a study as an indicator of whether or not e-prescribing had reached an acceptable level of adoption among providers and pharmacies, and that if an acceptable level of adoption among providers and pharmacies had been demonstrated, that the computer-generated facsimile exemption could be eliminated.

Similarly, other commenters suggested that the exemption should be eliminated in 2012 when disincentives under the MIPAA e-prescribing incentive program go into effect, or in 2014, when e-prescribing provider disincentives/penalties are maximized under the MIPPA. Another commenter urged that we reinstate the original (from the November 7, 2005 final rule (70 FR 67568)) exemption for computer-generated facsimiles in its entirety, not just for prescription refill requests and transmission failures.

Response: We agree with the commenters regarding the impact of the MIPPA. In general, the MIPPA provides payment incentives for eligible professionals who are ''successful electronic prescribers'' as that term is defined in the law. The incentive payments are 2 percent of the eligible professional's allowed charges under the PFS for CY 2009 through CY 2010; 1.5 percent in CY 2011 through CY 2012, and a 0.5 percent in CY 2013. Conversely, the MIPPA calls for payment reductions, or disincentives, for those who are not successful electronic prescribers beginning in CY 2012. For CY 2012, the payment amount under the PFS will be reduced by 1 percent for eligible professionals who are not successful electronic prescribers. In subsequent years, the payment reduction is increased by 0.5 percent each year through CY 2014, and then is fixed at 2 percent for later years. For more information on the e-prescribing provisions of the MIPPA, please see section 132 of the MIPPA legislation enacted on July 15, 2008 (Pub. L. 110–275, *http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ275.110.pdf).*

We envision that the MIPPA-created incentive payments for those prescribers who successfully implement electronic prescribing in accordance with MIPPA guidelines will provide the ''tipping point''—an adequate level of industry adoption of e-prescribing using electronic data interchange (EDI) that would in turn move the entire industry toward widespread e-prescribing adoption. We believe that data from the e-prescribing incentive program under the MIPPA and eventually from Part D e-prescribing will offer evidence of the rate of e-prescribing adoption, therefore making a study of e-prescribing for purposes of determining e-prescribing adoption rates unnecessary.

We analyzed the industry feedback that we received in response to the computer-generated facsimile exemption proposals in the CY 2009 PFS proposed rule in light of the recent MIPPA legislation. While the MIPPA legislation was not yet been enacted at the time of the CY 2009 PFS proposed rule's publication, it was enacted in time for commenters to discuss its provisions in their comments to our proposals. Based on MIPPA-based and other comments received in response to our proposal to further modify the computer-generated facsimile exemption, and taking into consideration the potential positive impact on the industry of the Part D e-prescribing incentives included in the recently-enacted MIPPA legislation, we are reinstating the original exemption for computer-generated facsimiles effective January 1, 2009. We also agree with those commenters who suggested that the computer-generated facsimile exemption should be eliminated (in all instances other than transient/temporary network transmission failures) once provider e-prescribing disincentives under the MIPAA program are initiated.

Although several commenters suggested that we should wait until the disincentives are maximized in 2014, we feel that it is more appropriate to eliminate the reinstated exemption (in all instances other than temporary/transient network transmission problems) sooner, when the MIPPA e-prescribing program disincentives for those who are not successful electronic

prescribers begin in 2012. We believe that the January 1, 2012 compliance date for the elimination of the computer-generated facsimile exemption (in all instances other than temporary/transient transmission problems) will take advantage of the momentum that will be built by the e-prescribing incentive program under the MIPPA, and affords the industry an additional 3 years from the effective date of this final rule with comment period to move toward true e-prescribing. We also believe that the January 1, 2012 date will enable the industry to begin taking advantage of the benefits of e-prescribing sooner, and in so doing pass those advantages on to their patients in the way of increased patient safety and convenience. Therefore effective January 1, 2012, we will eliminate the reinstated exemption to the requirement to utilize the NCPDP SCRIPT standard for entities that transmit prescriptions or prescription-related information for Part D covered drugs prescribed for Part D eligible individuals by means of computer-generated facsimiles in all instances other than transient/temporary network transmission failures.

We do not believe that a computer-generated facsimile exemption is needed for pharmacies in areas where prescribers who do not have access to the technology that would allow them to e-prescribe under the ''significant hardship'' exception contained in the MIPPA. We would expect that by the year 2012, the effective date of the elimination of the computer-generated facsimile exemption (in all instances other than temporary and transient network transmission failures), that most areas would have the telecommunication and/or Internet connectivity capacity to allow providers to conduct e-prescribing, and an exemption is not warranted in the rare instance where this may not be the case.

Comment: We received feedback from 19 commenters who agreed with the proposal to extend the exemption to computer-generated facsimiles for the prescription refill request transaction in cases where the physician is not NCPDP SCRIPT enabled.

Response: We agree with commenters. This issue will be resolved with this final rule's reversal of the CY 2008 PFS final rule's e-prescribing provisions that would have eliminated the computer-generated faxing exemption (in all instances other than temporary and transient network transmission failures) effective on January 1, 2009, and concurrent reinstatement of the original exemption for computer-generated facsimiles from the November 7, 2005 final rule effective January 1, 2009. However, we will eliminate the reinstated exemption for computer-generated facsimiles (in all instances other than transient/temporary network transmission failures) effective when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

Comment: Some commenters expressed opposition to the proposed elimination of the exemption for computer-generated facsimiles in all instances other than temporary/transient network transmission failures. One commenter erroneously identified January 1, 2010 as the proposed compliance date, but still asked for additional time for NCPDP SCRIPT-noncompliant providers to become compliant with the NCPDP SCRIPT standard.

Another commenter stated that the overall e-prescribing adoption rate has not met a critical mass to justify a January 2009 deadline for the elimination of the computer-generated facsimile exemption in all instances other than transient/temporary network transmission failures. The commenter noted that with the effective date fast approaching, unless the computer-generated facsimile exemption is modified once again, many organizations will have to hastily implement e-prescribing solutions or revert back to paper prescribing.

Response: We agree with commenters that it is in the best interests of the industry and consumers that the CY 2008 PFS final rule's modifications to the computer-generated facsimile exemption be reversed and the broad exemption originally created in the November 7, 2005 final rule for computer-generated facsimiles in Part D e-prescribing be reinstated to prevent a reversion by providers to paper prescriptions, and a reversion by pharmacies to traditional paper faxing. Therefore, by this rule we have reinstated the original exemption for computer-generated facsimiles effective January 1, 2009. However, we will eliminate the reinstated computer-generated facsimiles exemption in all instances other than transient/temporary network transmission failures effective when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

Comment: Some commenters requested clarification of our proposed amendment to the exemption for computer-generated facsimiles. One commenter stated that their customers believe that all Part D prescriptions, without exception, must be sent via electronic transmission as of January 1, 2009, and otherwise they may be liable for conducting an ''illegal'' transaction. To avoid undue hardship, costs, and confusion, the commenter asked that CMS clearly specify that e-prescribing is preferred but still voluntary for providers and dispensers; and those prescribers not currently e-prescribing under the Medicare Part D pharmacy benefit program may still write paper prescriptions, or call in or fax their prescriptions using a traditional paper fax machine to a pharmacy.

Another commenter asked CMS to clarify that providers who use prescription writing systems that enable computer based facsimiles but do not enable NCPDP SCRIPT transactions are not subject to the provisions of the computer-generated facsimile exemption. One commenter asked CMS to clarify the definition of a ''true'' e-prescribing system.

Response: We recognize that there might be some confusion for prescribers and dispensers with the elimination of certain portions of the computer-generated facsimile exemption. In the November 7, 2005 e-prescribing final rule (70 FR 67568), we defined ''e-prescribing'' to mean the transmission, using electronic media, of prescription or prescription-related information, between a prescriber, dispenser, PBM, or health plan, either directly or through an intermediary, including an e-prescribing network.

As we noted above, section 101 of the MMA amended title XVIII of the Act to establish the Part D prescription drug benefit program. As part of that program, the Congress required the establishment of a ''voluntary'' e-prescribing program. It is voluntary in that providers and dispensers are not required to conduct e-prescribing for Medicare covered drugs prescribed for Medicare Part D eligible beneficiaries, but if they do conduct such e-prescribing, they must do so using the applicable standards that are in effect at the time of the transmission. Part D sponsors, in turn, must support e-prescribing so that providers and dispensers who wish to conduct e-prescribing transactions with plans will be able to do so using the adopted standards that are in effect at the time of the transaction. We refer those commenters with questions regarding the creation and scope of the Medicare Part D e-prescribing program to the ''Background'' section of the E-Prescribing and the Prescription Drug Program proposed rule published in the February 4, 2005 **Federal Register** (70 FR 6256)

In the CY 2008 PFS proposed rule (72 FR 38194), we proposed to revise

§ 423.160(a)(3)(i) to eliminate the computer-generated facsimile exemption to the NCPDP SCRIPT standard for the communication of prescription or certain prescription-related information between prescribers and dispensers for the transactions specified in § 423.160(b)(1)(i) through (xii). In keeping with the comments that we received, we finalized modifications that required prescribers and dispensers to use NCPDP SCRIPT compliant e-prescribing software when they conduct e-prescribing transactions for Part D covered drugs that are prescribed for Part D eligible individuals in all instances other than transient/temporary network transmission failures, effective January 1, 2009. Those prescribers who choose not to e-prescribe Part D covered drugs for Part D eligible individuals can continue to use non-computer-generated facsimiles as a means to deliver such prescriptions to a dispenser.

Providers who use electronic prescription writing systems that are only capable of producing computer-generated facsimiles are not in conformance with the adopted standards because they do not transmit information using the adopted NCPDP SCRIPT standard. Those who utilize their NCPDP SCRIPT enabled systems to produce computer-generated facsimiles are likewise not in compliance with the adopted standards because computer-generated facsimiles on these systems also do not use the adopted standard. We believed that eliminating the exemption (in all instances other than transient/temporary network transmission failures) might encourage those with NCPDP SCRIPT capabilities that have not been activated to use the NCPDP SCRIPT standard in electronic data interchanges, and those without such capabilities to upgrade their current software products, or, where upgrades are not available, to switch to new products that would enable such true e-prescribing.

We believe that eliminating the computer-generated facsimile exemption in 2012 would provide sufficient notice to prescribers and dispensers who would need to implement or upgrade e-prescribing software to look for products and upgrades that are capable of generating and receiving transactions that utilize NCPDP SCRIPT. Eliminating the reinstated computer-generated facsimile exemption in 2012 would also afford current e-prescribers time to work with their trading partners to eventually eliminate the use (in all instances other than transient/temporary network transmission failures) of computer-generated facsimiles in e-prescribing transactions.

From our analysis of the public comments that asked that the elimination of the computer-generated facsimile exemption (in all instances other than temporary/transient network transmission failures) be reversed, and in view of the recent MIPPA legislation that provides a more powerful incentive to providers to e-prescribe in accordance with the standards adopted under Medicare Part D, we are reversing the modifications to the computer-generated facsimile exemption that were made in the CY 2008 PFS final rule with comment period and reinstating the original computer-generated facsimile exemption that was adopted in the November 7, 2005 e-prescribing final rule in its entirety, effective January 1, 2009. However, we will eliminate the reinstated exemption for computer-generated facsimiles in all instances other than transient/temporary network transmission failures when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

Comment: Several commenters who agreed with our proposal to eliminate the computer-generated facsimile exemption (in all instances other than transient/temporary network transmission failures) suggested that we delay the January 1, 2009 effective date stated in the CY 2008 PFS final rule with comment period. One commenter urged CMS to conduct studies on the barriers to use of NCPDP SCRIPT compliant systems, and then work with stakeholders to identify pathways toward more widespread use of e-prescribing systems. Another commenter noted that the recent merger of the two major e-prescribing information exchange networks still may hold unforeseen consequences for those vendors who have been previously certified or are in the process of being certified by either of those two networks. The commenter stated that any software changes that the network may demand as a result of their merger may take time to develop, and as a result, the effective date should be delayed.

A few commenters said that we should tie the computer-generated facsimile exemption compliance to the April 1, 2009 compliance date of the most recent round of final e-prescribing standards. One commenter suggested that we delay the effective date of the CY 2008 PFS final rule with comment period modifications to the computer-generated facsimile exemption to 2012, when wireless broadband upload connectivity is expected to achieve a speed of faster than 1MB/second.

Response: We do not see a correlation between the e-prescribing network certification process, and the commenter's request to delay the elimination of the computer-generated facsimile exemption based on what may or may not take place in that process. Additionally, the process for vendors to certify their products to an e-prescribing information exchange network is a marketplace issue to which we are not a party.

We understand that some prescribers and dispensers may not have been prepared to e-prescribe using the adopted standards by the January 1, 2009 effective date of the CY 2008 PFS final rule's e-prescribing provisions. However, with this final rule's reversal of those modifications and reinstatement of the original computer-generated facsimile exemption that was adopted in the November 7, 2005 e-prescribing final rule in its entirety, effective January 1, 2009, we believe we have addressed commenters' concerns regarding effective dates. However, we will eliminate the reinstated exemption for computer-generated facsimiles in all instances other than transient/temporary network transmission failures when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

Comment: A comment concerning the computer-generated facsimile exemption issue relative to non-NCPCP SCRIPT enabled pharmacies (including many independent pharmacies) stated that there are still significant segments of the retail pharmacy market not yet in a position to receive electronic prescriptions because they are only facsimile-enabled. The commenter cited national prescription information exchange network data showing that only about 42,000 of the nation's pharmacies are NCPDP SCRIPT e-prescribing enabled, and about 20,000 of the nation's pharmacies are only manual (traditional paper-based) facsimile or computer-generated facsimile-enabled.

One commenter stated that e-prescribing technology has not yet been perfected by its developers, and that the receiving parties (that is, pharmacies) have not fully integrated this technology into their workflows. The commenter also indicated that use of e-prescribing technology is dependent on the availability of telecommunications services and Internet connectivity, and this is problematic especially in rural areas where there may be a lack of such telecommunications and/or Internet connectivity services needed to support e-prescribing systems.

A vendor expressed concern that their client pharmacies that rely solely on computer-generated facsimiles may not be able to send or receive computer-generated facsimile transmissions through national prescription information exchange networks after January 1, 2009.

Response: We recognize that pharmacies that are not now conducting e-prescribing transactions using the NCPDP SCRIPT standard will incur costs to implement this capability, and that pharmacies will likely experience an increase in e-prescribing transaction volumes and costs as utilization of such transactions increases.

We agree that independent pharmacies and pharmacies that employ only computer-generated facsimile capabilities need to be given the opportunity to upgrade their systems and that elimination of the computer-generated facsimile exemption (in all instances other than transient/temporary network transmission failures) would place them at a disadvantage at a time when the MIPPA incentive program is expected to generate increased e-prescribing volumes. Therefore, for this reason and the other reasons stated herein, we are reversing the modifications to the computer-generated facsimile exemption that were made in the CY 2008 PFS final rule with comment period and reinstating the original computer-generated facsimile exemption that was adopted in the November 7, 2005 e-prescribing final rule in its entirety, effective January 1, 2009. However, we will eliminate the exemption for computer-generated facsimiles in all instances other than transient/temporary network transmission failures when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

Comment: We received comments requesting confirmation that the proposed revisions to the computer-generated facsimile exemption would not now apply to long term care providers. Another asked that CMS allow long term care facilities to continue to transmit prescriptions via computer-generated facsimile to pharmacies that are not yet using systems capable of receiving NCPDP SCRIPT transactions appropriate to this setting (NCPDP SCRIPT Version 10.2 or higher). A professional association noted that eliminating the exemption for computer-generated facsimiles (in all instances other than transient/temporary network transmission failures) is unlikely to spur adoption among long term care providers and could, if left standing, force some facilities to resort to manual facsimiles. The commenter also urged CMS to eliminate the e-prescribing exemption for long term care facilities.

Response: In § 423.160(a)(3)(iii), long term care facilities were specifically exempted from the requirement to use the adopted standards in e-prescribing under Medicare Part D due to their unique workflows and complexities associated with prescribing for patients in long term care settings. This exemption remains in effect for long term care facilities. Therefore, long term care facilities may continue to use computer-generated facsimiles, and such facilities will continue to be exempt from the requirement to use the NCPDP SCRIPT Standard in prescription transactions between prescribers and dispensers where a non-prescribing provider is required by law to be a part of the overall transaction process.

Comment: Comments regarding other issues relevant to e-prescribing in general, and the elimination of the computer-generated facsimile exemption (in all instances other than transient/temporary network transmission failures) specifically included comments requesting amendments to the computer-generated facsimile exemption that would address when a prescriber or dispenser is prohibited from using the NCPDP SCRIPT standard for e-prescribing. The commenter noted that the Drug Enforcement Administration's (DEA) prohibition of e-prescribing of controlled substances would prevent a provider from prescribing such controlled substances under the Part D program in accordance with the adopted standards. One commenter stated that vendors would have to disable electronic communication of prescriptions from their client prescribers through the prescription information exchange network to those pharmacies that are only computer-generated facsimile-enabled. The vendor assumed that if their client prescriber attempts to send those prescriptions electronically that the prescription will be rejected by the prescription information exchange network because the pharmacy is not activated with the network for electronic transactions using the NCPDP SCRIPT standard. This same commenter noted that the network has heretofore insulated the prescriber from having to be concerned with whether or not the patient's choice of pharmacy was enabled to receive prescriptions in a particular way. After the proposed January 2009 compliance date, the commenter felt that additional burdens would be placed on the prescriber to obtain this information from the patient up front, or could compel patients to make different pharmacy choices which could result in lost business for pharmacies that are only facsimile-enabled.

Response: The DEA has authority through the Controlled Substances Act over the electronic prescribing of controlled substances, and does not currently allow for the electronic prescribing of Schedule II drugs. As such substances currently may not be prescribed electronically, there is no conflict of law at this time. As noted previously, e-prescribing under Medicare Part D is voluntary for prescribers and dispensers—they are not required to issue prescriptions in electronic form. Although the DEA has published a notice of proposed rulemaking to allow for the electronic prescribing of controlled substances, we have no indication as to when the DEA will make a final determination on this issue. We continue to work with the DEA to help facilitate a solution that addresses both their enforcement requirements with respect to the electronic prescribing of controlled substances, and the needs of the healthcare community for a solution that is interoperable with existing e-prescribing systems, scalable and commercially viable.

After reviewing these comments, in the interest of patient care and safety, and to foster the adoption of true e-prescribing among prescribers and dispensers, we are reversing the modifications to the computer-generated facsimile exemption that were made in the CY 2008 PFS final rule with comment period and reinstating the original computer-generated facsimile exemption that was adopted in the November 7, 2005 e-prescribing final rule, effective January 1, 2009. However, we will also eliminate the reinstated exemption for computer-generated facsimiles in all instances other than transient/temporary network transmission failures when the MIPPA e-prescribing program disincentives take effect on January 1, 2012.

L. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

Comprehensive outpatient rehabilitation facilities (CORFs) and rehabilitation agencies are Medicare providers that are certified to provide certain rehabilitation services. Currently covered CORF clinical services and rehabilitation agency services are paid through the PFS.

In the CY 2008 PFS final rule with comment period (72 FR 66399), we

revised the CORF regulations at 42 CFR parts 410 and 413 to ensure that the regulations reflected the statutory requirements applicable to CORFs under sections 1834(k) and 1861(cc) of the Act. Many of these changes were technical in nature. Specifically, the regulatory changes: (1) Revised the definitions of ''physicians' services,'' ''respiratory therapy services,'' ''social and psychological services,'' ''nursing services,'' ''drugs and biologicals,'' and ''supplies and durable medical equipment,'' and ''home environment evaluation''; (2) amended the payment provisions for CORF services; and (3) made other clarifications and changes to the conditions for coverage for CORF services.

In the CY 2009 PFS proposed rule, we addressed the comments received in response to the CY 2008 PFS final rule with comment period (72 FR 66222), proposed new provisions, and proposed revising other provisions. We solicited comments on all of the proposed changes.

1. Personnel Qualifications

We stated in the CY 2008 PFS final rule with comment period that we would propose updated qualifications for respiratory therapists in future rulemaking (72 FR 66297). It has been our policy that only the respiratory therapist (and not the respiratory therapy technician), who possesses the educational qualifications necessary to provide the level of respiratory therapy services required, is permitted to provide respiratory therapy in a CORF setting.

In the CY 2008 PFS final rule with comment period, we received a comment indicating that our regulations were outdated and did not conform to current respiratory therapy professional standards. Specifically, the American Association for Respiratory Care (AARC) stated that the terms ''certified respiratory therapist (CRT)'' and the ''registered respiratory therapist (RRT)'' have replaced the terms ''respiratory therapy technician'' and ''respiratory therapist,'' respectively. In addition, the qualifications for CRTs and RRTs differ from those applicable to respiratory therapy technicians and respiratory therapists. The CRT designation is awarded after an individual successfully passes the entry-level respiratory therapy examination. In order to be eligible for the RRT examination, an individual must be a graduate of an advanced level respiratory therapy educational program and have obtained the RRT credential.

We proposed to revise § 485.70(j) of the Conditions of Participation of CORF services—setting forth the personnel qualifications for respiratory therapists in CORFs—to be consistent with current qualification requirements for RRTs, as recommended by AARC. We also proposed to delete § 485.70(k), which sets forth personnel qualifications for CRTs (previously referred to as respiratory therapy technicians) in CORFs. In the past, we have not reimbursed CORFs for respiratory therapy services provided by respiratory therapy technicians or CRTs, and we believe that removing the technician definition would clarify our position. We stated that we believed that current medical standards continue to require that the provision of skilled respiratory therapy services to patients in the CORF setting be furnished by RRTs. While CRTs furnish general respiratory care procedures and may assume some clinical responsibility for specified respiratory care modalities involving the application of therapeutic techniques under the supervision of an RRT or a physician, the educational qualifications that a RRT possesses allow him or her to evaluate, treat, and manage patients of all ages with respiratory illnesses. RRTs participate in patient education, implement respiratory care plans, apply patient-driven protocols, follow evidence-based clinical practice guidelines, and participate in health promotion, disease prevention, and disease management. RRTs also may be required to exercise considerable independent judgment.

This was implemented in the CY 2002 PFS final rule with comment period (66 FR 55246 and 55311) and the CY 2003 PFS final rule with comment period (67 FR 79966 and 79999) when we developed and discussed G codes, CORF respiratory therapy services, and specifically recognized the RRT as the appropriate level of personnel to provide these CORF services. Finally, the CORF regulations at § 485.58(d)(4) state that as a condition of participation for CORFs, CORF personnel must meet the qualifications described at § 485.70.

For CY 2009, to maintain consistency in the conditions of participation for both CORFs, home health agencies (HHAs), and other outpatient service providers, we proposed to amend the material addressing personnel qualifications in § 485.70. Specifically, we proposed to amend paragraphs § 485.70(c) and § 485.70(e) by referencing the personnel qualifications for HHAs at § 484.4. This change would align CORF personnel requirements not only with HHA requirements, but also with other regulations in Part 485 addressing provision of physical therapy, speech-language pathology, and occupational therapy services.

Also, at 485.58(a)(1)(i), we proposed to amend the duties of a CORF physician to include medical supervision of nonphysician staff. This change conforms to changes made to the CORF conditions for coverage in the CY 2008 PFS final rule with comment period. We believe that adding medical supervision of nonphysician staff to the duties of CORF physicians more accurately reflects the duties and responsibilities of the CORF physician. We also believe that this change could increase the quality of care provided to patients of CORFs.

The following is a summary of the comments received concerning Personnel Qualifications and our responses.

Comment: Commenters generally supported our proposed changes. We received a comment that supported the spirit of our proposed changes to the definitions of respiratory therapists and provided further clarification regarding current professional standards. Specifically, in previous comments, the commenter noted that the term ''respiratory therapy technician'' is an obsolete term. This is because today's curriculum and educational standards are no longer structured to teach at a technician level.

The commenter noted that, in our discussion of the issue in the proposed rule, we stated that it was AARC's belief that the term ''certified respiratory therapist'' (CRT) had replaced the obsolete term ''respiratory therapy technician'' and the term ''registered respiratory therapist'' (RRT) has replaced the term ''respiratory therapist.'' The commenter informed us that our statement was incorrect. According to the commenter, today's educational programs prepare students for the registry (RRT) examinations administered by the National Board for Respiratory Care (NBRC). Before graduates are eligible to sit for the RRT examinations they must first pass the NBRC's entry-level examination, which results in the CRT credential. Thus the CRT-credentialed individual is considered an ''entry-level respiratory therapist,'' but unlike other allied health professions, the terms ''technician'' or ''assistant'' are not used in the respiratory therapy profession.

According to AARC, in the profession today, it is accepted clinical and medical terminology that individuals holding the credentials of both CRT and RRT are known simply as ''respiratory therapists.'' Also, most State laws that require licensing of respiratory therapists make no distinction in the

license as to whether the individual holds a credential of CRT or RRT. They are both licensed as ''respiratory therapists.'' To the best of AARC's knowledge, there are only six States that require a separate license for a CRT or a RRT. AARC recommended that the proposed definition be revised.

Since CMS uses the term ''respiratory therapist'' in other regulatory provisions and manual instructions where applicable, AARC recommended that CMS delete the word ''registered'' from the proposed definition. This would also be consistent with the terms ''physical therapist'' and ''occupational therapist'' used to define qualified personnel in those professions.

AARC also believes that CMS can ensure that only registered respiratory therapists, and not individuals holding only the CRT, meet the personnel qualifications by revising the curriculum requirements to require that respiratory therapists have passed the registry examination administered by the NBRC. AARC also noted that the name of the Board administering the certification and registry exams is the NBRC, not the National Board for Respiratory Therapy, Inc.

Response: We thank the commenters for their support of our proposed revisions. We believe that the comments provided by AARC reflect and further clarify our intent to provide appropriate respiratory care to patients served by CORFs. We want to ensure that only respiratory therapists with the highest level of education and training can furnish respiratory therapy services in a CORF. Therefore, only those individuals holding the credential of registered respiratory therapist (RRT) conferred by the NBRC would qualify. Qualifying by being ''eligible to take the registry examination,'' as we proposed, results in the unintended consequence of permitting CRTs who have not yet taken the registry exam to meet the personnel qualifications.

As a result of the public comments, we are finalizing the proposed revisions that reference personnel qualifications for HHAs at § 485.70(c) and (e). We are also finalizing our proposed revision to § 485.58(a)(i)(1) that amends the duties of CORF physicians to include medical supervision of nonphysician staff (we received no comments on this provision). We are adopting the revisions to the personnel qualifications for respiratory therapists at § 485.70(j) as suggested by AARC, to read as follows:

(j) A respiratory therapist must—

(1) Be licensed by the State in which practicing, if applicable; and

(2) Have successfully completed a nationally-accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exams, and have passed the registry examination administered by the NBRC, or

(3) Have equivalent training and experience as determined by the National Board for Respiratory Care (NBRC) and passed the registry examination administered by the NBRC.

2. Social and Psychological Services

In the CY 2008 PFS final rule with comment period (72 FR 66297), we clarified that all CORF services, including social and psychological services, must directly relate to or further the rehabilitation goals established in the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment. We believe that using a full range of clinical social and psychological CPT codes to describe CORF social and psychological services is inappropriate because social and psychological CORF services do not include independent clinical treatment of mental, psychoneurotic, and personality disorders. CPT codes 96150 through 96154 and CPT codes 90801 through 90899 are inappropriate for CORF use because all of these CPT codes represent full-scale clinical treatment for these disorders. As we stated in the CY 2008 PFS final rule with comment period, we believe that for purposes of providing care in a CORF, social and psychological services should represent only case management and patient assessment components as they relate to the rehabilitation treatment plan (72 FR 66297 through 66298). Consequently, after notice and comment, we changed our policy and payment for CORF social and psychological services; these services may no longer address a CORF patient's mental health diagnoses except insofar as they relate directly to other services provided by the CORF.

We specified in the CY 2008 final rule with comment period (72 FR 66298) that only the CPT code 96152 for health and behavior intervention (with the patient) could be used to bill for CORF social and psychological services. This code was part of a series of codes that was created by CPT in 2002 to address health and behavior assessment issues. These services are offered to patients who present with established illnesses or symptoms, who are not diagnosed with mental illness, and may benefit from evaluations that focus on the biopsychosocial factors related to the patient's physical health status, such as patient adherence to medical treatment, symptom management and expression, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness. We also adopted the more limited definition of CORF social and psychological services in § 410.100(h) (72 FR 66399). The regulations state that social and psychological services include the assessment and treatment of an individual's mental and emotional functioning and the response to and rate of progress as it relates to the individual's rehabilitation plan of treatment, including physical therapy services, occupational therapy services, speech-language pathology services, and respiratory therapy services.

We also noted that a HCPCS G-code could more accurately describe these unique CORF services, but believed that it was inappropriate to create such a G-code in the final rule with comment period without first proposing to do so in proposed rulemaking.

Therefore, we proposed to create a CORF specific G-code, GXXX5, *Social work and psychological services*, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF), to accurately describe the unique social and psychological services provided by CORF staff and to establish appropriate payment for these services. We proposed to use salary and wage data from the Bureau of Labor Statistics to institute a blended social worker/psychologist clinical labor category using a price per minute rate of $0.45 for the PE component of GXXX5. We proposed to assign a malpractice RVU of 0.01. Because the services described by GXXX5 are solely furnished by a CORF social worker or clinical psychologist, and not by a physician, we did not propose to allocate a work RVU for these services.

We also proposed to revise § 410.100(h) to delete the reference to ''and treatment.'' As discussed above and in the CY 2008 PFS final rule with comment period (72 FR 66297), we believe all CORF services, including social and psychological services, must directly relate to or further the rehabilitation goals established in the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment. Accordingly, social and psychological CORF services do not include clinical treatment of mental, psychoneurotic, and personality disorders. We stated that we are concerned that the phrase ''and treatment'' currently included in the definition of CORF social and psychological services may be

misconstrued to include social and psychological services for the independent clinical treatment of mental illness. Therefore, we proposed to delete this language in order to clarify that only those social and psychological services that relate directly to a rehabilitation plan of treatment and the associated rehabilitation goals are considered CORF social and psychological services.

In addition, we proposed to remove § 410.155(b)(1)(ii) regarding the application of mental health limitations to CORF social and psychological services. As we previously stated, CORF services, including social and psychological services, must directly relate to or further the rehabilitation goals established in the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment. In the CY 2008 PFS final rule with comment period (72 FR 66400), we stated that CORF services must be furnished under a written plan of treatment that indicates the diagnosis and rehabilitation goals, and prescribes the type, amount, frequency, and duration of the skilled rehabilitation services, including physical therapy, occupational therapy, speech-language pathology and respiratory therapy services. Section 410.155(b) specifies that the mental health payment limitation applies when there is a diagnosis of mental, psychoneurotic, and personality disorders (mental disorders identified by a diagnosis code within the range of 290 through 319) prior to beginning services. Under our revised definition, CORF social and psychological services must directly relate to the physical therapy or other rehabilitation plan of treatment and its associated goals. Since these patients are receiving CORF services because they have a need for skilled rehabilitation services, any social and psychological services provided in a CORF under § 410.100(h) must include an assessment of the individual's mental and emotional functioning exclusively as such functioning relates to their rehabilitation plan of treatment. In our view, such services provided in a CORF would not be ''treatment of mental, psychoneurotic, and personality disorders of an individual'' as set out in section 1833(c) of the Act, so that the statutory mental health payment limitations would not apply. We proposed changes to § 410.155(b) to reflect our view regarding the limited nature of these services.

The following is a summary of the comments received concerning our proposal to create a HCPCS G-code to describe the unique CORF social and psychological services and our responses.

Comment: One commenter stated that the G-code is more specific to rehabilitation services and its implementation will support future adoption as a CPT code. Another commenter stated that occupational therapy services are a core CORF service. The commenter requested that CMS clarify that the new G-code would not have a negative impact on the provision of occupational therapy services to meet patient needs that are similar to those addressed by the G-code. The commenter stated that occupational therapy, as with all therapy services, includes assessment of the patient level of functioning as an integral part of the therapy services. Other commenters suggested that therapists and psychologists assess and treat mental, cognitive, and emotional functioning as they relate to a patient's rehabilitation plan of care. The commenters further suggested that CMS revisit its decision not to allow CORF therapists and psychologist to bill the Health and Behavioral Assessment/ Intervention codes (CPT codes 96150 through 96155), which are used to identify and treat ''biopsycholosocial factors important to physical health problems.'' One commenter also requested that the new G-code include physician work in the RVUs since all other codes billed by psychologist include physician work. Another commenter stated that the statute clearly defines social and psychological services so there is no need for the development of a G-code.

Response: Section 1861(cc)(2)(B) of the Act defines the term CORF to mean a facility which provides at least physician services (as defined at § 410.100(a)), physical therapy services and social or psychological services. As such, occupational therapy services are not considered one of the core CORF services but are optional. The CORF must provide the core CORF services. In addition it may furnish any of the optional covered and medically necessary services and items such as occupational therapy, speech-language pathology, or respiratory therapy services. These optional services must directly relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the rehabilitation goals. Occupational therapy services include assessment of an individual's level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. The patient's plan of treatment will document all the covered and medically necessary items and services that the patient requires which will include the core CORF services as well as any of the optional services such as occupational therapy.

In the CY 2007 PFS final rule with comment period, we revised § 410.100(h) states that CORF social and psychological services include the assessment and treatment of a CORF patient's mental health and emotional functioning and the patient's response to/and rate of improvement and progress towards the rehabilitation plan of treatment. In our view, social and psychological services must contribute to the improvement of the individual's rehabilitation condition and may not relate to a mental health diagnoses. In the CY 2008 PFS final rule (72 FR 66298), we discussed the use of CPT codes 96150 through 96155 for health and behavior assessment and treatment, which represent full-scale clinical treatment of mental, psychoneurotic, personality disorders and biopsychosocial functioning. We revised the previous definition of CORF social and psychological services and instructed that these services should be limited to those described by CPT code 96152. We stated that provision of other therapeutic services was outside of the scope of coverage for CORFs. Since these CPT codes were not a part of the proposed regulation, we will not revisit the use of these CPT codes in this final regulation.

We are finalizing our proposal to create the CORF specific G-code which will be G0409. The description of this G-code will be G0409, *Social work and psychological services*. This code will directly relate to and/or further the patient's rehabilitation goals, each 15 minutes, face-to face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF), to accurately describe the unique social and psychological services provided by CORF staff and to establish appropriate payment for these services. The code does not include any physician work RVUs because the social and psychological services are performed by a CORF social worker with a Bachelor of Science degree or a Masters-level psychologist and not by a physician as defined in the statute at section 1861(r) of the Act.

We did not receive any comments on our proposal to eliminate the mental health limitation requirement. The mental health limitation is no longer

applicable because under our revised definition, CORF social and psychological services must directly relate to the physical therapy or other rehabilitation plan of treatment and its associated goals and do not relate to a general diagnosis of mental, psychoneurotic, and personality disorders which the mental health limitation addresses. Therefore, we are finalizing our proposed change to remove § 410.155(b)(1)(ii) regarding the application of mental health limitations to CORD social and psychological services.

3. CORF Conditions of Participation

In the CY 2008 final rule with comment period (72 FR 66400), we finalized changes to the CORF coverage and payment rules. However, all conforming regulations in the CORF Conditions of Participation (CoPs) were not updated at that time.

In the CY 2009 PFS proposed rule, we proposed to revise § 485.58(e)(2). Section 485.58(e) currently provides that as a CoP, a CORF facility must provide all CORF services on its premises with the exception of—(1) physical therapy, occupational therapy, and speech-language pathology services furnished away from the premises of the CORF, if Medicare payment is not otherwise made for these services; and (2) a single home visit for the purpose of evaluating the potential impact of the patient's home environment on the rehabilitation goals. We proposed to clarify that the alternate premises for provision of physical therapy, occupational therapy, and speech-language pathology services may be the patient's home.

The following is a summary of the comments received concerning CORF CoPs and our responses.

Comment: Commenters concurred with the proposed clarification regarding the patient's home as an alternate premise for provision of physical therapy, occupational therapy, and speech-language pathology services.

Response: We thank the commenters for their support of this provision. As a result of the public comments, we are finalizing the revisions to § 485.58(e)(2) as proposed.

4. Extension Location

We proposed to add a definition for an ''extension location'' of a rehabilitation agency to the definitions at § 485.703. While there are currently no provisions that allow rehabilitation agencies to offer services in an extension location, there are currently 2,875 rehabilitation agency primary locations and 2,486 rehabilitation agency offsite practice locations. While our State Operations Manual recognizes that these rehabilitation agency extension locations exist, it also includes language stating that the extension locations must meet applicable rehabilitation agency CoPs. However, it is difficult to apply CoP requirements to a location that currently is not identified in the CoPs. Creating a definition in the CoPs that applies to the extension locations will allow us to survey and monitor the care provided in these extension locations on a consistent basis.

Therefore, we proposed to define an ''extension location'' as: (1) A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site; (2) is part of the rehabilitation agency; and (3) is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

The following is a summary of the comments received concerning an extension location and our responses.

Comment: Some commenters supported our proposed revisions and suggested that we add additional clarifying information. One commenter suggested that we clarify the status of space that a rehabilitation agency may use within another facility (for example, a room used by the agency within a nursing facility). Another commenter suggested that we specify a mile radius from the rehabilitation agency's primary site within which an extension location may exist.

Response: We thank the commenters for their input. Regarding a mile radius, mileage, and travel times from the primary location to the extension location are significant factors to consider because they are implicitly referenced in the proposed regulation. However, each alone would not be the single issue in determining appropriateness as a sole means for approving an extension location. We have decided to leave it to the rehabilitation agency to prove to the State survey agency that the rehabilitation agency is close enough to the extension location to provide supervision of staff during its hours of operation. Supervision of the extension location staff must be adequate to support the care needs of the patients. We believe that our proposed definition for an extension location is adequate, as it has been used successfully in our State Operations Manual for other provider types. We are not making any changes to our proposed revisions based on public comments, and are finalizing them as proposed.

5. Emergency Care

We proposed to revise § 485.711(c), Standard: Emergency care, to reflect current medical practice. We proposed to remove the requirement that the rehabilitation agency provide for one or more doctors of medicine or osteopathy to be available on call to furnish necessary medical care in case of an emergency. We do not believe that the patients serviced by rehabilitation agencies regularly experience medical emergencies that necessitate the retention of an on-call physician.

Therefore, we proposed that each rehabilitation agency establish procedures to be followed by personnel in an emergency that cover immediate care of the patient, persons to be notified, and reports to be prepared.

The following is a summary of the comments received concerning Emergency care and our responses.

Comment: Most commenters concurred with our proposed changes to the emergency care standard. Specifically, the commenters supported our proposed elimination of the requirement that rehabilitation agencies retain a physician on call for emergencies. The commenters cited difficulty in recruiting physicians for this role, and stated that it is often impractical to contact a physician in the rare case of an emergency. One commenter also supported the revisions to the emergency provisions because they allow facilities to develop emergency care plans most appropriate for an individual facility's location and patient population.

Response: We thank the commenters for their support, and agree that these revisions will allow facilities to plan for, and respond to, emergency care situations in appropriate ways. As a result of the public comments, we are finalizing the provision as proposed with slight non-policy revisions for grammatical purposes. We are also revising the stem statement to remove the reference to the physician's presence in emergency situations.

6. Technical Changes for Rehabilitation Agencies

Under section 1861(p) of the Act, rehabilitation agencies are tasked with furnishing outpatient physical therapy and speech-language pathology services. Unlike CORFs, which provide comprehensive outpatient rehabilitation services, rehabilitation agencies primarily provide physical therapy services. Some of the other services

offered by CORFs, such as respiratory therapy and social services are outside the scope of rehabilitation agency practice.

The current definition of ''rehabilitation agency'' at § 485.703 (paragraph (2)(ii) of the definition) requires that rehabilitation agencies provide social or vocational adjustment services. This requirement is outside of the rehabilitation agency's scope of practice and has caused confusion for these providers because we do not reimburse rehabilitation agencies for furnishing social or vocational services. Accordingly, in § 485.703, we proposed to delete the requirement in paragraph (2)(ii) of the rehabilitation agency definition requiring a rehabilitation agency provide social or vocational services.

The following is a summary of the comments received concerning the technical change and our responses.

Comment: Most commenters responded in support of this proposed revision. Some commenters stated that this requirement, which is an unfunded mandate, is burdensome, and that patients often resent being required to release their personal information to a social worker they will likely never meet or work with. The commenters also agreed that social and vocational services are outside the scope of practice for rehabilitation agencies.

Response: We thank the commenters for their support of this change. As a result of the public comments, we are finalizing the provision as proposed.

We also proposed to make a conforming change at § 485.717, the Condition of participation: Rehabilitation program. At 485.711(b)(3), we proposed to remove the reference to § 410.61(e), since § 410.61(e) no longer exists in regulation.

The following is a summary of the comments received concerning this technical change and our responses.

Comment: Some commenters concurred with this conforming change while others objected to this conforming change because the commenters believe that we did not also address the statement in § 485.711(b)(3) that states that the patient plan of care must be reviewed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant at least every 30 days. The commenters believe that this conflicts with CMS payment policy, which requires recertification of the plan of care at least every 90 days. We also received several unsolicited comments requesting that we correct this perceived discrepancy.

Response: We did not propose to revise the language to conform to changes in the timing for recertification of outpatient therapy plans of care as discussed in the CY 2008 PFS final rule with comment period (72 FR 66396). Currently, § 485.711(b)(3) requires that the plan of care and results of treatment be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken, which for Medicare patients being treated in rehabilitation agencies must be at least every 30 days. We believe that this requirement is in the best interests of rehabilitation agency patients, and note that by meeting this condition of participation, facilities would automatically meet the CMS payment policy requiring review at least every 90 days.

We are not making any changes to our proposed revisions as a result of public comments, and are finalizing the conforming change as proposed.

M. Technical Corrections for Therapy-Related Issues

We proposed the following technical changes to the regulations concerning therapy services:

- In § 409.17(a), we proposed to delete the reference to paragraph (a)(1)(ii) which no longer exists.
- In § 409.23, we proposed to revise the title of this section from ''Physical, occupational and speech therapy'' to ''Physical therapy, occupational therapy and speech-language pathology services.''

Commenters voiced no objections to these technical corrections, and we are finalizing these technical corrections as proposed.

Several commenters brought to our attention changes made to the text of a regulation in the CY 2008 PFS final rule with comment period that did not reflect our policy as expressed in the preamble discussion. We intended to modify our regulations to make the policies for therapy services consistent across all settings. We added § 485.635(e) for the purpose of conforming the policies for physical therapy, occupational therapy and speech-language pathology in the critical access hospitals (CAHs) to the policies for therapy services in § 409.17. Section 485.635(e) describes therapy services when furnished at the CAH as those that ''are provided as direct services by staff qualified under State law, and consistent with the requirements for therapy services described in § 409.17.'' The reference in the regulation to ''direct services'' was not intended to address the employment status of staff providing those services, but we now recognize that it could be interpreted as such. Therefore, we are making a technical correction to the regulatory language at § 485.635(e) to remove the words ''as direct services.''

N. Physician Self-Referral and Anti-Markup Issues

1. Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x))

a. Introduction

In the CY 2009 PFS proposed rule (73 FR 38502), we proposed a new exception to the physician self-referral law for incentive payment and shared savings programs. The proposed exception covered various types of hospital-sponsored pay-for-performance (P4P), shared savings (for example, gainsharing), and similarly-styled programs that offer financial incentives to physicians intended to foster high quality, cost-effective care. The exception, as proposed, would provide more flexibility than existing physician self-referral exceptions available for such programs (73 FR 38548).

When establishing a new exception to the physician self-referral law, we rely on the authority granted to us in section 1877(b)(4) of the Act, which mandates that financial relationships permitted under an exception, such as the types of compensation arrangements contemplated by the proposed exception, not pose a risk of program or patient abuse. As described more fully in the CY 2009 PFS proposed rule, in order to ensure that we did not exceed this authority, the proposed exception was targeted and relatively narrow. We acknowledged that it was unlikely to cover as many arrangements as interested stakeholders would like, and sought comments on ways that we might expand the proposed exception without a risk of program or patient abuse.

We received approximately 55 timely public comment letters regarding the proposed exception for incentive payment and shared savings programs. The majority of commenters supported the establishment of the following: (1) An exception for incentive payment and shared savings programs; or (2) two exceptions—one for incentive payment programs and one for shared savings programs. However, most of these commenters urged us to finalize such an exception or exceptions only if substantial modifications were made to the conditions proposed. We also received a number of comment letters urging us not to finalize an exception for incentive payment and shared savings programs, some of which asserted that

we lack statutory authority to do so and contended that any such exception necessarily would pose a risk of program or patient abuse.

As we stated in the CY 2009 PFS proposed rule (73 FR 38548):

> In reviewing various programs and industry suggestions, we have been struck by the considerable variety and complexity of existing arrangements, and the likelihood of continued future innovation in the structure and method of these programs. This variety and complexity make it difficult to craft a ''one-size-fits-all'' set of conditions that are sufficiently ''bright line'' to facilitate compliance and enforceability, yet sufficiently flexible to permit innovation without undue risk of program or patient abuse.

Our goal in establishing an exception or exceptions for incentive payment and shared savings programs is ''to promulgate an exception that is as broad as possible'' yet consistent with the statutory requirement that any arrangement excepted under an exception issued using our authority in section 1877(b)(4) of the Act pose no risk of program or patient abuse (73 FR 38548). Although we received thoughtful and instructive comments, we did not receive through the initial public comment process sufficient information or agreement among commenters regarding possible modifications to the proposal to allow us to finalize an exception that expands the proposed exception in any meaningful way. Therefore, we are reopening the public comment period to obtain the specific information described below. We believe that, if ultimately provided through the extended public comment process, the additional information we are requesting will assist us in finalizing an exception or exceptions for incentive payment and shared savings programs. The comment period will be reopened for an additional 90 days following publication of this final rule with comment period in the **Federal Register**. Information regarding the submission of public comments can be found in the **ADDRESSES** section of this final rule with comment period. We will summarize and respond to all comments received in response to our proposal (or any future proposal for an exception (or exceptions) to the physician self-referral law for incentive payment and shared savings programs), including the 55 comment letters noted above, in a final rulemaking.

For ease of reference, we are numbering our solicitations of comments in a continuous sequential order, and we encourage commenters to refer to these numbers in their submissions to us. Although we have offered many specific solicitations of comments in an effort to stimulate and focus discussion, we do not mean to imply that we are interested in receiving comments only on the specific questions noted below; rather, we encourage comments on any and all relevant issues to an exception or exceptions for incentive payment and shared savings programs. In addition, we request that commenters consider all of the issues in context and in conjunction with each other, as well as consider the exception holistically rather than piecemeal. Many of the specific solicitations below are related to each other and may be better addressed if grouped together.

We urge commenters to respond with specificity and to include detailed, practical examples whenever possible. Commenters are encouraged to consider the requirement under section 1877(b)(4) of the Act that any new regulatory exception pose no risk of program or patient abuse. Although the following discussion segregates individual issues, commenters are encouraged to comment on and recommend combinations of conditions for an exception or exceptions that would meet the ''no risk'' standard, would be sufficiently bright line to be enforceable and to facilitate compliance, and would be sufficiently flexible to foster beneficiary arrangements. Commenters should consider suggesting alternative safeguards when recommending the elimination or modification of a proposed condition or when recommending adoption of an alternative to a proposed condition. As an initial matter, we are interested in comments that address the best ways in an exception or exceptions for incentive payment or shared savings programs to achieve transparency and accountability, ensure quality of care, and prevent disguised payments for referrals. We request that commenters address these goals in their comments.

To better understand and address the variety of incentive payment and shared savings programs that exist in the industry or that parties would like to implement, we are interested in detailed descriptions of incentive payment programs and shared savings programs that include specific descriptions of the structure and operations of the programs and payments. We are also interested in views addressing the likely evolution of these programs.

b. Background: Incentive Payment and Shared Savings Programs

As we discussed in both the CY 2009 PFS proposed rule, and the FY 2009 IPPS proposed rule, the term ''gainsharing'' is commonly used to describe certain programs that seek to align physician behavior with the goals of a hospital by rewarding physicians for reaching predetermined performance outcomes. Several types of programs exist (including, but not limited to, gainsharing) for the purpose of achieving quality standards, generating cost savings, and reducing waste. We refer to these programs as ''incentive payment'' and ''shared savings'' programs. Within the category of ''incentive payment'' programs, we include P4P, also known as quality-based purchasing, and other quality-focused programs that do not involve the sharing of cost savings from the reduction of waste or changes in administrative or clinical practice. Within the category of ''shared savings'' programs, we include programs that involve the sharing of cost savings attributable to physicians' efforts in controlling the costs of providing patient care, as well as hybrid programs that involve both the sharing of cost savings and payment for improvement or maintenance of patient care quality. For a discussion of incentive payment and shared savings programs, DHHS initiatives with respect to such programs, and our proposed exception for incentive payment and shared savings programs, we refer the reader to our solicitation of comments in the FY 2009 IPPS proposed rule regarding the necessity of an exception to the physician self-referral law for gainsharing programs (73 FR 23692 through 23695) and the CY 2009 PFS proposed rule (73 FR 38548 through 38552).

In the CY 2009 PFS proposed rule, we described our concerns regarding potential program and patient abuse from the implementation of improperly structured incentive payment and shared savings programs. Specifically, we stated:

> Although properly structured incentive payment programs can enhance health care quality and efficiency, improperly structured programs pose significant risks of program or patient abuse, including adversely affecting patient care. Moreover, such programs could be vehicles to disguise payments for referrals, including incentives to steer healthier patients to the hospital offering the incentive payment program. Programs that cannot be adequately and accurately measured for quality would also pose a high risk of program or patient abuse (73 FR 38549).

We stated further:

> Although properly structured shared savings programs may increase efficiency and reduce waste, thereby potentially increasing a hospital's profitability and contributing to

quality of care, improperly designed or implemented programs pose the same risks of program or patient abuse described above in connection with incentive payment programs. Additional risk is posed by shared savings programs that reward physicians based on overall cost savings (for example, the amount by which the total costs attributable to a particular hospital department decreased from 1 year to the next) without accountability for specific cost reduction measures (73 FR 38550).

In addition, we expressed our continued concern about stinting (limiting the use of quality-improving but more costly devices, tests or treatments), cherry-picking (treating only healthier patients as part of an incentive payment or shared savings program), steering (avoiding sicker patients at the hospital sponsoring the incentive payment or shared savings program), and quicker-sicker discharges (discharging patients earlier than clinically indicated either to home or to post-acute care settings).

c. Solicitation of Additional Public Comments

i. Distinguishing between ''incentive payment'' and ''shared savings programs''

In the CY 2009 PFS proposed rule, we sought comments regarding ''whether separate exceptions for incentive payment and shared savings programs would be preferable and, if so, how they should be structured, and which requirements should appear in each'' (73 FR 38552). Most commenters in support of establishing an exception for incentive payment and shared savings programs recommended that we establish two separate exceptions. Here, we are requesting specific comments regarding how [1] to define the terms ''incentive payment program'' and ''shared savings program.'' We also request comments regarding [2] whether the terminology ''incentive payment'' and ''shared savings'' programs is appropriate or whether different terminology would better describe the range of nonabusive programs we intend to cover under the proposed exception(s). Whatever terminology we employ, we must define the terms with sufficient clarity to enable parties to determine which exception, if more than one is finalized, would be applicable to the specific arrangement being analyzed.

Commenters in support of the adoption of two separate exceptions frequently asserted that many of the conditions in the proposed exception are not applicable, or need not be applicable, to incentive payment programs, asserting that incentive payment programs do not pose the same risk of program or patient abuse as traditional gainsharing programs or shared savings programs. We are seeking comments that [3] identify with specificity which conditions should be made applicable to incentive payment programs (and why), [4] identify which conditions need not or should not be made applicable to incentive payment programs (and why), and [5] indicate why it would not be necessary to impose the same safeguards against program or patient abuse on both types of programs. For example, we seek comments on [6] whether a program involving cost savings measures that also improve quality should be treated as an incentive payment or shared savings program.

ii. Risk of Program or Patient Abuse

As noted above, several commenters questioned our ability to promulgate an exception for shared savings programs that satisfies the mandate under section 1877(b)(4) of the Act that any exception issued using that authority pose no risk of program or patient abuse. The commenters asserted that, because gainsharing implicates sections 1128A(b)(1) and (b)(2) of the Act, commonly referred to as the Civil Monetary Penalty (CMP) statute, any exception to the physician self-referral law for incentive payment and shared savings programs would necessarily pose a risk of program or patient abuse and would be outside the scope of our authority under section 1877(b)(4) of the Act. We disagree with these commenters. We believe that it is possible within the meaning of section 1877(b)(4) of the Act to establish a set of safeguards to guard against program and patient abuse. Moreover, it is our understanding that many incentive payment programs would not involve payments to physicians to reduce or limit services to hospital patients. However, we are interested in comments that [7] specifically address this issue in greater detail, including [8] how we can satisfy the requirements of section 1877(b)(4) of the Act if we do not include a condition prohibiting payment to a physician (under the incentive payment or shared savings program) for reducing or limiting items or services furnished to Medicare or Medicaid beneficiaries under the physician's direct care. In addition, we are interested in comments regarding [9] the utility of an exception that incorporates conditions that are the same as or similar to conditions that have appeared in favorable advisory opinions issued by the OIG on gainsharing arrangements.

iii. Design of the Program

In the CY 2009 PFS proposed rule, we proposed protecting documented programs that seek to achieve the improvement of quality of hospital patient care services through changes in physician clinical or administrative practices or actual cost savings for the hospital resulting from the reduction of waste or changes in physician clinical or administrative practices (73 FR 38553). To be protected, the program must achieve one or both of these goals without an adverse effect on, or diminution in, the quality of hospital patient care services.

(1) Objective Medical Evidence and Independent Review

Under the proposed exception, incentive payment and shared savings programs must be supported by objective, independent medical evidence indicating that the applicable cost-savings or quality performance measures would not adversely affect patient care. We also proposed that patient care quality measures must derive from CMS' Specifications Manual for National Hospital Quality Measures. Many commenters objected to this limitation; however, the comments, for the most part, did not contain suggestions regarding other appropriate lists of quality measures or whether (and in what manner or under what circumstances) we should permit parties to establish their own quality measures for inclusion in a protected incentive payment or shared savings program. We are seeking comments on this issue, including [10] how we might avoid protecting payments based on sham measures or measures that do not reflect objective quality outcomes or standards but instead may be vehicles to reward referrals.

We proposed in the CY 2009 PFS proposed rule that an incentive payment or shared savings program must be reviewed prior to implementation of the program and at least annually thereafter to ascertain the program's impact on the quality of patient care services provided by the hospital. We proposed that this review must be performed by an independent medical reviewer; that is, the review must be conducted by a person or organization with relevant clinical expertise that is not affiliated with the hospital operating the program under review and not affiliated with any physician participating in the program or with any physician organization with which a participating physician is affiliated. We also proposed that the reviewer could not be participating (at the time of the review) in any incentive

payment or shared savings program operated by the hospital (73 FR 38553 through 38554). A substantial number of commenters objected to the requirement of independent medical review, claiming that the expense of independent medical review would likely be significant, and that many hospitals may not be able to find an ''independent'' medical reviewer. Commenters also contended that the impact on patient care can best be ascertained through individuals associated with the hospital, because hospital personnel and medical staff physicians are intimately aware of hospital operations and patient populations.

We seek comments on [11] whether, assuming that there is a need for independent medical review, the need would be greater if the exception were to include outcome measures that are not on the CMS-approved list. We also seek comments on an alternative to independent medical review that would provide an objective, accurate and complete review. Specifically, we request comments addressing [12] how, if no independent medical review is required, we could ensure that a hospital is objective in the review of its incentive payment and shared savings program, that programs operate appropriately to improve (or maintain) patient care quality, and that the incentive payment or shared savings program results in no diminution of patient care quality or inappropriate reduction in care. Finally, and irrespective of whether we would require independent medical review or permit ''in-house'' review, we seek comments on: [13] How, when and what type of (for example, further review, corrective action, or termination of the incentive payment or shared savings program) recommendations should be made by the reviewer when the program review identifies concerns with patient care quality or the diminution in patient care quality resulting from the implementation of the incentive payment or shared savings program; and [14] requirements (including timeframes) for the hospital to take corrective action based on the reviewer's recommendations.

(2) Participating Physicians and Payment Amounts

The proposed exception included a requirement that the incentive payment or shared savings program be structured to require physician participation in the program in pools of five or more physicians, with payments being distributed to members of each pool on a *per capita* basis. Under the proposed exception, all physicians participating in the program must be on the medical staff of the sponsoring hospital at the commencement of the program. Most commenters objected to these requirements, but did not provide clear suggestions regarding how to address our concern regarding disguised payments that reward referrals or other business generated by the physician in the absence of such structural requirements. Therefore, we are seeking specific comments on alternatives to these participation and payment restrictions, as well as other safeguards that we could include in an exception(s) if we were to omit the ''five-physician pool,'' *per capita* payment distribution, and/or medical staff membership requirements. We request comments as to [15] whether, if pools of less than five physicians are permitted, what the minimum number of physicians should be; [16] whether all participating physicians must be in the same specialty, and, if not, what issues are raised by protecting arrangements between hospitals and multi-specialty physician groups; [17] whether participating physicians should be required to be on the medical staff at the hospital at the commencement of the program and, if not, how we should address the risk that programs will be used inappropriately as recruiting tools; and [18] whether medical staff members may be added during an ongoing program and, if so, how we should address the risk that payments would be made to recruit physicians from other area hospitals, especially hospitals that might not be able to afford to offer a similar program.

We also seek comments with respect to limitations on payments under an incentive payment or shared savings program. Specifically, we are interested in comments regarding whether: [19] We should impose a cap on the payment made per participating physician, regardless of the amount of cost savings or achievement of patient care quality goals attributable to a particular physician; [20] whether payments should be limited in duration and, if so, whether 3 years or some other period should be the maximum time period for payments; and [21] whether protected payments should be reasonably related to the measure that is achieved and, if so, how a reasonable relationship should be determined, and, if not, how we could protect against excessive payments that might induce referrals. In this regard, we are interested in comments addressing [22] methods for protecting against excessive payments to referring physicians who participate in the program but may contribute little or no work or expertise to the program. We are further interested in comments on [23] the types of physicians who should be protected participants and what it should mean to be a ''participating'' physician. Finally, we are interested in comments addressing [24] the concept of restricting physicians from receiving payments for previously achieved cost savings or for meeting quality improvement goals that are, or have become over time, standard practice (for example, we are concerned about payments that amount to little more than supplemental payments to physicians to do nothing more than what they are already doing) (73 FR 38555 through 38556).

In the CY 2009 PFS proposed rule, as described above, we proposed that payments to physicians be made (whether directly to the physician or to his or her qualifying physician organization) on a *per capita* basis. We also solicited comments that would ''outline alternate approaches to the *per capita* payment model for the distribution of incentive payments or shared savings payments, such as paying a physician more or less according to whether he or she contributed more or less to the achievement of the performance measures'' included in the program (73 FR 38555). Although many commenters stated support for permitting payments to physicians that directly correlate to their personal efforts and achievement of performance measures in an incentive payment or shared savings program, few comments provided sufficient detail regarding how we could incorporate this expansion into the exception without risk of program or patient abuse. We are interested in comments that [25] outline with specificity how a hospital would track or otherwise determine the ''personal efforts'' of a physician and correlate the achievement of performance measures to a particular physician's personal efforts and, in turn, to the amount of the payment.

We also proposed a condition that would prevent physicians from being paid in a manner that reflected increased volumes of Federal health care program patients or services. Commenters generally opposed this proposed restriction. We recognize as we stated in the CY 2009 PFS proposed rule that volume changes can occur due to market forces and physician practice growth, rather than from changes in referral patterns due to financial incentives available to physicians participating in an incentive payment or shared savings program (73 FR 38555). Where changes in the volume of Federal

health care patients or services occur because of financial incentives, a risk of abuse exists. We are soliciting comments that [26] specifically address how to account for legitimate fluctuations in the volume of Federal health care patient procedures or services and consider the potential that volume increases can indicate altered referral patterns when a physician is participating in an incentive payment or shared savings program. In addition, we are seeking comments regarding [27] possible ways to ensure against increases in total Medicare expenditures for patients for whom services are provided under an incentive payment or shared savings program.

We proposed to require hospitals to make payments directly to participating physicians or to a ''qualified physician organization,'' which we proposed to define as a physician organization composed entirely of physicians participating in the incentive payment or shared savings program (73 FR 38553). We sought comments regarding possible expansion of this condition to allow payments to a physician organization even if all of its affiliated physicians were not participating in the incentive payment or shared savings program under which the payment is made. We reiterate our concern that payments made to physician organizations with nonparticipating physicians could be used to reward such nonparticipating physicians for their referrals. Many commenters objected to the strict limitations on the parties to whom a hospital may make a payment under an incentive payment or shared savings program. Commenters generally urged greater flexibility in the distribution of payments. We are seeking here specific information regarding [28] conditions that could be imposed to ensure no risk of program or patient abuse including, for example, conditions on the use and distribution of payments made to physician organizations on behalf of participating physicians.

(3) Costs Savings for Shared Savings Programs

With respect to shared savings programs, we proposed various methods and sought comments on other methods for limiting or capping the total amount of cost savings available under the program. We proposed a flat, 50 percent limit on the amount of cost savings eligible for sharing with participating physicians, and also proposed requiring rebasing of the baseline statistics against which reduction in waste and cost savings would be measured. In the alternative, we proposed a surrogate method of capping total available payments that would be actuarially equivalent to a 50 percent cap with annual rebasing of baseline statistics. Many commenters responded that we should impose no limits on how a hospital determines the amount available for shared savings payments, while other commenters objected to the 50 percent cap and/or the rebasing requirement. As we noted in the CY 2009 PFS proposed rule and above, our goal is to finalize an exception (or exceptions) that provide sufficient flexibility for hospitals to structure and implement a variety of nonabusive incentive payment and shared savings programs. We are seeking comments that specifically address: [29] What safeguards we could include in an exception if we do not include a cap on the total amount of cost savings available for distribution to participating physicians; [30] What safeguards we could include in an exception to ensure that physicians are not paid for achieving performance measures they achieved in prior periods of the program if we do not require rebasing of the baseline against which reductions in waste or costs are measures; [31] whether it is appropriate to permit payments for continued achievement (or maintenance) of performance measures, waste reduction or cost savings and, if so, what safeguards we could include in an exception if we were to do so (for example, reduced payments for maintenance of patient care quality compared with payments for the achievement of targets); and [32] whether the answer to [33] differs for incentive payment programs as opposed to shared savings programs.

We have had limited opportunity to review incentive payment and shared programs for compliance with the physician self-referral law, and we lack familiarity with the specifics of measuring achievements and calculating payments under such programs. We received insufficient information in the public comments to set forth with enough specificity conditions regarding the calculation of cost savings so as to enable parties to evaluate compliance with the exception. We proposed to require that payments that result from cost savings be calculated based on acquisition costs for the items at issue, as well as the costs involved in providing the specified services, and that they be calculated on the basis of all patients, regardless of insurance coverage (73 FR 38556). Many commenters stated that the term ''acquisition costs'' was unclear or that it is difficult to determine the actual costs involved in providing specified services, and suggested that we provide additional guidance regarding these concepts if we were to finalize this condition on payments. We are seeking additional and specific comments regarding [34] the calculation of the amount of total cost savings available for distribution under a shared savings program, including a discussion of formulae used by parties to existing arrangements.

(4) Protecting Quality of Care

We proposed that, under an exception for incentive payment and shared savings programs, no payments could be made if the program resulted in a diminution of patient care quality. Additional issues were raised in the public comments, and we seek further comments on the following: [35] Whether and, if so, how we should address the situation in which the implementation of an incentive payment or shared savings program results in a diminution in patient care quality measures not included in the incentive payment or shared savings program; [36] whether we should permit payments based on the global improvement in patient care quality instead of individually identified and tracked patient care quality measures; [37] if a program is structured to result in payments when global quality improves, whether and, if so, how should we permit payments to be made if only some of the quality measures are met; [38] whether payments should be permitted for the maintenance of patient care quality (as opposed to the improvement of patient care quality) [39] whether payments should be permitted for the achievement of intermediate targets for patient care quality and how intermediate targets should be defined and measured; [40] what types of medical evidence should support quality measures, and how we can ensure that quality measures are supported by credible medical evidence; and [41] whether measures must have some relation to the patient populations and practices at the hospital and, if so, what the relation should be, and, if not, how we could protect against programs that are structured to reward physicians for reaching subjective or limited goals that do not substantially benefit the hospital's patients.

We seek additional information on how parties measure patient care quality and determine appropriate payment amounts for the achievement of targets for patient care quality measures. For example, we request comments on: [42] How quality improvement should be

measured, including how a baseline (that is, starting point) should be set from which to measure the improvement, how recent the baseline should be, and whether the targets should reflect regional data, national data, or some other data; [43] whether we should recognize a difference between ''quality improvement'' and ''quality maintenance'' and, if so, how we should define those terms in relation to each other, whether an exception should protect payments for both, and whether they should be valued differently (based on the supposition that improving quality may require more effort than maintaining it); and [44] how we can prevent protecting payments for programs that are not meeting their quality goals or for measures that, when achieved, result in a diminution of patient care quality.

iv. Structure of the Arrangement Between the Hospital Sponsoring the Program and the Physicians Participating in the Program

(1) Documentation

In the CY 2009 PFS proposed rule, we included in the proposed exception for incentive payment and shared savings programs a requirement that the sponsoring hospital maintain certain documentation regarding the program that must be made available to the Secretary upon request. Many commenters supported this requirement, while others stated that it presented an undue administrative burden. We are seeking comments regarding [45] possible ways to reduce the administrative burden and cost for hospitals that would not hinder the government's ability to enforce the physician self-referral law and ensure compliance with a final exception (or exceptions). We are also seeking additional comments regarding [46] the inclusion of an audit requirement with respect to the calculations of cost savings and payment amounts under the incentive payment or shared savings program. Many commenters supported such a requirement, and stated that we should permit the audit to be performed ''in-house.'' We are seeking comments here regarding [47] whether such an audit could satisfy our concerns regarding the objectivity and accuracy of the audit. Specifically, we seek comments on [48] whether parties should be required to monitor and track each cost savings or quality measure and, if so, how we should address the need for transparency and accountability.

(2) Sharing of Global Savings

Of particular concern from a fraud and abuse perspective is the sharing of total (or global) savings for a particular department or service line. Many commenters urged us to permit hospitals to share with physicians a percentage or share of the total savings in a particular department or service line, calculated from one period to another. The calculation and sharing of such global savings would not involve individually-tracked and measured performance measures, a cornerstone of the programs that have received favorable advisory opinions from the OIG to date. We seek comments regarding [49] necessary safeguards to ensure that a final exception for shared savings programs, when considered in its totality, would not present a risk of program or patient abuse if we permitted the sharing of departmental or service line global cost savings. In addition, we are interested in [50] the impact that sharing such savings with physicians would have on other potential requirements of a final exception, such as the requirement that the calculation of cost savings and physician payments be audited.

(3) Miscellaneous

We request comments on [51] whether the exception should protect contracts/arrangements between hospitals and physician groups or only contracts/arrangements between hospitals and individual referring physicians (and, if the exception should allow contracts/arrangements between hospitals and physician groups, how we could protect against payments to physicians who do not actively participate in the program and who might be rewarded merely for making referrals). Also, we seek comments on [52] whether, if a physician group participates, the physician group may be paid if some of its physicians fail to make quality improvements; and [53] whether all physicians in the physician group should be required to participate in the same measures.

v. Availability of Other Physician Self-Referral Exceptions

We note that there are many exceptions for compensation arrangements in § 411.355 and § 411.357 of our regulations, including exceptions for *bona fide* employment relationships (§ 411.357(c)), personal service arrangements (§ 411.357(d)), arrangements involving fair market value compensation (§ 411.357(l)), arrangements involving indirect compensation (§ 411.357(p)), and services provided by an academic medical center (§ 411.355(e)). We believe that properly structured arrangements involving physician participation in an incentive payment or shared savings program may meet the requirements of one or more of the existing physician self-referral exceptions for compensation arrangements. (An arrangement that implicates the physician self-referral statute need not satisfy more than one exception.) We request comments on [54] the extent to which a ''stand-alone'' exception(s) for incentive payment and shared savings programs is necessary given the existence of other compensation exceptions, including the ones mentioned above. We request comments on [55] whether it would preferable for us to modify aspects of the existing exceptions to protect a broader range of beneficial, nonabusive incentive payment and shared savings programs.

d. Conclusion

It is evident from the variety of comments that we received and the detailed descriptions from some commenters of existing or ''ideal'' incentive payment or shared savings programs that such programs can be structured in a multitude of ways. Experience with one program model does not ensure an understanding of the impact of another program model. The structures of programs with similar positive outcomes do not necessarily resemble each other.

We intend to continue working toward finalizing an exception (or exceptions) for incentive payment and shared savings programs. We do not believe, as several commenters suggested, that we must or should delay the issuance of a final exception until the completion of the gainsharing demonstrations authorized by section 1866C of the Act and section 5007 of the DRA. (See 73 FR 38550 for a description of these initiatives.) However, without the additional information discussed in this preamble, our efforts to finalize an exception(s) will be hindered. By soliciting additional public comments on the proposed exception for incentive payment and shared savings programs, we hope to acquire information that will better inform the development of an exception that is sufficiently flexible to encourage the development and implementation of beneficial, nonabusive incentive payment and shared savings programs that foster high quality, cost-effective care for our beneficiaries.

2. Changes to Reassignment Rules Related to Diagnostic Tests (Anti-Markup Provisions)

Section 1842(n)(1) of the Act requires us to impose a payment limitation on certain diagnostic tests where the physician performing or supervising the test does not share a practice with the physician or other supplier that bills for the test. We implemented section 1842(n)(1) of the Act by applying an ''anti-markup'' payment limitation to technical components (TCs) of diagnostic tests purchased from an outside supplier, which has long appeared in our regulations in § 414.50 and which is applicable to diagnostic tests covered under section 1861(s)(3) of the Act and paid for under 42 CFR part 414 (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act). In the CY 2008 PFS final rule with comment period (72 FR 66222), relying on section 1842(n)(1) of the Act, our general rulemaking authority under sections 1102(a) and 1871(a) of the Act, and authority under section 1842(b)(6) of the Act, we amended the anti-markup provision in § 414.50. Specifically, we revised the anti-markup provision to apply to the TC of diagnostic tests that are ordered by the billing physician or other supplier (or ordered by a party related by common ownership or control to such physician or other supplier) when the TC is outright purchased or when the TC is not performed in the ''office of the billing physician or other supplier.'' We revised § 414.50(a)(2)(iii) to define the ''office of the billing physician or other supplier'' as medical office space where the physician or other supplier regularly furnishes patient care. For a billing physician or other supplier that is a physician organization, as defined at § 411.351, the ''office of the billing physician or other supplier'' is space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally. We also imposed an anti-markup payment limitation on the professional component (PC) of diagnostic tests that are ordered by the billing physician or other supplier (or ordered by a party related by common ownership or control to such physician or other supplier group) if the PC is outright purchased or if the PC is not performed in the office of the billing physician or other supplier. Under the CY 2008 PFS final rule with comment period, if a physician or other supplier bills for the TC or PC of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control) and the diagnostic test is either purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier, the payment to the billing physician or other supplier (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge; or
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

In the CY 2009 PFS proposed rule (73 FR 38502), we proposed revisions to the anti-markup provisions in § 414.50, and solicited comments on how best to implement these approaches. We proposed that the anti-markup provisions would apply in all cases where the TC or the PC of a diagnostic testing service is either: (i) Purchased from an outside supplier; or (ii) performed or supervised by a physician who does not share a practice with the billing physician or other supplier. We proposed two alternative approaches to determining whether the performing or supervising physician ''shares a practice'' with the billing physician or other supplier. We also solicited comments regarding other possible approaches to address our concerns regarding overutilization that can occur when a physician or physician organization is able to profit from diagnostic testing services not actually performed by or supervised by a physician who ''shares a practice'' with the billing physician or other supplier.

In what we designate here as ''Alternative 1,'' we proposed that a physician who is employed by or contracts with a single physician or physician organization ''shares a practice'' with that physician or physician organization. We stated that, when a physician provides his or her efforts for a single physician organization (whether those efforts are full-time or part-time), he or she has a sufficient nexus with that practice to justify not applying the anti-markup provision as contemplated under section 1842(n)(1) of the Act. In light of this proposal, we also requested comments on how to consider *locum tenens* and other arrangements under which a physician provides occasional services outside of his or her physician organization, as we recognized that circumstances may exist under which it is beneficial or necessary for a physician to provide diagnostic testing services to more than one physician practice.

We proposed a second alternative proposal, which we designate here as ''Alternative 2,'' which would maintain much of the current regulation text, and its ''site-of-service'' approach to determining whether a physician ''shares a practice'' with the billing physician or other supplier, that was finalized in the CY 2008 PFS final rule with comment period. In other words, we reproposed to apply the anti-markup payment limitation to non-purchased TCs and PCs that are performed outside the office of the billing physician or other supplier. We also solicited comments on whether this is the best anti-markup approach or whether we should employ a different approach.

Specifically, in Alternative 2, we proposed to amend § 414.50 to: (1) Clarify that the ''office of the billing physician or other supplier'' includes space in which diagnostic testing is performed that is located in the same building in which the billing physician or other supplier regularly furnishes patient care (and to make two other revisions to the definition); (2) clarify that, with respect to TCs, the anti-markup provision applies if the TC is either conducted or supervised outside the office of the billing physician or other supplier; (3) clarify when we consider the TC of a diagnostic test to be purchased from an outside supplier; (4) clarify that, for purposes of applying the payment limitation in § 414.50(a)(1)(i) only, with respect to the TC, the ''performing supplier'' is the physician who supervised the TC and, with respect to the PC, the ''performing supplier'' is the physician who performed the PC; and (5) include an exception for diagnostic tests ordered by a physician in a physician organization (as defined at § 411.351) that does not have any owners who have the right to receive profit distributions. Finally, we solicited comments on how to define ''net charge'' and on whether we should delay beyond January 1, 2009, the application of the revisions made by the CY 2008 PFS final rule with comment period, or the proposed revisions (to the extent they are finalized), or both.

We received numerous comments in response to the proposals related to the anti-markup provisions. Some commenters requested that we withdraw both the CY 2008 PFS rulemaking and the current proposals. Other commenters offered varied

support or criticism for one or both of the proposed alternatives. Some commenters expressed concerns about eliminating legitimate, nonabusive arrangements that serve Medicare beneficiaries. Quality concerns were raised by commenters both in favor of and opposed to the proposals.

Commenters in support of Alternative 1 believe that it would be more straightforward and easier to implement than Alternative 2. Some commenters responded to Alternative 1 by requesting that a physician be able to ''share a practice'' with up to 3 physicians or physician organizations in order to accommodate arrangements that currently exist among many part-time physicians and the groups for whom they work. These commenters also stated that they would no longer be able to support an in-office laboratory employing part-time physicians if the Alternative 1 approach was implemented as proposed.

Some commenters offered support for Alternative 2 and its ''site-of-service'' approach, which they argued would curb abusive overutilization while granting physicians more flexibility in how to structure arrangements to provide care as they see fit. Commenters opposed to Alternative 2 were concerned that this approach focuses only on where the test is performed and not by whom. Some commenters did not support our proposal to clarify ''office of the billing physician or other supplier'' as including diagnostic testing performed in the ''same building,'' but not in a ''centralized building,'' preferring that ''office of the billing physician or other supplier'' also encompass diagnostic testing performed in a ''centralized building.''

Most commenters agreed with our proposed clarification that the TC of a diagnostic test is not ''purchased from an outside supplier'' if the TC is both conducted by the technician and supervised by the physician within the office of the billing physician or other supplier. We received a few comments, some in favor of and some opposed to, the proposed exception for diagnostic tests ordered by physicians in a physician organization with no owners who have the right to receive profit distributions. Most of the comments that we received in response to the ''net charge'' solicitation expressed dissatisfaction regarding the disallowance of overhead costs in the calculation of the ''net charge.'' Other commenters, however, agreed that these costs should not be included and that only those charges that are incurred from paying the physician providing the PC or supervising the TC should be included.

We received a number of comments addressing issues outside the scope of this rulemaking, in particular, the in-office ancillary services exception to the physician self-referral law, which is codified in § 411.355(b) of our regulations. Commenters believed that we must curtail the types of arrangements currently permitted under the in-office ancillary services exception in order to curb overutilization through the ordering of unnecessary diagnostic tests.

After careful consideration of the comments that we received, we are adopting a flexible approach that incorporates both proposed alternatives. We are finalizing Alternative 1 with some modifications, and retaining with some modifications the present ''site-of-service'' approach (Alternative 2) to allow physicians to consider both approaches in determining if the anti-markup provisions apply to particular diagnostic testing services. Arrangements should be analyzed first under Alternative 1. Thus, where the performing physician (that is, the physician who supervises the TC or performs the PC, or both) performs substantially all (at least 75 percent) of his or her professional services for the billing physician or other supplier, none of the services furnished by the physician on behalf of the billing physician or other supplier will be subject to the anti-markup payment limitation in § 414.50. If the performing physician does not meet the ''substantially all'' services requirement of Alternative 1, an analysis under the Alternative 2 requirements may be applied on a test-by-test basis to determine whether the anti-markup payment limitation applies. Under the Alternative 2 ''site-of-service'' approach, only TCs conducted and supervised in and PCs performed in the office of the billing physician or other supplier by an employee or independent contractor physician will avoid application of the anti-markup payment limitation. Both the ''substantially all professional services'' and ''site-of-service'' tests are measures of whether a performing/supervising physician ''shares a practice'' with the billing physician or other supplier. With respect to Alternative 2, we believe that restrictions regarding the location of the conducting and supervising of the TC are essential to ensure that, if the test is to be billed as performed by the billing physician or other supplier, the billing physician or other supplier exercise sufficient control and a proper nexus to the individuals conducting and supervising the test. Requiring that the TC be conducted and supervised in the office of the billing physician or other supplier, under Alternative 2, creates this control and nexus. We believe that allowing billing physicians and other suppliers that cannot satisfy Alternative 1 to comply with the requirements of Alternative 2 on a case-by-case basis affords physicians flexibility while addressing our concerns regarding the ordering of unnecessary diagnostic tests.

As we noted above, we have made one modification to Alternative 1 in response to comments we received. Rather than requiring that a physician work exclusively for one physician practice, in order to ''share a practice'' with a particular physician or physician organization, a physician must provide ''substantially all'' of his or her professional services for that practice. For purposes of Alternative 1, we are defining ''substantially all'' as ''at least 75 percent.'' In this regard we note that ''substantially all,'' as used in certain of our physician self-referral rules, is defined as ''at least 75 percent'' (see § 411.352(d) and § 411.356(c)(1)). Although the anti-markup provisions in § 414.50 and the physician self-referral rules in § 411.350 through § 411.389 are separate and distinct, we believe that ''at least 75 percent'' is an appropriate test within the context of Alternative 1, and we also wish to avoid any unnecessary confusion that could result from having one numerical test for the anti-markup provisions and another numerical test for the physician self-referral rules. Thus, for purposes of determining whether the anti-markup provisions apply, the performing physician (that is, the physician supervising the TC or performing the PC, or both) is considered to share a practice with a physician group for which he or she provides at least 75 percent of his or her professional services—even if the physician works for one or more billing physician groups or other health care entities. The final rule provides at revised § 414.50(a)(2)(ii) that the ''substantially all'' requirement is satisfied if the billing physician or other supplier has a reasonable belief at the time it submits a claim that: (1) The performing physician has furnished substantially all of his or professional services through the billing physician or other supplier for the period of 12 months prior to and including the month in which the service was performed; or (2) the performing physician is expected to furnish substantially all of his or her professional services through the billing physician or other supplier during the

following 12 months (including the month the service is performed).

We believe that our modification to the proposal for Alternative 1 will satisfy the concerns regarding *locum tenens* arrangements (and part-time and other on-call or similar arrangements), provided that the performing physician is not furnishing more than 25 percent of his or her professional services as a *locum tenens* physician (or in some other capacity, such as a part-time physician for another billing group or moonlighting at a hospital).

We are also retaining the present site-of-service approach to determining whether a physician ''shares a practice'' with the billing physician or other supplier. This approach was reproposed as Alternative 2, with a proposed clarification that diagnostic testing performed in the ''same building'' (as defined at § 411.351) in which the ''office of the billing physician or other supplier'' is located would not be subject to the anti-markup provisions (provided that the testing was not purchased from an outside supplier). We are adopting this clarification, but deleting the references to purchased TCs and PCs from § 414.50, for the reasons explained below. We are also adopting certain proposed clarifications and definitions. Specifically, a physician or other supplier may have more than one ''office of the billing physician or other supplier,'' and the ''office of the billing physician or other supplier'' is defined as space in which the *ordering* physician or other *ordering* supplier regularly furnishes care (and with respect to physician organizations, is the space in which the *ordering* physician performs substantially the full range of patient care services that the *ordering* physician provides generally). We are adding to Alternative 2 the requirement, with respect to the TC, that the physician supervising the TC be an owner, employee, or independent contractor of the billing physician or other supplier, and, with respect to the PC, that the physician performing the PC be an employee or independent contractor of the billing physician or other supplier. We are doing this in order to simplify our rules and to avoid having a separate basis for imposing an anti-markup payment limitation for TCs supervised and PCs performed by outside suppliers. We explain our rationale for this change in the next paragraph.

We are not finalizing a definition of outside supplier, and instead we are deleting references to a ''purchased'' test or interpretation in § 414.50 because they are unnecessary, as explained below. We note that section 1842(n)(1) of the Act requires us to impose an anti-markup payment limitation on diagnostic tests that are performed or supervised by a physician who does not share a practice with the billing physician or other supplier. Traditionally, we have interpreted section 1842(n)(1) of the Act as applying to purchased TCs from an outside supplier. Our longstanding policy of having an anti-markup payment limitation on purchased TCs was codified in § 414.50, and retained in the CY 2008 PFS final rule with comment period. (Similarly, we imposed an anti-markup payment limitation on purchased PCs in the CY 2008 PFS final rule with comment period and we proposed in the CY 2009 PFS proposed rule to retain status as a purchased PC as a separate basis imposing an anti-markup payment limitation.) Based on our decision to adopt Alternative 1 and to allow arrangements that do not meet the requirements of Alternative 1 to nevertheless avoid the anti-markup payment limitation if diagnostic testing services meet the requirements of Alternative 2, we believe that it is not necessary, and unduly complex, to use purchased tests and purchased interpretations as separate bases for imposing an anti-markup payment limitation. We provide a fuller explanation below, at section N.2.h., for deleting from § 414.50 references to TCs and PCs purchased from an ''outside supplier.''

We are not creating an exception for tests ordered by a physician in a physician organization with no physician owners who have the right to receive profit distributions. By finalizing both proposed alternatives, we believe that our concern that the Alternative 2 approach could disadvantage nonproblematic arrangements involving nonprofit multi-specialty groups that have campus-based treatment facilities (and thus do not perform diagnostic testing in the same building as where patients are seen) largely becomes moot, as most such arrangements should be able to be structured to fit into Alternative 1, or failing that, Alternative 2.

With respect to our specific solicitations of comments, we are not revising the meaning of ''net charge'' at this time. Moreover, we are not requiring at this time direct billing instead of permitting reassignment under certain circumstances; however, we may propose to do so in a future notice of proposed rulemaking. We considered the various recommendations commenters offered for the effective date for our revisions. We have decided to not deviate from the effective date that is generally applicable to this final rule with comment period and, thus, the revisions to § 414.50 will become effective on January 1, 2009.

Finally, we did not propose to make changes to the in-office ancillary services exception and are not making any changes to that exception in this final rule; however, we are aware of the commenters' concerns and may propose rulemaking on this issue in the future.

a. General comments

Comment: Some commenters were concerned with their perceived complexity of the anti-markup provisions and requested that we delay making any revisions to the rule. A commenter argued that extending the application of the anti-markup payment limitation only adds another layer of unnecessary complexity and confusion to an area where physicians want to provide high quality services in a cost efficient manner. Some commenters, including a large medical association, requested that we withdraw the proposals of this rule, as well as the proposals contained in the CY 2008 PFS final rule with comment period. In contrast, one commenter stated that the anti-markup provisions are consistent with the aforementioned medical association's code of ethics, which states that a physician should not charge a markup, commission, or profit on services rendered by others. A second commenter noted that the same medical association and many hospital bylaws strongly discourage fee-splitting. Other commenters urged us to not weaken or dilute last year's important anti-markup provision.

Response: We believe that the anti-markup provisions in § 414.50, as revised by this final rule with comment period, are not inordinately complex. We agree that it would be simpler to not have any anti-markup provisions beyond what existed prior to the CY 2008 PFS final rule with comment period, but we remain convinced that additional rulemaking is necessary to address the potential for overutilization through unnecessary testing. Likewise, we agree that it would be simpler to adopt the approach, as suggested by one commenter, that we not allow any reassignment of diagnostic testing services and, instead, require direct billing, but, without studying that approach further, we have concerns that doing so may unnecessarily prevent nonabusive arrangements. Thus, the resulting rule presents some complexity in order to both allow flexibility for the industry while implementing statutory intent and addressing our concerns of

the potential for overutilization and patient abuse. To some extent, we have simplified the anti-markup provisions in § 414.50 by deleting superfluous references to purchased TCs and PCs as bases for imposing an anti-markup payment limitation, for the reasons discussed above and more fully below at II.N.2.h.

Comment: A commenter recommended that we finalize a combination of both Alternative 1 and Alternative 2, so that in order for the anti-markup provision to not apply, an employee or contractor physician should work solely for the billing group *and* meet the ''site-of-service'' requirements. Two other commenters recommended that we finalize both approaches and allow arrangements to avoid application of the anti-markup provisions if they comply with *either* approach.

Response: We have adopted an ''either or'' approach to the two proposed alternative approaches. Diagnostic testing services furnished by physicians who meet the requirements of Alternative 1 (the ''substantially all'' services approach) will not be subject to an anti-markup payment limitation. However, arrangements that do not meet the requirements of the Alternative 1 approach nevertheless will avoid application of the anti-markup provisions if they comply with Alternative 2 (the ''site-of-service'' approach), as clarified in this final rule. We believe that compliance with either one of the two approaches finalized in this rule will implement statutory intent and address our concerns regarding overutilization and abusive billing by establishing a sufficient nexus with the billing entity to justify not applying an anti-markup payment limitation.

Comment: One commenter noted that the application of some of the proposed changes, both with respect to the anti-markup provisions in § 414.50 and with respect to the IDTF standards in § 410.33, may restrict the diagnostic testing services that physicians perform for Medicare beneficiaries and may result in more physicians electing to not accept new Medicare patients. A commenter stated that the proposed revisions to the anti-markup provisions threaten cooperative ventures and arrangements and, consequently, beneficiary access to quality Medicare services, including ultrasound and other diagnostic testing services. Other commenters asserted that both proposed approaches are misguided and do not acknowledge the way that physicians provide care under practical circumstances. A commenter contended that both proposals would hamper the ability of large groups to provide diagnostic services. Essentially, physician groups may have to bill differently for some physicians, resulting in an administrative burden for physician groups, and possibly curtailing the locations that a Medicare beneficiary can receive diagnostic tests and thus affecting patient care. Several commenters argued that the adoption of this rule will have the effect of eliminating many legitimate, nonabusive arrangements that serve to expand access to care to Medicare beneficiaries, while resulting in little or no countervailing benefit to the Medicare program

Response: We do not believe that the revisions included in this final rule with comment period will discourage significantly or negatively impact significantly legitimate, nonabusive arrangements. We believe that the revisions strike an appropriate balance between allowing billing physicians and other suppliers flexibility in structuring their arrangements while protecting against program abuse caused by unnecessary diagnostic testing. As explained in section II.I. of this final rule, we are not finalizing our proposals at this time to require physician offices to comply with the IDTF standards in § 410.33.

Comment: Some commenters stated that there is no evidence that bringing diagnostic services into a physician practice automatically leads to overutilization; rather, many practices do so in order to improve quality of patient care and efficiency and not for financial gain.

Response: We disagree with the commenters' statement that there is no evidence that self-referral of diagnostic services leads to overutilization. We cited several studies in the CY 2008 PFS final rule with comment period that supported the proposition that physician self-referral (that is, the referral of diagnostic tests provided within the physician practice) leads to overutilization (72 FR 66311 through 66312). Additionally, since publication of that rule, the Government Accountability Office (GAO) has published a study indicating the overuse of some diagnostic testing when performed in a physician's office. The GAO report, *Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices,* (GAO–08–452), showed that spending for imaging services paid under the PFS more than doubled over a 6-year period from 2000 through 2006. The report's findings reflect a link between spending growth and the provision of imaging services in physician offices. The proportion of Medicare spending on imaging services performed in-office rose from 58 percent to 64 percent and physicians received an increased share of their total Medicare revenue from imaging services. We recognize that not all arrangements necessarily lead to overutilization. However, we are not able to regulate per individual practice and instead must issue rules of general applicability to implement statutory intent and address our concerns regarding the potential for overutilization through unnecessary diagnostic testing.

b. Statutory Authority

Comment: A commenter noted that the anti-markup provisions in section 1842(n)(1) of the Act are limited to ''diagnostic tests described in section 1861(s)(3) [of the Act].'' According to the commenter, the physician interpretation of a diagnostic test is not a service described in section 1861(s)(3) of the Act, as physician services are described in section 1861(s)(1) of the Act. Other commenters stated that, in enacting section 1842(n) of the Act, the Congress specifically limited the applicability of the anti-markup provisions to diagnostic tests. Commenters expressed concern that applying an anti-markup payment limitation to the PC of diagnostic tests is inconsistent with the plain meaning of the law and Congressional intent.

Response: As explained in the preamble to the CY 2008 PFS final rule with comment period (72 FR 66308 through 66309), despite the fact that we implemented section 1842(n)(1) of the Act to impose an anti-markup payment limitation only on the TC of diagnostic tests, we are not prevented from applying an anti-markup payment limitation to the PC of a diagnostic test.

We believe that our general rulemaking authority under sections 1102(a) and 1871(a) of the Act provides us with authority to effectuate fully the Congress's intent in enacting section 1842(n)(1) the Act to remove the profit incentive for ordering unnecessary diagnostic tests. As we indicated in the preamble to the CY 2008 PFS final rule with comment period, the profit incentive to order unnecessary diagnostic tests remains if the billing physician or other supplier may markup the PC of the test (72 FR 66315). Moreover, and as also discussed in the preamble of the CY 2008 PFS final rule with comment period, section 1842(b)(6) of the Act authorizes us, but does not command us, to allow reassignment of physician services, including the PC of a diagnostic test (72

FR 66309). At this time, we are not prohibiting reassignment of PCs and instead requiring direct billing, but we are imposing restrictions on the reassignment of PCs. That is, a PC that is reassigned by the performing physician to the billing physician or other supplier that ordered the PC may not be marked up by the billing physician or other supplier, unless the performing physician shares a practice with the billing physician or other supplier. If a physician or other supplier that orders a PC does not find that billing for the PC under an arrangement that is subject to the anti-markup provisions is profitable or financially worthwhile, that physician or other supplier is free to not accept reassignment and instead have the performing physician or other supplier bill directly for the PC.

Comment: Several commenters questioned the appropriateness or the legality of imposing an anti-markup payment limitation on the TC supervised by, or the PC personally performed by, a physician in the same group practice as the ordering physician. Some commenters asserted that, because the anti-markup provision in section 1842(n) of the Act, with its relatively general language, came first, and the much more specific requirements of the physician self-referral law in section 1877 of the Act came later, the Congress has defined specifically what it means for physicians to ''share a practice'' for Medicare purposes and we should not interpret these provisions differently, particularly without providing a clear rationale for doing so. One commenter contended that the ''share a practice'' concept in section 1842(n) of the Act simply was the Congress' short-hand version of what later became the lengthy definition of ''group practice'' in section 1877(h)(4) of the Act. Other commenters asserted that, through the anti-markup provisions, we are overlaying a new and inconsistent set of requirements for providing diagnostic testing, with respect to *bona fide* group practices meeting the physician self-referral law requirements. According to these commenters, we are doing so by relying on the ''anti-mark-up'' language of section 1842(n)(1) of the Act, even though that language pre-dates the physician self-referral law and explicitly exempts testing performed by physicians who ''share a practice.'' One commenter stated that our proposals, if adopted, would impose a new and untenable burden on physician practices that have already taken pains to comply with the complex and onerous strictures imposed by the physician self-referral law. Two commenters stated that developing policies under one law only to make them largely irrelevant under another law represents arbitrary government action.

Response: Section 1877(h) of the Act expressly states that the definitions it sets forth apply only for purposes of section 1877 of the Act. There is no indication in either the text or the legislative history of section 1877(h) of the Act that the Congress intended the definition of ''group practice'' to correlate with the term ''shares a practice'' in section 1842(n)(1) of the Act. Also, we note that the definition of group practice in section 1877(h) of the Act is relatively narrow. That is, the definition of ''group practice'' in section 1877(h) of the Act refers only to ''members'' of a group practice, which could be construed to mean only physicians with an ownership or investment interest in the group. (Note also that the definition of ''group practice'' in section 1877(h) of the Act allows the Secretary to impose other standards by regulation.) Likewise, the text of the in-office ancillary services exception in section 1877(b) of the Act, which allows referrals within a group practice, can be read as being restricted to services referred and performed by members of the group (and services performed by employees who are supervised by a member of the group). Therefore, even if the Congress did intend the definition of ''group practice'' in section 1877(h) of the Act for purposes of the physician self-referral law to correlate with ''shares a practice'' in section 1842(n)(1) of the Act for purposes of the statutory anti-markup provision, and also intended that individuals whose referrals are protected under the statutory in-office ancillary services exception to the physician self-referral law necessarily ''share[] a practice'' for purposes of the statutory anti-markup provision (and we agree with neither proposition), we would not be required to take an expansive view of what it means to ''share[] a practice'' for purposes of the statutory anti-markup provision. We also note that section 1842(n)(1) of the Act does not prohibit us from using other authority to impose an anti-markup payment limitation on TCs and PCs.

As a policy matter, we do not agree with the commenters that suggested that we should except from the anti-markup provisions any arrangement that complies with the physician self-referral rules. The anti-markup provisions, when applied, limit only how much a physician or other supplier may bill Medicare, whereas the physician self-referral rules, when implicated and not satisfied, prevent a physician or other supplier (or provider) from billing Medicare (for any amount). Accordingly, we approach physician self-referral rulemaking with added caution, lest we prohibit a broad class of arrangements that in some cases and under certain circumstances do not pose a risk of abuse. Thus, using our general rulemaking authority and authority in section 1877(b)(2) of the Act, we have provided some flexibility, with respect to which referrals are protected under the in-office ancillary services exception and the definition of a ''centralized building,'' for purposes of our physician self-referral rules. However, the fact that the physician self-referral law, as interpreted or implemented by us, does not prohibit a certain type of arrangement does not mean that we should not take measures, through an anti-markup approach, to address the potential for overutilization or other abuse that exists with certain arrangements that seek to take advantage of our definitions of ''group practice'' and ''centralized building'' that are used for purposes of the physician self-referral exception for in-office ancillary services.

c. Alternative 1 (''Substantially All'' Professional Services)

Comment: Under Alternative 1 as proposed, which we referred to in the proposed rule as the ''shares a practice'' approach (although the second alternative was also designed to ensure, through a site-of-service methodology, that performing physicians ''share a practice'' with the billing physician or other group), the anti-markup payment limitation would not apply if a service is provided or supervised by a physician who ''shares a practice'' with the billing physician or other supplier by virtue of working exclusively with that physician or other supplier. Several commenters noted that this alternative mirrors the statutory language, but contended that the definition of ''shares a practice'' suggested by the preamble of the proposed rule (that is, if a physician contracts with more than one group, he or she does not ''share a practice'' with any group) is inconsistent with a common sense interpretation of that term. A commenter stressed that even a physician who spends 1 percent of his or her time interpreting echocardiograms for an area hospital but spends the remainder of his or her time working for his or her group practice would not be considered to ''share a practice'' with the group under the

proposed approach. Some commenters suggested that physicians should be able to have two or three relationships with physician organizations and still be deemed to share a practice with each one and not be subject to the anti-markup provisions. Some commenters requested that the anti-markup provisions not apply when a physician works for a physician group and also works for another type of health care provider or supplier, such as a hospital, independent lab, or medical school. Another commenter proposed that a physician who spends more than 40 percent of his ''total time spent on patient care services'' (as defined at § 411.352(d)) as a physician in any group practice should be considered to ''share a practice'' with that group practice for purposes of the anti-markup provisions. According to the commenter, this requirement would ensure that a physician has a meaningful level of actual economic and professional integration with a group practice for which the physician provides DHS from which the group can profit, but it would not penalize a physician for providing professional and supervisory services to others. The commenter suggested that we should permit a physician to share a practice with no more than two groups and require extensive integration with each group.

A commenter stated that, if a physician is a full-time or part-time employee of a physician group, that employment relationship in and of itself should establish a sufficient nexus with that group to justify not applying the anti-markup payment limitation to his or her professional services for the physician group. This commenter also noted that, under the proposed IDTF revisions in the CY 2009 PFS proposed rule (73 FR 38533 through 38535), a physician may serve as an IDTF medical director for no more than three IDTFs, and suggested that a similar standard could be used for the application of the anti-markup provisions by not allowing physicians to contract to provide services for more than three physician organizations.

One commenter stated its belief that compliance with the proposed requirements of the Alternative 1 approach may be possible by some medical practices, such as those with the capital and testing volumes sufficient to warrant engaging or contracting for exclusive physician services needed to perform or supervise diagnostic testing. However, the commenter also asserted that the proposal may be burdensome to many physician offices. Another commenter asserted that some practices do not have sufficient patient volume to support a full-time pathologist or radiologist. A commenter representing an oncology practice noted that the practice currently can bill a global fee for the TC and PC, but the Alternative 1 proposal would apply the anti-markup payment limitation to the PC. The commenter stated that use of a part-time radiologist does not encourage overutilization, and, therefore, the anti-markup payment limitation should not apply.

Response: We are modifying the proposed Alternative 1 approach so that a performing physician (that is, a physician who supervises the TC or performs the PC, or both) will be considered to share a practice with a physician, physician organization, or other supplier if the physician furnishes ''substantially all'' (at least 75 percent) of his or her professional services through that physician, physician organization, or other supplier. This means that a physician may furnish up to 25 percent of his or her professional services through any number of physicians (including himself or herself), physician organizations or other suppliers, through acting as a *locum tenens* physician, or in other circumstances without disqualifying himself or herself from sharing a practice with the physician or physician organization for which he or she provides the bulk (that is, at least 75 percent) of his or her professional services. For example, suppose Physician A furnishes at least 75 percent of her services through Physician Organization B, and furnishes 25 percent of her professional services through Physician C and Laboratory Supplier D. Under this example, Physician A would be considered to be sharing a practice with Physician Organization B.

Revised § 414.50(a)(2)(ii) provides that the ''substantially all'' requirement is satisfied if the billing physician or other supplier has a reasonable belief, when submitting a claim, that: (1) The performing physician has furnished substantially all of his or her professional services through the billing physician or other supplier for the period of 12 months prior to and including the month in which the service was performed; *or* (2) the performing physician will furnish substantially all of his or professional services through the billing physician or other supplier during the following 12 months (including the month the service is performed).

Comment: In response to our request for comments on how to address *locum tenens* relationships under Alternative 1, several commenters recommended that the *locum tenens* relationships should not count in calculating whether a physician shares a practice with another physician or other supplier. Another commenter suggested that abuse of *locum tenens* arrangements could be avoided through requirements for these arrangements in the Medicare Claims Processing Manual, 100–04, Chapter 1, § 30.2.11. One commenter stated that, provided that *locum tenens* physicians satisfy Medicare's requirements governing the use of and billing for such physicians, the anti-markup payment limitation should not apply to tests performed or supervised by such physicians.

One commenter enumerated additional circumstances in which group practice physicians provide services to or through entities other than their primary group affiliation. These circumstances included: (1) Covering for another practice while it recruits to replace a retired or deceased physician; (2) providing specialty services at hospitals or primary care clinics in areas (often rural, but not always) that would otherwise not have those specialties available and convenient to patients; and (3) providing specialty services to a different practice that has only a part-time need for the service.

Another commenter noted the potential for situations where a non-radiology practice contracts with a radiologist as a *locum tenens* physician to circumvent the anti-markup provision. The commenter recommended that we exclude only same-specialty *locum tenens* arrangements from the anti-markup provision.

Response: In the CY 2009 PFS proposed rule, we requested comments on how, under Alternative 1, we could permit a physician to provide occasional services outside of his or her physician organization without the secondary arrangement precluding the physician from sharing a practice with the physician organization for purposes of applying the anti-markup provisions. To accommodate such temporary physician arrangements, we have modified Alternative 1 so that a physician will be considered to share a practice with a physician, physician organization, or other supplier if the physician furnishes at least 75 percent of his or her professional services through that physician, physician organization, or other supplier. Thus, the final rule allows a physician to furnish up to 25 percent of his or her professional services through other arrangements (including for the purpose of acting as a *locum tenens* physician)

without disqualifying himself or herself from sharing a practice with his or her primary physician practice. We believe that our modification provides assurance that the performing physician has a sufficient nexus with the billing physician or other supplier so as to share a practice with such physician or other supplier. We are not persuaded that we should disqualify the performing physician from sharing a practice with the billing physician or other supplier if his or her *locum tenens* or part-time arrangements do not involve performing work for a billing physician or other supplier engaged in the same specialty as the performing physician.

Immediately above, we address the issue of whether a physician may share a practice with a billing physician or other supplier despite furnishing some services through other arrangements, including acting as a *locum tenens* physician. In this paragraph, we address the ''flip side'' of this issue, that is, whether a billing physician or other supplier can avoid application of the anti-markup payment limitation where a *locum tenens* physician is substituting for a physician who does in fact perform ''substantially all'' of his or her professional services through the billing physician or other supplier. We wish to clarify that, with respect to *locum tenens* situations *only*, whether an arrangement satisfies Alternative 1 depends on whether the permanent physician (that is, the physician for whom the *locum tenens* physician is substituting) performs ''substantially all'' of his or her professional services through the billing physician or other supplier. For example, assume Physician A contracts with Group Practice C to render services in place of Physician B, who is on vacation. Physician B performs 100 percent of her professional services through Group Practice C. This arrangement meets the requirements of Alternative 1, because Physician B performs at least 75 percent of her professional services through Group Practice C. It is irrelevant whether, or the extent to which, Physician A furnishes professional services for Group Practice C outside the *locum tenens* arrangements, for purposes of determining whether the anti-markup payment limitation applies to the services provided by Physician A under the *locum tenens* arrangement.

Comment: Many commenters were opposed to the proposed Alternative 1 approach to determining whether a physician shares a practice with the billing physician or other supplier. Some commenters stated that they employ a pathologist in-house in order to improve quality of care by: (1) Using specialized pathologists for digestive diseases; (2) forming normative standards based on the practices of the physicians in the practice; and (3) decreasing the turnaround time for diagnostic tests. Other commenters, who are physicians, stated that they were unhappy with the professional services provided by commercial laboratory companies due to slow turnaround time on pathology reports or difficulty in asking follow-up questions of pathologists at remote laboratories. According to these commenters, by employing a pathologist, a group practice is able to ensure that the pathologist is a specialist in a particular practice area (for example, gastroenterology), something the commenters asserted they were unable to do with commercial laboratories.

A commenter expressed concern regarding Alternative 1 because, in the commenter's view, it would unfairly limit a specialty practice (such as gastroenterology or urology) from billing and collecting the full global reimbursement from the Medicare program for services rendered by an in-office pathologist unless that pathologist works only for that physician group. The commenter stated that it should not matter if the pathologist works for more than one group practice. This commenter expressed concern that eliminating the in-office laboratory model would be a detriment to Medicare beneficiaries. Another commenter objected to our assertion that anatomic pathology services provided in a physician's office can result in overutilization. The commenter expressed its view that gastroenterologists do not overutilize anatomic pathology, even when profiting from it, because a colon biopsy is much more invasive than clinical laboratory tests such as fingerstick for hematocrit or a dipstick urine.

Response: Billing physicians and other suppliers will continue to be able to employ a physician specialist on a part-time basis. Under Alternative 1, if the specialist furnishes ''substantially all'' (at least 75 percent) of his or her professional services through the billing physician or other supplier, the specialist ''shares a practice'' with the billing physician or other supplier. Because this rule finalizes both proposed approaches, if an arrangement does not satisfy the ''substantially all'' test of Alternative 1, the billing of a TC or PC may still avoid application of the anti-markup payment limitation if it meets, as determined on a case-by-case basis, the ''site-of-service'' requirements of Alternative 2. Alternatively, part-time physicians can bill Medicare directly.

Comment: Some commenters contended that adoption of Alternative 1 would interfere unfairly with the practice of medicine by severely limiting physician practices' right to organize themselves as they see fit to deliver quality care to their patients. These commenters stated that adoption of Alternative 1 would prevent a group from hiring a part-time pathologist, as is common for gastroenterology practices that provide pathology services to their patients. According to the commenters, the elimination of full reimbursement (that is, the PFS amount) for pathology services provided by part-time pathologists would interfere with the multidisciplinary approach that the commenters have chosen to best serve patients. One commenter asserted that, despite the fact that the pathologist simply may bill the Medicare program directly, Alternative 1 interferes with the practice of medicine. The commenter asserted that our proposal is equivalent to saying that a physician group cannot hire a part-time pathologist as part of its practice. The commenter contended that finding a pathologist who would travel to its offices was not easy, and that informing a pathologist that he or she can bill Medicare directly from the group's office provides no incentive to the pathologist. This commenter predicted that the approach outlined in Alternative 1 would force pathology to revert to the traditional model of referring physicians sending specimens to a laboratory and receiving pathology reports, rather than communicating with the pathologist directly. One commenter stated its belief that, if we permit a pathologist to bill for professional services directly, there is no reason for the pathologist to travel to different physician's offices if he or she can collect the same amount for professional fees while working in his or her own office. This commenter also suggested that our proposal would discriminate against small groups that cannot afford to employ a full-time pathologist. The commenter asserted that full-time pathologists based in small communities do not have the resources to bill and collect on their own and working for one group on a part-time basis is not sufficient.

One commenter stated that it would support Alternative 1 if it was extended to allow a physician to be employed by or under contract with up to three physicians or physician organizations. Commenters recommended that the ''one practice'' requirement be eliminated so as not to harm small and

mid-sized practices that cannot afford to employ a full-time pathologist. Two commenters stated that a physician should be allowed to maintain ''two or three'' independent contractor or employee relationships with physician organizations and be viewed as sharing a practice with each. In the commenters' view, this less restrictive approach would account for different practice situations while still providing considerable protection against Medicare program abuse. Another commenter requested that, in drafting any final rule, we permit physicians to provide services in rural health or medically underserved areas without the secondary arrangement precluding the physician from sharing a practice with his or her physician organization.

Response: We have modified Alternative 1 so that a physician group will be allowed to hire a part-time physician who will ''share a practice'' with that group, provided that the part-time physician furnishes ''substantially all'' (at least 75 percent) of his or her professional services through the group. Again, in order to avoid application of the anti-markup payment limitation under this final rule, billing physicians and other suppliers have the option of satisfying either the requirements of Alternative 1 (the ''substantially all'' professional services approach), or the requirements of Alternative 2 (the ''site-of-service'' approach).

Comment: One commenter suggested that Alternative 1 may be simpler and more effective if we clarify that the anti-markup provisions apply only when the billing physician or physician organization generated the referral for the pathology services. The commenter noted that, in States that prohibit the corporate practice of medicine, independent clinical laboratories contract with pathology groups to perform pathology services. Because such pathologists have employment or contractual relationships with both a pathology group and an independent lab, the anti-markup provisions could be triggered under Alternative 1 as proposed. The commenter cited the CY 2008 PFS final rule with comment period, where we stated that independent laboratories and pathologists do not trigger the initial order for pathology services. Thus, the commenter suggested that we clarify that, under the CY 2009 PFS proposals, anti-markup provisions still would only apply if the physician billing for the services was also the physician or supplier who provided the initial order for the service. Several commenters were concerned that we did not mention this in our commentary on the proposal.

Response: As finalized in the CY 2008 PFS final rule, and as retained in this final rule with comment period, the anti-markup provisions for the TC or PC of a diagnostic test apply only when the billing physician or other supplier has ordered the TC. For example, if a laboratory contracts with a pathologist instead of employing the pathologist to perform the PC of a diagnostic test (because the laboratory is located in a State that has a prohibition on the corporate practice of medicine), the anti-markup payment limitation would not apply to the lab if the lab chooses to bill for the pathologist's interpretation, if the lab (or a party related to the lab by common ownership or control) did not order the test. For example, Physician Group A orders the TC and PC of a diagnostic test. Laboratory B performs TC and contracts with Physician C to perform the PC, and Laboratory B bills for the TC and the PC. In this example, the anti-markup provisions would not apply to the TC or the PC billed by Laboratory B. However, if the interpreting pathologist decides to order additional tests that are then performed and/or interpreted by another pathologist, the anti-markup payment limitation potentially would apply if the ordering pathologist wishes to bill for the additional interpretations performed by the different pathologist. Whether the anti-markup payment limitation in fact would apply would depend on whether the arrangement between the ordering/billing pathologist and the pathologist performing or supervising the TC/performing the PC satisfies the requirements of Alternative 1 (and, if not, whether it satisfies, on a case-by-case basis, the requirements of Alternative 2).

Comment: Some commenters offered support for Alternative 1. The commenters believed that this alternative has greater potential to limit self-referral arrangements by requiring that a physician practice should not be able to mark up anatomic pathology tests unless the physician who performs and supervises the pathology services is dedicated solely to that physician practice. Another commenter strongly urged us to focus on this alternative to apply the anti-markup provision to all TCs and PCs of diagnostic tests that are ordered by the billing physician or other supplier unless the physician who performs and supervises the pathology services is dedicated solely to that physician practice or physician organization. According to the commenter, this would protect legitimate multi-specialty group practices that employ their pathologists on a full-time basis.

One commenter expressed support for not allowing a pathologist to work for more than one group (pathology or subspecialty) in order to maintain the quality and integrity of anatomic pathology. Other remedies proposed by this commenter included disallowing any profit made from anatomic pathology by the physician taking the biopsy, or allowing ''upcharging'' only on tests that can be reported that same day.

Response: We believe that it is not necessary to go so far as requiring a physician not to work for more than one physician organization, because requiring a physician to furnish ''substantially all'' (at least 75 percent) of his or her professional services through a billing physician or other supplier addresses our concerns regarding overutilization and abusive billing and also allows physicians the flexibility to work for other physician groups or health care entities or to work as a *locum tenens* physician.

Comment: A commenter requested that, if Alternative 1 is finalized, we clarify that a physician employee would be considered to be sharing a practice with a physician or a physician group whether the physician is hired directly or is a leased employee, whereas other commenters stated that employment and contractual arrangements might not be enough for determining whether a physician ''shares a practice'' as this could be circumvented via shareholder, ownership, or joint partnership arrangements.

A commenter asked that we consider including physicians who are employed by affiliated (common ownership) organizations. This would allow affiliated organizations to share physician resources and expertise when interpreting tests via teleradiology. The commenter also noted a concern that employers may not have knowledge of all independent physician and supplier contracts and may not have sufficient mechanisms to ensure sole employment. This commenter requested clarification on how to manage independent physician and supplier contracts to ensure that physicians are employed by only one organization.

Response: As finalized, *any* physician (that is, regardless of employment status or whether he or she is an owner of the billing entity) who performs ''substantially all'' (at least 75 percent) of his or her professional services for a billing physician or other supplier will be deemed to share a practice with that billing physician or other supplier.

d. Alternative 2 (''Site-of-Service'')

Comment: One commenter opposed our reproposal of the existing ''site-of-service'' approach for determining whether the physician performing or supervising the TC or PC of a diagnostic test shares a practice with the billing physician or other supplier, asserting that it will do little to stifle the growth of self-referral in lab arrangements. According to the commenter, this alternative focuses only on where the test is performed and not by whom, and, thus, specialty practices could profit from their referrals simply by bringing ''pod labs'' in-house to the location where the group provides physician services. The commenter advocated for the rule to require clearly a greater connection and integration between the performing physician and the practice before the practice can profit from lab tests ordered by physicians in the group.

Response: We recognize the potential for arrangements that may be troublesome to be restructured so that the diagnostic testing is performed in the same building as where the testing is ordered; however, we are also concerned that adopting Alternative 1 without leaving in place the site-of-service approach of § 414.50 (which we reproposed as Alternative 2) may unnecessarily disrupt some arrangements that do not appear problematic to us. We will continue to monitor arrangements and may propose further changes if necessary. Also, we continue to examine industry use of the in-office ancillary services exception of the physician self-referral rules, and may propose changes to that exception in a future rulemaking.

Comment: Some commenters did not believe that site-of-service distinctions are relevant to determining the appropriate scope of section 1842(n) of the Act. According to the commenters, it should not matter if physicians are in a *bona fide* group practice that has one building or ten, and, if ten, the particular geographic configuration of the ten buildings should not matter. The commenters questioned the legal or policy justification for applying different site-of-service rules for purposes of the anti-markup provision than those that are employed in the physician self-referral regulations. Of particular concern for these commenters are distinctions that treat groups differently from solo practitioners and that discriminate between different types of groups. The commenter gave the example of a solo practitioner with five offices with an x-ray machine in each: provided that he or she regularly practiced in each office, he could order diagnostic tests at all five locations, or from any one of them, and the tests would be treated as ''furnished'' inside the practice rather than ''purchased.'' According to the commenter, a group practice, on the other hand, that has primary care physicians in one building and specialists in another either has to have x-ray machines in both buildings, to be used only by the physicians in each building, or do diagnostic testing in only one building and treat the group practice members in the other building as ''purchasing'' the tests. The commenter also described its understanding of the proposed rule, stating that, when diagnostic tests are provided in a centralized building by a non-profit multi-specialty group, they would be considered ''furnished,'' but the same tests provided by a physician-owned group that is otherwise comparable in size and scope would be considered ''purchased.'' The commenter questioned the relevance of these distinctions related to quality, convenience, efficiency, utilization, or potential abuse.

Response: Because the definition of ''centralized building'' at § 411.351 contains no requirements for minimum size, proximity to the billing group's office, or staffing, and because our current policy under the physician self-referral rules is to allow billing groups to have more than one centralized building, we are concerned that the potential exists for overutilization of diagnostic testing through arrangements involving a billing group and physicians who have little or no real connection to the billing group other than to serve as a point of referral to generate profits for the billing group. We believe that a site-of-service approach, employing the ''same building'' test, is a reasonable means of determining whether a physician shares a practice and has a sufficient nexus with the billing physician or other supplier.

We reiterate that, in addition to section 1842(n) of the Act (and our general rulemaking authority in sections 1102(a) and section 1871(a) of the Act to ''gapfill'' in order to effectuate fully the Congress's intent in section 1842(n) of the Act to impose an anti-markup provision on certain diagnostic tests), we have authority under section 1842(b)(6) of the Act to prescribe limitations on the reassignment of tests and test interpretations. However, in this final rule with comment period, we have adopted an ''either/or'' approach to the two proposed alternatives. That is, a billing physician or other supplier can avoid application of the anti-markup provisions by meeting either the ''substantially all'' professional services approach of Alternative 1 or, on a case-by-case basis, the ''site-of-service'' approach of Alternative 2, which are set forth in revised § 414.50(a)(2)(ii) and (iii). We believe that compliance with either one of the two approaches finalized in this rule will further our goal of reducing the potential for overutilization and other program or patient abuse while providing sufficient flexibility for the industry.

Comment: One commenter contended that a ''one building'' ''site-of-service'' standard is not a realistic means of ensuring proper billing arrangements, as large single specialty practices often span beyond one building. Another commenter remarked that the site-of-service alternative should not be finalized because it would be problematic for groups where specimens are collected at multiple sites but pathology diagnostic testing services are done at a separate location owned or leased by the group (the ''hub-and-spoke'' arrangement). Some cardiologists also expressed concern that interpretations of EKGs and other diagnostic testing services may be limited by the proposed site-of-service approach. One commenter provided the example of a group that has three offices but only one with a CT scanner. The commenter noted that under the site-of-service approach, the anti-markup provision would apply to tests ordered and supervised by physicians employed by the group unless the physicians worked in the same office where the CT scanner was located.

Response: We believe that allowing billing physicians and other suppliers to comply with either the ''substantially all'' professional services approach of Alternative 1 or the ''site-of-service'' approach of Alternative 2 will address our concerns while providing sufficient flexibility for the industry. In the situations described by the commenters, if the performing physician furnished substantially all of his or her professional services through the billing group, the anti-markup payment limitation would not apply.

Comment: A commenter stated that the Alternative 2 site-of-service approach is useful in deterring program abuse at locations other than the office of the billing physician, and may benefit from being merged with Alternative 1. However, the commenter asserted that we must address the issue of the level of supervision that is required for the TC of a pathology service. According to the commenter, it is unclear what level of supervision of the TC must be furnished and where it must be furnished, as CLIA does not govern the TC of a pathology service. The

commenter suggested that we require that the TC be supervised by a physician who meets, at a minimum, the general supervisor requirements under CLIA, including the requirements for the subspecialties of histopathology or dermatopathology, as necessary.

Another commenter expressed concerns about supervision requirements, noting that ''the physician who supervised the TC'' is not defined in the proposed rule or CLIA. The commenter suggested that the supervising physician should meet the requirements for a laboratory director under CLIA or use IDTF requirements. The commenter noted that, in a separate proposal in the CY 2009 PFS proposed rule (73 FR 38533 through 38535), we proposed to require physicians performing testing in their offices to enroll as IDTFs and meet the IDTF requirements. Among the applicable requirements of that proposal are that the supervising physicians have proficiency in the testing service being supervised and meet the specific requirements established by medical specialty groups or carriers.

Response: With respect to our proposal to revise the anti-markup provisions in § 414.50, we did not propose to impose special standards or qualifications on the physician supervising the TC, and decline to do so here. Section 410.32 establishes the level of supervision (general, direct, or personal) for diagnostic tests potentially subject to the anti-markup provisions (that is, services covered under section 1861(s)(3) of the Act and paid under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act)).

Comment: A commenter requested that if we adopt the Alternative 2 approach, we clarify that block leases meeting the in-office ancillary services exception ''same building'' test would not trigger the anti-markup provision. Another commenter stated that it favored the Alternative 2 ''site-of-service'' approach and that the anti-markup provisions should apply to any shared facility in the ''same building.''

Response: We are adopting, in part, the position favored by the first commenter. Specifically, we are finalizing the Alternative 2 approach, which employs the definition of ''same building'' as defined at § 411.351 (as we proposed). However, we are not incorporating each element of the same building ''location'' test from the in-office ancillary services exception as set forth in § 411.355(b)(2). A TC that is performed (that is, both conducted by the technician and supervised by the physician) in the ''office of the billing physician or other supplier'' will not be subject to the anti-markup payment limitation. Likewise, a PC that is performed in the ''office of the billing physician or other supplier'' will not be subject to the anti-markup payment limitation. Diagnostic testing services are performed or interpreted in the ''office of the billing physician or other supplier'' if they are performed or interpreted in the ''same building'' (as defined in § 411.351) as the space in which the ordering physician or other ordering supplier regularly furnishes patient care. In the CY 2008 PFS, we stated that various stakeholders informed us that a physician organization, such as a multi-specialty group, may not provide substantially its full range of services for a certain specialty at any one location, but rather may provide substantially the full range of services for a certain specialty in one location, substantially the full range of services for a second specialty in a second location, and so forth. In order to address this situation, we proposed to focus on the medical office space where the *ordering* physician provides substantially the full range of patient care services that the *ordering* physician provides generally.

We are not adopting the approach suggested by the second commenter. The fact that diagnostic testing services are performed or interpreted in a space that is leased by two or more groups (but which is located in the same building as the space in which the billing physician or other supplier regularly furnishes patient care) does not cause the testing to be subject to the anti-markup provisions. Example: Physician A has an office located on the first floor of Medical Office Building. In his office, Physician A performs the full range of services that he provides generally (and thus the space meets the criteria for the ''office of the billing physician or other supplier'' under § 414.50(a)(2)(iii). Physician A orders a diagnostic test, which is conducted by a technician and supervised by Physician B in a diagnostic testing facility located in the basement of Medical Office Building. Physician B also performs the PC of the test in the diagnostic testing facility. Physician B reassigns her right to bill for the TC and the PC of the test to Physician A. The diagnostic testing facility is shared, under block-time exclusive use leases, by Physicians A, C and D. Neither the TC, nor the PC, is subject to the anti-markup payment limitation, because the TC and the PC were performed in the ''office of the billing physician or other supplier.'' We are permitting shared space arrangements for diagnostic testing services that occur in the ''same building'' because we believe that such arrangements can promote efficiency without raising the same concerns for overutilization or other abuse as arrangements that involve centralized buildings for diagnostic testing. We reiterate however, that we continue to have concerns with the present use of the in-office ancillary services exception and that we may issue a proposed rulemaking at a future date to address those concerns.

Comment: One commenter supported the Alternative 2 ''site-of-service'' approach as a reasonable approach to curbing potential overutilization. One commenter characterized the ''site-of-service'' approach as more fair than the Alternative 1 approach, even though, according to the commenter, Alternative 1 may control perceived overutilization while respecting the rights of pathologists and clinicians to practice medicine in the best manner possible. Another commenter generally was supportive of both alternatives but favored the Alternative 2 ''site-of-service'' approach because, in the commenter's view, it would better protect against physicians who wish to profit from their own referrals by preventing a multi-specialty physician organization with several practice locations from benefiting from its referrals to one central anatomic pathology laboratory. The commenter acknowledged that these ''hub-and-spoke'' arrangements may offer the advantage of patient convenience where diagnostic testing occurs following an office visit with the patient present (for example, an x-ray), but, in the context of anatomic pathology services, these arrangements do not benefit the patient and may result in overutilization and the provision of lower quality, less specialized services.

Response: We received support for both alternatives regarding when to apply the anti-markup provision to the TC and PC of diagnostic tests. After reviewing all the comments, we have decided to finalize, with some modification, both approaches. (As explained elsewhere in this preamble, we have modified the Alternative 1 approach so that the performing physician shares a practice with the billing physician or other supplier if the performing physician furnished ''substantially all'' (that is, at least 75 percent) of his or her professional services through the billing physician or other supplier, and we have modified

the Alternative 2 approach by clarifying that the performing physician must be an employee or independent contractor of the billing physician or other supplier (which has enabled us to delete the references to purchased tests from an outside supplier.) Thus, billing physicians and other suppliers may satisfy the Alternative 1 ''substantially all'' professional services approach or, on a case-by-case basis, the Alternative 2 ''site-of-service'' approach in order to avoid application of the anti-markup payment limitation. We believe that complying with either approach will address our concerns regarding potential overutilization and other abuse by establishing a sufficient nexus with the billing entity.

e. Exception for Physician Organizations That Do Not Have Any Owners Who Have the Right To Receive Profit Distributions

Comment: We proposed an exception to the requirement that diagnostic testing be performed in the ''office of the billing physician or other supplier'' in order to avoid application of the anti-markup payment limitation. We proposed that (except for the purchase of a TC from an outside supplier) the anti-markup provisions would not apply to diagnostic tests ordered by a physician in a physician organization that does not have any owners who have the right to receive profit distributions. Some commenters supported adopting the proposed exception. One commenter requested clarification regarding whether the exception would apply only where the physician organization does not have *any* owners who have the right to receive profit distributions, or whether it would apply provided that the physician organization does not have any *physician* owners who have the right to receive profit distributions. In the commenter's view, if a physician organization without physician owners is a non-profit entity with a member that is another non-physician non-profit entity with typical membership rights, the proposed exception still would apply to avoid application of the anti-markup provisions. Another commenter stated that an exception for diagnostic tests ordered by a physician in a physician organization that does not have any physician owners with a right to receive profit distributions is a bright-line approach and consistent with program safeguards. Another commenter also asked that physician practices with ''titular'' owners not be subject to the final rule and that the definition be consistent with the definition of ''titular'' ownership in the FY 2009 IPPS Final Rule (73 FR 48434, 48693).

One commenter questioned whether there is evidence suggesting tax-paying medical groups behave, or are likely to behave, in a manner substantially different than tax exempt medical groups. The commenter also stated that it was unaware of any instances where the Medicare program differentiates policies based solely on institutional mode of ownership, incorporation, or tax status, and questioned if we have statutory authority to create such an exception based on type of ownership.

Response: We have determined that it is not necessary to finalize an exception for diagnostic tests ordered by a physician in a physician organization that does not have any owners who have the right to receive profit distributions. By finalizing both proposed alternative approaches to avoiding application of the anti-markup payment limitation we believe that our concern that the Alternative 2 approach could hinder arrangements involving nonprofit multi-specialty groups that have campus-based treatment facilities (and, thus, do not perform diagnostic testing in the same building where patients are seen) largely becomes moot, as most such arrangements should be able to be structured (or are already structured) to meet the requirements of either the Alternative 1 or Alternative 2 approach finalized here. Similarly, there is no need to create an exception for titular owners.

f. Definition of the ''Office of the Billing Physician or Other Supplier''

Comment: One commenter, generally supportive of our proposed clarification of the definition of ''office of the billing physician or other supplier'', questioned its application in Example 2 from the proposed rule (73 FR 38547) which would allow two separate physician organizations to share space used for diagnostic testing that is located in the same building in which the physician organizations have their respective offices. The commenter asserted that allowing two or more providers to share a laboratory undermines the anti-markup payment limitation, essentially enabling ''pod labs'' to regain their ability to facilitate markups by the referring physician or physician organization. The same commenter also requested clarification regarding Example 3 in the proposed rule (73 FR 38547), in which a ''group practice treats patients in Buildings A, B, and C. In each of its offices in Buildings A and B, the group practice provides substantially the full range of patient care services that it provides generally, but that is not true for space located in Building C. The group practice provides diagnostic testing services in Buildings B and C.'' We noted in this example that, under the proposed definition of the ''office of the billing physician or other supplier,'' the anti-markup payment limitation would not apply to diagnostic testing services provided in Building B, but would apply to those services provided in Building C. The commenter stated that it agreed with our conclusion, *if* the ordering physician or supplier's services were provided *in* Building B. According to the commenter, *if* the ordering physician provided his or her services *in* Building A, the anti-markup provisions should apply.

Response: We do not agree with the commenter's assertion that our revisions to § 414.50(a)(2)(iv) undermine the anti-markup provisions and enable ''pod labs'' to regain their ability to facilitate markups. In particular, we refer the reader to the definition of the ''office of the building physician or supplier'' at § 414.50(a)(2)(iv), which includes space in which diagnostic testing services are performed, that is in the ''same building,'' (as defined at § 411.351), in which the ordering physician or ordering supplier regularly furnishes patient care (and more specifically, for physician organizations, in the same building in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally). Many of the potentially abusive pod lab arrangements that led to our extension of the anti-markup provisions to the PC of diagnostic testing services involved independent contractor pathologists who performed services in off-site pathology labs. Those arrangements did not have the type of nexus with the group practice required under § 414.50(a)(2) (that is, the pod labs were not within the same building in which the ordering physician provided substantially the full range of patient care services).

We do agree with the commenter's analysis of Example 3 given in the proposed rule.

Comment: One commenter requested that, if adopted, the proposal for Alternative 2 should include detailed examples that provide clear definitions for several key terms, including ''office of the billing physician or other supplier,'' ''conducting and supervising the TC,'' and ''full range of services.'' The commenter believes that, without these definitions, our intent will be misconstrued and subject to potential abuse.

Response: We do not provide a definition for ''conducting and supervising the TC'' in the regulation text, as we believe that the meaning of ''conducting'' is clear on its face; that is, the term ''conducting the TC'' refers to the technician's (or physician's) performance of the test. Nor do we believe that it is necessary to define the term ''supervising.'' For a service to be covered by Medicare, the regulations at § 410.32 define and specify various levels of supervision (that is general, direct, or personal supervision). The anti-markup provisions, when applied, limit the amount a physician or other supplier may bill Medicare. In the context of the applicability of the anti-markup provisions, we are requiring that the physician supervising the TC be present in the same building (as defined at § 411.351); however, this has no impact on other Medicare billing requirements, which may require a specific level of supervision as described above. We decline to define the term ''full range of services,'' because this would vary greatly based on factors such as the specialty of the ordering physician, the types of services within the physician's specialty, and the focus of services at the specified practice.

Comment: According to one commenter, the ''office of the billing physician or other supplier'' for multi-specialty groups should include medical office space in which the physician group provides substantially the full range of services of one or more of the specialties of the group. The commenter contended that this requirement would ensure an adequate nexus between the physician practice and the testing being conducted in the building. The commenter asserted that limiting the location to a building in which the ordering physician provides substantially the full range of services that the ordering physician typically provides imposes unnecessary restrictions that are overly burdensome when compared to the purpose of the proposed rule. Another commenter, in similar comments, urged us to consider replacing ''ordering physician'' with the words ''ordering physician or a member of the ordering physician's group practice.'' According to the commenter, this revision would permit any physician member of a group practice to utilize the group's centralized designated health service (''DHS'') facility (and bill under the normal physician fee schedule), provided that the facility is located in the same building where the group practice provides patient care services on a full-time basis. To avoid the potential problem presented by a group practice with multiple offices, none of which provide the full range of patient care services provided by the group as a whole, the group proposed that we eliminate the requirement that the group practice provide in the same building ''substantially the full range of patient care services that [it] provides generally.'' The commenter suggested replacing this requirement with a requirement that the group practice provide in the same building ''physician services unrelated to the provision of DHS on a full time basis.'' According to the commenter, this revision would be consistent with the physician self-referral law and regulations, would permit all physician members of a group practice to utilize the group's centralized DHS facility (provided that the facility is located in the same building where the group provides other physician services), and would permit the group to bill for all DHS provided in such a facility under the Medicare physician fee schedule.

Response: We believe that the changes recommended by the commenters would not guard adequately against potential overutilization. In addition, we believe that sufficient flexibility is afforded multi-specialty groups and others by allowing arrangements to satisfy the requirements of either the Alternative 1 or the Alternative 2 approach, as revised.

Comment: One commenter expressed concern that the provision is more complicated than necessary and, rather than a definition of ''office of the billing physician or other supplier,'' a definition of an ''outside entity'' is needed to determine which services would be affected by the anti-markup provisions. The commenter suggested ''outside entity'' should be defined as an entity with a different identification number (for example, tax identification number) than the billing entity. The commenter asserted that our attempt to define ''office of the billing physician or other supplier'' results in ''nonsensical situations'' in which the anti-markup provisions do not apply if the diagnostic test is done on a different floor of the same building but do apply if it is done in a different building, even if the two buildings are closer together than the two floors.

Several commenters argued that the ''same building'' test is unworkable and contrary to longstanding CMS policy concerning testing performed in a ''centralized building.'' According to the commenters, the ''same building'' proposal assumes an old-fashioned health care delivery system—that is, that all physician services are still delivered in a single practice location. According to these commenters, given market demands for services in multiple urban, suburban and rural locations, the idea that diagnostic testing services should be provided only in a building where ''substantially the full range'' of other physician services also are provided is anachronistic. The commenters opposed the implementation of the ''same building'' test as it relates to the proposed anti-mark-up provisions due to the alleged economic losses and decreased operating efficiencies that will result. The commenters contended that the fact that the diagnostic equipment is located in a separate building does not support an inference that the diagnostic services are not an integral part of the practice, as our proposal assumes.

Response: Under this final rule, the anti-markup provisions will not apply to the TC or PC of a diagnostic test where the performing physician shares a practice with the billing physician or other supplier. With respect to a TC or PC of a diagnostic testing service, the performing physician is considered to share a practice with the billing physician or other supplier if: (1) He or she furnishes substantially all (at least 75 percent) of his or her professional services through the billing physician or other supplier; or (2) the TC is conducted and supervised, or the PC is performed, in the office of the billing physician or other supplier. We believe that, in the situation where an arrangement would otherwise be subject to the anti-markup payment limitation because the performing physician does not furnish at least 75 percent of his or her professional services through the billing physician or other supplier, services that satisfy the site-of-service approach indicate a sufficient nexus between the performing physician and the billing physician or other supplier. We proposed clarifying that the ''office of the billing physician or other supplier'' protects diagnostic testing that takes place in the ''same building'' (as defined at § 411.351) in which the ordering physician sees patients because, following publication of the CY 2008 PFS final rule with comment period, stakeholders expressed concern that arrangements in which the diagnostic testing takes place on one floor of a building, but the billing physician or other supplier sees patients on another floor, could be subject to the anti-markup provisions. We agree with those stakeholders that it would be unnecessarily disruptive to impose the anti-markup payment limitation on

those types of arrangements, but we do not believe that it is appropriate to go further and define ''office of the billing physician or other supplier'' as including diagnostic testing space that is in a separate building from where the ordering physician sees patients. Specifically, we are unwilling to define ''office of the billing physician or other supplier'' as including diagnostic testing space in a ''centralized building'' due to the potential overbreadth of that definition with respect to some arrangements. We also reject a square footage test in lieu of using the ''same building'' definition because the former may be more difficult to enforce and the latter is an already-existing, well-defined concept.

Comment: Several commenters responded to our solicitation for comments that would describe current business arrangements, such as those that take place on a ''campus,'' and that would suggest any additional or alternative criteria to permit such arrangements to avoid application of the anti-markup provisions. We received a few comments suggesting that we exempt arrangements taking place on a campus, and suggesting criteria for how we would define ''campus.'' For example, one commenter suggested that, to be considered ''on campus,'' the diagnostic center/building/entity must be located within the main building(s), or located in the physical area immediately proximate to the provider's main building(s). Alternatively, the commenter suggested, the diagnostic testing could be performed in other areas or buildings that are not proximate to the main building(s) but which are fully integrated (that is, financially integrated and administered in concert with overall operations standards, guidelines, rules and directives), with governance and operations functions determined by central administrative processes and structures. Another commenter encouraged us to consider the ''office of the billing physician or other supplier'' to encompass all buildings on a campus or within a multi-campus organization and the area of the entire legally-owned organization, regardless of where the service is performed. Another commenter noted that physician practices currently are required to list each practice location with the Part B carrier, and asserted that, because of this, there is adequate information for CMS (through the carrier) to monitor the campus arrangement to assure that the geographic layout of the physician practice is a *bona fide* campus.

Response: We believe that, at this time, providing a definition of ''campus'' that would be both workable for the industry yet address our concerns of potential overutilization would be difficult and may add unnecessary complexity to the final rule. We believe that the commenters' concerns will be alleviated by allowing arrangements to satisfy the requirements of either the Alternative 1 or the Alternative 2 approach, as revised.

Comment: A commenter questioned whether we intended ''ordering physician'' to mean an individual physician or any physician in the group. According to the commenter, in many specialty groups, a particular ordering physician will work at only one location, but the diagnostic services are provided at another location, where other physicians in the same group and in the same specialty provide substantial physician services. The commenter asserted that, if we mean that, in order to avoid application of the anti-markup payment limitation, a specific individual physician must provide the substantial physician services in that particular location where the diagnostic services are provided, the proposal would render unprofitable many existing lawful arrangements for single-specialty practices with multiple locations. The commenter further asserted that our proposal would require physicians in multi-practice locations to rearrange schedules so as to rotate through practice locations where the diagnostic testing services are provided.

One commenter contended that the focus on where the ordering physician regularly furnishes care will affect all physician groups where all the physicians are not located in the same building and diagnostic testing services are only offered in a few of the group's locations. According to the commenter, the physician self-referral law requires a group practice with multiple locations to function as one group, and group practices have structured their arrangements to meet existing governmental requirements and to serve patients. The commenter asserted that changing these requirements may make it impossible for some groups to continue to provide these services to Medicare beneficiaries.

Response: We believe that the commenters' concerns that physician practices with multiple locations will not be able to meet the ''site-of-service'' approach are adequately addressed by allowing billing physicians and other suppliers to comply with either the requirements of Alternative 1 or Alternative 2.

Comment: A commenter requested that the definition of ''office of billing physician or other supplier'' be modified to include a mobile van that is used in the parking lot of a building in which the physician group sees patients. Otherwise, the commenter argued, the use of mobile MRI essentially will be barred. According to the commenter, physician groups that use mobile MRI on an exclusive basis because of the nature of their practices are not committing any abuse that we should address in the anti-markup provisions. Another commenter noted that alternative 2, as proposed, would not allow groups to operate mobile diagnostic testing services performed in mobile vehicles, vans or trailers because they are specifically excluded from the definition of ''same building'' at § 411.351.

Response: We are not modifying the definition of the ''office of the billing physician or other supplier'' to include a mobile van that is used in the parking lot of a building in which the physician group sees patients. ''Same building,'' as defined at § 411.351 of the physician self-referral regulations, specifically *excludes* a mobile vehicle, van, or trailer. Therefore, unless provided in a mobile unit that qualifies as a ''centralized building'' (as defined at § 411.351), diagnostic services provided in the parking lot of a building in which a physician group sees patients already would be subject to the physician self-referral restrictions and would not be protected under the in-office ancillary services exception. In the January 4, 2001 Phase I final rule with comment period, we discussed our specific reasons for declining to include within the definition of ''same building'' a mobile van or other unit (66 FR 889 through 892). We are concerned with the potential for confusion if we were to have one definition of ''same building'' for physician self-referral purposes and another, more expansive definition for purposes of applying the anti-markup payment limitation. Moreover, we decline to expand the definition of ''same building'' for purposes of applying the anti-markup provisions given the potential we see for overutilization through arrangements that take place outside the ''same building.'' Again, arrangements that do not satisfy the requirements of the Alternative 2 ''site-of-service'' approach may fit under the requirements of the Alternative 1 ''substantially all'' professional services approach.

g. Services Performed at a Site Other Than the Office of the Billing Physician or Other Supplier

Comment: A commenter offered strong support for the proposed

clarification that ''if the TC is conducted outside the office of the billing physician or other supplier, the anti-markup provision applies irrespective of whether the supervision takes place in the office of the billing physician or other supplier.'' The same commenter also supported our proposal that the anti-markup payment limitation would apply if ''either the conducting of the TC *or* the supervising of the TC takes place outside the office of the billing physician or other supplier.'' Another commenter supported the proposed change that the anti-markup payment limitation would apply if the TC is either conducted or supervised outside the office of the billing physician or other supplier in order to eliminate confusion among providers when determining whether the TC is deemed to be provided by an outside supplier for purposes of the anti-markup provisions. Another commenter expressed concern that the TC will be considered to be performed outside the office of the billing supplier if the physician is not in the office when the test is being performed. According to the commenter, this runs counter to long standing Medicare regulation and policy regarding the supervision of diagnostic tests, as many of these tests do not require physician presence during the performance of the test. The commenter argued that changing this, requiring physicians to be present, would only inflate healthcare costs.

A commenter recommended that TCs and PCs of non-purchased items performed outside the office of the billing physician or other supplier not be subject to the anti-markup provisions, noting that many audiologists are self-employed and perform testing services for off-site physicians. The commenter further asserted that audiology services do not require physician supervision, and per CMS transmittal 84 (issued February 29, 2008 and effective April 1, 2008), these services are to be billed by the provider of the service and benefits reassigned to the employer. The commenter contended that there has been no evidence of abuse with respect to billed audiology services, so no change is warranted.

Response: We are adopting our proposal that, for purposes of satisfying the requirements of Alternative 2 with respect to the TC, the TC must be both conducted and supervised in the office of the billing physician or other supplier. Although the requirement that the supervising physician be present in the office of the billing physician or other supplier may be more restrictive than some Medicare coverage and payments regulations governing supervision of tests, we believe that our amendment to § 414.50(a)(2)(iii) is necessary in order to minimize the potential for overutilization and program abuse. We do not believe that healthcare costs would be inflated if physicians were required to be present in the office of the billing physician or other supplier. If the test was not conducted within the office of the billing physician or other supplier, and/or the physician supervision did not occur within the office of the billing physician or other supplier, the service would still be payable by Medicare.

We recognize that where audiologist services are performed by an audiologist, no physician supervision is necessary, and therefore the anti-markup provisions do not apply (because § 414.50 applies to tests performed by a physician). We note further, however, that the TC of some audiological tests can be conducted by a technician and supervised by a physician, in which case, the anti-markup provisions potentially are applicable to the TCs and PCs of such tests. Although the commenter stated that there is no evidence of abuse with respect to billed audiology services, we are not required to demonstrate that fraud or abuse has occurred in order to finalize our proposals, but rather we attempt to guard against the potential for overutilization or patient abuse, and we strive to make distinctions between specific types of diagnostic services only when there is a persuasive reason to do so. We are unpersuaded to make such a distinction here. As noted above at section II.N.2., and as discussed more fully below at section II.N.2.h. in response to a comment, we are deleting references to purchased TCs and PCs from § 414.50.

Comment: Commenters expressed concern that the anti-markup provisions would apply when cardiologists perform the PC of a diagnostic testing service procedure in a hospital or other facility, as is often the case for complex or high risk procedures, because the test is conducted outside the office of the billing physician. Commenters asserted that cardiology groups that provide outreach services in rural areas and are the only providers of certain cardiac subspecialty services in such areas are concerned that their provision of hospital-based cardiac diagnostic tests to rural patients could become financially impossible under the anti-markup provisions, thereby reducing access to care for this already underserved population.

Response: We do not expect the anti-markup payment limitation would apply in the situation described by the commenter, because, under Alternative 1 as finalized in this final rule with comment period, the performing cardiologist likely would share a practice with the cardiology group billing for the PC (or would be billing for the PC himself or herself). If the cardiologist reassigns payment to the hospital which then bills for the PC, the anti-markup payment limitation would not apply because the hospital did not order the PC.

h. Definition of Outside Supplier

Comment: We proposed that the TC of a diagnostic test is not purchased from an outside supplier if the TC is both conducted and supervised in the office of the billing physician or other supplier and the supervising physician is an employee or independent contractor of the billing physician or other supplier. (For ease of reference, we refer to this below as the ''primary proposed definition''.) In the alternative, we proposed that: (1) If the TC is conducted by a technician who is not an employee of the billing supplier, the TC is considered to be purchased from an outside supplier, regardless of where the technician conducts the TC, and notwithstanding the employment status of the supervising physician and the fact that the test is supervised in the office of the billing physician or other supplier; and (2) where the TC is conducted by a non-employee of the billing physician or other supplier and outside the office of the billing physician or other supplier, the TC nevertheless will not be considered a purchased test if the supervising physician is an employee or independent contractor of the billing physician or other supplier and performs the supervision in the office of the billing physician or other supplier. Several commenters offered support of the primary proposed definition of outside supplier. One such commenter also requested that the final rule make clear that, for anti-markup purposes only, the performing supplier with respect to the TC would be the physician who supervised the TC, even when the technician is not an employee of the billing physician or other supplier.

One commenter supported the first alternative proposed definition of outside supplier. This commenter suggested that the physician organization should be permitted to mark up the TC only if the technician is an employee and the supervising physician is on-site and is also an employee of the billing physician or physician organization. One commenter

supported adoption of the second alternative proposed definition. The commenter expressed its view that this definition provides sufficient flexibility to ensure that the anti-markup provisions will not be applied unless there is an inadequate relationship between the individual who performs or supervises the test and the billing entity.

Response: As explained above at II.N.2., we are deleting from § 414.50 purchased tests and interpretations from an ''outside supplier'' as separate bases for imposing an anti-markup payment limitation. After reviewing the comments, we have concluded that employing the concept of a purchased TC or PC as a separate basis for imposing an anti-markup payment limitation is unnecessary, redundant, and potentially confusing in light of our decision to finalize Alternative 1 and to allow arrangements that do not meet the requirements of Alternative 1 to avoid application of the anti-markup provisions if they meet, on a case-by-case basis, the requirements of Alternative 2. If we were to adopt any of our proposals for the definition of ''outside supplier,'' it would mean we would effectively impose an anti-markup payment limitation on some arrangements that meet the ''substantially all'' services requirement of Alternative 1. We believe that a physician who performs ''substantially all'' of his services through a particular billing physician or other supplier ''shares a practice'' not only within the meaning of Alternative 1, but also within the meaning of section 1842(n)(1) of the Act. Moreover, although we considered adopting the second proposed alternative definition of ''outside supplier'' so that a TC would not be a purchased test if the supervising physician is an employee or independent contractor of the billing physician or other supplier and performs the supervision in the office of the billing physician or other supplier (regardless of the employment status of the technician or where the technician conducts the test), this too would be problematic in light of our decision to adopt Alternative 1 but also allow arrangements that do not meet the requirements of Alternative 1 to avoid application of the anti-markup provisions by meeting, on a case-by-case basis, the site-of-service criteria of Alternative 2. That is, with respect to arrangements that do not meet the requirements of Alternative 1 and thus must meet the site-of-service requirements of Alternative 2, adopting our second alternative definition of ''outside supplier'' would have been superfluous because, under Alternative 2, the TC must be both conducted and supervised within the office of the billing physician or other supplier. We retain the requirement, present in all of the proposed definitions of ''outside supplier,'' that the physician must be an employee or independent contractor of the billing physician or other supplier by incorporating the requirement into the Alternative 2 criteria. Similarly, we believe that an anti-markup payment limitation on purchased PCs is unnecessary with respect to diagnostic testing services that meet the requirements of Alternative 2, because we are adding the requirement to Alternative 2 that the physician performing the PC is an employee or independent contractor of the billing physician or other supplier. Thus, as finalized, we are deleting the references in § 414.50 to purchased tests and interpretations from an outside supplier. As finalized, the anti-markup payment limitation will apply to TCs and PCs that meet neither the requirements of Alternative 1 nor Alternative 2, without regard to whether the TC or PC was purchased from an outside supplier.

Comment: A commenter requested that we clarify our use of the term ''conducted or supervised'' because a physician may ''supervise'' an imaging procedure, for instance, even though he or she is not necessarily the physician who will be interpreting a test. According to the commenter, Medicare's determination as to the level of supervision required for a specific test supports this conclusion. The commenter stated that a CT scan, for instance, when performed without contrast requires only general supervision, whereas the same test performed with contrast requires direct supervision. The commenter asserted that this difference is due to the relative levels of medical risk to a patient during a test, not the interpretation of results. The commenter requested that we clarify that a ''supervising'' physician need not be the physician responsible for interpreting test results or images.

Response: The commenter is correct that the supervising physician need not be the physician responsible for interpreting test results or images.

Comment: For purposes of the anti-markup payment limitation only, we proposed to define the ''performing physician'' with respect to the TC as the physician who supervised the TC and, with respect to the PC, as the physician who performed the PC. One commenter supported this proposal, but requested several clarifications. The commenter understood the proposal to mean that the performing supplier of the TC is the physician who supervised the TC rather than the technician who actually conducted the test. The commenter inquired whether, if the anti-markup provision were applied in this instance, the group could recover only the fees it paid to the physician for the TC and not any amounts paid directly to the histotechnologist who furnished the TC. The commenter also requested clarification regarding application of the rule where a group purchases the TC directly from an outside supplier or histotechnologist, without any physician involvement.

Response: The commenter is correct in that the performing supplier of the TC is the physician who supervised the TC. Where the anti-markup payment limitation applies, the billing physician or other supplier may bill for the lowest of the following amounts: (1) The performing supplier's net charge to the billing physician or other supplier; (2) the billing physician or other supplier's actual charge; or (3) the fee schedule amount for the test that would be allowed if the performing supplier billed directly. With respect to the commenter's question regarding whether a TC purchased from a supplier ''without any physician involvement,'' as noted in this section II.N.2.h., we have deleted the references to purchased tests or interpretations from an ''outside supplier.'' The anti-markup payment limitation will apply if a TC is supervised by a physician who does not, within the meaning of Alternative 1, share a practice with the billing physician or other supplier *and* the TC does not meet the site-of-service requirements of Alternative 2 (that is, the TC was not conducted in the ''office of the billing physician or other supplier'' or was not supervised in the ''office of the billing physician or other supplier'' by a physician who is an owner, employee, or contractor of the billing physician or other supplier). If the TC does not require physician supervision under our rules, the anti-markup provisions are inapplicable.

i. Specific Solicitation of Comments

(1) Net Charge

Comment: We stated that we were interested in receiving comments concerning the calculation of the ''net charge'' when the anti-markup provisions apply (73 FR 38548). In response, many commenters expressed concern that we did not propose to allow practices to which the anti-markup provisions apply to recoup at least their direct practice costs where the practice is limited to billing Medicare its ''net charge'' for the testing

service. One commenter asserted that if a group provides diagnostic tests at a site other than the ''office of the billing physician or other supplier,'' the calculation of a net charge is difficult and punitive because a group practice cannot consider all of the actual components of costs incurred, thereby compelling the group practice to lose money. Another commenter argued that it is ''grossly unfair'' to not allow physicians to recover any overhead costs. The commenter further contended that, although we may be concerned about physicians who may ''pad'' their charges with illegitimate amounts, this does not justify penalizing providers who incur appropriate and often costly overhead costs. According to the commenter, it would go against well-established Medicare policy to not allow physicians to include legitimate costs in calculating a net charge. Another commenter stated that many suppliers would incur a loss, not just fail to profit, if these ''confusing and hyper-technical rules'' are adopted. For example, the commenter asserted, a billing physician would be prohibited from billing for the costs incurred when a technician performs the TC of a test because the physician group may bill only for the cost of the physician who supervised the test. The commenter also stated that the proposal effectively prohibits the payment for qualified technicians in the performance of the TC of diagnostic tests, or, in the alternative, requires that physicians who choose to provide their patients with such tests do so at a loss.

One commenter explained that it is common practice for physician groups to provide pathologists with office space, equipment, administrative services, billing and collection services, and other services and then bill for the PC itself. The commenter urged that net charges should be defined to include these overhead costs rather than just the amount the physician group pays the pathologist to perform the PC. According to this commenter, it is critical that physicians be able to recoup actual and readily allocable costs attributable to these services. If they cannot, the commenter predicted, gastroenterology groups will be forced to stop utilizing their labs for Medicare-reimbursed services, and patient care will suffer.

Another commenter suggested that we allow a group practice to include in the calculation of ''net charge'' actual additional incremental costs incurred by the group which are directly allocable to the provision of the service, for example, rental charges for a facility used exclusively to provide diagnostic tests. If billing or administrative staff are hired by the group solely to provide billing services related to the provision of diagnostic tests, such costs should appropriately be considered in calculating net charge. The commenter contended that requiring that such costs be associated exclusively with providing the diagnostic tests for which payment is sought will ensure that only costs actually needed to provide the tests are included in the calculation of net charge. The commenter further asserted that this will permit groups to provide better diagnostic health care services for their clients without losing substantial money on every test performed.

A commenter stated that, without a proposed definition for ''net charge,'' it did not understand how the anti-markup provisions could be applied fairly and consistently to testing provided by physician groups. The commenter stated that physician groups have standard fees for diagnostic test components that they charge to patients and payers and that, in order to determine an ''inside'' charge the group's usual and customary external charges would have to be recognized. According to the commenter, a fair net charge calculation would need to include the cost of equipment, supplies, technical personnel, related benefits, and allocated space, utilities, taxes and general overhead, which vary between practitioners.

Another commenter stated that there should not be an allowance made to recover overhead expenses, such as billing expenses, rental charges, or equipment expenses, as these expenses will only help underwrite the cost of the laboratory and will be contrary to the goal of reducing overutilization. According to this commenter, the only costs that should be included in the calculation of ''net charge'' are those directly paid to the pathologist performing the PC or supervising the TC and should be limited to the W–2 salary income of the pathologist, not including any bonus.

Response: After considering the issue further, we decline at this time to make any changes to what we allow to be included in the calculation of ''net charge.'' As we stated in the preamble to the CY 2008 PFS final rule (72 FR 66319 through 66320), we are concerned that, allowing billing physicians and other suppliers to recoup costs such as overhead in situations in which the anti-markup provisions apply, would undermine a purpose of the anti-markup payment limitation because the incentive to overutilize (to recover capital outlays and other costs) would still be present. Therefore, where the billing physician or other supplier pays the performing supplier a fixed fee for the TC or the PC, the ''net charge'' is the fixed fee (exclusive of any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier, per § 414.50(a)(2)(i)). Where a fixed fee is not paid, the billing physician or other supplier is limited to the salary and benefits it paid to the performing supplier for the TC or PC. As we indicated in the CY 2008 PFS final rule, it is the responsibility of the billing entity to ascertain the amount it paid for the TC or PC. The billing entity should maintain contemporaneous documentation of the methodology and information used to calculate the net charge, and may do so in any reasonable manner (72 FR 66318).

(2) Direct Billing

Comment: In the CY 2009 PFS proposed rule, we solicited comments on whether, in addition to or in lieu of the anti-markup provisions, we should prohibit reassignment in certain situations and require the physician supervising the TC or performing the PC to bill Medicare directly (73 FR 38548). One commenter opposed any requirement that a physician performing either the TC or the PC of diagnostic tests directly bill for such services. The commenter stated that the Congress enacted the anti-markup provisions in section 1842(n) of the Act rather than adopt the already established direct billing requirement for clinical laboratory services. The commenter argued that we should not second-guess the Congress' decision and choose to eliminate the system of assignment and reassignment that is currently in place. Another commenter agreed with the first commenter and stated that reassignment is beneficial to both physicians and patients because physicians gain flexibility to establish the most appropriate employment or contractual relationships for their lives and lifestyles and patients benefit by having medical services combined on one bill, which avoids confusion and additional paperwork. A commenter opposed to direct billing stated that, with respect to the situation in which multiple suppliers are engaged in the treatment of a patient, a prohibition on reassignment would force suppliers to bill Medicare directly only for the services provided directly by each supplier, resulting in a doubling of the claims that are submitted, with an increase in billing expenses. The commenter asserted that this prohibition would also be a concern for

locum tenens physicians who are, by agency definition, independent contractors. According to the commenter, it does not have the infrastructure to submit and collect payments from Medicare, and thus its contracts are based on the ability to reassign its Medicare claims to the physician or practice it is supporting.

Some commenters were in favor of direct billing, stating that itemized billing encourages transparency relative to the amounts paid for the TC and PC of tests ordered by the billing physician or group. The commenters stated that an itemized bill would identify the PC and TC providers, the services provided, and associated charges as separate line items on a single Medicare claim form. The commenters further asserted that we would be able to reconcile TC and PC components without an increase in billing expenses to either the providers or Medicare. One commenter expressed its view that the most straightforward way to address potential overutilization caused by physicians being able to profit by billing for diagnostic services performed by others would be to implement a direct billing requirement. The commenter suggested that this would be a simple, understandable, bright-line rule that could be effectively implemented and monitored. Another commenter supported the establishment of direct billing for anatomic and clinical pathology services for all payers, public and private, so that payment should be made only to the person or entity that performed or supervised the service, except for referrals between laboratories independent of a physician's office. According to this commenter, this policy would be consistent with ethics principles that discourage fee-splitting.

Response: We appreciate the comments on whether, in addition to or in lieu of the anti-markup provision, we should prohibit reassignment in certain situations and require the physician supervising the TC or performing the PC to bill Medicare directly. The issues raised and the suggestions made by the commenters will be taken into consideration for purposes of future rulemaking. As we noted above in section II.N.2.a., we agree that it would be simpler to adopt the approach, as suggested by one commenter, that we not allow any reassignment of diagnostic testing services and, instead, require direct billing. However, without studying that approach further, we have concerns that doing so may unnecessarily prevent nonabusive arrangements.

(3) Effective Date

Comment: In the CY 2009 PFS proposed rule, we solicited comments on whether revisions made by the CY 2008 PFS final rule with comment period (but which were delayed until January 1, 2009 through a final rule published on January 3, 2008 (73 FR 404)) should go into effect on January 1, 2009, and whether any proposals from the CY 2009 PFS proposed rule that we may finalize should go into effect on that date, or whether some or all of the revisions should be delayed past January 1, 2009. One commenter urged us to implement the anti-markup provisions without delay, as we have been studying this issue since 2004. The commenter asserted that sufficient time has passed for consideration of comments on the issue. The commenter also expressed its view that the anti-markup payment limitation will not affect access to critical patient services, only the ability of ordering providers to profit from their referrals.

One commenter suggested an effective date of July 1, 2009, to provide sufficient time to restructure affected relationships. Another commenter, opposed to the anti-markup proposals, suggested that, if we revise the provisions currently in effect, the new provisions should not be effective until December 31, 2010 at the earliest. The commenter asserted that such a delay would ensure providers a reasonable amount of time to restructure their service and billing arrangements for consistency with the new provisions.

Another commenter asserted that the delayed portions of last year's rule should not go into effect on January 1, 2009, and that neither of the alternative approaches discussed in this year's proposal should be finalized. The commenter stated that we achieved our goal of regulating so-called ''pod labs,'' and asserted that extending similar rules based on site-of-service beyond the pathology laboratory context risks disruption to a wide variety of diagnostic testing services that are genuinely ''inside'' group practices. Commenters claimed that these proposals have made it virtually impossible for physician practices or suppliers potentially subject to these rules to plan for compliance or alternative arrangements by January 1, 2009. One commenter requested that, if we do proceed with the extension of the anti-markup provision, the effective date of the rule be delayed until regulatory language can be proposed for each of the alternatives under consideration and there has been additional time to understand the impact of each proposal.

A commenter recommended that we delay beyond January 1, 2009, the application of any further revisions until we can fully evaluate the effect of such revisions on physician groups and work with the medical community to simplify and streamline the anti-markup provisions, so that their application is clear to all involved. One commenter requested that we consider delaying the proposals until further evaluation is completed on the impact of recent changes affecting physicians such as MIPPA, DRA, ''Bottom-Up Methodology'' and the proposed IDFT requirements. Another commenter recommended that implementation should be delayed and that we should use the process set forth by the Congress in MIPPA to establish accreditation requirements for medical imaging to assess the appropriate use of imaging services and to examine the perceived overutilization of in-office imaging. A commenter recommended that we defer to the Congress regarding concerns of overutilization of diagnostic testing services. According to the commenter, the directives in MIPPA, released after the current proposed rule, are much clearer on this issue. The commenter noted that the Congress did not amend the anti-markup provision, choosing instead to direct the agency to develop a demonstration project to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries and require accreditation of advanced diagnostic imaging suppliers by 2012.

Response: We do not agree with the commenters that suggested a delayed effective date beyond January 1, 2009 for either the revisions made by the CY 2008 PFS final rule with comment period or the revisions that we are making in this CY 2009 PFS final rule with comment period. We have decided to make the finalized revisions effective as of January 1, 2009. When we delayed, until January 1, 2009, the application of the revisions to § 414.50 we made in the CY 2008 PFS final rule with comment period (except with respect to certain diagnostic testing arrangements involving anatomic pathology performed in a ''centralized building'' for which the revisions were applicable January 1, 2008), we stated that we planned to issue clarifying guidance as to what constitutes the ''office of the billing physician or other supplier'' within the following 12 months (73 FR 405). We proposed the clarification and other revisions in the CY 2009 PFS proposed rule in order to introduce the possible changes under consideration.

The revisions being finalized in this regulation stem from that proposal and we believe that sufficient time has been given for consideration of and response to the anti-markup revisions.

Irrespective of whether ''pod lab'' arrangements otherwise would continue to exist or proliferate, we believe that the anti-markup provisions are needed in order to address potential program and patient abuse through the ordering of unnecessary diagnostic tests. Although several commenters made mention of MIPPA and the impact that it may have, we are not swayed by these arguments. MIPPA is a separate authority with a different focus than that of the anti-markup provisions. If, in the future, the anti-markup provisions are impacted through our implementation of MIPPA, we will address this in subsequent rulemaking.

j. Miscellaneous

Comment: One commenter, a professional association of pathologists, suggested an exception from the anti-markup provisions for single-specialty pathology physician groups and independent laboratories. The commenter suggested that such entities be defined as those in which all physicians within the group are pathologists and for which 75 percent of all CPT codes billed by the entity are pathology and laboratory CPT codes. According to the commenter, such an exception would ''clarify'' that dedicated pathology groups and independent laboratories are not subject to the anti-markup provisions for certain purchased diagnostic tests and interpretations or the ordering of special stains to perform better the tests ordered by outside, independent physicians. The commenter asserted that its proposed exception would be consistent with the physician self-referral's exclusion from the definition of ''referral'' for services ordered by pathologists (and radiologists and radiation oncologists) pursuant to a consultation with another physician. According to the commenter, the exclusion from the definition of ''referral'' reflects the Congress's recognition that services ordered by such physicians pursuant to a consultation with another physician do not pose the same risk of abuse that physician self-referral generally poses. The commenter also suggested an alternative to its proposed exception, for independent laboratories for which at least 75 percent of the diagnostic tests have been ordered by physicians outside the laboratory. A second commenter representing pathologists also suggested an exception for pathology practices (which it would define as any entity for which at least 75 percent of all CPT codes billed by the entity are pathology and laboratory codes). The commenter also cited the exclusion from the definition of ''referral'' in the physician self-referral rules for services ordered by pathologists pursuant to a consultation, and asserted that there should not be a self-referral or mark-up concern when pathology groups order special stains or other tests. A third commenter stated that the ''rapid rise'' in special stains in the last eight years is not a result of in-office pathology services or TC/PC arrangements, but rather is a result of the failure of national, regional, and hospital-based pathology laboratories to follow standard protocol for tissue biopsies. The commenter contended that over-utilization of anatomic pathology testing can be managed by imposing tighter controls on such laboratory-based pathologists with respect to what stains they order and the reasons for ordering them.

Response: We are not establishing an exception that would be applicable to pathology practices or independent laboratories, to the anti-markup provisions. We note that we did not propose such an exception and, thus, question whether we would have the authority to provide for such an exception in this final rule. Moreover, we are not convinced of the need for or wisdom of such an exception. We believe that the same potential that exists for the overutilization of diagnostic tests ordered by single-specialty physician groups and other suppliers, due to the profit motive, also exists for the ordering of special stains or other tests by pathology groups or independent laboratories.

Comment: An association that represents physician group practices suggested that we establish a multi-specialty medical group ''carve out'' for ''merit,'' that is, an exemption from the anti-markup provisions based on delivery of high-quality health care services in the multi-specialty/organized system of care model. According to the commenter, the potential and risk for inappropriate actions is outweighed by the attributes and meritorious actions of multi-specialty groups. The commenter noted that, in section 131 of MIPPA, the Congress recognized the coordinated approach to patient care that multi-specialty medical groups provide.

A different commenter requested that multi-specialty group practices *not* be permitted to use the employment or independent contractor arrangements to bring pathology services in-house and then claim that a referral is exempt from the physician self-referral prohibition because it meets the requirements of the in-office ancillary services exception or some other exception. The commenter stated that pathology is a separate physician specialty and the provision of these services is not ancillary to the provision of urology or gastroenterology. According to the commenter, pathology services provided in-office do not serve the patient's convenience or increase access to these services as they are too time consuming and complex to perform, as the patient has always left the doctor's office by the time the pathology examination is complete and the report issued. The commenter argued that not allowing pathology services to be protected by the in-office ancillary services exception would be consistent with the physician self-referral law and would eliminate the incentive for overutilization that currently exists.

Response: For the same reasons expressed in the response to the previous comment, we are not establishing an exception to the anti-markup payment limitation, for multi-specialty groups. We also note that because we have adopted the first proposed alternative with modification, whereby the anti-markup provisions will not apply to TCs and PCs supervised or performed by a physician who performs ''substantially all'' of his or her professional services for the billing physician or other supplier, ''hub and spoke'' arrangements of multi-specialty groups should not have significant difficulty avoiding application of the anti-markup provisions. We understand the commenter's concerns about the use of the in-office ancillary services exception and may propose rulemaking on this issue in the future.

Comment: A commenter stated that dermatologic surgeons who order and read their own diagnostic tests should not be penalized for doing so by the addition of new and overly cumbersome regulations that the commenter argued are inconsistent with the existing physician self-referral law. According to the commenter, a dermatopathologist has the expertise to diagnose and monitor diseases of the skin, which entails the examination and interpretation of specially prepared tissue sections, cellular scrapings, and smears of skin lesions by means of routine and special (electron and fluorescent) microscopes. The commenter was also concerned that patient access to care in rural and underserved areas will be affected. The commenter urged that practices that

order and interpret their own diagnostic tests in these areas should have the same ability to recoup the costs of equipment, space, and medical records management for services performed within their practices as those practices that utilize an outside supplier for the TCs or PCs of their tests.

Response: We are unclear as to what the commenter is suggesting. We did not propose to, and this final rule does not, impose tighter billing restrictions on TCs and PCs ordered by dermatologic surgeons than for other specialties, and does not impose tighter billing restrictions for dermatologic surgeons who perform TCs and PCs than it does for those physician practices that purchase TCs and PCs from an outside supplier. We note that the commenter did not provide an explanation of why patient access to care in rural or underserved areas would be affected by our proposed revisions.

Comment: A letter writing campaign expressed concern regarding the proposals to the anti-markup provisions, contending that it would limit the ability of allergists to provide services on a part-time basis with more than one group and, in particular, would limit access to allergy care (including allergy diagnostic tests), to Medicare beneficiaries in rural or underserved areas. The commenters urged that our proposals not be implemented.

Response: We have adopted the first proposed alternative with modification, whereby the anti-markup provisions will not apply to TCs and PCs supervised or performed by a physician who performs ''substantially all'' (at least 75 percent) of his or her professional services for the billing physician or other supplier, which provides some flexibility for the performing physician to work for more than one billing physician or other supplier. Moreover, this final rule provides additional flexibility by allowing arrangements that do not come within the protection of the ''substantially all'' test to avoid the application of the anti-markup payment limitation by complying on a case-by-case basis with the existing site-of-service approach (as clarified by this final rule with comment period). We believe that this addresses the commenters' concerns.

O1. Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

i. Division B of the Tax Relief and Health Care Act of 2006—Medicare Improvements and Extension Act of 2006 (MIEA–TRHCA) and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA): Requirements for the PQRI Program Prior to Enactment of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Section 101(b) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1848 of the Act by adding subsection (k). Section 1848(k)(1) of the Act requires the Secretary to implement a system for the reporting by eligible professionals of data on quality measures as described in section 1848(k)(2) of the Act. Section 1848(k)(1) of the Act authorizes the Secretary to specify the form and manner for data submission by program instruction or otherwise which may include submission of such data on Part B claims. Section 1848(k)(3)(B) of the Act specifies that for the purpose of the quality reporting system, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, and qualified speech-language pathologists. Section 101(c) of the MIEA–TRHCA, as amended by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), authorizes ''Transitional Bonus Incentive Payments for Quality Reporting'' in 2007 and 2008, for satisfactory reporting of quality data, as defined by section 101(c)(2) of the MIEA–TRHCA. We have named this quality reporting system the ''Physician Quality Reporting Initiative (PQRI)'' for ease of reference.

The MMSEA required the Secretary to establish alternative reporting periods and alternative criteria for satisfactorily submitting data on quality measures through medical registries and for reporting groups of measures for 2008 and 2009.

For 2009, section 1848(k)(2)(B)(ii) of the Act, as amended by the MMSEA, requires the Secretary to publish a proposed set of quality measures that would be appropriate for eligible professionals to use to submit data in 2009 in the **Federal Register** by August 15, 2008. Such measures shall be measures that have been endorsed or adopted by a consensus organization, such as the National Quality Forum (NQF) or the AQA (formerly the Ambulatory Care Quality Alliance), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. In addition, the measures shall include structural measures, such as the use of electronic health records (EHRs) and electronic prescribing (e-prescribing) technology. The Secretary must publish the final set of measures in the **Federal Register** no later than November 15, 2008, as required by section 1848(k)(2)(B)(iii) of the Act, as amended by the MMSEA.

Although section 101(c) of the MIEA–TRHCA, as amended by the MMSEA, authorized the Secretary to make incentive payments for satisfactorily reporting quality measures data on covered professional services furnished by eligible professionals during the reporting period for 2007 and 2008, neither MIEA–TRHCA nor MMSEA authorized an incentive payment for PQRI for 2009. Also unlike the 2007 or 2008 PQRI, neither the MIEA–TRHCA nor the MMSEA defined a specific reporting period for the 2009 PQRI.

ii. Extension of and Enhancements to the PQRI Program Authorized by the MIPPA

The MIPPA, which was enacted after the publication of the CY 2009 PFS proposed rule, included a number of provisions that impact the 2009 PQRI. Prior to enactment of the MIPPA, the MIEA–TRHCA, as amended by the MMSEA, was the authorizing legislation for PQRI. The MIPPA codifies the PQRI under sections 1848(k)(2) and 1848(m) of the Act. First, the MIPPA makes the PQRI a permanent program and authorizes us to make incentive payments for satisfactorily reporting data on quality measures for covered professional services furnished by eligible professionals during the 2009 PQRI reporting period equal to 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period that are submitted no later than 2 months after the end of the reporting period. In addition, the reporting period for the 2009 PQRI is defined as the entire year, or January 1, 2009 through December 31, 2009. Therefore, for the 2009 PQRI, eligible professionals who satisfactorily report data on quality measures for covered professional services furnished between January 1, 2009 through December 31, 2009 will receive an incentive payment equal to 2.0 percent of the total estimated allowed charges submitted by no later than February 28, 2010 for all covered professional services furnished between January 1, 2009 and December 31, 2009.

Beginning with the 2009 PQRI, the MIPPA also amended the definition of ''eligible professional'' to include qualified audiologists (as defined in section 1861(11)(3)(B) of the Act). Thus, for purposes of the 2009 PQRI, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists.

In addition, section 1848(k)(2)(D) of the Act, as added by the MIPPA, requires that for each 2009 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.''

Section 1848(m)(3)(A) of the Act, as amended and redesignated by the MIPPA, also requires that for years after 2008, the PQRI quality measures shall not include e-prescribing quality measures. Even with the removal of the e-prescribing measure, we continue to meet the requirements under section 1848(k)(2)(B)(ii) of the Act to include the use of structural measures.

Section 131(b)(6) of the MIPPA also specifies that none of the amendments to the Social Security Act resulting from the MIPPA will impact the operation of the PQRI for 2007 or 2008. Additional information regarding the MIPPA provisions can be found in section III of this final rule with comment period.

iii. General Program Comments and Responses

In the CY 2009 PFS proposed rule (73 FR 38558 through 38559), we provided a longer summary of the history of the PQRI and a more detailed discussion of the pertinent MIEA–TRHCA and MMSEA requirements than is provided above in this section. We proposed to define the 2009 PQRI reporting period to be the entire CY 2009, but also proposed alternative reporting periods and alternative criteria for satisfactorily reporting quality measures data for measures groups and registry-based reporting as required by the MMSEA (73 FR 38559 through 38564). The CY 2009 PFS proposed rule (73 FR 38564 through 38565) also included proposed reporting options and reporting periods for satisfactorily reporting quality measures data extracted from EHRs.

To satisfy section 1848(k)(2)(B) of the Act, as amended by the MMSEA, we published 175 proposed 2009 PQRI quality measures in the CY 2009 PFS proposed rule (73 FR 38565 through 38572). We also proposed 9 measures groups for the 2009 PQRI on which eligible professionals may report (73 FR 38572 through 38574) and described potential uses of the PQRI information (73 FR 38574 through 38575).

In the CY 2009 PFS proposed rule (73 FR 38558 through 38575), we solicited comments on the following areas:

- Implications of including or excluding any given measure from the set of proposed 2009 quality measures.
- The new measures groups proposed for 2009 including suggestions for other measures groups based on individual measures included in the proposed 2009 PQRI measure set.
- The proposed use of the consecutive patient reporting criteria for measures groups.
- The proposed use of 30 consecutive patients as the required sample under the consecutive patient reporting criteria during the full-year 2009 reporting period.
- The proposed options and planned use of registries for registry-based quality measures results and numerator and denominator data on quality measures data reporting to PQRI in 2009.
- The advisability of expanding the number of PQRI quality measures beyond the 119 measures in the 2008 PQRI quality measure set given that there is no specific authorization for an incentive payment for the 2009 PQRI and beyond.
- Various issues that we identified in the proposed rule to help us determine the most appropriate uses of PQRI data.

We received 161 comments from the public on the CY 2009 PFS proposed rule related to the PQRI. In this section of the final rule with comment period, we first summarize the comments about the PQRI program in general and our responses to those comments immediately below. The remaining comments received and our responses to those comments are discussed under the relevant topic areas of this section of the final rule with comment period.

Comment: Several comments commended CMS and the PQRI program for providing more flexibility and were generally supportive of the program including the proposed addition of measures in the 2009 PQRI and the continued development and implementation of a variety of reporting periods and reporting methodologies.

Response: We appreciate the commenters' positive feedback.

Comment: Several commenters suggested that we conduct an independent, formal evaluation of the PQRI program's processes and to analyze and validate the data that has been gathered to date. One of the major reasons cited for needing an evaluation component was the fact that a relatively small percentage of those eligible professionals who participated in the 2007 PQRI actually received an incentive payment. Other common reasons cited include to assess the range of specialties reporting information to ensure that most eligible professionals have the opportunity to participate, to better understand why some eligible professionals did not participate, and to fully understand how improvements affect participation rates prior to expansion of the PQRI.

Response: We are continuing to evaluate the results of the 2007 PQRI and will evaluate the results of the 2008 PQRI as they become available as we develop and implement strategies for enhancing the PQRI in the future.

Comment: A number of commenters also offered to assist us in improving physician quality measure design and to help us better understand the barriers to and the stimuli for participating by requesting to review the data files used for calculating the 2007 and/or 2008 incentive payments.

Response: Information about individuals that is retrieved by the individuals' names or other personal identifiers is subject to the Privacy Act of 1974 (that is, the Privacy Act), Freedom of Information Act and other Federal government rules and regulations. As such, the information cannot be released without the individual's written consent, unless the Privacy Act permits release. See 5 U.S.C. 552a(b).

We employ strict security measures to appropriately safeguard individual privacy and seek to ensure that files containing physician and/or beneficiary identifiers are used only when necessary and in accordance with disclosure provisions of the Privacy Act. The Privacy Act, as well as the notice that is published in the **Federal Register** for each CMS System of Records (SOR), provide the permitted disclosures of individually identifiable information and explain the procedures that need to be followed to safeguard the information. The notices that describe each CMS SOR can be found on the CMS Web site at *http://www.cms.hhs.gov/PrivacyActSystemofRecords/SR/list.asp#TopOfPage*.

All research requests for individually identifiable data must be submitted to the Research Data Assistance Center (ResDAC) for initial review. More information on the policies and procedures for data requests for data that are protected by the Privacy Act can be found on the CMS Web site at *http://www.cms.hhs.gov/*

PrivProtectedData/01_Overview.asp#TopOfPage.

Comment: Many commenters recommended we redesign the PQRI section of the CMS Web site, including suggestions to provide an updated listing of measures under formal consideration by the various measure developers, as well as to provide more detailed information about the PQRI measures.

Response: We concur with commenters' suggestions to redesign the PQRI section of the CMS Web site. We are currently working to make the Web site more user-friendly and will consider the commenters' suggestions.

Comment: A few commenters suggested we establish a multi-stakeholder advisory council or that we actively engage more stakeholders, such as consumers and hospitals. Active engagement of stakeholders could be used for a variety of purposes, such as to help understand why some eligible professionals may not have participated; to engage and obtain feedback and observations from those who will be measured as well as those who successfully participated; to ensure that the PQRI measures provide clinically-significant information while being structured in the least administratively-burdensome manner possible; or to advise us as we proceed with making information derived from the PQRI publicly available.

Response: We plan to continue our dialogue with the stakeholder community and will consider their and PQRI participants' input as we continue to evaluate the results from the PQRI and to develop and implement strategies for enhancing the PQRI in the future.

Comment: One commenter recommended different incentives that we could employ to increase participation, such as reducing eligible professionals' costs for collecting Medicare payments.

Response: We are bound by statute with respect to the types of incentives that we can provide to eligible professionals, how those incentives are calculated, and the amount of the incentive. The only incentives we are authorized to provide eligible professionals are an incentive for eligible professionals who satisfactorily report quality measures data through the PQRI as discussed below and the new incentive that we are implementing in 2009 for eligible professionals who are successful electronic prescribers as discussed in section II.O2. below.

Comment: Other specific suggestions for improving the PQRI provided by commenters include renaming the PQRI the ''Provider'' or ''Practitioner'' Quality Reporting Initiative to acknowledge potential participation of all types of Medicare providers; separating the quality reporting from the billing process by removing the requirement that ''G'' codes are reported on the same claim as the denominator service; developing guidelines on which measures are appropriate for reporting by different medical specialties; designing reporting options in a manner that would allow smaller providers to more easily participate; considering assigning all measures to clinical area groups; providing an appeal process for eligible professionals who participate but are not deemed to be successful; and ensuring greater transparency in all aspects of the program including, but not limited to, in the measure selection process, in the provision of feedback, and in the implementation of the pertinent MIPPA provisions.

Response: We appreciate and value the constructive feedback that we have received from the wide variety of commenters who have provided insights and information and partnered with us to disseminate information about PQRI. As reflected in the variety of reporting options that we are making available for the 2009 PQRI and the expansion of measures groups, it is our desire to allow as many eligible professionals to participate with as little additional burden as possible. To the extent that we find it practical, feasible, and appropriate to implement the commenters' suggestions, we would do so via notice and comment rulemaking for future years' PQRI.

With respect to the commenters' suggestion to provide an appeals process for eligible professionals who participate but are not deemed to be successful, we note that section 1848(m)(5)(e) of the Act, as amended by MIPPA, provides that with respect to the PQRI there shall be no administrative or judicial review under sections 1869 or 1879 of the Act, or otherwise of (1) the determination of measures applicable to services furnished by eligible professionals; (2) the determination of satisfactory reporting; and (3) the determination of any incentive payment. Therefore, we have no authority to establish an appeals process for the subject of eligible professionals ''not deemed to be successful'' which we read to fall within the determination of satisfactory reporting.

Comment: We received numerous comments providing general recommendations for enhancing the Medicare program, such as suggestions to transition the PQRI from a pay-for-reporting program to a pay-for-performance program as quickly as possible; addressing problems of underuse, overuse, and misuse of services; assuring that all Americans receive the right care by reducing health care disparities and encouraging that quality care be provided to at-risk populations; encouraging care coordination and support for the integration and delivery of services across providers and across care settings; and providing payment that supports the re-engineering of care, such as providing payment for e-visits and efficiency-enhancing forms of telemedicine. One commenter expressed a desire to see the development of a quality reporting mechanism similar to the PQRI that is applicable to a pediatric population and Medicaid.

Response: While we appreciate these suggestions for enhancing the Medicare and Medicaid programs mentioned, we note that those programs are beyond the scope of this section of the final rule with comment period. This section of the final rule with comment period is limited to the 2009 PQRI.

Comment: Many commenters also commented on the MIPPA provisions that were not directly related to the PQRI. For example, we received many comments related to the plan for transitioning to a value-based purchasing program for physicians' services that we are required to submit to the Congress by May 1, 2010 under the MIPPA.

Response: While we appreciate the commenters' input for implementing the MIPPA provisions, we note that MIPPA provisions that are not directly related to the PQRI program are beyond the scope of this section of the final rule with comment period. This section of the final rule with comment period is limited to the 2009 PQRI.

Comment: Several commenters expressed confusion about participation requirements and recommended that we implement an aggressive education and outreach campaign on how to successfully participate, to help eligible professionals who did not receive a bonus understand why, and that provides participating eligible professionals with confidential interim and final feedback and compliance reports.

Response: We agree that with increased flexibility comes more potential for confusion about participation requirements. Section 1848(k)(6) of the Act requires the Secretary to provide for education and outreach to eligible professionals on the operation of the PQRI.

To minimize any potential confusion, we have hosted monthly national

provider calls on the PQRI in which our PQRI subject matter experts are available to answer questions on the PQRI. We have also provided guidance on specific topics on these calls, such as accessing the 2007 PQRI feedback reports, how the 2007 incentive payments were calculated, and the various 2008 reporting options.

In addition to the national provider calls, we have worked with various medical specialty societies, such as the American Academy of Family Physicians, the American College of Physicians, American Academy of Ophthalmology, American Optometric Association, and the American Gastroenterological Association Institute to host Special Open Door Forums to educate their membership on the PQRI. We anticipate continuing these education and outreach activities as we implement the 2009 PQRI.

Information about these CMS-sponsored calls, including information about upcoming calls, can be found on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.* The Web site itself also serves as a useful resource for obtaining the most up to date information on the PQRI. For example, the PQRI Tool Kit found on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/31_PQRIToolKit.asp#TopOfPage* contains valuable resources to help eligible professionals in the successful integration of PQRI into their practices. We encourage eligible professionals to visit this Web site and to review the frequently asked questions found on this Web site.

Comment: Many commenters stated they were pleased the Congress extended PQRI and authorized a 2.0 percent incentive payment for 2009, but others noted that the incentive payment was not enough to outweigh the burden of participating or noted concern about the number of ''quality and efficiency'' measures imposed on physicians without evidence of improved health outcomes, health status, and reduced system costs. One commenter recommended that we base the incentive payment on RVUs rather than the amount billed to Medicare.

Response: We do not have the authority to change the basis for calculation of the incentive payment. Section 1848(m)(1) of the Act, as redesignated and amended by the MIPPA, authorizes us to make incentive payments for satisfactorily reporting data on quality measures for covered professional services furnished by eligible professionals during the 2009 PQRI reporting period equal to 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period that are submitted no later than 2 months after the end of the reporting period. However, we are committed to exploring and supporting practical, effective mechanisms for quality-of-care data submission that promote efficiency by streamlining participants' and our data collection and handling. As such, and as described below in this section of the final rule with comment period, we have developed and are implementing options for registry-based submission of quality measures data and plan to implement options for EHR-based submission of quality measures data after some additional testing.

In addition, we have increased the number of measures groups and individual PQRI quality measures available for the 2009 PQRI in an effort to expand opportunities for eligible professionals to participate in PQRI.

Comment: We received many comments urging us to ensure that all eligible professionals have meaningful opportunities to participate in the PQRI. Some commenters were specifically concerned that funding for the Quality Insights of Pennsylvania (QIP) project to develop nonphysician quality measures has ended and hoped that CMS will continue to extend funding in the future for the development and implementation of quality measures for nonphysicians as well as to move measures already developed by the QIP through the NQF endorsement and/or AQA approval process.

Several commenters were also concerned that therapists who work in certain outpatient settings (for example, acute care hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, or rehabilitation agencies) are unable to participate in PQRI since they do not use the 1500 or 837–P claim form and instead submit claims on the UB–04 or 837–I form where there is no place to report the individual National Provider Identifier (NPI) of the eligible professional furnishing the service. The commenters recommended registry-based alternatives for PQRI participation.

A few commenters noted that pathologists who bill via independent laboratories are also not able to participate in the PQRI because we are not yet able to capture this billing situation.

Response: We agree with the goal of providing as many eligible professionals the opportunity to participate in the PQRI as is practical and feasible. As we stated in the CY 2009 PFS proposed rule (73 FR 36566), one of the considerations we employed in the selection of measures for the 2009 PQRI is to select measures that increase the scope of applicability of measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to increase the circumstances where eligible professionals have at least three measures applicable to their practice.

For the 2008 PQRI, we supported, via contract with QIP, the development of structural measures and measures applicable to a broad cross-section of PQRI eligible professionals, including some NPPs who had few or no measures available in the 2007 PQRI. We prioritized development of these measures available or otherwise in development and on a need to address as broad a cross-section of eligible professions or specialties as possible within the limited volume of measures for which we could support development in time for inclusion in the 2008 PQRI. As the contracted measure developer, QIP was responsible for supporting the measures through the AQA adoption process. CMS funded a project with the NQF which reviewed the measures for endorsement.

We plan to continue working to fill gaps in available consensus endorsed or adopted measures consistent with available time and resources. However, we largely depend on and encourage the development of measures by professional organizations and other measure developers. Ideally, in the future, there will be a sufficient number of clinician-level quality measures that meet the statutory requirements that CMS would be able to just select PQRI measures from these existing measures rather than needing to fund the development of additional clinician-level quality measures.

Regarding the concerns cited by therapists unable to participate in PQRI since they do not use the 1500 or 837–P claim form, we note as we did in the CY 2008 PFS final rule with comment period (73 FR 66337) that our analysis of claims-based alternatives to enable participation determined that extensive modifications to the claims processing systems of CMS and providers would be required. Such modifications would represent a material administrative burden to us and providers and/or modifications to the industry standard claims formats, which would require substantial time to effect via established processes and structures that we do not maintain or control.

Our analysis of the two registry-based alternatives suggested by the commenters indicate that it would be possible for therapists in this situation

to participate in a registry because there are registries ''qualified'' to participate in our 2008 PQRI program that intended to report all of the PQRI measures and that are open to all eligible professionals who would like to participate with them. However, it would not be possible to calculate an incentive payment for the therapists' participation since our claims processing systems do not allow us to attribute services furnished by therapists who bill through fiscal intermediaries to an individual eligible professional to calculate the incentive amount. As required by section 1848(1)(A)(ii) of the Act, as redesignated and added by the MIPPA, the 2009 PQRI incentive must be calculated based on each eligible professional's allowed charges for covered professional services that are based on or paid under the Medicare PFS. Although we are in the process of evaluating the impact of making the changes to the fiscal intermediary claims processing systems needed to be able to accept the PQRI quality data codes and attribute them to an eligible professional, it is unknown at this time whether these changes can be made without undue burden to our systems or what the timeline for potential implementation would be.

Regarding the concern that pathologists who bill through independent laboratories are unable to participate in the PQRI, we note that only eligible professionals as defined in section 1848(k)(3)(B) of the Act are eligible to participate in PQRI. As discussed in section II.O1.a.ii. above, ''eligible professional'' is defined to include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists for the purposes of the 2009 PQRI. As noted in the comment, independent laboratories are suppliers and are therefore not eligible to participate in PQRI. Pathologists who bill directly to Medicare, however, are eligible to participate in PQRI.

Comment: Several commenters noted the mechanism for viewing the feedback reports was too cumbersome and were concerned about the lack of timely feedback (both in terms of when the feedback reports are received and when incentive payments are received). Several commenters requested that more detailed information be provided in the feedback reports so that eligible professionals can reconcile CMS' data with their own claims information to ensure that codes were submitted accurately, captured by the Medicare Administrative Contractor (MAC), transferred to the PQRI data system, and result in meaningful data that corresponds to the eligible professional's own experience.

Response: Although, as discussed in sections II.SG.6. and III. of this final rule with comment period, section 1848(n) of the Act, as added by the MIPPA, requires the Secretary to establish a Physician Feedback Program to provide confidential reports to physicians (and, if determined appropriate by the Secretary, groups of physicians) that measure the resources involved in furnishing care to Medicare Part B patients, we are not statutorily required to provide participants with feedback reports on the quality measures data submitted for the PQRI and are not committing to provide feedback reports for claims-based submission of quality measures data for the 2009 PQRI. For registry-based reporting in 2009, we would rely on the participating registries to provide feedback to participating eligible professionals.

We do, however, understand the value of receiving meaningful feedback reports and, to the extent that we continue to provide PQRI participants with feedback reports for claims-based submission of quality measures data for the 2009 PQRI, we will consider such concerns as part of our ongoing dialogue with stakeholders in order to collaboratively identify ways to enhance the program's value to its participants and to the Medicare program. We note though that information on all aspects of care billed to Medicare, including quality data codes, is found on the remittance advice that eligible professionals receive. We urge PQRI participants to review the information received on the remittance advice along with their own records (such as their own claims information) to ensure that PQRI quality information is being accurately submitted and captured on claims. We also note that 2007 was the first broad scale implementation of quality data submission through the claims process. We are aware that practice management systems have the capability to analyze information received on the remittance advice. We anticipate that practice management systems may be adapted in the future for analysis of quality data code submission, as well. Such systems could provide contemporaneous feedback and analysis for physicians.

With respect to the timeframe when incentive payments are received, it is unlikely that we will be able to issue incentive payments for participation in PQRI for a particular year much sooner than the middle of the following year because of the way in which the incentive payments are calculated. The incentive payments are calculated based on the total estimated allowed charges for the reporting period. As required by section 1848(m)(1)(A)(ii) of the Act, as redesignated and added by the MIPPA, we must wait until 2 months after the end of the reporting period to allow eligible professionals to submit claims for covered professional services furnished during the reporting period.

Comment: The MIPPA requires that by January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice shall be treated as satisfactorily submitting data on quality measures for the PQRI. A few commenters welcomed this option and offered to assist CMS in defining ''group practice.'' Another commenter noted that it would be more cost-effective for multi-specialty group practices to participate under this new option.

Response: We welcome the commenters' interest in our plans for implementing future enhancements to the PQRI based on the MIPPA. However, we note that the scope of this section of the final rule is limited to the 2009 PQRI. Our plans for future years' PQRI, including our plans for implementing the MIPPA provisions that affect future program years, will be discussed in future notice and comment rulemaking. Thus, commenters can expect to see a discussion of our plans for implementing the physician group practice option for the 2010 PQRI in the CY 2010 PFS proposed rule next year.

b. Satisfactory Reporting Criteria and Reporting Periods—Reporting Options in the 2009 PQRI

In the CY 2009 PFS proposed rule (73 FR 38559), we proposed to define the reporting period for the 2009 PQRI as the entire year (January 1, 2009–December 31, 2009) and proposed two alternative reporting periods for reporting measures groups and for registry-based reporting: (1) January 1, 2009 through December 31, 2009; and (2) July 1, 2009 through December 31, 2009.

As discussed in section III. of this final rule with comment period, the MIPPA defines the reporting period for the 2009 PQRI to be the entire year. Therefore, for the 2009 PQRI the reporting period will be January 1, 2009 through December 31, 2009. We are retaining the two alternative reporting periods, which were unaffected by MIPPA, for reporting measures groups and registry-based reporting (that is, January 1, 2009 through December 31, 2009 and July 1, 2009 through December 31, 2009) as proposed. These reporting periods result in several reporting

options available to eligible professionals that vary by the reporting mechanism selected. The reporting mechanisms and criteria for satisfactorily reporting quality measures data for the 2009 PQRI are described in the following section.

i. Claims-Based Submission of Data for Reporting Individual Measures

Under section 1848(m)(3) of the Act, as redesignated and added by the MIPPA, the criteria for satisfactorily submitting data on individual quality measures through claims-based submission require the reporting of at least three applicable measures in at least 80 percent of the cases in which the measure is reportable. If fewer than three measures are applicable to the services of the professional, the professional may meet the criteria by reporting on all applicable measures (that is, one to two measures) for at least 80 percent of the cases where the measures are reportable. It is assumed that if an eligible professional submits quality data codes for a particular measure, the measure applies to the eligible professional. These criteria were proposed for the January 1, 2009 through December 31, 2009 reporting period.

We received a few comments on the proposed reporting period and criteria for satisfactorily submitting quality data through claims for reporting individual measures, as discussed below.

Comment: A few commenters encouraged CMS to establish alternative reporting periods for claims-based submission of individual quality measures. One commenter specifically requested us to extend the alternative reporting period of July 1, 2009 through December 31, 2009 to eligible professionals participating in PQRI through claims-based reporting of individual quality measures. The commenter stated that measures groups and/or registries are not always an option for eligible professionals.

Response: We appreciate the commenter's suggestions, which are intended to enhance the claims-based reporting of individual measures by providing greater flexibility. However, as discussed above and in section III. of this final rule with comment period, the MIPPA defines the reporting period for the 2009 PQRI to be the entire year and, as discussed in section II.O1.a.i. above, the MMSEA authorizes the Secretary to establish alternative reporting periods for registry-based reporting and for reporting on measures groups only. We note, however, that for years after 2009, the MIPPA authorizes the Secretary to revise the reporting period for claims-based submission of quality measures data if it is determined that such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.

Additionally, there are registries currently participating in the 2008 PQRI that report or are able to report all of the PQRI quality measures. Alternative reporting periods are available for registry-based submission of quality measures data, which enables all eligible professionals who wish to participate in PQRI to do so through a registry. For the 2008 PQRI, there are 32 registries ''qualified'' to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals.

Based on our review of this comment, we are retaining the reporting option for claims-based submission of data on individual quality measures as summarized in Table 11. That is an eligible professional can meet the criteria for satisfactorily reporting quality data by reporting at least three applicable measures (or one to two measures if fewer than three measures apply) for at least 80 percent of the cases in which each measure is reportable, during January 1, 2009 through December 31, 2009.

TABLE 11—FINAL 2009 PQRI CLAIMS-BASED REPORTING OPTIONS FOR INDIVIDUAL MEASURES

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	At least 3 PQRI measures, or 1–2 measures if less than 3 apply to the eligible professional, for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009–December 31, 2009.

ii. Satisfactory Reporting of Data on Quality Measures and Reporting Periods for Measures Groups, Through Claims-Based Reporting and Registry-Based Reporting

As described in the CY 2009 PFS proposed rule, section 101(c)(5)(F) of the MIEA–TRHCA, as added by the MMSEA and redesignated by the MIPPA as section 1848(m)(5)(F) of the Act, requires that the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. In establishing these alternatives, we have labeled these groups of measures ''measures groups.'' We define ''measures groups'' as a subset of PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

For the 2009 PQRI, we proposed to expand the available measures groups to a total of nine measures groups. We proposed to carry forward three of the four 2008 measures groups for the 2009 PQRI: (1) Diabetes Mellitus; (2) Chronic Kidney Disease (CKD); and (3) Preventive Care. In addition, we proposed to add six new measures groups for the 2009 PQRI:

(1) Coronary Artery Bypass Graft (CABG) Surgery;

(2) Coronary Artery Disease (CAD);

(3) Rheumatoid Arthritis;

(4) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS);

(5) Perioperative Care; and

(6) Back Pain.

We proposed to allow measures groups to be reported through claims-based or registry-based submission for the 2009 PQRI.

We proposed that the form and manner of quality data submission for 2009 measures groups would be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* no later than December 31, 2008, and will detail specifications and specific instructions for reporting measures groups via claims and registry-based reporting.

The final 2009 PQRI measures groups and the measures selected for inclusion in each of the 2009 measures groups are listed in section II.O1.d.v. of this final rule with comment period.

We proposed (73 FR 38561) establishing three options for satisfactorily reporting measures groups using claims-based reporting and three options for satisfactorily reporting measures groups using registry-based

submission for the 2009 PQRI. We proposed two basic criteria for satisfactory reporting of measures groups for both claims-based submission and registry-based submission. For claims-based reporting, the two criteria were:
(1) The reporting of quality data for 30 consecutive Medicare Part B FFS patients for one measures group for which the measures group is applicable during a full-year reporting period; or (2) the reporting of quality data for at least 80 percent of Medicare Part B FFS patients for whom the measures group is applicable (with a minimum number of patients commensurate with the reporting period duration). For registry-based submission, the two criteria were: (1) The reporting of quality measures results and numerator and denominator data for 30 consecutive patients for one measures group for which the measures group is applicable during a full-year reporting period; or (2) the reporting of quality measures results and numerator and denominator data for at least 80 percent of patients for whom the measures group is applicable (with a minimum number of patients commensurate with the reporting period duration).

We proposed that the 30 consecutive patients reporting criteria apply only to the entire year (January 1, 2009 through December 31, 2009) reporting period, but would apply to both claims-based submission and registry-based submission mechanisms.

We proposed that the alternative criteria for measures groups based on reporting on 80 percent of patients for which one measures group would be applicable for the January 1, 2009 through December 31, 2009 reporting period (with a minimum of 30 patients) and to the July 1, 2009 through December 31, 2009 reporting period (with a minimum of 15 patients). These alternative criteria would also be applicable for either claims-based or registry-based reporting of measures groups.

In the CY 2009 PFS proposed rule (73 FR 38561), we requested comments on the proposed use of the consecutive patient reporting criteria and on the use of 30 consecutive patients (for claims-based reporting, the consecutive patients must all be Medicare FFS patients) as the required minimum sample under these criteria during the full-year 2009 reporting period.

We received numerous comments on the proposed alternative reporting periods and alternative criteria for satisfactory reporting of data on measures groups, including the proposed use of the consecutive patient reporting criteria and proposed use of 30 consecutive patients. These comments are summarized and addressed below.

Comment: Some commenters suggested that we establish general rules governing measures groups reporting involving multiple providers from separate entities.

Response: To qualify for the PQRI incentive, each individual professional must separately qualify, based on the criteria for reporting measures groups and the services rendered by the individual professional. The reporting by other professionals and the establishment of rules relating to the reporting of multiple providers from separate entities is not germane to satisfactory reporting at the individual level. Each individual professional must qualify based on that individual's satisfactory reporting. No later than December 31, 2008, we will post the detailed specifications and specific instructions for reporting measures groups at *http://www.cms.hhs.gov/pqri*. This document is intended to promote an understanding of how to implement and facilitate satisfactory reporting of quality measures results and numerator and denominator data by individual eligible professionals who wish to participate in PQRI via measures group reporting.

Comment: Many commenters strongly supported the continued use of measures groups, the expansion of measures groups, registry-based submissions of measures groups, and alternative reporting periods for measures groups.

Response: We are pleased that many commenters are supportive of the measures groups concept, the expansion of measures groups, registry-based submissions for measures groups, and alternative reporting periods. These options provide for program efficiency, flexibility and opportunities for physicians and other eligible professionals to more broadly demonstrate their clinical performance for particular services and provide a better basis for comparison among professionals. We plan to continue a dialogue with stakeholders to discuss opportunities for program efficiency and flexibility.

Comment: Many commenters were in support of the 30 consecutive patient reporting option for the full year 2009 reporting period. One commenter noted that a sample consisting of consecutive patients would result in a nonrandom sample of patients. Another commenter requested clarification on which 30 patients should be included in the consecutive patient sample.

Response: We are pleased that many commenters found the 30 consecutive patient reporting option to be useful and were supportive of this option. We agree that a sample of 30 consecutive patients would be a nonrandom sample, but it is our intention to allow physicians and other eligible professionals greater flexibility and opportunities to participate in PQRI. In addition, requiring consecutive patients would prevent eligible professionals from being able to selectively report cases to enhance their performance rates.

While we do not have the results of the 2008 PQRI reporting, we believe that a minimum sample size of 30 consecutive patients is sufficient to calculate comparable performance rates across eligible professionals furnishing comparable services. Patient sample sizes of 30 are commonly considered to be a reasonable minimum threshold for being able to reliably report health care performance measurement results. Results from our Better Quality Information for Medicare Beneficiaries (BQI) pilot project indicate that minimum patient sample sizes of between 30 through 50 patients per physician are needed to make reliable distinctions between physicians' performance. (Delmarva Foundation for Medical Care. Enhancing Physician Quality Performance Measurement and Reporting Through Data Aggregation: The BQI Project. October 2008.) We expect additional experience with PQRI reporting to clarify optimal sample sizes and reporting criteria for use in future reporting periods. We will continually evaluate our policies on sampling and notify the public through future notice and comment rulemaking if we make substantive changes. As we evaluate our policies, we plan to continue a dialogue with stakeholders to discuss opportunities for program efficiency and flexibility.

As described in Table 12, for claims-based reporting of measures groups, eligible professionals wishing to report data on measures groups using the consecutive patient criteria should include only Medicare Part B FFS patients in the consecutive patient sample. For registry-based reporting of measures groups, eligible professionals wishing to report data on measures groups using the consecutive patient criteria may include some non-Medicare FFS patients. However, there must be more than one Medicare Part B FFS patient included in this patient sample as well.

Comment: We received a large volume of comments in support of discontinuing the 15 consecutive patients for a 6-month reporting period

(that is, July 1 through December 31). We also received a few comments suggesting we continue the option of allowing eligible professionals to report data on 15 consecutive patients for a 6-month reporting period.

Response: Unlike in the 2008 PQRI, we will not include a reporting option for 15 consecutive patients for a 6-month reporting period. While we do not have the results of the 2008 reporting, we are concerned that samples of fewer than 30 consecutive patients may be insufficient to calculate comparable performance rates across eligible professionals furnishing comparable services. We expect additional experience with PQRI reporting to clarify optimal sample sizes and reporting criteria for use in future reporting periods.

Comment: We received comments recommending that, regardless of the reporting mechanism selected, the criteria for satisfactorily reporting data on measures groups and individual quality measures be expanded to include the reporting data on measures groups and/or individual quality measures for 100 percent of patients for whom the measures group and/or individual quality measures are applicable. One commenter thought that we should specifically require eligible professionals who report via registries to report on 100 percent of their eligible patients. Another commenter suggested that for the option to report on 80 percent of patients for registry-based reporting of measures groups we accept quality measures results and numerator and denominator data on quality measures on all patients, regardless of payer, rather than quality measures results and numerator and denominator data on quality measures on Medicare Part B FFS beneficiaries only. The commenter, however, opposed requiring a minimum number of Medicare FFS patients be included in the data submitted from the registry. Another commenter thought that registry reporting and claims-based reporting requirements should be the same.

Response: While we would encourage eligible professionals to report data on measures groups and/or individual quality measures for all patients who qualify for a measure they are reporting and eligible professionals are not precluded from reporting data on measures groups and/or individual quality measures for 100 percent of their eligible patients, satisfactory reporting was established by the MIEA–TRHCA to include reporting in at least 80 percent of the cases for which the respective measure is reportable. Analysis of the 80 percent reporting threshold has indicated it to be a sufficiently large sample size to be representative of an eligible professional's patient population. That is, 80 percent is a sufficiently large reporting rate that the performance rates calculated from the 80 percent sample are substantially the same as the performance rates calculated from 100 percent of applicable cases. Although a 100 percent sample of cases for which individual quality measure or measures groups are applicable would eliminate any sampling error, requiring 100 percent reporting of applicable cases would cause eligible professionals to be ineligible for an incentive payment based on a failure to report data on a single missed case that falls into the quality measure's denominator.

Additionally, the 80 percent reporting criteria for individual quality measures is statutorily required through 2009 for individual quality measures reported through claims. While the Secretary is authorized to establish a different reporting threshold for measures groups and registry-based reporting, we believe that it is necessary and desirable to maintain consistency and to achieve a balance amongst the reporting options in order to promote a successful program.

With respect to requiring a minimum number of Medicare Part B FFS patients in the sample for registry-based reporting options for reporting on measures groups for at least 80 percent of applicable cases, our primary interest is in improving the quality of care Medicare beneficiaries receive. If we do not specify a minimum number of Medicare Part B FFS on which eligible professionals should report, it is feasible that an eligible professional could meet the 80 percent threshold by treating just one or two beneficiaries. Thus, for those eligible professionals who treat few Medicare beneficiaries, the sample size would be too small to do any meaningful analysis of the eligible professional's performance on that particular measure even though the sample consists of 80 percent of the eligible professional's Medicare beneficiaries to whom the measure applies.

Comment: One commenter suggested that registries ''facilitate quality measures reporting for measures groups reporting regardless of the relationship of the reporting provider to the registry.'' The commenter suggested that we further clarify that in order to become qualified to submit quality measures results and numerator and denominator data on quality measures to the PQRI on behalf of eligible professionals, a registry must assure a mechanism by which multiple providers who collectively report the individual measures comprising a measures group can do so and that there are no barriers to the reporting of such information by any provider regardless of the provider's relationship to the registry.

Response: Registries provide an alternative to claims-based reporting. Regardless of the reporting mechanism (that is, claims or registries), there is no provision for reporting by multiple professionals under the PQRI since each individual eligible professional must separately meet the criteria for satisfactory reporting of PQRI quality measures. Registries have no responsibility to establish a relationship with any particular professional. An eligible professional who does not have a relationship with a qualified registry has the option of submitting data on measures groups through claims or establishing a relationship with a qualified registry unless he or she wishes to report the CABG surgery measures group. The measures in the CABG surgery measures group are reportable only through a registry.

Comment: One commenter thought we should allow satisfactory reporting of measures groups via registries to count for 2 years of PQRI reporting.

Response: Our statutory authority authorizes an annual PQRI program. For each year, there are established specific reporting periods and reporting criteria. The incentive payment for PQRI must be for covered professional services furnished during a given reporting period. We do not have the authority to allow satisfactory reporting of measures groups via registries for a 1-year reporting period to count as satisfactory reporting for another year or reporting period.

Based on the comments received, we are finalizing the six options proposed for satisfactorily reporting on measures groups as described in Table 12. The details of the requirements for registries are contained in section II.O1.b.iii.

TABLE 12—FINAL 2009 PQRI REPORTING OPTIONS FOR MEASURES GROUPS

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	One Measures Group for 30 Consecutive Medicare Part B FFS Patients.	January 1, 2009–December 31, 2009.
Claims-based reporting	One Measures Group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009–December 31, 2009.
Claims-based reporting	One Measures Group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009–December 31, 2009.
Registry-based reporting	One Measures Group for 30 Consecutive Patients. Patients may include, but may not be exclusively, non-Medicare patients.	January 1, 2009–December 31, 2009.
Registry-based reporting	One Measures Group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009–December 31, 2009.
Registry-based reporting	One Measures Group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009–December 31, 2009.

While claims are submitted to CMS on Medicare patients only (for claims-based reporting), the 30 consecutive patients option for registry-based submission for the January 1, 2009 through December 31, 2009 reporting period may include some, but may not be exclusively, non-Medicare patients. We include this limited option to report quality measures results and numerator and denominator data on quality measures that includes non-Medicare patients for registry-based submission because of the desirability of assessing the overall care provided by a professional rather than just that provided to a certain subset of patients, and the benefit of having a larger number of patients on which to assess quality.

iii. Registry-Based Submission for Reporting Individual Measures

As discussed in the CY 2009 PFS proposed rule (73 FR 38562), section 101(c)(5)(F) of the MIEA–TRHCA, as added by MMSEA and redesignated by the MIPPA as section 1848(m)(5)(F) of the Act, requires us to establish alternative criteria for satisfactorily reporting PQRI quality measures data through medical registries. For 2009, we proposed that eligible professionals would be able to report 2009 PQRI quality measures results and numerator and denominator data on quality measures through a qualified clinical registry by authorizing or instructing the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf (73 FR 38562). Similar to the 2008 PQRI, we proposed (73 FR 38562) that the data to be submitted for the 2009 PQRI would include the reporting and performance rates on PQRI measures or PQRI measures groups, as well as the numerators and denominators for the reporting rates and performance rates.

For the 2009 PQRI, we proposed (73 FR 38562) to continue the PQRI reporting criteria for satisfactorily reporting through registry-based submission of 3 or more individual PQRI quality measures data that are described in the ''2008 PQRI: Establishment of Alternative Reporting Periods and Reporting Criteria'' document (*http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIalterrptperiods.pdf*). That is, we proposed to accept quality measures results and numerator and denominator data on quality measures from registries that qualify as data submission vendors. We proposed that these criteria would be available for each of the two alternative reporting periods.

We also proposed (73 FR 38563) to require registries to complete a self-nomination process based on meeting specific technical and other requirements to submit on behalf of eligible professionals pursuing incentive payment for reporting clinical quality information on services furnished during 2009 for reporting both on individual measures and measures groups. We proposed that this self-nomination would be required regardless of whether or not the registry participated in any way in PQRI in 2008 (73 FR 38563).

In the CY 2008 PFS proposed rule (73 FR 38564), we requested comments on the proposed options for registry-based PQRI reporting of data on measures and measures groups for services furnished in 2009. We received several comments on the proposed options for registry-based PQRI reporting of data on measures and measures groups for services furnished in 2009. Comments related to the proposed options for registry-based PQRI reporting of data on measures groups were summarized and addressed above in section II.O1.b.ii of this final rule with comment period. A summary of the comments received related to our proposed use of registries and the proposed options for registry-based PQRI reporting of data on individual quality measures and our responses to those comments are discussed below.

Comment: We received numerous comments in support of continuing to allow registries to report quality measures results and numerator and denominator data on quality measures to CMS on behalf of eligible professionals who submit quality data to them. Some commenters thought permitting registry reporting would allow us to better track patient outcomes by looking at results over a period of time rather than only track processes of care and that registry reporting is less burdensome. Additionally, one commenter suggested we allow those registries that were ''qualified'' to report to PQRI in 2008 be ''qualified'' to report to PQRI in 2009.

Response: For the 2009 PQRI, we are finalizing our proposal to accept quality measures results and numerator and denominator data on quality measures from registries as described in the

proposed rule (73 FR 38562 through 38564). The specifications and qualifications for registries to participate in the 2009 PQRI will be listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* under the reporting tab, by November 15, 2008.

Based on the commenter's suggestion that registries that were ''qualified'' to report to PQRI in 2008 be ''qualified'' to report to PQRI in 2009, registries that were ''qualified'' for 2008 will not need to be ''re-qualified'' for 2009 unless they are unsuccessful at submitting PQRI data for 2008 (that is, fail to submit 2008 PQRI data per the 2008 PQRI registry requirements). By March 31, 2009, registries that were ''qualified'' for 2008 and wish to continue to participate in 2009 should indicate their desire to continue participation for 2009 and their compliance with the 2009 PQRI registry requirements using the process described below.

If a qualified 2008 registry is unsuccessful at submitting 2008 PQRI data (that is, fails to submit 2008 PQRI data per the 2008 PQRI registry requirements), the registry will need to go through the full qualification process similar to the qualification process that took place for the 2008 PQRI. By March 31, 2009, registries that are unsuccessful submitting quality measure results and numerator and denominator data for the 2008 PQRI will need to be able to meet the specifications listed below and in the document on the Web site and send a letter of self-nomination to us.

Registries that were not qualified for the 2008 PQRI will need to be able to meet the specifications listed below and in the document on the Web site and send a letter of self-nomination to us by January 31, 2009.

Comment: One comment supported registry use if they were open to all providers.

Response: We assume that by ''providers'' the commenter was referring to eligible professionals. As we stated previously, registry reporting is voluntary. There are ''qualified'' registries in our 2008 PQRI program that intend to report all of the PQRI measures. These registries are accepting eligible professionals who wish to sign up as new clients of the registry and are open to all eligible professionals who would like to participate with them. There may be costs associated with participating through registries but this is outside of the purview of PQRI.

We note that although registries are not required to report all PQRI measures, eligible professionals who wish to report PQRI quality measures data through registries are required to report on at least 3 quality measures when reporting on individual quality measures or to report all measures in at least one measures group when reporting on measures groups. Thus, the eligible professional is responsible for ensuring that the registry that he or she selects has the ability to report the measures that the eligible professional intends to report for PQRI.

Comment: We received one comment requesting eligible professionals with only 1 or 2 measures to be able to report via registries.

Response: We did not propose to allow registry reporting of 1 or 2 measures if less than 3 measures apply. Analytically it would be difficult to implement in that if an eligible professional submits fewer than 3 measures via registries, we would not know whether the eligible professional did so because only 2 measures applied or because the registry only accepts data for 2 of the provider's measures and he or she is reporting their third measure via claims. The amount of cross-checking via different submission options that would be necessary makes it impractical to implement the commenter's suggestion.

Comment: A few comments were received regarding the process for correcting data that was sent in via registries that is incorrect.

Response: We highly discourage eligible professionals from changing data once it is submitted to CMS from the registry. Allowing data to be resubmitted for one or more professionals would not only be time-consuming and delay reports and payment, but it could also result in duplicating or erroneously leaving out some professionals' quality measures results and/or numerator and denominator data on quality measures.

Comment: Two commenters requested that we specify what constituted an acceptable validation strategy for registries.

Response: As a result of the MMSEA, which was enacted in December 2007, and modified the PQRI, we implemented registry-based submission for the 2008 PQRI. Thus, for 2008, we required registry vendors to supply CMS with their validation strategy that would detail how the registry would ensure that the data the registry reported to CMS was accurate. We found that there are several variations for this process that registries use. We do not believe we have enough experience with registries to specify a single validation strategy that all should employ and we believe we are benefited from allowing a variety of such techniques to be employed based on our approval at this point. Therefore, for the 2009 PQRI, registry vendors will again be required to supply us with their validation strategy that details how the registry would ensure that the data the registry reports to us is accurate. In addition, we note that registries are required to sign an attestation statement to CMS vouching for the accuracy of the data that they submit to CMS on behalf of their eligible professionals.

As we gain more experience with registry submission, we would expect to further specify through rulemaking qualification requirements for registries that may include more comprehensive validation requirements. As we evaluate our policies, we plan to continue a dialogue with stakeholders to discuss opportunities for program efficiency and flexibility.

Comment: One commenter requested that the registry record layout and requirements be published by December 31, 2008. Similarly, many commenters requested that the registry record layout and requirements be published in this final rule with comment period.

Response: We intend to have the requirements posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* by November 15, 2008. However, the technical specifications (that is, specifications for the XML file format that registries would need to use to submit PQRI quality measures results and numerator and denominator data on quality measures to CMS) are not finalized and will be made available to a registry after the registry passes an initial qualification process. This will prevent registries that cannot satisfy the requirements listed on the Web site from expending resources trying to meet the technical specifications. Meeting only the technical specifications would not in and of itself qualify the registry to participate.

Comment: A commenter requested that CMS work with standards development organizations to align our measures and specifications for registries and EHRs with the standards development organizations' standards.

Response: We agree with the commenter's suggestion and do actively interact with standards development organizations. We desire to use such standards when available and to promote the adoption and use of such standards.

Based on the comments received, the 2009 reporting options for registry-based submission of at least three individual PQRI measures are finalized as proposed and are listed in Table 13.

TABLE 13—FINAL 2009 PQRI REGISTRY-BASED SUBMISSION REPORTING OPTIONS FOR INDIVIDUAL MEASURES

Reporting mechanism	Reporting criteria	Reporting period
Registry-based reporting	At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009–December 31, 2009.
Registry-based reporting	At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	July 1, 2009–December 31, 2009.

As discussed in section II.O1.b.ii. of this final rule with comment period, we are also establishing the three reporting options for registry-based submission of quality measures results and numerator and denominator data on PQRI measures groups summarized in Table 12.

To report quality measures results and numerator and denominator data on quality measures or measures groups through registries, eligible professionals will need to enter into and maintain an appropriate legal arrangement with an eligible clinical registry. As we described in the CY 2009 PFS proposed rule (73 FR 38562), such arrangements will provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on behalf of the eligible professional to CMS for the PQRI. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as ''data submission vendors.'' Such ''data submission vendors'' would have the requisite legal authority to provide clinical registry data on behalf of the eligible professional to the Quality Reporting System developed in accordance with the statute. The registry, acting as such a data submission vendor, will submit registry-derived measures information to the CMS designated database within the Quality Reporting System, using a CMS-specified record layout.

To maintain compliance with applicable statutes and regulations, including but not limited to the HIPAA, our program and its data system must maintain compliance with HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also must maintain compliance with the HIPAA requirements.

To submit on behalf of eligible professionals pursuing incentive payment for reporting clinical quality information on services furnished during 2009 for reporting both on individual measures and measures groups, registries that were ''qualified'' for 2008 will not need to be ''re-qualified'' for 2009 unless they are unsuccessful at submitting 2008 PQRI data (that is, fail to submit 2008 PQRI data per the 2008 PQRI registry requirements). Registries that were ''qualified'' for 2008 and wish to continue to participate in 2009 should indicate their desire to continue participation for 2009 by submitting a letter indicating their continued interest in being a PQRI registry for 2009 and their compliance with the 2009 PQRI registry requirements by March 31, 2009. Such letters should be sent to: 2009 PQRI Registry Nomination, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Blvd., Mail Stop S3–02–01, Baltimore, MD 21244–1850.

If a qualified 2008 registry is unsuccessful at submitting 2008 PQRI data (that is, fails to submit 2008 PQRI data per the 2008 PQRI registry requirements), the registry will need to go through the full self-nomination process again. By March 31, 2009, registries that are unsuccessful submitting quality measure results and numerator and denominator data for 2008 will need to be able to meet the specifications listed in this final rule with comment period and in the document on the Web site and send a letter of self-nomination to the above address. Registries that were not ''qualified'' for 2008 will need to be able to meet the specifications listed in this final rule with comment period and in the document on the Web site and send a letter of self-nomination to the above address by January 31, 2009.

As we stated in the CY 2009 PFS proposed rule (73 FR 38563), we will make every effort to ensure that registries that are ''qualified'' will be able to successfully submit quality measures results and numerator and denominator data on PQRI quality measures or measures groups, but we cannot assume responsibility for the successful submission of data on PQRI quality measures or measures groups, by the registry.

The 2009 registry technical requirements will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* by November 15, 2008. In general, to be considered qualified to submit individual quality measures on behalf of professionals wishing to report under the 2009 PQRI, a registry must:

- Have been in existence as of January 1, 2009.
- Be able to collect all needed data elements and calculate results for at least three measures in the 2009 PQRI program (according to the posted 2009 PQRI Measure Specifications).
- Be able to calculate and submit measure-level reporting rates by NPI/Taxpayer Identification Number (TIN).
- Be able to calculate and submit measure-level performance rates by NPI/TIN.
- Be able to separate out and report on Medicare Fee for Service (Part B) patients only.
- Provide the Registry name.
- Provide the Reporting period start date (covers dates of services from).
- Provide the Reporting period end date (covers dates of services through).
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting.
- Provide the measure title for the PQRI quality measures on which the registry is reporting.
- Report the number of eligible instances (reporting denominator).
- Report the number of instances of quality service performed (numerator).
- Report the number of performance exclusions.
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance).
- Be able to transmit this data in a CMS-approved XML format.
- Comply with a secure method for data submission.
- Submit an acceptable ''validation strategy'' to CMS by March 31, 2009. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their

participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method.

• Enter into and maintain with its participating professionals an appropriate legal arrangement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.

• Obtain and keep on file signed documentation that each NPI whose data is submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must meet the standards of applicable law, regulations, and contractual business associate agreements.

• Provide CMS access (if requested) to review the Medicare beneficiary data on which 2009 PQRI registry-based submissions are founded.

• Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen.

• Registries must provide CMS an ''attestation statement'' which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete.

In addition to the above, registries that wish to submit 2009 quality measures information on behalf of their participating eligible professionals seeking to participate in the 2009 PQRI based on satisfying the criteria applicable to reporting of measures groups must be able to:

• Indicate whether each eligible professional within the registry who wishes to submit PQRI using the measures groups will be doing so for the 6- or 12-month period.

• Base reported information only on patients to whom services were furnished during the 12-month reporting period of January through December 2009 or the 6-month reporting period of July 2009 through December 2009.

• Agree that the registry's data may be inspected by CMS under our health oversight authority if non-Medicare patients are included in the consecutive patient group.

• Be able to report data on all of the measures in a given measures group and on either 30 consecutive patients from January 1 through December 31, 2009 (note this consecutive patient count must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 30 patients during the January 1, 2009 through December 31, 2009 reporting period or a minimum of 15 patients during the July 1, 2009 through December 31, 2009 reporting period).

• If reporting consecutive patients, provide the beginning date of service that initiates the count of 30 consecutive patients.

• Be able to report the number of Medicare Fee for Service patients and the number of Medicare Advantage patients that are included in the consecutive patients reported for a given measures group.

Registries that were ''qualified'' for 2008 and wish to continue to participate in 2009 must indicate their compliance with the above requirements for 2009 at the time that they indicate their desire to continue participation for 2009.

We will provide the technical specifications (that is, specifications for the XML file format that registries would need to use to submit PQRI quality measures results and numerator and denominator data on quality measures to CMS) to registries after a registry passes an initial qualification process for the 2009 PQRI. This will prevent registries that cannot satisfy the requirements listed on the Web site from expending resources trying to meet the technical specifications. Meeting only the technical specifications would not in and of itself qualify the registry to participate.

iv. EHR-Based Submission for Reporting Individual Measures

In addition to the testing of registry-based submission, we also described in the CY 2009 PFS proposed rule (73 FR 38564 through 38565) our plans to test the submission of clinical quality data extracted from EHRs for five 2008 PQRI measures and proposed to accept PQRI data from EHRs and to pay the incentive payment based on that submission for a limited subset of the proposed 2009 PQRI quality measures.

We proposed to begin accepting submission of clinical quality data extracted from EHRs on January 1, 2009 or as soon thereafter as is technically feasible, based upon our completion of the 2008 EHR data submission testing process and our determination that accepting data from EHRs on quality measures for the 2009 PQRI is practical and feasible. We proposed in the CY 2009 PFS proposed rule (73 FR 38564) that the date on which we will begin to accept quality data submission on services furnished in 2009 would depend on having the necessary information technology infrastructure components and capacity in place and ready to accept data on a scale sufficient for national implementation of PQRI submission through this mechanism.

We proposed that EHR vendors that would like to enable their customers to submit data on PQRI that is extracted from their customers' EHRs to the CMS-designated clinical warehouse should update or otherwise assure that their EHR products capture and can submit the necessary data elements identified for measure specifications and technical specifications for EHR-based submission. We proposed that we would use Certification Commission for Healthcare Information Technology (CCHIT) criteria and the Healthcare Information Technology Standards Panel (HITSP) interoperability standards where possible and we encouraged vendors to do so also. We encouraged the use of EHRs that have been certified by the CCHIT for data submission, but recognized that there would be some eligible professionals who are using systems in specialties for which there are no appropriate CCHIT certified EHR systems, or who purchased and implemented their EHR prior to the availability of CCHIT certification.

We proposed as criteria for satisfactory submission of data for quality measures for covered professional services by EHR-based submission for the 2009 PQRI the same criteria for satisfactory reporting and the same reporting period that we proposed for claims-based submission of data for individual 2009 PQRI measures. The proposed reporting criteria for EHR-based submission of individual PQRI measures are summarized in Table 14.

TABLE 14—PROPOSED 2009 PQRI EHR-BASED SUBMISSION REPORTING OPTIONS FOR INDIVIDUAL MEASURES

Reporting mechanism	Reporting criteria	Reporting period
EHR-based reporting	At least 3 PQRI measures, or 1–2 measures if less than 3 apply to the eligible professional, for 80% of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009–December 31, 2009.

In the CY 2008 PFS proposed rule (73 FR 38565), we invited comments on the proposed use of EHR-based data submission for PQRI. We received numerous comments on the proposed use of EHR-based data submission for PQRI, which are summarized and addressed below.

Comment: We received many comments in favor of accepting quality measures data through EHRs in 2009. These commenters cited EHRs as a means for increasing PQRI participation and being able to report more accurate data. There were a few commenters who, while favoring EHR data submission in general, thought that it was premature to begin this process in 2009.

Response: We proposed to begin EHR data submission for PQRI in 2009 based on anticipation that we would have sufficient testing completed to be confident that systems would be in place and operational by January 1, 2009. At this point, the testing process is incomplete. As a result, we agree with the commenter's suggestion that it is premature to begin EHR submission as part of the 2009 PQRI. Rather, we believe that it is more prudent to allow the 2008 testing process to be completed.

Furthermore, we are aware of the importance of promoting and aligning with the work of health information technology (HIT) standards development organizations. By postponing implementation of EHR submissions for PQRI, we believe this alignment with and promotion of the adoption and uses of HIT standards will be enhanced.

Finally, we believe it would benefit eligible professionals to know in advance of the start of a PQRI reporting period which EHR vendors are qualified to submit clinical quality data extracted from their EHR to CMS. At this point, we would be unable to identify such vendors in view of the incomplete testing process.

Rather than implement EHR reporting for the 2009 PQRI, and in order to prepare for possible implementation of EHR reporting for the 2010 PQRI, we will complete the 2008 testing and continue additional testing in 2009. In addition, upon completion of satisfactory testing, we intend to qualify EHR vendors and their specific products to submit clinical quality data extracted from their EHR products to the CMS quality data warehouse. As vendors qualify, we would post the names on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* for informational purposes.

It should be noted, however, that qualification of vendors for EHR data submission does not assure that we will include EHR data submission as an option for satisfactorily reporting data on quality measures for the 2010 PQRI. Rather, this will be the subject of future notice and comment rulemaking.

The process we will use to qualify EHR vendors and their specific products is described below.

Comment: One commenter suggested we allow non-CCHIT certified EHRs to submit data to PQRI.

Response: We are not planning to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in the 2009 PQRI and instead will only continue testing in the 2009 PQRI. We do not intend to limit testing to CCHIT certified EHRs given the fact that relevant certification standards may not yet have been adopted. Any EHR quality data submission will be required to comply with all current regulations regarding security, privacy, and HIPAA.

Comment: A few commenters suggested allowing EHRs to report quality measures data on measures groups.

Response: We did not propose this option because of our concerns with the feasibility of such reporting. In addition, as discussed previously, we are not including EHR reporting for the 2009 PQRI as an option but instead will continue testing during 2009.

Comment: A commenter was concerned that CMS does not inadvertently facilitate anti-competitive behavior by allowing reporting of information on quality measures via EHRs.

Response: We are unclear as to how allowing quality data reporting through EHRs could result in anti-competitive behavior.

Comment: A few commenters suggested either paying more money so that providers can adopt HIT or paying more incentives for measures submitted electronically.

Response: We are authorized by statute to provide incentive payments in 2009 to eligible professionals who satisfactorily report PQRI quality measures data and/or who are successful electronic prescribers only. We lack specific authority to pay eligible professionals more incentives for the adoption of HIT or for measures submitted electronically.

The basis for the calculation of the incentive payment for PQRI is also statutorily defined and previously discussed. We do not have the authority to modify the amount of payments to promote particular objectives, nor to base the incentive payments for PQRI on using an electronic means of submission. As identified in section II.O1.d.i. below, we note that one of the structural measures selected for inclusion in the 2009 PQRI is an HIT measure (Measure #124). Thus, an eligible professional who reports this measure along with meeting the other criteria for satisfactorily reporting for the 2009 PQRI can earn an additional 2.0 percent of their estimated total allowed charges for covered professional services furnished during the 2009 PQRI reporting period for their adoption and use of HIT.

Additionally, as described in section II.O2. of this final rule with comment period, we are authorized to pay a 2.0 percent incentive payment for eligible professionals who are successful electronic prescribers in 2009. The 2.0 percent incentive payment for successful electronic prescribers is a separate incentive payment from the 2.0 percent incentive payment authorized for satisfactory reporting of quality information for the 2009 PQRI.

Comment: A few commenters requested that we publish the submission standards for EHRs as soon as possible to allow practitioners and vendors adequate time to modify their systems by January 1, 2009. In addition, several commenters requested that the final rule specify the procedures and requirements that EHR vendors must meet to minimize errors in the EHR reporting process during the reporting period as well as procedures to be followed to correct for errors that may

occur when the vendor submits data to CMS.

Response: As stated above, we are not planning to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in the 2009 PQRI. We intend, however, to continue testing in 2009 and to qualify EHR vendors and their specific products to submit clinical quality data extracted from their EHR products to the CMS quality data warehouse so that we may potentially begin to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in future PQRI reporting. Therefore, by December 31, 2008, we anticipate posting on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* a list of requirements that EHR vendors must be able to meet in order to self-nominate to have their product ''qualified'' to be able to participate in the continued testing phase in 2009 and with anticipation that such vendors' systems may be able to submit quality measures data in the future to CMS for PQRI on behalf of the eligible professional(s) using the system(s).

Based on the comments received related to our proposal to begin accepting data from EHRs for the 2009 PQRI and our experience thus far with testing the EHR reporting mechanism, we are not finalizing our proposal to allow eligible professionals to submit clinical quality data extracted from EHRs for purposes of receiving an incentive payment for the 2009 PQRI. Instead, we will continue to test the submission of clinical quality data extracted from EHRs in 2009. The measures on which specifications are available for testing EHR data submission are identified in Table 15. The specifications for these measures can be found on the QualityNet Web site at *http://www.qualitynet.org/dcs/ContentServer?cid=1214232460333&pagename=Qnet Public%2FPage%2FQnetTier3&c=Page*.

By December 31, 2008, we also anticipate posting on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* a list of requirements that EHR vendors must be able to meet in order to self-nominate to have their product ''qualified'' to potentially be able to submit quality measures data for the 2010 PQRI to CMS. Qualifying EHR vendors ahead of actual data submission will facilitate the live data submission process.

EHR vendors interested in engaging in the 2009 testing and qualification process should review the EHR requirements document that will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov*. If an EHR vendor wishes to be included in the testing and qualification process, the vendor should submit a letter of self-nomination to CMS by February 13, 2009 to: PQRI EHR Nomination, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Blvd, Mail Stop S3–02–01, Baltimore, MD 21244–1850.

The EHR vendors who self-nominate will be included in a ''qualifying'' process (similar to the process previously established for registries) to assess their capabilities. If they are found to meet the requirements, the EHR vendors will be included in the data submission testing. These processes will have firm timelines that vendors must meet. Failure to meet any of these deadlines will be a basis for not continuing to consider the EHR vendor for qualification to submit data to the CMS quality data warehouse. The number of self-nominated vendors will determine the timeframe needed to complete the testing and qualification process. However, it is expected that this process will conclude by mid-summer 2009. The measures and reporting mechanism for the 2010 PQRI will be the subject of future notice and comment rulemaking. As previously noted, the completion of the EHR vendor quality data submission qualification process does not ensure that EHR reporting will be an option for the 2010 PQRI.

c. Statutory Requirements for Measures Included in the 2009 PQRI

i. Overview and Summary

Section 1848(k)(2)(B)(ii) of the Act requires CMS to publish in the **Federal Register** by no later than August 15, 2008, a proposed set of quality measures that the Secretary determines would be appropriate for eligible professionals to use to submit data in 2009. In addition, section 1848(k)(2)(B)(iii) of the Act requires CMS to publish in the **Federal Register** by no later than November 15, 2008, the final set of quality measures that would be appropriate for eligible professionals to use to submit data in 2009.

As discussed in the CY 2009 PFS proposed rule (73 FR 38565), in examining the statutory requirements of section 1848(k)(2)(B)(i) of the Act, as amended by the MMSEA, we believe that the requirement that measures be endorsed or adopted by a consensus organization applies to each measure that would be included in the measure set for submitting quality data and/or quality measures results and numerator and denominator data on the quality measures on covered professional services furnished during 2009. Likewise, the requirement for measures to have been developed using a consensus-based process (as identified by the Secretary) applies to each measure. By contrast, we do not interpret the provision requiring inclusion of measures submitted by a specialty to apply to each measure. Rather, we believe this requirement means that in endorsing or adopting measures, a consensus organization must include in its consideration process at least some measures submitted by one physician or organization representing a particular specialty.

We also believe that under sections 1848(k)(2)(B)(ii) through (iii) of the Act, the Secretary is given broad discretion to determine which quality measures meet the statutory requirements and are appropriate for inclusion in the final set of measures for 2009. We do not interpret section 1848(k)(2)(B) of the Act to require that all measures that meet the basic requirements of section 1848(k)(2)(B)(i) of the Act be included in the 2009 set of quality measures. The statutory requirements for consensus organizations and the use of a consensus-based process for developing quality measures as they relate to the requirements for the 2009 PQRI measures were discussed in the CY 2009 PFS proposed rule (73 FR 38565 through 38566). As discussed in the proposed rule, consistent with the principle that measures used for 2009 be endorsed or adopted by a consensus organization and developed through the use of a consensus-based process, but without limiting the 2009 PQRI measures to those meeting the definition of a voluntary consensus standard under the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113) (NTTAA), we interpret ''consensus-based process for developing measures'' as used in section 1848(k) of the Act to encompass not only the basic development work of the formal measure developer, but also to include the achievement of consensus among stakeholders in the health care system.

In addition, section 1848(k)(2)(D) of the Act, as added by the MIPPA, requires that for each 2009 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.'' Eligible professionals have the opportunity to provide input during the development of a measure during the public comment phase of a measure's

development. As part of the measure development process, measure developers typically solicit public comments on measures that they are testing in order to determine whether additional refinement of the measure(s) is needed prior to submission for consensus endorsement. Additional information on the measure development process used by CMS contractors is available in the ''Quality Measures Development Overview'' document found on the CMS Web site at *http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityMeasuresDevelopmentOverview.pdf*. Eligible professionals also have the opportunity to provide input on a measure as the measure is being vetted through the consensus endorsement and/or adoption process. Both the NQF and AQA employ a public comment period for measures vetted through their respective consensus endorsement or adoption processes. Finally, eligible professionals have an opportunity to provide input on measures selected for inclusion in PQRI through the notice and comment rulemaking process we use to announce the measures selected for inclusion in PQRI each year. As required by section 1848(k)(2)(B)(ii) of the Act, we proposed measures for the 2009 PQRI in the **Federal Register** in July, which was followed by a 60-day comment period in which eligible professionals had the opportunity to comment. Accordingly, we believe the additional requirement under MIPPA with regard to the 2009 PQRI has been met in multiple ways.

ii. Summary of Comments and Responses

We received several comments related to the statutory requirements for measures included in the 2009 PQRI and/or our approach to the selection of measures, which are summarized and addressed below.

Comment: Several comments expressed concerns about the AQA's structure and original intended purpose not being ideally suited to its current role in PQRI, and its role in the measure endorsement process not clearly adding value to the process. Many comments noted that the AQA does not meet the NTTAA definition of a ''voluntary consensus standards body.''

Response: Both the NQF and the AQA were identified as examples of consensus organizations under section 1848(k)(2)(B)(i) of the Act. We interpreted this to mean that for purposes of the PQRI, these organizations, as constituted on the date of enactment of the MIEA–THRCA authorizing legislation, are considered to be consensus organizations. On the other hand we stated that we found the NQF to be an organization organized and operating in a manner that meets the NTTAA definition of a ''voluntary consensus standards body,'' but we did not find that the AQA constituted such an organization. We also stated our policy preference for measures endorsed by an organization that meets the NTTAA definition of ''voluntary consensus standards body'' to one that does not so qualify. Further, we stated our policy that a measure that was specifically declined for endorsement by the NQF would not be included in PQRI even though it was adopted by AQA.

Comment: Several commenters commended NQF for the scientific rigor of its structure and review processes. Some commenters in favor of establishing a single consensus organization entity whose approval would qualify a measure for PQRI inclusion went on to name NQF as the leading or only named candidate for such an organization.

Response: As stated previously, we have stated a policy preference for NQF-endorsed measures. However, we are not limited by statute to using only NQF-endorsed measures.

Comment: We received some comments supportive of having measures that originate from a variety of sources and opposed to requiring PQRI measurement development to come solely from physician controlled organizations. At the same time, several commenters suggested we consider establishing as policy that quality measures to be used by, and analyzed at the level of, individual PQRI-eligible professionals, must be developed by clinician controlled organizations to assure relevance and promote uptake by the eligible professional community. Multiple commenters suggested that explicit preference be given for measures developed or endorsed by physician specialty societies, in the context of consensus-organization review and CMS measure selection processes. Some commenters stated that the AMA–PCPI should be the sole source for physician level measures. Several commenters specifically presented an interpretation of the requirement under section 1848(k)(2)(B)(i) of the Act for the 2009 PQRI measures to include measures submitted by a physician specialty as meaning that the 2009 PQRI should include only measures developed by physician organizations, to assure physician control of available measures applicable to assessing the clinical performance of individual physicians.

Response: Physician involvement and leadership is standard in the work of both measure developers and consensus organizations. As a result, physicians are actively involved at all levels of measure development and consensus adoption and endorsement. We are in agreement that physician expertise is an important ingredient in measure development and in the consensus process. We further recognize the leadership of physician organizations, as is reflected in the large number of physician quality measures included in PQRI which were developed by the AMA–PCPI and its participating specialty societies.

However, we do not agree that physicians should be in complete control of the process of measure development, as would be the case if measures were required to be developed solely by physician-controlled organizations. Any such restriction would unduly limit the basic development of physician quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. We do not interpret the provisions in section 1848(k)(2)(B)(i) of the Act to place special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Similarly, we do not interpret section 1848(k)(2)(B)(i) of the Act to require that each measure included in the 2009 PQRI have been developed by a physician specialty.

Section 1848(k)(2)(B)(i) of the Act, thereby, maintains flexibility in potential sources of measure consensus review, which is, like having multiple sources of measure development, key to maintaining a robust marketplace for development and review of quality measures.

Comment: Several comments addressed gaps in the PQRI measure set, such as the lack of measures related to patient-centeredness, equity/disparities, and episodes of care based efficiency. One comment expressed concern that the PQRI measures appear to be targeted to single conditions and to patients where classical treatment goals are appropriate and do not contain any quality measures specifically addressing multiple, co-morbid conditions. A few comments urged CMS to adopt quality measures that would enable the full range of physicians to participate and to identify and add more quality measures to fill the gaps. The commenters also requested that we consider developing interim opportunities for eligible professionals for whom there is a

shortage of available measures to participate in the PQRI and to receive an incentive for doing so. One comment urged funding for consumer-relevant measure development to fill the existing gaps and to include language in the measure development contracts that reflects the perspectives of consumers and purchasers. Another commenter urged us to include more measures on which specifications for electronic data submission via EHRs are available.

Response: Health care quality measures are currently developed by a variety of organizations and used by a variety of governmental and nongovernmental, and public-private initiatives which have various and at times differing priorities and programmatic needs for quality measures. As reflected by the considerations for identifying proposed PQRI quality measures described in the CY 2009 PFS proposed rule (73 FR 38566), we are committed to having a broad and robust set of quality measures for the PQRI. However, we largely depend on the development of measures by professional organizations and other measure developers. Although we had significant involvement in the development of measures applicable to eligible professionals at the start of the PQRI, ideally we would not need to be closely involved in the development of clinician-level quality measures but would select from measures that meet the statutory requirements. Thus, we encourage professional organizations and other measure developers to fund and develop measures that address some of the gaps identified by the commenters.

Comment: One comment suggested that we add additional measures in July of each year for implementation in that year's PQRI. For example, in July 2009, we should announce additional measures for inclusion in the 2009 PQRI.

Response: Section 1848(k)(2)(B)(ii) requires us to publish a proposed set of quality measures for inclusion in a particular year's PQRI program in the **Federal Register** by no later than August 15th of the prior year. Additionally, section 1848(k)(2)(B)(iii) requires us to publish a final set of quality measures for inclusion in a particular year's PQRI program in the **Federal Register** by no later than November 15th of the prior year. We are not authorized to make any changes to the final set of PQRI quality measures for a particular year once the set has been published in the **Federal Register**.

However, as explained in the CY 2009 PFS proposed rule (73 FR 38570) we introduced a test measures process during 2008, which gives eligible professionals the opportunity to submit the quality data codes for measures included in the 2008 Measure Testing Process. No financial incentive is associated with the reporting of these 2008 test measures though. Instead, the test measures process helps provide experience with using the measures which can contribute to future consideration for the PQRI. We proposed and are finalizing as 2009 PQRI measures certain measures included in the 2008 Test Measures Process.

d. The Final 2009 PQRI Quality Measures

In the CY 2009 PFS proposed rule (73 FR 38566 through 38567), we solicited comments on the implication of including or excluding 175 specific quality measures in 4 categories. We also explained that while we recognized that some commenters may wish to recommend additional measures for inclusion in the 2009 PQRI measures that we had not proposed, we would not be able to consider such additional measures for inclusion in the 2009 measure set. We also described several considerations used for selecting the measures proposed for the 2009 PQRI.

We received multiple comments on the proposed 2009 PQRI quality measures, which are addressed below.

Comment: A number of comments requested or recommended that we make readily available on an ongoing basis more detailed information on the measure development process and measures in development. Numerous commenters also requested final measure specifications be published as far in advance of the beginning of the reporting period as possible, and that more detailed information about measures proposed or finalized for use in PQRI be published at the same time as or in advance of future rulemaking.

Response: We agree that it is desirable for the public to have information on the measures development process and measures in development. To this end CMS has developed a standardized process to be used for CMS contracted measures development. This standardized process is detailed in the ''Quality Measures Development Overview'' document found on the CMS Web site at *http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityMeasuresDevelopmentOverview.pdf*. Under the standardized measures development process, we plan that all CMS contracted measures developers, in the future, will post the measures for public comment on the CMS Web site rather than solely on the individual contractor's Web site. This will allow a uniform access point for information during the CMS contracted basic development process for measures intended for PQRI. Additionally, other major measures developers publish measures and specifications during development and seek public comment as do both NQF and AQA during their consensus processes.

We agree with the commenters that it is desirable to provide final measure specifications sufficiently in advance of the reporting period to allow reasonable time for professionals to analyze new or revised measures and implement any needed changes in their office workflows to accurately capture and successfully submit data on a selection of measures applicable to their practice on which they can act to improve the quality of the services they furnish. Having detailed information on measures available in advance of the reporting period also enhances the ability of vendors (such as practice-management software, billing services, and electronic health records vendors) to support professionals' successful implementation of revised data-capture processes for the measures.

Given that section 1848(k)(2)(B)(iii) requires that we publish the final list of 2009 PQRI measures in the **Federal Register** no later than November 15, 2008, we expect to publish detailed specifications shortly after that date. Detailed measure specifications for measures new or revised for 2009 PQRI will be posted on the Measures/Codes tab of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.* These detailed specifications will include instructions for reporting and identifying the circumstances in which each measure is applicable. The detailed technical specifications for measures in the final listing for the 2009 PQRI remain potentially subject to corrections until the start of the 2009 reporting period, as we stated in the proposed rule. In addition, the 2009 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2008. Specifications for all 2009 PQRI quality measures, whether or not included in the 2008 PQRI program, must be obtained from the specifications document for 2009 PQRI quality measures.

Since its inception, the PQRI program has expanded rapidly in terms of the number of measures included in the PQRI. This rapid growth was necessary in order to meet a primary objective of having a sufficient number of measures to allow broad participation by eligible professionals who cover a broad scope

of services provided to Medicare beneficiaries. We now have a broad range of measures and expect to rely more on the test measures program to introduce new measures. In this way, by the time they may be proposed for inclusion in a set of measures for a particular year, the measures specifications will be published, established, and utilized by eligible professionals for test submission.

Comment: Numerous commenters suggested quality measures in addition to the quality measures we had proposed in Tables 11 through 14 of the CY 2009 PFS proposed rule (73 FR 38567 through 38572) for the 2009 PQRI.

Response: We have not included in final 2009 PQRI quality measures any quality measures that were not identified in the CY 2009 PFS proposed rule as proposed 2009 PQRI measures. As discussed above in this rule, we are obligated by section 1848(k)(2)(B)(ii) of the Act to publish and provide opportunity for public comment on proposed 2009 PQRI quality measures. Measures recommended for selection via comments on the proposed rule that were not included in the proposed rule have not been placed before the public as part of notice and comment rulemaking process. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2009 PQRI quality measure set that is required to be finalized via publication in the **Federal Register** by November 15, 2008 in accordance with section 1848(k)(2)(B)(iii) of the Act.

However, we have captured these recommendations and will have them available for consideration in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent or possibly to be introduced as part of a PQRI Test Measures Process.

Comment: We received a few comments that suggested that some measures are not conducive to claims-based reporting but are good measures if submitted via a registry or an EHR.

Response: We are not finalizing the proposal to allow submission of clinical quality data extracted from EHRS for the 2009 PQRI. We, however, agree that some measures are not conducive to claims-based reporting. For the 2009 PQRI, there are 18 measures that will only be accepted for reporting via registries due to their complex measure specifications, which require multiple diagnosis codes; a low number of satisfactory submissions during the 2007 PQRI; and a high occurrence of inaccurate quality date codes reporting for the 2007 PQRI. These measures are identified in Tables 15, 16, 18, and 22 with a ''+'' after the Measure Title.

For the 2009 PQRI, the following 5 quality measures in Table 15 will be reportable only through registries as individual quality measures:

- Measure #7 CAD: Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
- Measure #33 Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
- Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
- Measure #81 End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients
- Measure #82 ESRD: Plan of Care for Inadequate Peritoneal Dialysis

The following 8 quality measures in Tables 16 and 22 will be reportable only through registries as individual quality measures or part of the CABG measures group for the 2009 PQRI:

- CABG: Prolonged Intubation (Ventilation)
- CABG: Deep Sternal Wound Infection Rate
- CABG: Stroke/Cerebrovascular Accident (CVA)
- CABG: Post-operative Renal Insufficiency
- CABG: Surgical Re-exploration
- CABG: Anti-platelet Medications at Discharge
- CABG: Beta Blockade at Discharge
- CABG: Lipid Management and Counseling

Finally, the following 5 quality measures in Table 18 will be reportable only through registries as individual quality measures for the 2009 PQRI:

- Pediatric ESRD: Adequacy of Hemodialysis
- HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
- HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
- HIV/AIDS: HIV RNA Control After 6 Months of Potent Antiretroviral Therapy

Comment: One commenter suggested that CMS accept as many measures as possible that are based solely on information derived from administrative claims so that professionals would not have to do additional coding.

Response: Under the PQRI program eligible professionals are provided an incentive payment for submission of quality data. What is suggested would not involve submission of quality data but merely normal claims submission from which quality inferences would be made. An important difference in that approach to PQRI is that under PQRI, by submitting quality data, the eligible professional indicates that the patient is appropriately attributed to that professional. When purely administrative data are used, attribution rules would need to be applied, with which the physician or other eligible professional may not agree. Thus, focusing on administrative-data based measures only could have the unintended consequence of holding the eligible professional responsible for certain services which the eligible professional might feel are beyond their scope of care for a particular patient.

Comment: Several commenters recommended changes to specific quality measures' titles, definitions, and detailed specifications or coding. Many of these recommendations were based on alternative interpretations of clinical evidence or concerns about the utility of the measures. Some requests were specifically concerned that measures be expanded to include specific professionals to whom the measure may be applicable such as occupational therapists, registered dieticians, and audiologists. Specifically, one commenter suggested that in order to maximize the impact of Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus, the PQRI specifications should continue to require a performance period of 12 months and reporting that identifies whether A1c control is good (that is, A1c $\leq$ 7.0 percent), moderate (that is, A1c $\leq$ 9.0 percent, but $>$ 7.0 percent), or poor (that is, A1c $>$ 9.0 percent). Another commenter requested that CMS re-evaluate the use of inpatient site of service codes (99241 through 99245) for Measure #5 Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD), Measure #6 CAD: Oral Antiplatelet Therapy Prescribed for Patients with CAD, Measure #7 CAD: Beta-Blocker Therapy for CAD Patients with Prior MI, and Measure #8 Heart Failure: Beta-Blocker Therapy for LVSD. Also another commenter requested the addition of specifications for inpatient reporting for Measure #56 Community-Acquired Pneumonia (CAP): Vital Signs, Measure #57 CAP: Assessment of Oxygen Saturation, Measure #58 CAP: Assessment of Mental Status, and Measure #59 CAP: Empiric Antibiotic. One commenter expressed gratitude that audiologists are now eligible to

participate in PQRI and willingness to work with the measure developer to expand Measure #94 Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility and Measure #95 Otitis Media with Effusion (OME): Hearing Testing. Lastly, one commenter requested that we not use Measures #73 Cancer: Plan for Chemotherapy Documented and Measure T143 Cancer Care: Medical and Radiation—Plan of Care for Pain until the measure developers revise the measure specifications to include all chemotherapy and biologic disease modalities recognized in clinical guidelines. Also, this same commenter requested that we not use the Rheumatoid Arthritis measures group until the measures' developer revises the measures to include all biologic disease-modifying antirheumatic drugs (DMARDS) used as a monotherapy or in combination with nonbiologic DMARDS, such as methotrexate.

Response: Quality measures that have completed the consensus processes of NQF or AQA have a designated party (generally the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. The measure maintainer and/or the developer/owner of a measure included in the final set of quality measures selected for the 2009 PQRI is identified as the ''Measure Source'' in Tables 15 through 18. In addition, NQF has, for its endorsed measures, an established maintenance process which may be accessed.

The Secretary is required to select measures through notice and comment rulemaking. We do not, however, use notice and comment rulemaking as a means to update or modify measure specifications. We retain the ability to update or modify specifications to the measures until December 31, 2008. After that date, there will be no changes to the measure for the 2009 reporting period(s).

Comment: A number of comments requested or recommended that CMS include ''paired'' measures in the 2009 PQRI. Commenters noted that while under review by the NQF Steering Committee several measures proposed for 2009 were recommended to be implemented as ''paired measures'' by the NQF. Commenters referenced the following proposed measures as paired measures based on the NQF Steering Committee's recommendations:

(1) Hepatitis C: Hepatitis A Vaccination and Hepatitis C: Hepatitis B Vaccination.

(2) Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment and Hepatitis C: HCV Genotype Testing Prior to Therapy.

(3) Oncology: Medical and Radiation—Pain Intensity Quantified and Oncology: Medical and Radiation—Plan of Care for Pain.

Response: The 2009 PQRI will include four measures sets that can be considered paired measures. Each paired measures set consists of two closely related individual measures, but which are composed of two similar and complementary aspects of care. The measures assess uniquely different constructs in the assessment and/or management of a particular condition. Thus, while we note the recommendation that the measures in a particular paired measures set be reported together, we do not require for the 2009 PQRI that the measures in a particular paired measures set be reported together.

These paired measures do not constitute a measures group. These measures may be subject to the measures validation strategy posted on PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage*. Under the measures validation strategy for eligible professionals that satisfactorily report less than three measures, failure to report the additional measure(s) in a valid set would cause the eligible professional to fail to meet the validation requirements.

The four paired measures sets for the 2009 PQRI are as follows:

(1) Hepatitis C: Hepatitis A Vaccination and Hepatitis C: Hepatitis B Vaccination.

(2) Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment and Hepatitis C: HCV Genotype Testing Prior to Therapy.

(3) Oncology: Medical and Radiation—Pain Intensity Quantified and Oncology: Medical and Radiation—Plan of Care for Pain.

(4) Falls: Risk Assessment and Falls: Plan of Care.

Reporting instructions and detailed measure specifications for the 2009 PQRI quality measures will be available by no later than December 31, 2008 on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.*

Based on our review of these comments, the final set of 153 quality measures selected for the 2009 PQRI are listed in Tables 15 through 18. These measures can be categorized as follows: (1) Measures selected from the 2008 PQRI quality measures set; (2) additional NQF-endorsed measures; (3) additional AQA-adopted measures; and (4) additional measures that had not received NQF endorsement or AQA adoption at the time the proposed rule was published but whose selection was contingent upon whether they received NQF endorsement or AQA adoption by August 31, 2008.

No changes (that is, additions or deletions of measures) will be made after publication of this final rule with comment period. However, as was the case for 2008, we may make modifications or refinements, such as revisions to measures titles and code additions, corrections, or revisions to the detailed specifications for the 2009 measures until the beginning of the reporting period. Such specification modifications may be made through the last day preceding the beginning of the reporting period. The 2009 measures specifications will be available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* when they are sufficiently developed or finalized. We are targeting finalization and publication of the detailed specifications for all 2009 PQRI measures on the PQRI section of the CMS Web site by November 15, 2008 and will in no event publish these specifications later than December 31, 2008. The detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable.

As described in section II.O1.b.ii. above, we are establishing a total of seven measures groups for use in the 2009 PQRI. The measures selected for inclusion in each of the 2009 measures groups are listed in Tables 19 through 25.

i. Measures Selected From the 2008 PQRI Quality Measures Set

In the CY 2009 PFS proposed rule (73 FR 38567 through 38570) we proposed to include in the 2009 PQRI quality measures set 111 2008 PQRI quality measures. We received several comments on the 111 proposed measures selected from the 2008 PQRI quality measure set. The comments and our responses to those comments are discussed below.

Comment: We received numerous comments in support of the 2008 PQRI measures selected for the 2009 PQRI. One commenter supports the retention of all the 2008 PQRI measures proposed for 2009. Other commenters specifically support inclusion of the following proposed 2008 PQRI measures in the 2009 PQRI:

- Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

- Measure #6 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients With CAD
- Measure #11 Stroke and Stroke Rehabilitation: Carotid Imaging Reports
- Measure #24 Osteoporosis: Communication With the Physician Managing Ongoing Care Post-Fracture
- Measure #39 Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- Measure #40 Osteoporosis: Management Following Fracture
- Measure #41 Osteoporosis: Pharmacologic Therapy
- Measure #48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Measure #58 Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- Measure #84 Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
- Measure #85 Hepatitis C: HCV Genotype Testing Prior to Therapy
- Measure #86 Hepatitis C: Consideration for Antiviral Therapy in HCV Patients
- Measure #94 Otitis Media With Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility
- Measure #95 Otitis Media With Effusion (OME): Hearing Testing
- Measure #110 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
- Measure #111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
- Measure #112 Preventive Care and Screening: Screening Mammography
- Measure #113 Preventive Care and Screening: Colorectal Cancer Screening
- Measure #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use
- Measure #115 Preventive Care and Screening: Advising Smokers to Quit
- Measure #128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

We also received several comments specifically suggesting that Measure 73 Cancer: Plan for Chemotherapy Documented be removed from the 2009 PQRI quality measures for failure to achieve NQF endorsement.

Response: Table 15 shows that 101 of 111 proposed 2008 PQRI quality measures have been finalized for the 2009 PQRI. All of the measures specifically supported by commenters are included in Table 15. As suggested by commenters Measure #73 Cancer: Plan for Chemotherapy Documented has been removed from the 2009 PQRI quality measures set because the measure was considered and specifically declined for endorsement by NQF on or before August 31, 2008.

Comment: With respect to the two proposed structural measures (Measure #124 and Measure #125), we received 2 comments suggesting that we allow a practice or an eligible professional to simply attest to the use of an EHR or electronic prescribing in their office rather than report it on a claim as this was considered burdensome. Another comment recommended we treat an eligible professional's recognition under the National Committee for Quality Assurance (NCQA) Physician Practice Connection (PPC) as equivalent to reporting the two structural measures (Measures #124 and #125).

Response: For those professionals using an EHR, their system should be able to auto populate a superbill with the appropriate G code for this measure. Many EHRs already code the visit with diagnosis and level of service. The G code could be added to the superbill in this way. The EHR measure (Measure #124) requires more than just having an EHR system and software available in the office; rather the measure also measures ongoing use of the systems.

As required by section 1848(m)(3)(A) of the Act, as redesignated and amended by the MIPPA, we are removing the electronic prescribing measure (measure #125) from the 2009 PQRI quality measure set and adopting the measure for use in the e-prescribing incentive program described in section II.O2. of this final rule with comment period.

With respect to the recommendation to consider recognition under the NCQA PPC as equivalent to satisfactory PQRI reporting, a fundamental PQRI requirement is that the data be reported on PQRI measures. The PPC is a proprietary recognition program that does not utilize PQRI Measures #124 or #125.

Comment: One commenter requested clarification of a statement made in the proposed rule regarding the 2008 PQRI Measure #4 Screening for Future Fall Risk not proposed for 2009. This commenter noted that the measure developer did not make a request to retire this measure from PQRI nor was the measure replaced by a new AQA-adopted or NQF-endorsed measure proposed for 2009 as stated in the CY 2009 PFS proposed rule (73 FR 38567). The commenter advocated for Measure #4 Screening for Future Fall Risk to remain available for the 2009 PQRI. Another commenter supported the removal of Measure #4 Screening for Future Fall Risk as a result of two new substantially similar fall measures proposed for 2009.

Response: The commenter was correct in noting that the proposed rule incorrectly stated that the 2008 PQRI Measure #4 Screening for Future Fall Risk not proposed for 2009 was retired and intended to be replaced by new AQA-adopted or NQF-endorsed measures proposed for 2009.

However, we are not including Measure #4 Screening for Future Fall Risk in the final set of 2009 PQRI quality measures. We consider the following proposed AQA-adopted measures included in the final 2009 PQRI quality measures set listed in Table 17 to substantially cover the same care process as Measure #4 Screening for Future Fall Risk and more comprehensive: Falls: Risk Assessment and Falls: Plan of Care.

In addition, as previously stated in this final rule with comment period, we are obligated by section 1848(k)(2)(B)(ii) of the Act to publish and provide opportunity for public comment on proposed 2009 PQRI quality measures prior to including them in the final 2009 PQRI quality measures set.

Based on whether a measure retained its NQF endorsement status as of August 31, 2008 and the comments received, we are finalizing in the 2009 PQRI quality measure set the following 101 of 111 proposed 2008 PQRI measures identified in Table 15.

TABLE 15—FINAL 2008 PQRI MEASURES SELECTED FOR 2009

Measure number and title	Measure source
1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus*	NCQA.
2. Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus*	NCQA.
3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus*	NCQA.
5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	American Medical Association—Physician Consortium for Performance Improvement (AMA–PCPI).

TABLE 15—FINAL 2008 PQRI MEASURES SELECTED FOR 2009—Continued

Measure number and title	Measure source
6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA–PCPI.
7. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)+,*.	AMA–PCPI.
8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA–PCPI.
9. Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD.	NCQA.
10. Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	AMA–PCPI/NCQA.
11. Stroke and Stroke Rehabilitation: Carotid Imaging Reports	AMA–PCPI/NCQA.
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	AMA–PCPI/NCQA.
14. Age-Related Macular Degeneration (AMD): Dilated Macular Examination	AMA–PCPI/NCQA.
18. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	AMA–PCPI/NCQA.
19. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	AMA–PCPI/NCQA.
20. Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician	AMA–PCPI/NCQA.
21. Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	AMA–PCPI/NCQA.
22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA–PCPI/NCQA.
23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	AMA–PCPI/NCQA.
24. Osteoporosis: Communication With the Physician Managing Ongoing Care Post-Fracture	AMA–PCPI/NCQA.
28. Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA–PCPI/NCQA.
30. Perioperative Care: Timing of Prophylactic Antibiotics—Administering Physician	AMA–PCPI/NCQA.
31. Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage.	AMA–PCPI/NCQA.
32. Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	AMA–PCPI/NCQA.
33. Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge+.	AMA–PCPI/NCQA.
34. Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t–PA) Considered	AMA–PCPI/NCQA.
35. Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA–PCPI/NCQA.
36. Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	AMA–PCPI/NCQA.
39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA–PCPI/NCQA.
40. Osteoporosis: Management Following Fracture	AMA–PCPI/NCQA.
41. Osteoporosis: Pharmacologic Therapy	AMA–PCPI/NCQA.
43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Isolated CABG Surgery.	The Society of Thoracic Surgeons (STS).
44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	STS.
45. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	AMA–PCPI/NCQA.
46. Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility+	AMA–PCPI/NCQA.
47. Advance Care Plan	AMA–PCPI/NCQA.
48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA.
49. Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA.
50. Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA.
51. Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	AMA–PCPI.
52. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	AMA–PCPI.
53. Asthma: Pharmacologic Therapy	AMA–PCPI.
54. 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	AMA–PCPI/NCQA.
55. 12-Lead Electrocardiogram (ECG) Performed for Syncope	AMA–PCPI/NCQA.
56. Community-Acquired Pneumonia (CAP): Vital Signs	AMA–PCPI/NCQA.
57. Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA–PCPI/NCQA.
58. Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA–PCPI/NCQA.
59. Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA–PCPI/NCQA.
64. Asthma: Asthma Assessment	AMA–PCPI.
65. Treatment for Children with Upper Respiratory Infection (URI)—Avoidance of Inappropriate Use.	NCQA.
66. Appropriate Testing for Children with Pharyngitis	NCQA.
67. Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.	AMA–PCPI/American Society of Hematology (ASH).
68. Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy.	AMA–PCPI/ASH.
69. Multiple Myeloma: Treatment With Bisphosphonates	AMA–PCPI/ASH.
70. Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	AMA–PCPI/ASH.
71. Breast Cancer: Hormonal Therapy for Stage IC–III Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	AMA–PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN).
72. Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	AMA–PCPI/ASCO/NCCN.
76. Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter Insertion Protocol.	AMA–PCPI.

TABLE 15—FINAL 2008 PQRI MEASURES SELECTED FOR 2009—Continued

Measure number and title	Measure source
79. End-Stage Renal Disease (ESRD): Influenza Vaccination in Patients with ESRD	AMA–PCPI.
81. End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients+.	AMA–PCPI.
82. End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis+	AMA–PCPI.
83. Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia	AMA–PCPI.
84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA–PCPI.
85. Hepatitis C: HCV Genotype Testing Prior to Therapy	AMA–PCPI.
86. Hepatitis C: Consideration for Antiviral Therapy in HCV Patients	AMA–PCPI.
87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA–PCPI.
89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA–PCPI.
90. Hepatitis C: Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy.	AMA–PCPI.
91. Acute Otitis Externa (AOE): Topical Therapy	AMA–PCPI.
92. Acute Otitis Externa (AOE): Pain Assessment	AMA–PCPI.
93. Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.	AMA–PCPI.
94. Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility.	AMA–PCPI.
95. Otitis Media with Effusion (OME): Hearing Testing	AMA–PCPI.
99. Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade.	AMA–PCPI/College of American Pathologists (CAP).
100. Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade.	AMA–PCPI/CAP.
102. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients.	AMA–PCPI.
104. Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	AMA–PCPI.
105. Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA–PCPI.
106. Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA–PCPI.
107. Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA–PCPI.
108. Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy	NCQA.
109. Osteoarthritis (OA): Function and Pain Assessment	AMA–PCPI.
110. Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old*	AMA–PCPI.
111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older*	NCQA.
112. Preventive Care and Screening: Screening Mammography*	NCQA.
113. Preventive Care and Screening: Colorectal Cancer Screening*	NCQA.
114. Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA–PCPI.
115. Preventive Care and Screening: Advising Smokers to Quit	NCQA.
116. Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis—Avoidance of Inappropriate Use.	NCQA.
117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA.
118. Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD).	AMA–PCPI.
119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	NCQA.
121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	AMA–PCPI
122. Chronic Kidney Disease (CKD): Blood Pressure Management	AMA–PCPI.
123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis—Stimulating Agents (ESA).	AMA–PCPI.
124. HIT: Adoption/Use of Electronic Health Records (EHR)*	Quality Insights of Pennsylvania (QIP)/CMS.
126. Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation.	American Podiatric Medical Association (APMA).
127. Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear	APMA.
128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	QIP/CMS.
130. Documentation and Verification of Current Medications in the Medical Record	QIP/CMS.
131. Pain Assessment Prior to Initiation of Patient Treatment	QIP/CMS.
134. Screening for Clinical Depression	QIP/CMS.

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.
* This measure is 1 of 10 measures on which specifications are available for testing electronic submission via EHRs.

The following proposed measures included in the 2008 PQRI on the basis of AQA adoption were considered and specifically declined for endorsement by NQF on or before August 31, 2008 and therefore are not included in the final measure set for the 2009 PQRI:

- Measure #73 Cancer: Plan for Chemotherapy Documented
- Measure #77 Gastroesophageal Reflux Disease (GERD): Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD
- Measure #78 ESRD: Vascular Access for Patients Undergoing Hemodialysis
- Measure #101 Prostate Cancer: Appropriate Initial Evaluation
- Measure #132 Patient Co-Development of Treatment Plan/Plan of Care.

As described in sections II.O2. and III. of this final rule with comment period, the MIPPA authorized a new incentive program for successful electronic prescribers. As a result, section 1848(m)(3)(A) of the Act, as redesignated by section 131(b)(3)(C) of the MIPPA and amended by section 131(b)(3)(D)(iii) of the MIPPA for 2009 and subsequent years, specifies that the PQRI quality measures shall not include electronic prescribing measures. Therefore, Measure # 125 HIT: Adoption/Use of Medication e-Prescribing is not included in the final set of 2009 PQRI quality measures. This measure will instead be used for the new e-prescribing incentive program authorized by MIPPA as discussed in section II.O2.

Lastly, we are not finalizing the following proposed measures included in the 2008 PQRI primarily because our analysis of the 2007 PQRI results indicate that there were no satisfactory submissions and no quality data codes accepted for these measures during the 2007 PQRI:

- Measure #96 OME: Antihistamines or Decongestants—Avoidance of Inappropriate Use
- Measure #97 OME: Systemic Antimicrobials—Avoidance of Inappropriate Use
- Measure #98 OME: Systemic Corticosteroids—Avoidance of Inappropriate Use
- Measure #120 CKD: ACE/ARB Therapy.

With respect to Measures #96 through #98, we also believe that eligible professionals would be unlikely to voluntarily report inappropriate actions. With respect to Measure #120, our analysis of the 2007 PQRI results revealed that the measure requires multiple diagnosis codes.

Please note that detailed measure specifications for 2008 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2009. The 2009 PQRI quality measure specifications for any given quality measure may, therefore, be different from specifications for the same quality measure used for 2008. Specifications for all 2009 PQRI quality measures, whether or not included in the 2008 PQRI program, must be obtained from the specifications document for 2009 PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2008.

As stated above, there are 5 measures listed in Table 15 that can be reported only via a registry for the 2009 PQRI and, therefore, are not reportable via claims-based reporting.

ii. Additional NQF-Endorsed Measures

We proposed to include in the 2009 PQRI quality measure set 17 new measures endorsed by the NQF but that were not included in the 2008 PQRI quality measures. We received several comments on the 17 proposed additional NQF-endorsed measures, which are summarized and addressed below.

Comment: We received several comments in support of the proposed additional NQF-endorsed measures. Comments were received specifically in support of the following measures:

- Anti-platelet Medications at Discharge.
- Hemodialysis Vascular Access Decision-making by Surgeons to Maximize Placement of Autogeneous Arterial Venous Fistula.

One commenter, also the measure's developer, recommended the removal of the proposed measure ''Use of Imaging Studies in Low Back Pain'' and noted that this measure does not share a common denominator with the other measures within the Back Pain measures group.

Response: We concur with the comments in support of the proposed additional NQF-endorsed measures. However, for the reasons recommended by the measure developer the proposed measure ''Use of Imaging Studies in Low Back Pain'' has been removed from the 2009 PQRI quality measures set.

For the 2009 PQRI quality measure set, we are finalizing 15 of the 17 proposed measures that were endorsed by the NQF but were not included in the 2008 PQRI quality measures. These 17 measures are identified in Table 16. Besides having NQF endorsement, these measures were considered ready for implementation for the purposes of the 2009 PQRI as of October 15, 2008 based on the following—(1) the final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure to be reported by claims have been established and will be effective for CMS claims data submission on or before January 1, 2009.

TABLE 16—FINAL ADDITIONAL NQF–ENDORSED MEASURES

Measure title	Measure source
Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	AMA–PCPI.
Back Pain: Initial Visit	NCQA.
Back Pain: Physical Exam	NCQA.
Back Pain: Advice for Normal Activities	NCQA.
Back Pain: Advice Against Bed Rest	NCQA.
Diabetes Mellitus: Foot Exam	NCQA.
Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)+	STS.
Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate+	STS.
Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)+	STS.
Coronary Artery Bypass Graft (CABG): Post-operative Renal Insufficiency+	STS.
Coronary Artery Bypass Graft (CABG): Surgical Re-exploration+	STS.
Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge+	STS.
Coronary Artery Bypass Graft (CABG): Beta Blockade at Discharge+	STS.
Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling+	STS.
Hemodialysis Vascular Access Decision-Making by Surgeons To Maximize Placement of Autogenous Arterial Venous Fistula.	Society for Vascular Surgeons (SVS).

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

As previously mentioned in this final rule, we are not finalizing the proposed measure, Use of Imaging Studies in Low Back Pain, in the final 2009 PQRI quality measures set listed in Table 16 based on comments received.

In addition, we are not finalizing the following proposed NQF-endorsed measure in the final 2009 PQRI measures because its adaptation to the PQRI format was subsequently found to be not feasible: Selection of Antibiotic Administration for Cardiac Surgery Patients. Substantive components of this measure are duplicative of Measure # 21 Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin, which is listed in Table 15.

As stated above, there are 8 measures listed in Table 16 that can be reported only via a registry for the 2009 PQRI and, therefore, are not reportable via claims-based reporting.

As described in the CY 2009 PFS proposed rule (73 FR 38570), measures designated as T### in the proposed rule indicated that the measure was included in the 2008 Measure Testing Process. The T#### identifier was removed from Table 16 in this final rule with comment because each measure in the final 2009 PQRI quality measures set will be assigned a unique number which may be obtained from the detailed specifications which will be made available on the PQRI section of the CMS Web site no later than December 31, 2008.

iii. Additional AQA Adopted Measures

As discussed in the CY 2009 PFS proposed rule (73 FR 38565 through 38566), in circumstances where no NQF-endorsed measure is available, a quality measure that has been adopted by the AQA would also meet the requirements of section 1848(k)(2)(B)(i) of the Act. As such, we proposed 21 new measures adopted by the AQA that had not yet been reviewed or endorsed by the NQF at the time the CY 2009 PFS proposed rule was published and that were not included in the final set of 2008 PQRI quality measures (73 FR 38571).

We received numerous comments on the 21 proposed additional AQA-adopted measures, which are summarized and addressed below.

Comment: Numerous commenters were in support of the inclusion of the following proposed additional AQA-adopted measures in the final 2009 PQRI measures:

- T138 Melanoma: Coordination of Care.
- T139 Cataracts: Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement.
- T140 Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.
- T141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care.
- T143 Oncology: Medical and Radiation—Plan of Care for Pain.
- Oncology: Medical and Radiation-Pain Intensity Quantified.
- Oncology: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer.

However, we received 2 comments specifically suggesting that the proposed measure, T144 Radiology: Computed Tomography (CT) Radiation Dose Reduction, not be finalized as part of the 2009 PQRI quality measures for failure to achieve a recommendation for endorsement by the NQF Steering Committee on Outpatient Imaging Efficiency.

Response: As suggested by commenters Measure T144 Radiology: Computed Tomography (CT) Radiation Dose Reduction will not be finalized as part of the 2009 PQRI quality measures set because the measure was specifically reviewed by NQF on or before August 31, 2008 but declined for endorsement. All other additional AQA-adopted measures specifically supported by commenters are being finalized for the 2009 PQRI.

We are including in the final 2009 PQRI quality measure set 19 of the 21 proposed measures adopted by AQA that had not yet been reviewed or endorsed by the NQF at the time the CY 2009 PFS proposed rule was published and that were not included in the final set of 2008 PQRI quality measures. These measures are identified in Table 17.

TABLE 17—FINAL ADDITIONAL AQA-ADOPTED MEASURES

Measure title	Measure source
Chronic Kidney Disease (CKD): Influenza Immunization	AMA–PCPI.
Melanoma: Follow-Up Aspects of Care	AMA–PCPI/NCQA.
Melanoma: Continuity of Care—Recall System	AMA–PCPI/NCQA.
Melanoma: Coordination of Care	AMA–PCPI/NCQA.
Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	AMA–PCPI/NCQA.
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA–PCPI/NCQA.
Primary Open-Angle Glaucoma (POAG) : Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care.	AMA–PCPI/NCQA.
Oncology: Medical and Radiation—Plan of Care for Pain	AMA–PCPI.
Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA–PCPI/NCQA.
Oncology: Medical and Radiation—Pain Quantified	AMA–PCPI.
Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA–PCPI.
Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	AMA–PCPI.
Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA–PCPI.
Falls: Plan of Care	AMA–PCPI.
Falls: Risk Assessment	AMA–PCPI.
Oncology: Radiation Dose Limits to Normal Tissues	AMA–PCPI.
Hepatitis C: Hepatitis A Vaccination	AMA–PCPI.
Hepatitis C: Hepatitis B Vaccination	AMA–PCPI.
Oncology: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer	STS.

The following proposed measures are not included in the final 2009 PQRI quality measure set because they were reviewed by NQF on or before August 31, 2008 and were not recommended for endorsement:

- Measure T144 Radiology: Computed Tomography (CT) Radiation Dose Reduction; and
- Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise.

Besides being adopted by the AQA, the measures we finalized were considered ready for implementation for the purposes of the 2009 PQRI as of October 15, 2008 based on the following—(1) the final, detailed

specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the CPT II codes required for the measure to be reported by claims have been established and will be effective for CMS claims data submission on or before January 1, 2009.

As described in section III.O.4.b, measures designated as T### in the proposed rule indicated that the measure was included in the 2008 Measure Testing Process. The T#### identifier was removed from Table 17 in the final rule with comment period because each measure in the final 2009 PQRI measure set will be assigned an unique number which may be obtained from the detailed specifications which will be made available on the PQRI section of the CMS Web site no later than December 31, 2008.

iv. Additional Measures Selected Contingent upon NQF Endorsement or AQA Adoption by August 31, 2008

We proposed to include in the 2009 PQRI quality measure set 26 new measures that had not yet received NQF endorsement or AQA adoption at the time of the publication of the proposed rule but whose selection was contingent on NQF endorsement and/or AQA adoption by August 31, 2008 (73 FR 38571 through 38572).

We received several comments on these 26 proposed measures, which are summarized and addressed below.

Comment: Several commenters were in support of the following proposed measures that have since been NQF endorsed and/or AQA adopted as of August 31, 2008:

- Nuclear Medicine: Correlation with Existing Imaging Studies for all Patients Undergoing Bone Scintigraphy; and
- Preventive Care and Screening: Unhealthy Alcohol Use—Screening & Brief Counseling.

One commenter, also the measure's developer, noted that the proposed measure Lipid Screening is not available for use in the 2009 PQRI. Several commenters stated the following proposed measures do not represent standards of care and have technical issues and therefore, opposed inclusion of these measures in the final 2009 PQRI measure set:

- Rheumatoid Arthritis: Appropriate Use of Biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs);
- Chronic Wound Care: Offloading of Diabetic Foot Ulcers;
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Arterial Disease—Ankle Brachial Index; and
- Palliative Care: Dyspnea Screening and Management.

Response: The final 2009 PQRI measures have been selected based upon the following criteria as stated in the proposed rule:

- Achievement of NQF endorsement or AQA adoption by August 31, 2008;
- Readiness for implementation for the purposes of the 2009 PQRI if by October 15, 2008—(1) the final, detailed specifications for use of the measure in data collection for PQRI have been completed and are ready for implementation, and (2) all of the CPT II codes required for the measure to be reported by claims have been established and will be effective for CMS claims based submission on or before January 1, 2009; and
- Proposed for use in the 2009 PQRI in the CY 2009 PFS proposed rule with an opportunity for public comment via the rulemaking process.

As identified in Table 18, we are including in the final 2009 PQRI quality measure set 18 of 26 proposed measures that were contingent upon NQF endorsement or AQA adoption by August 31, 2008.

TABLE 18—FINAL MEASURES SELECTED FOR 2009 CONTINGENT UPON NQF ENDORSEMENT OR AQA ADOPTION BY AUGUST 31, 2008

Measure title	Measure source
Nuclear Medicine: Correlation with Existing Imaging Studies for all Patients Undergoing Bone Scintigraphy	AMA–PCPI.
Preventive Care and Screening: Unhealthy Alcohol Use—Screening & Brief Counseling	AMA–PCPI.
Pediatric ESRD: Adequacy of Hemodialysis+	AMA–PCPI.
Pediatric ESRD: Influenza Immunization	AMA–PCPI.
Rheumatoid Arthritis: Tuberculosis Screening	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Periodic Assessment of Disease Activity	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Functional Limitation Assessment	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Glucocorticoid Management	AMA–PCPI/NCQA.
Endoscopy & Polyp Surveillance: Surveillance Colonoscopy Interval in Patients with History of Adenomatous Polyps	AMA–PCPI/NCQA.
Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA–PCPI/NCQA.
HIV/AIDS: CD4+ Cell Count or CD4+ Percentage+	AMA–PCPI/NCQA.
HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis+	AMA–PCPI/NCQA.
HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS who are Prescribed Potent Antiretroviral Therapy+	AMA–PCPI/NCQA.
HIV/AIDS: HIV RNA Control After 6 Months of Potent Antiretroviral Therapy+	AMA–PCPI/NCQA.
Elder Maltreatment Screen and Follow-up Plan	QIP/CMS.
Functional Outcome Assessment in Chiropractic Care	QIP/CMS.
Endarterectomy: Use of Patch During Conventional Endarterectomy	SVS.

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

These measures were selected based on the comments received, whether the measure received NQF endorsement and/or AQA adoption by August 31, 2008, and whether the measure was ready for implementation by October 15, 2008. A measure was considered ready for implementation for the purposes of the 2009 PQRI if by October 15, 2008—(1) the final, detailed specifications for use of the measure in data collection for PQRI have been completed and are ready for implementation, and (2) all of the CPT II codes required for the measure have been established and will be effective for CMS claims based submission on or before January 1, 2009.

These additional measures augment the opportunity for eligible professionals to submit quality data under the PQRI where there were limited measures. These additional measures include the addition of measures for nuclear medicine services, pediatric ESRD services, rheumatoid arthritis services, gastroenterology services, wound care, and chiropractic services.

The following proposed measures are not included in the final set of 2009

PQRI quality measures listed in Table 18 because they did not achieve NQF endorsement or AQA adoption as of August 31, 2008:

- Chronic Wound Care: Offloading of Diabetic Foot Ulcers;
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Arterial Disease—Ankle Brachial Index; and
- Endarterectomy: Perioperative Stroke or Death in Asymptomatic Patient Undergoing Carotid Endarterectomy (CEA).

The following proposed measures are not included in the final set of 2009 PQRI quality measures listed in Table 18 because they were not ready for implementation by October 15, 2008:

- Lipid Screening;
- Rheumatoid Arthritis: Appropriate Use of Biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs); and
- Participation by Physician or Other Clinician in a Systematic Clinical Database Registry that includes Consensus Endorsed Quality Measures.

That is, by October 15, 2008, (1) the final, detailed specifications for use of the measure in data collection for PQRI have not been completed and/or are not ready for implementation, or (2) all of the CPT II codes required for the measure to be reported by claims have not been established and/or will not be effective for CMS claims based submission on or before January 1, 2009.

In addition, we did not include in the final set of PQRI measures listed in Table 18 the following proposed measures that subsequently were adopted by the AQA, because their adaptation to the PQRI format was subsequently found to be not feasible:

- Palliative Care: Dyspnea Screening and Management.

Finally, we did not include in the final PQRI measures listed in Table 18 the following proposed measure:

- Endarterectomy: Peri-operative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy (CEA)

We did not include this measure in the final 2009 PQRI quality measures set for many reasons. First, this measure is not reportable through claims submission. The SVS did not self-nominate to become a qualified registry for the 2008 PQRI and the SVS registry is not currently collecting this measure. In addition, we are not aware of any other registries collecting this measure.

As stated above, however, there are 5 measures listed in Table 18 that can be reported only via a registry for the 2009 PQRI, and therefore, are not reportable via claims-based reporting.

v. Measures Selected for Inclusion in 2009 Measures Groups

As discussed in the CY 2009 PFS proposed rule, we proposed to retain three of the four 2008 PQRI measures groups for the 2009 PQRI—(1) Diabetes Mellitus, (2) CKD, and (3) Preventive Care. The measures proposed for inclusion in the 2009 Diabetes Mellitus, CKD, and Preventive Care measures groups were identified in the CY 2009 PFS proposed rule (73 FR 38572 through 38573).

In addition to these three proposed measures groups retained from 2008 with applicable modifications, there were six new measures groups proposed for the 2009 PQRI: (1) CABG Surgery; (2) CAD; (3) Rheumatoid Arthritis; (4) HIV/AIDS; (5) Perioperative Care; and (6) Back Pain. Each of the measures groups was proposed to contain at least four PQRI quality measures. Except for the Back Pain measures group, it was proposed that all measures included in a measures group could be reported individually or as part of a group. Measures in the Back Pain measures group were proposed to be reportable only as a part of this measures group.

In the CY 2009 PFS proposed rule (73 FR 38560), we invited comments on the proposed new measures groups, including suggestions for other measures groups based on individual measures included in the proposed 2009 PQRI measure set. We explained that for the 2009 PQRI, measures groups must contain at least 4 measures and asked that all measures in each measures group suggested by commenters be included in the list of measures proposed in the CY 2009 PFS proposed rule (73 FR 38567 through 38572). We explained that the individual measures included in the final measures groups for the 2009 PQRI will be limited to those which are included in the final set of measures for the 2009 PQRI, as identified below.

We received numerous comments on the proposed measures groups, which are summarized and addressed as follows.

Comment: Many commenters suggested that we create a composite code for reporting all of the aspects of care within a measures group. One commenter specifically recommended that the CABG Surgery measures group be limited to a smaller number of measures unless a composite code is created for all aspects of care in the measures proposed for inclusion in the CABG Surgery measures group.

Response: We continue to seek methods to simplify reporting and increase participation in PQRI. We agree with this suggestion and have taken the necessary steps to develop composite codes for reporting all of the aspects of care within a measures group. This composite code will aid to simplify and allow for ease of reporting for those eligible professionals who elect to report a measures group. The measures groups' specifications document will be updated to include composite codes. No later than December 31, 2008, we will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri*.

Comment: We received numerous comments suggesting additional measures groups. Examples of measures groups' topics suggested by commenters include, but are not limited to, geriatrics, hepatitis C, respiratory, ischemic vascular disease (IVD), cardiovascular disease and stroke care, stroke treatment, osteoporosis, and oral drug therapy. One commenter noted that the proposed measures groups are applicable to physicians only and encouraged us to consider other eligible professionals as new measures groups are identified. Some commenters suggested specific measures for inclusion in their suggested measures groups, but many commenters did not suggest specific groups of at least 4 measures.

Response: While we welcome the additional measures groups suggested by commenters, we are not able to consider such additional measures groups for inclusion in the 2009 PQRI since there is no opportunity for public comment on the measures groups' potential inclusion in the 2009 PQRI. However, to the extent that commenters suggested specific measures for inclusion in a particular measures group, we will take the commenters' suggestions into consideration for purposes of identifying measures groups for possible inclusion in future years' PQRI.

As stated in the CY 2009 PFS proposed rule (73 FR 38560), each measures group suggested by commenters must contain at least 4 measures and must consist of the proposed measures cited in section II.O.4. of the proposed rule, ''Proposed 2009 PQRI Quality Measures.'' The measures groups must have a particular clinical condition or focus in common, as identified by the denominator definition and coding of the measures groups.

We encourage professional organizations and measure developers to engage in the development of measures groups, including measures

groups that are applicable to other nonphysician professionals. We will continue working with stakeholders to fill gaps for measures groups.

Comment: We received multiple suggestions for altering the proposed measure groups.

Response: As stated previously, we requested in the CY 2009 PFS proposed rule that suggestions for new measures groups or measures included in a particular measures group, must be based on individual measures included in the proposed 2009 PQRI quality measure set. In response to the suggestions provided by commenters, the Use of Imaging Studies in Low Back Pain measure has been removed from the Back Pain measures group due to the frequency for the process of care being inconsistent with the other measures in this measures group. No new measures groups have been established outside of what was included in the CY 2009 PFS proposed rule. However, we encourage professional organizations and measure developers to engage in the development of measure groups. We plan to continue working with stakeholders to fill gaps for measures groups.

Comment: Several commenters recommended retaining the ESRD Measures Group for the 2009 PQRI by replacing the 2008 PQRI Measure #80: Plan of Care for ESRD Patients with Anemia which was declined for NQF endorsement with the proposed 2009 PQRI Measure #82 ESRD: Plan of Care for Inadequate Peritoneal Dialysis listed in section II.O1.d. of this final rule, ''The Final 2009 PQRI Quality Measures.''

Response: As stated in the proposed rule (73 FR 38560), the ESRD measures groups is not being included in the 2009 PQRI because one of the measures in the group is no longer NQF-endorsed. The denominator definition and coding of the ESRD measures proposed and selected for the 2009 PQRI do not meet the requirements for a measures group as stated in section II.O1.b.ii. of this final rule with comment period. However, the proposed 2009 PQRI Measure #82 ESRD: Plan of Care for Inadequate Peritoneal Dialysis is available to be reported as an individual quality measure in the 2009 PQRI.

Based on the comments we received, we are retaining three 2008 PQRI measures groups for the 2009 PQRI—(1) Diabetes Mellitus, (2) CKD, and (3) Preventive Care. In some cases, different or additional measures may be selected for inclusion in a particular measures group for use in 2009, compared to 2008. Therefore, the composition of the Diabetes Mellitus, CKD, and Preventive Care measures groups may be different for the 2009 PQRI than for the 2008 PQRI. The measures selected for inclusion in the 2009 Diabetes Mellitus, CKD, and Preventive Care measures groups are listed in Tables 19 through 21.

Some measures selected for inclusion in a 2009 measures group are current 2008 PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 19 through 25. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number have never been part of a PQRI measure set until now. A number will be assigned to such measures for the 2009 PQRI. As with measures group reporting in the 2008 PQRI, each eligible professional electing to report a group of measures for 2009 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by applicable reporting criteria (described above in section II.O1.b.ii.).

TABLE 19—FINAL MEASURES SELECTED FOR 2009 DIABETES MELLITUS MEASURES GROUP

Measure title	Measure source
1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA.
2. Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus	NCQA.
3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA.
117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA.
119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA.
Diabetes Mellitus: Foot Exam	NCQA.

TABLE 20—FINAL MEASURES SELECTED FOR 2009 CKD MEASURES GROUP

Measure title	Measure source
121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	AMA–PCPI.
122. Chronic Kidney Disease (CKD): Blood Pressure Management	AMA–PCPI.
123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis—Stimulating Agents (ESA).	AMA–PCPI.
Chronic Kidney Disease (CKD): Referral for Arteriovenous AV) Fistula	AMA–PCPI.
Chronic Kidney Disease (CKD): Influenza Immunization	AMA–PCPI.

TABLE 21—FINAL MEASURES SELECTED FOR 2009 PREVENTIVE CARE MEASURES GROUP

Measure title	Measure source
39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA–PCPI/NCQA.
48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA.
110. Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA–PCPI.
111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA.
112. Preventive Care and Screening: Screening Mammography	NCQA.
113. Preventive Care and Screening: Colorectal Cancer Screening	NCQA.
114. Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA–PCPI.

TABLE 21—FINAL MEASURES SELECTED FOR 2009 PREVENTIVE CARE MEASURES GROUP—Continued

Measure title	Measure source
115. Preventive Care and Screening: Advising Smokers to Quit	NCQA.
128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	QIP/CMS.

In addition to the three measures groups retained from 2008 with applicable modifications, there are four new measures groups that we are finalizing for the 2009 PQRI: (1) CABG Surgery; (2) Rheumatoid Arthritis; (3) Perioperative Care; and (4) Back Pain. Each of the measures groups contains at least four PQRI measures.

Tables 22 through 25 lists the measures selected for inclusion in each of these new measures groups.

TABLE 22—FINAL MEASURES SELECTED FOR 2009 CABG MEASURES GROUP

Measure title	Measure source
43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Isolated CABG Surgery	STS.
44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS.
Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation) +	STS.
Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate +	STS.
Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA) +	STS.
Coronary Artery Bypass Graft (CABG): Post-operative Renal Insufficiency +	STS.
Coronary Artery Bypass Graft (CABG): Surgical Re-exploration +	STS.
Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge +	STS.
Coronary Artery Bypass Graft (CABG): Beta Blockers Administered at Discharge +	STS.
Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling +	STS.

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

TABLE 23—FINAL MEASURES SELECTED FOR 2009 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure title	Measure source
108. Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA.
Rheumatoid Arthritis: Tuberculosis Screening	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Periodic Assessment of Disease Activity	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Functional Limitation Assessment	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis	AMA–PCPI/NCQA.
Rheumatoid Arthritis: Glucocorticoid Management	AMA–PCPI/NCQA.

TABLE 24—FINAL MEASURES SELECTED FOR 2009 PERIOPERATIVE CARE MEASURES GROUP

Measure title	Measure source
20. Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician	AMA–PCPI/NCQA.
21. Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin	AMA–PCPI/NCQA.
22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA–PCPI/NCQA.
23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA–PCPI/NCQA.

TABLE 25—FINAL MEASURES SELECTED FOR 2009 BACK PAIN MEASURES GROUP

Measure title	Measure source
Back Pain: Initial Visit	NCQA.
Back Pain: Physical Exam	NCQA.
Back Pain: Advice for Normal Activities	NCQA.
Back Pain: Advice Against Bed Rest	NCQA.

We are not finalizing the proposed CAD and HIV/AIDS measures groups. Analysis of the proposed CAD measures group has revealed difficulty with determining a common denominator and that two of the four measures within this measures group would require additional diagnosis codes in order to be applicable for the group. Analysis of the proposed HIV/AIDS measures group has revealed several barriers for establishing the common denominator and the consecutive patient determination. While these are meaningful individual quality measures, we believe that the issues as stated make it impractical to use these measures as measures groups.

The measures in the Diabetes Mellitus; CKD; Preventive Care; Rheumatoid Arthritis, and Perioperative Care measures groups are reportable either individually or as part of the measures group. The measures in these measures groups can be reported through claims-based or registry-based submission.

The measures in the Back Pain measures group are reportable only as a measures group, not as individual

measures. As individual measures, the measures in the Back Pain measures group are too basic; however, taken together they are meaningful indicators of quality of care for back pain. These measures are also reportable through claims-based or registry-based submission.

Eight measures in the CABG surgery measures group are reportable only via registry-based reporting as a measures group or as individual measures. These measures cannot be reported through claims-based reporting because they cannot be feasibly specified for claims-based reporting.

In addition, as discussed above, we did not finalize Measure #120 CKD: ACE/ARB Therapy in the 2009 PQRI. Therefore, we are removing Measure #120 from the CKD Measures Group and are instead replacing Measure #120 with the following 2 measures from Table 17:

- CKD: Referral for AV Fistula.
- CKD: Influenza Immunization.

Analysis of Measure #120 revealed that the measure requires multiple diagnosis codes, which is inconsistent with the other measures in the CKD Measures Group.

As noted in the CY 2009 PFS proposed rule (73 FR 38560), the detailed measure specifications and instructions for submitting data on those 2009 measures groups that were also included as 2008 PQRI measures groups may be updated or modified prior to 2009. Therefore, the 2009 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2008. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures. Additionally, the specifications for measures groups would not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2009 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* by no later than December 31, 2008.

e. Uses of PQRI Information

i. Overview and Summary

In the CY 2009 PFS proposed rule (73 FR 38574 through 38575) we indicated that we are contemplating a ''Physician Compare'' Web site similar to other Web pages we currently have at *http://www.medicare.gov* for the public reporting of quality data for hospitals (Hospital Compare), dialysis facilities (Dialysis Facility Compare), nursing homes (Nursing Home Compare) and home health facilities (Home Health Compare) by enhancing the information found on the Physician and Other Healthcare Professional Directory (see *http://www.medicare.gov/Physician/Home.asp?bhcp=1*) to include information about the quality of care and value for services provided by professionals to Medicare beneficiaries. There are a variety of data sources that could provide quality of care, value, and other information for services provided by professionals to Medicare beneficiaries that could be used to develop a Physician Compare Web site. As we indicated in the proposed rule, the data on PQRI quality measures that is submitted at the individual (that is, NPI) level by physicians and other eligible professionals could be the basis for public reporting of quality measurement performance results at either the individual or group (that is, TIN) level. We also indicated that as part of our broader goal to measure and make the quality of care for services furnished to Medicare beneficiaries publicly available and in support of the four cornerstones for value-driven health care (that is, connecting the health system through the use of interoperable health information technology; measuring and publishing information about quality; measuring and publishing information about price; and using incentives to promote high-quality and cost-effective care), we anticipate making information on the quality of care for services furnished by professionals to Medicare beneficiaries publicly available in the future. We also indicated that we anticipate exploring the use of information collected from the PQRI, including performance results, for this purpose. To assist us in determining the most appropriate uses of PQRI data, we invited comments on the following issues:

- Ways to effectively engage eligible professionals, consumers, and other stakeholders in the development and evaluation of a valid and reliable public reporting system related to professional services provided to Medicare beneficiaries.
- The venue and format for how PQRI information should be made publicly available.
- Types of data that would be most useful and meaningful to consumers (for example, reporting results and/or performance results).
- Types of data that would be most useful and meaningful for professionals.
- Level at which PQRI information should be publicly reported (that is, at the individual professional, or NPI, level or the group, or TIN, level).
- Types of PQRI measures and/or measures groups that would be most useful and meaningful to consumers.
- Types of PQRI measures and/or measures groups that would be most useful and meaningful to professionals.
- Review of the data to be publicly reported by eligible professionals.

In addition, subsequent to the publication of the CY 2009 PFS proposed rule, section 1848(m)(5)(G) of the Act, as added by the MIPPA and described in section III. of this final rule with comment period, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers as defined and discussed further below in section II.O2. This requirement, however, cannot be applied retrospectively to data that was collected prior to the enactment of the MIPPA.

ii. Summary of Comments and Responses

The following is a summary of the comments we received and our responses.

Comment: A few commenters expressed general support for publicly reporting physician performance and/or participation information and applauded CMS' efforts to assist beneficiaries in making informed decisions when choosing a health care provider. One commenter noted that although reporting performance information back to providers is an important first step, rapidly reporting performance information to the public is critical for informed decision-making by consumers and purchasers. Some commenters also expressed support for making specific types of information public about eligible professionals. Examples of information that commenters would like to see made public include, but are not limited to, board certification status and certification maintenance status, adding

hospital medicine to the list of specialties contained in the Physician and Other Healthcare Professional Directory, CAHPS patient survey data, an indicator of whether an eligible professional participates in a clinical data registry, and the numerators and denominators for any measure rates that are publicly reported.

Response: We are pleased to have the commenters' support for our broader goal to make information on physician performance publicly available. We agree that such information may be relevant and useful to a broad audience. Physicians and other eligible professionals can use information about their own performance and the performance of their peers to improve the quality of the care they deliver. Medicare beneficiaries and other consumers can use such information to inform their decision-making when it comes to selecting their health care providers. We note, however, that much of the information that commenters specifically requested be made public is beyond the scope of this final rule with comment period, which is limited to the public disclosure of PQRI information.

Comment: A few commenters suggested that we limit public reporting of PQRI information to the names of the clinicians and/or group practices that satisfactorily participated and earned an incentive payment.

Response: As stated previously, the MIPPA requires us to list the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI on our Web site. While we agree that information on who satisfactorily submits data on quality measures for the PQRI is useful information to have and plan to list only the names of physicians who satisfactorily participated in the 2009 PQRI and earned an incentive payment, it is our goal to eventually make performance information public as well. We have made information on quality of care in other care settings publicly available and hope to eventually do the same for physicians and other health care practitioners as part of our broader goal to measure and make the quality of care for services furnished to Medicare beneficiaries publicly available.

Comment: Several commenters felt that it would be premature to publicly report any information derived from PQRI at this time. Other commenters merely urged CMS to proceed cautiously when creating a Physician Compare Web site using PQRI data. Although some commenters supported limiting the information to be publicly reported to the names of eligible professionals and/or group practices that satisfactorily participate in PQRI and earned the bonus incentive payment, many commenters cited concerns with even listing just the names of participants. Some of the specific concerns cited include:

- Lack of program stability;
- Lack of evidence demonstrating that compliance with pay-for-reporting programs increases quality;
- Lack of evidence to demonstrate the validity of some of the PQRI quality measures;
- Successful participation demonstrates only an eligible professional's ability to implement a process and is not a measure of quality;
- Publicly reporting PQRI participation information may give beneficiaries or others who visit the Web site the false impression that eligible professionals who participated are practicing higher quality medicine than those who do not participate;
- Not clear how information on an individual's participation in the PQRI would be helpful or meaningful;
- The analysis of physician performance on some measures will be based on small numbers;
- CMS' data on PQRI participation may be an inaccurate representation of the number of eligible professionals participating or making a good faith effort to participate in PQRI since clearinghouses inappropriately removed NPI information from claims submissions;
- Major improvements are needed to the Physician and Other Healthcare Professional Directory before it can form the basis for a Physician Compare Web site because there are accuracy issues associated with the data on the Physician and Other Healthcare Professional Directory;
- It would be unfair to eligible professionals to publish PQRI information since no interim feedback reports are provided to help participants determine if they are reporting correctly;
- It would be especially unfair to publicly report 2007 and 2008 data because eligible professionals were not informed in advance that such information would be publicly reported;
- Publicly reporting 2007 PQRI participation information may be perceived by physicians as reneging on prior commitments that CMS made to physicians in which we indicated that we would not publicly report PQRI information at this time;
- While other providers, such as hospitals, home health agencies, and nursing homes had many months of advance notice that CMS would be launching public reporting programs for those provider settings, eligible professionals were given no advance notice that PQRI information would be made public until very recently;
- CMS does not have the authority to publicly report PQRI performance information since the Congress only gave CMS the authority to publicly report the names of successful participants;
- The PQRI program is too new and is a voluntary program;
- Many eligible professionals cannot participate in PQRI due to the lack of applicable measures;
- Experience with PQRI is limited and individual eligible professionals are still trying to determine how to integrate PQRI into their office billing processes; and
- There are numerous barriers, some of which are described above, that make it difficult for physicians and other eligible professionals to participate in the PQRI.

Response: We are appreciative of the commenters' thoughtful and constructive feedback and will take these concerns into consideration as we further develop our plans for publicly reporting PQRI information. While we understand the commenters' concerns, we note that section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires us to list the names of eligible professionals who satisfactorily submitted PQRI quality measures data in an easily understandable format on our Web site. As such, it is our intent to identify the eligible professionals who satisfactorily submit data on quality measures for the 2009 PQRI on the CMS Web site in 2010. We are not required, nor are we specifically authorized by MIPPA or preceding PQRI authorizing legislation, to publicly report 2007 and 2008 PQRI information submitted prior to July 15, 2008.

Comment: A number of the commenters urged CMS to delay the public reporting of information derived from PQRI that was authorized by the MIPPA because eligible professionals should have the opportunity to view their individual data for several years before it is made public. Several commenters provided recommendations for CMS to consider with respect to publicly reporting PQRI information and specifically as we proceed with implementing the MIPPA provision to list the names of the individuals or physician groups who successfully participate in the PQRI on CMS's Web site. Examples of some of the recommendations received include:

- CMS should educate the public on PQRI and its limitations and include disclaimer language on the Web site

explaining the PQRI program and its limitations, such as the program is voluntary, there are many barriers to participation and many valid reasons for nonparticipation, there are many factors that could impact participation, the year to year changes to the program, and PQRI participation status is not a proxy for quality.

• CMS should conduct a formal evaluation to closely review the 2007 and 2008 PQRI program, including the program's processes and the analysis and validation of the data gathered, before proceeding with public reporting of PQRI participation or performance data. No PQRI data should be publicly released until its accuracy and reliability is verified, otherwise, serious unintended consequences can occur. CMS must make every effort to ensure the accuracy of any information that will be made public, including demographic information and other information listed in the Physician and Other Healthcare Professional Directory, and provide the American Medical Association and medical specialty societies access to aggregate PQRI participation data so that these groups can analyze the data to ensure accuracy, improve upon identified quality gaps in specialty care, and work with physicians to boost participation.

• The Web site should positively recognize physicians who attempted to participate in the program and if a physician or other eligible professional attempted to participate but was not deemed to be a successful participant, CMS should provide the eligible professionals with the reasons why and give the eligible professional the opportunity to correct any errors, appeal, and/or request that the participant's explanation for why he or she was not successful be made public.

• Eligible professionals should also be given the opportunity to publicly explain why they did not participate, including the ability to describe any quality improvement initiatives the eligible professional participates in.

• CMS should provide more timely and detailed confidential feedback reports (including interim feedback reports) to providers so that they can quickly address any participation or performance issues before data is posted to the Web site.

• Eligible professionals should be notified prior to the start of data collection that data collected in a particular year will be publicly reported and should be given sufficient opportunity to review and comment on any information that will be made public prior to its public release following an initial dry run in which reports are shared only with the eligible professionals. In addition, there should be a formal process to allow eligible professionals to correct any errors. CMS should also make the comments received from the review period public.

• CMS should not report the names of those who satisfactorily submitted quality data until the data submission process and the reporting results have been verified.

• CMS should work closely with the physician community and other stakeholders in establishing a Physician Compare Web site and should establish a multi-stakeholder workgroup to provide input and feedback to CMS on the development of the Web site, including identifying potential problem areas. This includes conducting focus groups with consumers and providers to determine the goals for public reporting prior to deciding which data to report.

• CMS may want to consider reporting data at the physician group or team level as opposed to the individual level as well as consider reporting composite measures rather than individual measures.

• Eligible professionals should have the ability to opt-out of having their information made public.

• Public reporting of PQRI measurement results should be limited to those measures that have achieved an agreed upon baseline of scientific acceptability post-implementation or to those measures on which eligible professionals chose to submit data.

• CMS should publish the names of participating eligible professionals only in cases where the PQRI measures that the eligible professionals reported on has been in use in the PQRI for at least 3 years. This indicates at least some measure of stability in the program and allows CMS to recognize those eligible professionals that reported on measures that have been in use in PQRI for less than 3 years as early adopters.

• Any Physician Compare tool developed by CMS needs to be user-friendly and thoroughly vetted and evaluated prior to going live to the public. CMS should consider formats that balance the needs of end users with the amount of data to be displayed and permit specific action by patients, families, and others. The Web site should be designed to report current measure sets but be flexible enough to grow with the addition of measures and physicians over time.

• CMS should take a two-phase approach to publicly reporting PQRI information at the NPI level. In Phase 1 CMS should publicize only the names of those who participated. After 2 years, then CMS should publicize the names of those who participated, those who did not participate and those who participated successfully in Phase 2.

Response: We appreciate the numerous recommendations that were provided in the spirit of ensuring a successful launch of our efforts to make information about physician performance publicly available. As we proceed with making the names of the eligible professionals who satisfactorily report data on quality measures for the 2009 PQRI, we will consider these suggestions along with other input received (both formally and informally) as part of our ongoing dialogue with stakeholders. We believe that many of these suggestions are reasonable and will try to incorporate them into our plans to the extent that they are feasible and practical.

c. Plans for Publicly Reporting Information Derived From PQRI

To support the delivery of high-quality, efficient health care and enable consumers and providers to make more informed health care decisions, CMS plans to launch a Physician and Other Health Care Professional Compare Web site that will enhance the information found on the current Physician and Other Health Care Professionals Directory at *http://www.medicare.gov/Physician/Home.asp?bhcp=1*. CMS anticipates that the addition of a Physician and Other Health Care Professional Compare Web site to the compare family of Web sites will complement the quality information CMS already makes available for hospitals, dialysis facilities, nursing homes, and home health facilities. Similar to the other compare Web sites, Physician and Other Health Care Professional Compare will include information about the quality of care and value for services provided by physicians to Medicare beneficiaries.

As a first step, we plan to use information from the PQRI program to populate a Physician and Other Health Care Professional Compare Web site.

Based on the public comments received and the requirements under section 1848(m)(5)(G) of the Act, we will report publicly the names of eligible professionals that have satisfactorily submitted quality data for the 2009 PQRI. This information will be available in 2010, in an easily understandable format, on a Physician and Other Health Care Professional Compare Web site at *http://www.medicare.gov/Physician/Home.asp?bhcp=1*.

For purposes of publicly reporting the names of eligible professionals, on a Physician and Other Health Care

Professional Compare Web site, we will post the names of eligible professionals who have (1) submitted data on the 2009 PQRI quality measures through the claims-based reporting mechanism or through registry-based reporting, (2) met one of the satisfactory reporting criteria for the 2009 PQRI described in section II.O1.b above, and (3) received a PQRI incentive payment for covered professional services furnished between January 1, 2009 through December 31, 2009.

As with the other compare Web sites, CMS plans to continue to expand the information that is available on the Physician and Other Health Care Professional Compare Web site in the future. CMS may publicly report physician information that is maintained in the ''Performance Measurement and Reporting System (PMRS),'' SOR number 09–70–0584, as amended, in order to improve the quality and efficiency of health care delivery and enable consumers to make more informed health care decisions. This includes posting on an Internet Web site the names of those physicians who report data on quality measures through the PQRI as described above as well as other types of performance measurement information. More information about the PMRS SOR is available at *http://www.cms.hhs.gov/PrivacyActSystemofRecords/downloads/0584.pdf.*

O2. Electronic Prescribing (E-Prescribing) Incentive Program

a. Program Background and Statutory Authority

As discussed in section III. of this final rule with comment period, the MIPPA authorizes a new incentive program beginning for 2009 for eligible professionals who are successful electronic prescribers. Since MIPPA was enacted after publication of the CY 2009 PFS proposed rule, there was no discussion of this new incentive program in the CY 2009 PFS proposed rule. We note, however, that many of the requirements under MIPPA with respect to the new e-prescribing incentive program are self-implementing. In addition, section 1848(m)(5)(C) of the Act, as redesignated and amended by the MIPPA, authorizes us to implement certain aspects of the 2009 e-prescribing incentive program by program instruction or otherwise. Given that the e-prescribing quality measure developed under the PQRI program will be used in 2009, however, we are finalizing the 2009 e-prescribing incentive program in this final rule with comment period.

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

The MMA and the creation of the Medicare Prescription Drug Benefit Program (Part D) promoted the use of electronic prescribing by requiring the adoption of interoperable Part D standards for electronically prescribing Part D covered drugs prescribed to Part D eligible individuals. As required by section 1860(D)(4)(e) of the Act, as added by the MMA, ''foundation standards'' were adopted on November 7, 2005 (70 FR 67568) and additional Part D e-prescribing standards were adopted on April 1, 2008, that are to become effective April 1, 2009 (73 FR 18918).

Section 1860(D)(4)(e)(6) of the Act, as added by the MMA, also permitted third parties to offset the implementation costs for electronic prescribing by authorizing the creation of an exception to the physician self-referral (''Stark'') prohibition for certain donations of electronic prescribing technology. This enabled health plans, hospitals, and medical groups to provide in-kind support to physicians for electronic prescribing. Furthermore the MMA authorized the creation of a ''safe harbor'' to protect these entities from prosecution under the anti-kickback statute.

There are many potential advantages to e-prescribing. These advantages include, but are not limited, to:

- Improving patient safety and quality of care by (reducing medication errors by up to 86 percent):
  - Reducing illegibility.
  - Reducing oral miscommunications.
  - Providing warnings and alert systems.
  - Providing access to patient's medication history;
- Reducing time spent on pharmacy phone calls and faxing;
- Automation of renewals and authorization;
- Improving formulary adherence (from 14 percent to 88 percent after e-prescribing implementation) (Bell, Douglas S. and Friedman, Maria A. ''E-Prescribing and the Medicare Modernization Act of 2008.'' Health Affairs. 2005; Volume 24, no.5: 1159–1169); and
- Improving drug surveillance/recall;

A more detailed description of the benefits of e-prescribing can be found by clicking on the Clinician's Guide to Electronic Prescribing link at *http://www.ehealthinitiative.org/.* Many of these advantages were also discussed at a recent e-prescribing conference co-sponsored by CMS. Downloadable information from this conference is available at *http://www.e-prescribingconference.com.*

Although there are many benefits to electronic prescribing, there has been limited adoption and use of electronic prescribing by physicians and other professionals who prescribe medications. It is estimated that only 5 to 18 percent of providers currently use e-prescribing (Bell, Douglas S. and Friedman, Maria A. ''E-Prescribing and the Medicare Modernization Act of 2008.'' Health Affairs. 2005; Volume 24, no. 5: 1159–1169.). The enactment of the MIPPA in July, 2008, should encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment differentials. Financial incentives are available for the years 2009 through 2013, and payment differentials apply starting 2012 and for all subsequent years.

Specifically, for 2009, in accordance with section 1848(m)(2) of the Act, as added by section 132(a) of the MIPPA, a ''successful electronic prescriber'' as defined by MIPPA and further discussed below, is eligible to receive an incentive payment equal to 2.0 percent of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period for all covered professional services furnished during the 2009 reporting period. This new E-prescribing Incentive Program is separate from and in addition to any incentive payment that eligible professionals may earn through the PQRI program discussed above.

Incentive payments for successful electronic prescribers for future years are authorized as follows:

- 2.0 percent for 2010.
- 1.0 percent for 2011.
- 1.0 percent for 2012.
- 0.5 percent for 2013.

Under section 1848(a)(5) of the Act, as added by section 132(b) of the MIPPA, a PFS payment differential applies beginning in 2012 to those who are not successful electronic prescribers. Specifically, for 2012 and any subsequent year, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee

schedule that would otherwise apply by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014 and each subsequent years.

The application of the payment differential will be the subject of future notice and comment rulemaking and is beyond the scope of this rule.

Under section 1848(m)(6) of the Act, as amended by the MIPPA, the definition of ''eligible professional'' for purposes of eligibility for the electronic-prescribing incentive program is identical to the definition of ''eligible professional'' for the 2009 PQRI under section 1848(k)(3)(B) of the Act. In other words, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and beginning in 2009, qualified audiologists. However, eligibility is further restricted by scope of practice to those professionals who have prescribing authority.

b. Requirement for Successful Electronic Prescriber

Under section 1848(m)(3)(B) of the Act, as redesignated and added by the MIPPA, in order to qualify for the incentive payment, an eligible professional must be a ''successful electronic prescriber,'' which the Secretary is authorized to identify using one of two possible standards. For 2009, to be a successful electronic prescriber, the standard under section 1848(m)(3)(B)(ii) of the Act will apply, in which an eligible professional must report on at least 50 percent of applicable cases, on such electronic prescribing quality measure(s) established by the Secretary under the PQRI, for use in the Electronic Prescribing Incentive Program. For 2009, as will be further discussed, there is established one electronic prescribing measure, with the applicable cases being those where particular services are furnished to Medicare beneficiaries and billed under Part B.

The Secretary also has authority under section 1848(m)(3)(B)(iii) of the Act to identify a substitute standard for successful electronic prescriber based on the electronic prescribing of a sufficient number (as determined by the Secretary) of Part D prescriptions by an eligible professional for the requirement to report on electronic prescribing measure(s). However, under section 1848(m)(3)(B)(i) of the Act, if this standard were substituted by the Secretary for a particular year, then the standard based on the reporting on electronic prescribing measures would no longer apply or be available. If the Secretary decides to establish the substitute requirement, the Secretary is authorized to use Part D drug claims data to assess whether a sufficient number of prescriptions have been submitted by eligible professionals.

For the 2009 Electronic Prescribing Incentive Program, as described above, we will require eligible professionals to report on the existing electronic prescribing measure established by the Secretary as described in further detail below. In future years, we intend to consider the use of a certain number of Part D prescribing events as the basis for the incentive payment. However, our ability to use this substitute requirement for 2009 is not feasible. Our future consideration will depend on achievement of technical changes that may be necessary and would be addressed in future notice and comment rulemaking.

c. The 2009 Reporting Period for Successful Electronic Prescriber

Section 1848(m)(6)(C) of the Act, as redesignated and amended by the MIPPA, defines ''reporting period'' for the 2009 E-Prescribing Incentive Program to be the entire year. Therefore, like for the 2009 PQRI, the reporting period for the 2009 E-Prescribing Incentive Program is defined as the entire calendar year, or January 1, 2009 through December 31, 2009. Successful electronic prescribers are eligible to receive an incentive payment equal to 2.0 percent of the total estimated allowed charges submitted by no later than February 28, 2010 for all covered professional services furnished January 1, 2009 through December 31, 2009.

d. 2009 Electronic Prescribing Measure

Section 1848(m)(3)(B)(ii) of the Act provides that a successful electronic prescriber is required to report on each such electronic prescribing measure established under the PQRI and that are applicable to the eligible professional's services. There is one electronic prescribing measure that has been established for the PQRI. This measure was developed in response to the requirement under section 1848(k)(2)(B)(i) of the Act that the Secretary include structural measures for the 2008 PQRI, such as the use of electronic health records (EHRs) and electronic prescribing technology, and again proposed for the 2009 PQRI. The measure is identified as Measure #125 and is included in the 2008 PQRI: ''HIT: Adoption/Use of Medication E-Prescribing.'' This measure achieved AQA consensus adoption in October 2007, and was included in the 2008 PQRI. The measure was endorsed by the NQF during 2008. The measure is being reported by physicians and other eligible professionals as a quality measure for the 2008 PQRI. As required by section 1848(m)(3)(A) of the Act, we will finalize Measure #125 in this final rule with comment period (for use in the 2009 E-Prescribing Incentive Program) and then the PQRI will have no electronic prescribing measures for 2009 or thereafter.

We will post the updated measure and its specifications for the 2009 Electronic Prescribing Incentive Program (that is, Measure #125) on or about the date of publication of this final rule with comment period. However, as noted below, we retain the authority to make specification code changes to the electronic prescribing measure until December 31, 2008. Measure specifications and/or reporting instructions for Measure #125 for the 2008 PQRI are not identical to the measure specifications and/or reporting instructions for the 2009 E-Prescribing Incentive Program. The final measure specifications and reporting instructions for the E-Prescribing Measure #125 for the 2009 E-prescribing incentive program will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage* as soon as practical but by no later than December 31, 2008.

e. Reporting the Electronic Prescribing Measure

Reporting the electronic prescribing measure for 2009 is limited to claims based submission. The reporting of the measure is subject to the same technical requirements as for PQRI claims based measures in terms of the items that need to be submitted on the claim. Examples of technical requirements include submission of an NPI for the eligible professional, inclusion of the measure reporting codes on the same claim that contains the denominator codes, and no resubmission of the claims for purpose of reporting numerator codes. Detailed information on the technical submission requirements is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.*

Measure #125, like other PQRI measures, has two basic elements. These include: (1) A reporting denominator (for Measure #125, this consists of a set of procedure codes) that defines the circumstances when the measure is reportable; and (2) a reporting numerator (for Measure #125, this consists of three specific codes, one of

which must be reported for successful reporting.)

The measure becomes applicable to a particular patient and reportable when, in billing for Part B services, the professional includes at least one of the procedure codes making up the denominator on the claim for payment (for example, a medical visit for CPT code 99213). If one of the denominator codes is included on a claim for Part B services, then the physician or other eligible professional must report one of the numerator reporting codes on the same claim to meet the reporting requirement. Where the eligible professional fails to report a numerator reporting code specified for the measure on such a claim, then the case would be included in the denominator count, but not in the numerator count for satisfactory reporting. More detailed information on the specific technical requirements for correctly reporting quality data codes is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.*

i. Reporting Denominator

The Measure #125 denominator consists of specific billing codes for professional services. They are typically billed for services in the office or outpatient setting furnished by physicians or other eligible professionals. Currently, the denominator codes for the electronic prescribing measure are CPT Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, and G Codes: G0101, G0108, G0109. Measure #125 has no diagnosis codes or age/gender requirements in order to be included in the denominator (that is, reporting of the e-prescribing measure is not further limited to certain ages or gender). As previously discussed, for 2009, the measure becomes reportable when any one of these procedure codes is billed by an eligible professional as Part B services. As discussed further under section II.O2.e.iii, however, eligible professionals are not required to report this measure in all cases in which the measure is reportable. Physicians and other eligible professionals who do not bill for one of these procedure codes on at least one claim during 2009 for Part B services will have no occasion to report the electronic prescribing measure.

There is also a statutory limitation under section 1848(m)(2)(B) of the Act for the E-Prescribing Incentive Program that will be discussed below. For 2009, we are applying the limitation that requires that the total estimated Part B allowed charges for the denominator codes to which the electronic prescribing quality measure (that is, Measure #125) applies must constitute at least 10 percent of the professional's total Part B allowed charges for the incentive to apply. This limitation is designed to target the electronic prescribing incentive payments to physicians or other eligible professionals who have the opportunity to prescribe a statutorily determined sufficient amount of prescriptions and not provide incentive payments of 2.0 percent of allowed charges in a year to those physicians who do not have the opportunity to prescribe a threshold amount of prescriptions. However, this limitation does not affect the ability to report the measure, but rather we will apply it in the final determination as to whether an incentive is earned. See the discussion below.

As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. We have considered whether to expand the scope of the denominator codes to professional services outside the professional office and outpatient setting for 2009, such as professional services furnished in hospitals or skilled nursing facilities. Although we retain the authority to update technical specifications of the measure until December 31, 2008 for use in the 2009 E-Prescribing Incentive Program, we will not expand the basic scope of the denominator outside the professional office and outpatient setting.

We believe that several reasons support the limitation of the 2009 e-prescribing measure (that is, Measure #125) denominator codes to physician and other eligible professional office and outpatient settings. First, physicians and other eligible professionals have limited ability to influence the adoption and availability of electronic prescribing systems in hospitals or other provider settings. Second, including codes for professional services in provider facility settings may negatively impact the ability of professionals who practice in office and facility settings to successfully report the electronic prescribing measure at the required 50 percent of cases. Without access to electronic prescribing for services furnished in a provider setting, the professional would be unable to report and these cases would count as not reporting if such codes were included in the measure denominator. Third, the effect of the electronic prescribing incentive payment is likely to have its greatest impact in stimulating adoption and use of electronic prescribing in the professional office and outpatient setting. While outpatient services are an imperfect marker, outpatient services are likely to represent the largest opportunity to expand electronic prescribing where prescribing is frequent and the decision to adopt electronic prescribing systems is also dependent on the choices, practices and funding by eligible professionals. Fourth, the statutory limitation that applies to eligibility for the incentive also applies to the future differential payment provisions. Extension of the denominator codes to hospital-based settings of care, may cause professionals who exclusively practice in such settings to be liable for a differential payment for services furnished in a setting where they have limited ability to influence the adoption of electronic prescribing.

ii. Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report Measure #125 the eligible professional must report one of three ''G'' codes, as will be discussed below, on the same claim for which one of the denominator codes is billed. In reporting any of the G codes, however, and thereby qualifying for the incentive payment for e-prescribing in 2009, the professional must have and regularly use a ''qualified'' electronic prescribing system as defined in Measure #125. If the professional does not have general access to an e-prescribing system in the practice setting, there is nothing to report. In this way, Measure #125 is more than a ''pay-for-reporting'' measure since the reporting must relate to an already implemented e-prescribing system.

Required Functionalities for a ''Qualified'' Electronic Prescriber System. What constitutes a ''qualified'' electronic prescribing system is based upon certain required functionalities that the system can perform. As currently specified in Measure #125, a ''qualified'' electronic prescribing system is one that can:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe

situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions).

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2009 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D E-Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act, as redesignated and added by the MIPPA, requires that, to the extent practicable, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e) of the Act.'' Part D sponsors must use when they transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. In the qualified electronic prescribing system context of this rule, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D e-prescribing program. New Part D e-prescribing standards will be effective April 1, 2009. These new Part D e-prescribing standards can be found on the CMS Web site at *http://www.cms.hhs.gov/eprescribing*.

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, E-Prescribing Measure #125 requires that those functionalities required for a ''qualified'' electronic prescribing system must utilize the adopted Part D e-prescribing standards.

The Part D e-prescribing standards relevant to the four functionalities for a ''qualified'' system in Measure #125, described above and listed as (a), (b), (c), and (d), are:

(a) Generate medication list—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter ''NCPDP SCRIPT 8.1'') Medication History Standard;

(b) Transmit prescriptions electronically—Use the NCPDP SCRIPT 8.1 for the transactions listed at 42 CFR 423.160(b)(2);

(c) Provide information on lower cost alternatives—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter ''NCPDP Formulary and Benefits 1.0'');

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan—use:

(1) NCPDP Formulary and Benefits 1.0

(2) Accredited Standards Committee (ASC) X12N 270/271-Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibly information between Medicare Part D sponsors and prescribers.

(4) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between Medicare Part D sponsors and dispensers.

There are, however, Part D e-prescribing standards that are or will shortly be in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a ''qualified'' system under Measure #125. One example is Rx Fill Notification, which is discussed in the e-prescribing final rule (73 FR 18918, 18926). For purposes of the 2009 electronic prescribing program and incentive payments, it is not required that the electronic prescribing system contain all functionalities for which there are available Part D e-prescribing standards. Rather, the only required functionalities are those stated in the measure and described above in the section entitled ''Required Functionalities for a 'Qualified' Electronic Prescribing System.'' For those required functionalities described above, a ''qualified'' system must use the adopted Part D e-prescribing standards for electronic messaging. There are other aspects of the functionalities for a ''qualified'' system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network, but only that the system be a ''qualified'' system having the functionalities described based on Part D e-prescribing standards. While it is not appropriate for us to suggest particular products, we will post general information at or about the time of publication of this rule that may be helpful to the eligible professional in selecting a system that meets the requirements of a ''qualified'' system under Measure #125. Additionally, we will provide additional clarifying information, as needed, in the form of Frequently Asked Questions (FAQs) and post them on the CMS Web site.

iii. Reporting Numerator

To report for an applicable case where one of the denominator codes is billed on a claim for Part B services, an eligible professional must submit one of three G codes specified in Measure #125 on the same Medicare Part B claim.

- One G code is used to report that all prescriptions in connection with the visit billed were electronically prescribed;
- Another G code indicates that no prescriptions were generated during the visit; and
- A third G code is used when some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance.

As we have previously discussed, to qualify for an incentive payment under the electronic prescribing incentive program, the eligible professional must report applicable G codes on claims containing one or more denominator billing codes, in at least 50 percent of applicable cases. Since the measure does not apply to claims for services not containing one of the denominator codes, professionals need not report G codes for the electronic prescribing measure on claims not containing one of the denominator codes.

Although only one of the three reportable G codes indicates that the physician or eligible professional used electronic prescribing for all of the prescriptions provided during the encounter, the reporting of any one of the G codes counts as successful reporting and toward the required 50 percent reporting requirement. However, as previously discussed by reporting any one of the G codes, the physician or eligible professional is indicating that an electronic prescribing system has been adopted for use.

With respect to narcotics and controlled substances, the third G code is reported in connection with using written prescriptions rather than electronic prescribing for such medications, because electronic prescribing of these medications is currently prohibited by Federal regulation. We are aware that the Drug Enforcement Agency (DEA) has proposed regulatory changes which if finalized would allow electronic prescribing of controlled substances under certain circumstances. This third G code would continue to be reportable for the 2009 Electronic Prescribing Measure without regard to possible changes in the DEA's regulations with respect to the electronic prescribing of controlled substances. Based on concerns expressed to us, we are aware that professionals may find it impractical to utilize electronic prescribing for controlled substances, depending on specific requirements that may be finalized by the DEA. Therefore, to alleviate uncertainty with respect to the electronic prescribing incentive program, for 2009, physicians and other eligible professionals may report the electronic prescribing measure without any requirement to use electronic prescribing for narcotics or other controlled substances without regard to final action that the DEA may take on this subject, based on the G codes contained in the Electronic Prescribing Measure.

f. Determination of Successful Electronic Prescriber and Amount of Incentive Payment

Determination of professionals who are Successful Electronic Prescribers for 2009 is at the individual professional level, based on the National Provider Identifier (NPI) as it is under PQRI. However, payment is made to the practice represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services. Inasmuch as some individuals (NPIs) may be associated with more than one practice or TIN, determination of Successful Electronic Prescriber for 2009, as it is for PQRI, will be made for each unique NPI–TIN combination. Payment will be made to the applicable TIN.

Under PQRI, a physician or other eligible professional may meet, in theory, the criteria for satisfactory reporting on as few as a single patient falling within the denominator of a measure and correctly reporting on that measure. In the case of the E–Prescribing Incentive Program, however, section 1848(m)(2)(B) of the Act, as added by the MIPPA, imposes a limitation. As discussed above, for 2009, the limitation provides that the electronic prescribing incentive is not available to an eligible professional unless the eligible professional's total estimated allowed charges for covered Medicare Part B services furnished for the codes in the denominator of the 2009 Electronic Prescribing Measure make up at least 10 percent of the eligible professional's total allowed charges for all covered Medicare Part B professional services furnished by the eligible professional during the 2009 reporting period (that is, January 1, 2009 through December 31, 2009). The statutory limitation also applies to the future application of the payment differential, which limits those to whom the differential will apply as well.

Therefore, in determining whether an eligible professional will receive an electronic prescribing incentive payment, CMS will determine whether the 10 percent threshold is met based on the claims submitted by the eligible professional at the NPI/TIN level. This calculation is expected to take place in the first quarter of 2010 and will be performed by dividing the individual's total 2009 charges submitted for the measure's HCPCS codes by the individual's total Medicare Part B charges (as assessed at the NPI/TIN level). If the result is 10 percent or more, then the statutory limitation does not apply and a successful electronic prescriber would earn the electronic prescribing incentive payment. If the result were less than 10 percent, then the statutory limitation would apply and the eligible professional could not receive an electronic prescribing incentive payment.

As discussed previously, this limitation will be applied by CMS in determining whether the individual professional meets the requirements for the incentive payment. Although individual eligible professionals may decide about whether to report based on their own assessment of what portion of their allowed charges for Part B services are likely to be made up of services represented by the denominator codes, individual professionals may report the numerator codes without regard to the statutory limitation for the incentive payment.

If an eligible professional meets the 10 percent threshold for 2009, we will determine whether the professional is a successful electronic prescriber by reporting the numerator codes for 50 percent of applicable cases. If the professional is determined to be a successful electronic prescriber, then the incentive payment will be made.

As indicated above, for 2009, the electronic prescribing incentive payment is 2.0 percent of the total estimated Part B allowed charges for the reporting period (that is, the entire year, for 2009). Thus, the incentive payment is not solely 2.0 percent of the estimated Part B allowed charges for services for which the measure is reported, but 2.0 percent of *all* estimated Part B allowed charges for the year. In other words, although the measure denominator is limited to certain office and outpatient professional services, and the requirement to be an electronic prescriber is based on those services, the incentive payment is paid as 2.0 percent of all estimated Part B allowed charges for the professional, submitted by the end of February 2010.

g. Uses of Information on Successful Electronic Prescribers

As discussed in section II.O1.e.i. above, section 1848(m)(5)(G) of the Act, as added by the MIPPA and described in section III. of this final rule with comment period, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers. As noted previously, this requirement cannot be applied retrospectively to data that was collected prior to the enactment of the MIPPA.

In order to implement this requirement we will report publicly the names of eligible professionals who are successful electronic prescribers for the 2009 E-Prescribing Incentive Program. Along with the names of eligible professionals who satisfactorily submitted data on quality measures for the 2009 PQRI, the names of eligible professionals who are successful electronic prescribers will be available in 2010, in an easily understandable format, on a Physician and Other Health Care Professional Compare Web site at *http://www.medicare.gov/Physician/Home.asp?bhcp=1*.

Accordingly, we will post on the CMS Web site the names of eligible professionals (1) whose 2009 Medicare Part B charges for codes in the denominator of the E-Prescribing Measure #125 make up at least 10 percent of the eligible professional's Medicare Part B charges for 2009; (2) who reported the E-Prescribing Measure #125 in at least 50 percent of the cases in which the measure was reportable during 2009; and (3) who received an e-prescribing incentive payment for covered professional services furnished January 1, 2009 through December 31, 2009.

Since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs, it is feasible for an eligible professional who participated in both incentive programs to be listed both as an individual eligible professional who satisfactorily submitted data on quality measures for the PQRI and a successful electronic prescriber if he or she met the criteria for both incentive programs.

d. Summary of Comments and Responses

Although the MIPPA was not enacted until after publication of the CY 2009 PFS proposed rule, we received some comments related to this new incentive program that was authorized by the MIPPA. A summary of these comments and our responses is below.

Comment: We received a few comments about the PQRI Measure #125. These commenters suggested that prior to implementation of this quality measure in the e-prescribing incentive program, the quality measure and our design of the e-prescribing incentive program should go through a public comment process. One commenter indicated support for the e-prescribing incentive but noted that implementing e-prescribing in physicians' offices is resource intensive and many local pharmacies are not prepared to use e-prescribing.

Response: As described above, the MIPPA requires us to implement an incentive payment for successful electronic prescribers beginning in 2009. Many of the MIPPA requirements with respect to the incentive payment for successful electronic prescribers are generally self-implementing, require little exercise of discretion, and build on existing aspects of the PQRI that have already been proposed. In addition, although section 1848(m)(5)(C) of the Act, as redesignated and amended by the MIPPA, authorizes us to implement certain aspects of the 2009 e-prescribing incentive program by program instruction or otherwise, we are finalizing this program for 2009 in this final rule with comment period. The quality measure that we are using to determine whether an eligible professional qualifies as a successful electronic prescriber was available for public comment during its development by QIP as well as during the consensus process for AQA adoption and NQF endorsement, both of which have been achieved. Additionally, as this quality measure was one of the quality measures proposed for the 2009 PQRI in the CY 2009 PFS proposed rule, the public had an opportunity to comment on this quality measure during the proposed rule's comment period.

Comment: One commenter was concerned that future DEA regulation changes may complicate e-prescribing. The commenter urged us to exempt e-prescribing of controlled substances from any assessment of differential payments.

Response: We are aware of the proposed DEA regulation changes and believe the modification and explanation of the third G code described above adequately addresses this issue.

Comment: We received one comment that emergency department evaluation and management codes do not appear in the denominator of the e-prescribing measure proposed for the 2009 PQRI (Measure #125). Another commenter suggested that we maintain the eye visit codes in this measure so that ophthalmologists can participate in the e-prescribing incentive program.

Response: We have addressed in the body of the preamble the comment with respect to hospital based services of professionals. The current measure specifications contain office and outpatient codes applying to eye care. As stated above, we will post the final specifications for the e-prescribing measure for purposes of the 2009 e-prescribing incentive program no later than December 31, 2008.

Comment: A few commenters objected to the fact that there is no definition as to what constitutes an acceptable hardship exemption for the e-prescribing incentive initiative.

Response: As discussed briefly above, section 1848(a)(5)(A) of the Act, as added by the MIPPA, authorizes the Secretary, starting in 2012, to apply a differential fee schedule amount for covered professional services furnished by an eligible professional who is not a successful electronic prescriber. In accordance with section 1848(a)(5)(B) of the Act, the Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment differential if the Secretary ''determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.'' This hardship exemption is to be used at the discretion of the Secretary.

Since this hardship exemption pertains only to those eligible professionals subject to a payment differential because they did not meet the criteria for becoming a successful electronic prescriber, this provision will not become effective until 2012 when the payment differential for those eligible professionals who are not successful electronic prescribers is first required. As such, the definition of what constitutes an acceptable hardship is beyond the scope of this final rule with comment period.

P. Discussion of Chiropractic Services Demonstration

In the CY 2006, CY 2007, and CY 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the 2-year chiropractic services demonstration that ended on March 31, 2007. This demonstration was required by section 651 of the MMA to evaluate the feasibility and advisability of covering chiropractic services under Medicare. These services extended beyond the current coverage for manipulation to care for neuromusculoskeletal conditions typical among eligible beneficiaries, and covered diagnostic and other services that a chiropractor was legally authorized to perform by the State or jurisdiction in which the treatment was provided. The demonstration was conducted in four sites, two rural and two urban. The demonstration was required to be budget neutral as the statute requires the Secretary to ensure that the aggregate payment made under the Medicare program does not exceed the amount which would be paid in the absence of the demonstration.

Ensuring BN requires that the Secretary develop a strategy for recouping funds should the demonstration result in costs higher than those that would occur in the absence of the demonstration. As we stated in the CY 2006 and CY 2007 PFS final rules with comment period, we would make adjustments to the chiropractor fees under the Medicare PFS to recover aggregate payments under the demonstration in excess of the amount estimated to yield BN. We will assess BN by determining the change in costs based on a pre- and post-comparison of aggregate payments and the rate of change for specific

diagnoses that were treated by chiropractors and physicians in the demonstration sites and control sites. Because the aggregate payments under the expanded chiropractor services may have an impact on other Medicare expenditures, we will not limit our analysis to reviewing only chiropractor claims.

Any needed reduction to chiropractor fees under the PFS would be made in the CY 2010 and CY 2011 physician fee schedules as it will take approximately 2 years after the demonstration ends to complete the claims analysis. If we determine that the adjustment for BN is greater than 2 percent of spending for the chiropractor fee schedule codes (comprised of the 3 currently covered CPT codes 98940, 98941, and 98942), we would implement the adjustment over a 2-year period. However, if the adjustment is less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period. We intend to provide a detailed analysis of BN and the proposed offset during the CY 2010 PFS rulemaking process.

The following is a summary of the public comments we received and our responses.

Comment: We received one comment concerning the methodology for determining BN. The commenter stated that the Congressional intent for implementing BN is clearly spelled out in section 651(f)(1)(A) of the MMA. The commenter believes the demonstration's costs should be offset from the totality of services payable under the Part B Trust Fund, and not a discrete minority of services. The commenter stated that our methodology is flawed because it offsets demonstration costs only from existing chiropractic services.

Response: Section 651(f)(1)(A) of the MMA requires that ''* * * the Secretary shall ensure that the aggregate payment made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.'' The statute does not specify a specific methodology for ensuring BN. Our methodology meets the statutory requirement for BN and appropriately impacts the chiropractic profession that is directly affected by the demonstration. The BN adjustment under PFS will be limited to adjusting the chiropractor fee schedule codes (comprised of the 3 currently covered CPT codes: 98940, 98941, and 98942). No other codes would be affected.

Q. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists

In the CY 2009 PFS proposed rule (73 FR 38576), we proposed a technical correction to the nurse practitioner (NP) qualifications at § 410.75(b) to require that, in order for NP services furnished by an individual to be covered by Medicare, a NP who obtains Medicare billing privileges as a NP for the first time on or after January 1, 2003, must meet *all* of the following criteria: (1) Be a registered professional nurse who is authorized by State law to practice as a NP; (2) be nationally certified as a NP; and (3) have a master's degree in nursing. The current NP qualification standards in our regulations include progressive requirements that are not entirely date specific. The absence of a date specification for each of the qualification standards could allow nurses who have never been enrolled under Medicare and obtained Medicare billing privileges as a NP an opportunity to enroll as a NP after January 1, 2003, without a master's degree in nursing. Such an enrollment would be contrary to our policy, as explained further below.

We discussed the NP qualifications and our intent to move progressively toward requiring a master's degree in nursing as the standard for all new NPs enrolling and participating under the Medicare Part B benefit in the CY 2000 PFS proposed rule (64 FR 39625) and the subsequent final rule (64 FR 59411). In the CY 2000 PFS final rule, we stated, ''the requirement that a NP applying for a Medicare billing number for the first time must have a master's degree in nursing as of January 1, 2003, will provide NPs without a master's degree with enough time to earn such a degree. We believe it is reasonable to require ultimately, a master's degree as the minimum educational level for new practitioners independently treating beneficiaries and directly billing the Medicare program.''

In the CY 2009 PFS proposed rule (73 FR 38576), we also proposed to amend our regulations at § 410.75(b)(4) which require that NPs must have a master's degree in nursing. We proposed to also recognize a Doctor of Nursing Practice (DNP) doctoral degree (which can be obtained without a master's degree in nursing). In addition, we proposed to amend a similar qualification standard for clinical nurse specialists (CNSs) at § 410.76(b)(2) that requires advanced practice nurses (APNs) to have a master's degree in a defined clinical area of nursing from an accredited educational institution in order to allow CNSs, alternatively, to meet these requirements with a DNP doctoral degree.

In the proposed rule, we acknowledged that we are aware that some educational institutions are offering programs to prospective NPs and CNSs that allow students to move from a baccalaureate degree in nursing directly to the doctoral degree in nursing where they earn a DNP as a terminal clinical doctoral degree. Therefore, some APNs who earn the DNP degree do not receive a master's degree in nursing even though they will have met all of the educational requirements for a master's degree in nursing, in addition to the preparation that merits them the DNP degree. We noted that a *Wall Street Journal* article (published April 2, 2008) stated that by the year 2015, the American Association of Colleges of Nursing aims to make the doctoral degree the standard for all new APNs. We believe that it is logical for Medicare to recognize APNs with more extensive education and training. Therefore, we proposed to permit qualified APNs with the DNP degree to enroll and receive Medicare Part B payment as NPs and CNSs.

We received several comments on our proposals with the majority from national organizations. The following is a summary of the comments received and our responses.

Comment: All of the comments that we received on our proposed technical correction supported the change. The commenters agreed that the intent of the graduated NP educational qualifications was to ensure that practicing NPs and their patients were not left unable to enroll in Medicare after we adopted our rules requiring national certification and a master's degree in nursing for enrollment. Many commenters stated that these NPs had already been recognized and practicing as Part B suppliers. The commenters also stated that the technical correction does not appear to violate the intent of the NP educational qualifications and should reduce any confusion that might still remain regarding this requirement.

Response: We are finalizing the technical correction as proposed in order to clarify our requirement that effective on or after January 1, 2003, all NPs must have a master's degree in nursing.

Comment: The majority of commenters commended CMS for our proposal to recognize the DNP degree and stated that we are keeping pace with the transformation in advanced practice registered nursing education. The commenters applaud CMS for recognizing the DNP degree as a valid

degree that exceeds a master's degree in nursing and stated that recognition of the DNP degree will be positive for patients.

However, some commenters cautioned against eliminating the master's degree in nursing for NPs and CNSs and replacing it with the DNP degree only. The commenters stated that transitioning to the DNP degree as the national standard by 2015 is only a goal toward which the nursing profession will work and that it may take longer for some programs than others to address State licensing and institutional issues. Accordingly, the commenters requested that both the master's degree in nursing and the DNP degree must be recognized by CMS as appropriate credentials for APN reimbursement. Additionally, one commenter urged CMS not to require a master's of science in nursing (MSN) degree instead of a master's degree in nursing.

Response: As we stated in the CY 2009 PFS proposed rule, we believe that it is logical for Medicare to recognize APNs with more extensive education and experience while continuing to recognize NPs and CNSs with a master's degree in nursing. NPs or CNSs with a doctoral degree in nursing practice should not be denied enrollment in the Medicare program because our educational standard for NPs and CNSs is a master's degree. Additionally, we do not intend to eliminate the master's degree in nursing requirement and replace it with solely the DNP degree. We also have no plans to require a MSN degree in lieu of a master's degree in nursing.

Comment: Two commenters stated that they have not yet taken a position on the DNP degree and on the various DNP programs that graduate APNs. However, the commenters noted that many schools offering the DNP degree have programs that focus on areas other than clinical practice such as administration, leadership, business, and nursing policy. The commenters also stated that DNP graduates seeking to enroll in Medicare as new suppliers should hold a clinically-based DNP degree and also, ideally, attain advanced practice certification. The commenters believe that NPs and CNSs who graduate from DNP programs should not be allowed to bypass the master's degree in nursing before achieving the DNP degree because they believe that the master's education provides the appropriate foundation for CNS practice. One commenter is opposed to Medicare's recognition of the DNP degree in Medicare regulations at this time because of the varying routes of entry into a DNP program have not been resolved, there is a lack of standardization of DNP programs' multiple accreditation processes. The commenters also stated that, and Federal recognition of an unproven nursing doctoral program seems premature given that no State licensing agency or State board of nursing has developed statutes or regulations authorizing the utilization of the DNP as a substitute for the master's education requirement and NP or CNS certification.

Response: We believe that as any new educational program develops, there are likely to be some uncertainty and inconsistency inherent in the process. However, the APN community has a stated goal of moving toward a national standard of graduating APNs from DNP programs. We do not believe that it is sensible to deny Medicare enrollment to a registered professional nurse with a DNP degree who meets all of the other qualification requirements when we enroll nurses with a master's degree. We have relied on our contractors to enroll only those NPs and CNSs who have graduated with a master's degree in nursing in addition to meeting other qualification standards that require State licensure and certification by a recognized national certifying body. We believe that these collective qualifications ensure that only qualified nurses with proper clinical training furnish services to Medicare patients. However, we plan to study and monitor DNP programs as they continue to evolve. If we discover that APNs enrolling in Medicare as graduates of DNP programs are not sufficiently qualified to furnish services to Medicare patients, we will reconsider our education requirements and take appropriate action.

Comment: One commenter suggested revising the definition of a physician under the NP and CNS qualifications.

Response: We believe this comment is outside the scope of this regulation, and therefore, we are not addressing this comment at this time.

After reviewing the public comments, we are finalizing our proposals to amend the NP qualifications to incorporate the technical correction and to include the DNP degree under the educational qualification requirements for NPs and CNSs. However, we will continue to study and monitor DNP nursing programs, State legislative action, and the State boards of nursing as the DNP degree evolves.

R. Portable X-Ray Issue

The Conditions for Coverage (CfC) for Portable X-Ray services are authorized by section 1861(s)(3) of the Act and were adopted in January 1969. These requirements have, for the most part, been subjected to minimal modification over the years.

The current requirements in our regulations at § 486.104 (Qualifications, orientation, and health of technical personnel) are inconsistent with existing professional standards of practice and training requirements. Specifically, the current qualification requirements for x-ray personnel in § 486.104(a)(1), (a)(2), and (a)(3) rely on credentialing activities from the Council on Education of the American Medical Association (CEAMA) and the American Osteopathic Association (AOA) which no longer approve formal training programs for x-ray technology and have not done so since 1992.

Beginning in 1976, the Joint Review Committee on Education in Radiologic Technology (JRCERT) worked in collaboration with the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association (AMA) to accredit programs. However, the CAHEA was dissolved by the AMA in 1992 and JRCERT subsequently sought approval from the United States Department of Education (USDE) to approve and accredit x-ray technology programs. Approval was granted to JRCERT by the USDE in 1992. JRCERT is now the only accrediting entity recognized by the USDE that approves these programs; however, JCERT is not a recognized accrediting body under the current regulation at § 486.104.

Before an x-ray technology program can be approved by JRCERT, the American Society of Radiologic Technologists (ASRT) must approve the program's curriculum. Prior to 1992, the curriculum for x-ray technology programs was based on 24 months, which is reflected in the current regulations at § 486.104. ASRT no longer bases its evaluation on program duration, but rather on program requirements. Thus, a program could be less than 24 months in duration and still be eligible for JRCERT approval and accreditation if its curriculum was ASRT approved. Because § 486.104(a)(1) reflects the outdated 24-month standard, some x-ray technicians who actually meet community standards for education and training do not meet Medicare standards as they stand.

Since the current Medicare requirements in § 486.104(a)(1) are outdated, referencing organizations that no longer perform the stated function and requiring a specific duration of training that is no longer the community standard, we proposed to revise the regulation to reflect the current

requirements. References to schools approved by the CEAMA or the AOA will be deleted, and approval by JRCERT will be added. In addition, we proposed that the requirement for formal training of not less than 24 months in duration be deleted, since this criterion has not been part of the criteria established by entities that evaluate and approve x-ray technology programs since 1993.

We proposed to retain the 24-month criterion in § 486.104(a)(2) and (a)(3) (affecting persons obtaining training prior to July 1, 1966) as program duration was one determinant of program quality at that time. To address those who completed their training after July 1, 1966 but before January 1, 1993, the time period during which CEAMA and the AOA were approving training programs, we proposed the addition of a new paragraph § 486.104(a)(4) to this section. This addition will reflect the standards for credentialing activities during this time frame.

The following is a summary of the comments we received and our responses.

Comment: Commenters suggested an alternate requirement for qualification as an x-ray technologist, namely American Registry of Radiologic Technologists (ARRT) certification. The commenters also stated that restricting recognition to only graduates of JRCERT accredited educational programs could create a shortage of radiographers eligible to furnish procedures.

Response: We agree that certification by the ARRT is widely recognized; however, ARRT certification is voluntary, and therefore, may not be required as a condition of employment. Requiring ARRT certification would present an additional expense and testing obligation that individuals who are otherwise qualified might not choose to incur. Such a requirement would also make it necessary for those who are already working in the field to obtain ARRT certification if they are not already certified.

The goal of our proposed revision was to update our regulations to reflect the accurate accrediting entity and program requirements for x-ray technology programs. As it stood, the regulation was inaccurate by referencing organizations that no longer approve and accredit x-ray technology programs, and by specifying an outdated 24-month program requirement. It was not our intention to consider imposing new or additional qualification requirements for technicians.

In accordance with existing regulations, we will continue to recognize as qualified those individuals who have successfully completed a program of formal training in x-ray technology in a school approved by the JRCERT, as well as those who have earned a bachelor's or associate degree in radiologic technology from an accredited college or university. States will continue to have the autonomy to utilize the ARRT exam for State licensing purposes.

After reviewing the public comments, we are finalizing the provisions as proposed.

S. Other Issues

1. Physician Certification (G0180) and Recertification (G0179) for Medicare-Covered Home Health Services Under a Home Health Plan of Care (POC) in the Home Health Prospective Payment System (HH PPS)

In the CY 2009 PFS proposed rule (73 FR 38578), we solicited public comments on policy options regarding physician involvement in the certification and recertification for Medicare-covered home health services under a home health plans of care (POC), payment for those services, and the basis for those payments (relative resources measured in RVUs). Currently, we pay physicians for both the certification and recertification of home health POCs under HCPCS codes G0180 and G01779, respectively. We make payment for these services through the PFS.

In the CY 2009 PFS proposed rule, we expressed our concern that physician involvement in the home health POC may not be as extensive as we had hoped. We recognize that there exists a vast array of differing levels of physician involvement in the certification and recertification of home health POCs. We continue to believe that the active involvement of the physician (to include ''in-person'' contact with the patient) in the certification, recertification, and review of the home health POC is essential for delivery of high quality home health services to Medicare beneficiaries.

To that end, we offered different policy options and solicited the public for comment on those options in an effort to gather more information on this issue, and any other possible underlying issues that may exist.

The following is a summary of the comments and our response.

Comment: Most commenters suggested that we leave our current policies and payment to physicians unchanged, at least until the further analysis is completed. To that end, it was suggested by commenters that we continue to study the role of the physician in home care and determine which factors enhance a physician's ability to conduct oversight activities, ensure appropriateness of care, and work collaboratively with home health agencies without further burdening Medicare beneficiaries. Commenters urged CMS to engage with industry organizations that represent the physicians that furnish these services, to determine goals and assess options. Commenters further suggested that goals and options could include revising the procedure codes used for billing, assessing the current RVUs, and establishing documentation expectations.

Some commenters suggested that payments to physicians for certifying and recertifying HH POCs should be restructured to provide incentives for greater physician involvement, to include personally seeing the patients. Specifically, some commenters suggested adding different payments for the varying levels of physician involvement in the certification and recertification of HH POCs. Other commenters urged CMS to consider how home telehealth can be employed to a greater degree to increase input of clinical information directly to physicians in lieu of face-to-face contact.

Other commenters suggested that we actively support amending the Medicare statute to allow nurse practitioners (NPs) to certify and recertify HH POCs. Some commenters suggested that we actively support demonstrations and legislative proposals to build on the concept of merging home care with primary care under a single care management entity for persons in the advanced stages of chronic illnesses. Other commenters suggested that payment to medical directors should be restored to HHAs, along with requirements for their education and a definition of their role, and that we consider reimbursement for a planning teleconference between the physician and home health personnel.

Response: We appreciate the comments from the public on this matter and will continue to analyze and consider those comments and suggestions in future rulemaking.

2. Prohibition Concerning Payment of Continuous Positive Airway Pressure (CPAP) Devices

a. Background

Obstructive Sleep Apnea (OSA, sometimes referred to as Obstructive Sleep Apnea Hypopnea Syndrome-OSAHS) is associated with significant morbidity and mortality. It is a

commonly under-diagnosed condition that occurs in 4 percent of men and 2 percent of women. The prevalence increases with age (up to 10 percent in persons 65 and older), as well as with increased weight. Complications of OSA include excessive daytime sleepiness, concentration difficulty, coronary artery disease, and stroke. It is estimated that 10 percent of patients with congestive heart failure (CHF) have OSA, which is independently associated with systemic arterial hypertension. Also, untreated OSA is associated with a ten-fold increased risk of motor vehicle accidents.

Continuous Positive Airway Pressure (CPAP) is prescribed by physicians to treat OSA. The patient wears a face mask that provides air pressure to help keep the breathing passages open during sleep. The purpose is to prevent the collapse of the oropharyngeal walls and thereby prevent the obstruction to airflow during sleep, which occurs in OSA. This treatment is generally continued for the rest of the patient's life.

In 2006, Medicare spent approximately $750 million for the diagnosis and treatment of OSA. Sixty five percent of those expenditures represent the amount Medicare spent on diagnostic related costs of OSA using attended facility-based polysomnography (PSG). The remaining $260 million represents the amount spent on treatment related costs associated with the CPAP.

Stakeholders in the sleep community suggest that OSA is currently underdiagnosed and that the numbers of persons using of CPAP will rapidly grow with greater public awareness and the convenient availability of in home testing. It is difficult to precisely estimate the ultimate growth because the true proportion of undiagnosed beneficiaries is unknown, and the current stakeholder estimates may reflect the prior limited access to home sleep testing in the Medicare population. We expect that this combined with the March 2008 expansion of CPAP coverage may lead to significantly increased overall Medicare payments related to OSA diagnosis and CPAP treatment. Though we believe that most of this increase will likely arise from greater beneficiary access to medically appropriate care, we are concerned that even a limited proportion of fraud and abuse will be a significant vulnerability when applied in a very large benefit.

On March 13, 2008, we published a national coverage determination (NCD) that extends coverage of CPAP devices to beneficiaries whose OSA has been diagnosed by certain unattended sleep tests furnished in a setting other than a sleep laboratory facility, that is, tests that are furnished in the beneficiary's home, commonly referred to as home sleep tests (HSTs). Prior Medicare policy had covered CPAP devices only for beneficiaries who's OSA had been diagnosed by facility-based attended PSG. Attended facility-based PSG is a comprehensive diagnostic sleep test including at least electroencephalography, electro-oculography, electromyography, heart rate or electrocardiography, airflow, breathing effort, and arterial oxygen saturation furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed.

The NCD represents a significant expansion of coverage and facilitates the new participation of new entities that had not previously been involved in the provision of this benefit. This also allows testing to occur in patient homes, which are not regulated as health care facilities. For these and additional reasons we describe below, we believe that the diagnosis of OSA for coverage of CPAP merits proactive and ongoing oversight by CMS. Therefore, we intend to closely monitor this benefit.

During the NCD public comment period, we received many comments expressing concern that financial incentives could lead to abusive testing practices that may harm Medicare beneficiaries and the Medicare program. Though these concerns were largely focused on vulnerability that might accompany the entry of new types of entities into the sleep test business following a broad expansion of coverage, some commenters suggested that vulnerabilities would be found in sleep test facilities. Therefore, in the CY 2009 PFS proposed rule, we proposed to prohibit the provider of a qualifying sleep test—both PSG and HST—from also being the supplier of the CPAP device. Our use of the term provider throughout this rule refers to those individuals or entities that administer and/or interpret the sleep test and/or furnish the sleep test device, as described below. The provision of diagnostic sleep testing includes TCs and PCs related to the administration and interpretation of the test itself. Commonly one entity will furnish the sleep test device and another entity, such as a physician, will furnish the professional interpretation of the result generated by the device. Depending on the location in which the test is performed (that is, attended facility-based PSG or a HST), a sleep test provider may furnish the sleep test in its own physical facility, that is, the sleep laboratory, or may furnish the sleep test device and deliver it to and retrieve it from the beneficiary's home.

We believe that Medicare beneficiaries and the Medicare program are vulnerable if the provider of a diagnostic test has a financial interest in the outcome of the test itself. This creates incentive to test more frequently or less frequently than is medically necessary and to interpret a test result with a bias that favors self-interest. In the specific context of this rule, we believe that the provider of a sleep test has self-interest in the result of that test if that provider is affiliated with the supplier of the CPAP device that would be covered by the Medicare program. We believe that in most cases the provider that would be submitting a claim for payment related to the sleep test will not be the beneficiary's primary physician but will be another party, for example, another physician or a diagnostic testing entity. We note that only rarely would a Medicare participating physician also be enrolled as a Medicare DME supplier.

b. Regulation

In the CY 2009 PFS proposed rule, we proposed to prohibit DME supplier payment for a CPAP device if the provider of a sleep test that is used to diagnose obstructive sleep apnea (OSA) in the Medicare beneficiary is the DME supplier or an affiliate of the supplier of the CPAP machine used to treat the beneficiary's sleep apnea. The proposal applied to all sleep testing from attended facility-based PSG to unattended HST.

Based on section 1871(a)(1) of the Act, which provides the Secretary with the authority to ''prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title,'' and section 1834(j)(1)(B)(ii)(IV), which requires suppliers of equipment and supplies to ''meet such other requirements as the Secretary may specify,'' and due to our concerns with respect to the potential for unnecessary utilization of sleep tests, we shall prohibit payment to the supplier of the CPAP device when such supplier, or its affiliate defined as a person or organization that is related to another person or organization through a compensation arrangement or some type of ownership, is directly or indirectly the provider or the interpreter of the unattended out of facility sleep test that is used to diagnose a Medicare beneficiary with OSA.

We considered several options. We considered whether a narrower

prohibition could reasonably accomplish the purposes of this regulation at this time. Exceptions for providers that offer integrated disease management models were considered. We also considered allowing an exception for nationally accredited disease management programs but we are unaware of any current model that was encompass accreditation for both OSA diagnosis and CPAP supply under a single accreditation certificate.

Therefore, we proposed to revise the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier enrollment safeguards set forth at § 424.57 to protect the Medicare program and its beneficiaries from fraudulent or abusive practices that may be related to CPAP devices. We also proposed to add new definitions to paragraph (a) to define ''Continuous positive airway pressure (CPAP)'' and ''sleep test'' and to add a new paragraph (f), which would establish a specific payment prohibition that would not allow the supplier to receive Medicare payment for a CPAP device if that supplier, or its affiliate as defined above, is directly or indirectly related to the provider of the sleep test that would used to diagnose the beneficiary with OSA.

In this final rule, in response to public comment, we are adding additional definitions for ''affiliate'', and ''attended facility-based polysomnogram'', and clarify the definitions of ''Continuous positive airway pressure (CPAP)'', and ''sleep test.'' In addition, we are adding a new paragraph (g), which would create an exception to the prohibition contained in (f) if the sleep test is an attended facility-based PSG.

The following is a summary of the comments we received and our responses.

Comment: Many commenters maintained that the prohibition is unfair and that it ''singles out'' sleep diagnostics and therapies for a special payment prohibition. They maintain that there is no evidence that sleep tests promote ''self interested'' referrals any more than do referrals from any other diagnostic tests.

Response: We disagree. During the process leading to the revised NCD, we received many public comments expressing concern that financial incentives involving sleep test providers being affiliated with CPAP suppliers might very well lead to abusive practices that would harm Medicare beneficiaries and threaten the integrity of the Medicare program.

As we noted above, testing for the diagnosis of OSA will expand into settings that are not regulated as health care facilities. CPAP for the treatment of OSA differs from many other DME items in several ways that are significant here. The clinical symptoms that prompt the use of CPAP, for example, snoring, sleeplessness, daytime drowsiness, generally occur in the home setting and are self reported by the patient. The physical findings of patients with OSA are also seen in persons who do not have OSA.

The diagnosis of OSA which may lead to coverage of CPAP hinges upon the results of a clinical examination and a diagnostic test, the single night sleep study. The interpretation of a sleep study is subject to inter-interpreter variability. Sleep study results are known to vary from night to night and are also technique dependent. Other conditions for which Medicare covers DME, for example chronic obstructive pulmonary disease, are generally diagnosed based on the combined results of multiple tests such as chest x-rays, arterial blood gas measurements and pulmonary function tests. Thus it is less likely that a diagnosis of OSA will be supported by consistent findings across multiple test platforms. We are concerned that the provider of a sleep test will have a bias to interpret an inconclusive sleep test as positive if that provider has a financial interest in the payment for the CPAP device that would be used to treat the beneficiary. We believe that this represents a vulnerability to the Medicare program.

We believe that we have sufficient reason to believe that OSA and CPAP are more amenable to fraud and abuse than some other items and services. We have seen program vulnerabilities in a similar benefit, specifically oximetry testing in the home for coverage of the home use of oxygen. For example, our local contractors informed us that laboratories and DME suppliers were, without an order from the treating physician, initiating oximetry testing. As a result, we acted to prohibit DME suppliers from furnishing the oximetry testing used in part to establish the beneficiary's eligibility for home oxygen coverage.

Comment: Several commenters state that the best models utilize high degrees of coordination and affiliation. The commenters claim that integrated care models result in higher CPAP compliance and better quality of care for the patient. The commenters state that the proposed rule would force integrated sleep management programs to refer beneficiaries to outside entities for the CPAP device, thus creating a break in continuity and accountability. During the public comment period on the proposed rule, several institutional stakeholders noted that if finalized unchanged, the regulation would essentially eliminate integrated sleep management programs that furnish coordinated management of OSA from testing to therapy including provision of CPAP. The commenters claimed that these programs, all facility-based, provide a level of patient support in ensuring appropriate provision and titration of CPAP that is not typical with many DME suppliers. These programs note that under this scenario they would have reduced ability to monitor the beneficiary's compliance with CPAP, including ensuring that the CPAP device has been and continues to be optimized for the individual beneficiary. The commenters believe that finalization of the proposed rule would remove this option, thus they believe leading to fragmented care, loss of accountability and potential harm to patients.

Response: Integrated sleep management programs furnish comprehensive diagnostic and therapeutic services with a single coordinated program that commonly includes ongoing assessment of the patient's response to therapy and modifications to therapy as needed.

If finalized as proposed, the regulation would likely result in these programs referring all beneficiaries to outside DME suppliers for the CPAP device, thus creating a break in continuity of care.

This concern, which we recognize with attended facility-based PSG furnished in integrated sleep management programs, is not applicable outside of this setting. There is no substantive claim of continuity of care and coordinated disease management in other settings where a sleep test provider may have some other relationship with a DME supplier.

Our administrative contractors informed us that they have not historically found these integrated sleep management programs furnishing attended facility-based PSG to be a significant vulnerability. We cannot at this time confidently exclude the possibility that disrupting this model of care might be harmful to some patients. To avoid disrupting established integrated sleep management programs, this final rule with comment period will not prohibit DME payment to suppliers of CPAP to beneficiaries who have been diagnosed with OSA using attended facility-based PSG.

We are unaware of a reliable way to prospectively distinguish bona fide integrated sleep management programs from other entities for the purposes of this regulation. As we note below, there

is no currently available accreditation program under which an entity can, under a single certificate, be accredited for sleep diagnosis and the supply of CPAP treatment. Thus we considered how to balance these concerns and minimize disruptions to continuity of care while maintaining the necessary protections for the Medicare program and its beneficiaries.

We believe that creating an exception for facility-based PSG strikes a reasonable balance of these concerns. In the context of OSA diagnosis and treatment for Medicare beneficiaries these integrated sleep management programs have historically (before the March 2008 NCD) used attended facility-based PSG for OSA diagnosis, as alternative diagnostic strategies did not support Medicare coverage of the CPAP device.

Excepting attended facility-based PSG from the payment prohibition for CPAP does not exempt HST furnished by the same entity, that is, the exception is at the test level not the program or facility level. Thus, this final rule with comment period avoids disrupting established integrated sleep management programs when they furnish attended facility-based PSG while affording the public more time to propose alternatives.

Comment: Several commenters stated that they would be forced to provide supplementary, nonreimbursable services to CPAP patients as a result of the rule. Sleep clinicians point to the fact that follow-up care of an OSA patient is a requirement for AASM accreditation. The commenters stated that under the provisions of the proposed rule, the DME supplier would be reimbursed for the care, even when the DME fails to furnish the follow up care.

Response: We disagree. We expect that treating physicians and other recognized clinicians who evaluate and manage beneficiaries' sleep apnea would continue to submit claims for Medicare payment for the services that they furnish. This rule does not prohibit treating physicians from appropriately providing follow up care to their patients who use CPAP. A DME supplier that is not also enrolled by Medicare as a physician would not furnish services that are properly within the scope of practice of the beneficiary's physician, and we would not expect to receive claims for Medicare payment for such services.

Comment: Several commenters suggested that accredited entities should be exempt from the prohibition. Some commenters have proposed that facilities that have been accredited by a recognized accrediting body to provide full diagnostic, therapeutic, and DME services should have an exception from the prohibition required as stated in the proposed rule.

Response: We agree that an entity that has been accredited by a recognized sleep therapy accrediting body would likely have protections in place that would minimize the potential fraud and abuse concerns we addressed above. We believe that the scope of such accreditation programs should be broad enough to include OSA diagnosis and the supply of CPAP treatment under a unified certificate.

We have contacted JCAHO and AASM (American Academy of Sleep Medicine) to determine whether either has an accreditation program that could be applied to an integrated sleep management program that includes complete patient management to include managing the DME. AASM accredits sleep testing but not DME; JCAHO has nonspecific criteria that might be applied to the testing and DME supplier separately. However, we are unaware of any current model that would encompass both under a single accreditation certificate. One commenter estimated that it would take approximately 6 months to develop such an accreditation framework. We expect that it would take 1 to 2 years to implement and accredit sufficient programs to make this a viable alternative.

Ideally, we would like to require that all entities that furnish both sleep testing and CPAP be accredited. We solicit public input on accreditation models that might support this option. Once we are made aware of appropriate accrediting models, we may readdress this issue in future rulemaking.

Comment: Several commenters expressed concern regarding the delays from time of OSA diagnosis to time of CPAP treatment that might arise if the beneficiary is supplied CPAP from an unaffiliated supplier. The commenters believe that this will have an adverse impact on the patient and will affect their follow through related to the plan of care.

Response: OSA is not an acute condition. We are not aware of credible evidence of serious harm due to delay of days or weeks between OSA diagnosis and CPAP treatment.

The attended facility-based PSG testing paradigm may include same night initiation and titration of CPAP treatment. The final rule provides an exception for attended facility-based PSG. Thus, we believe that the exception provides a reasonable option should the beneficiary's treating physician determine that there is a pressing need for urgent treatment in the case of an individual beneficiary.

Comment: Several commenters believe that the adoption of this rule would cause disruptions in care of OSA treatments for patients in rural areas by imposing new restrictions. These commenters expressed wishes for a Stark-like rural exception, based on access to care arguments.

Response: Though various commenters have compared the provisions of this rule to the ''Stark'' rules, this rule is distinct from Stark and addresses separate concerns.

We acknowledge that rural beneficiaries are more likely to live at greater distances from sleep facilities. Thus, these beneficiaries would be more likely to avail themselves of home sleep testing if it were available.

We also note that the final rule allows an exception for attended facility-based PSG. Thus, when compared to Medicare coverage before the March 2008 NCD expansion, the final rule's provisions in this regard do not impose new restrictions for Medicare beneficiaries located in rural areas. Therefore we believe that a specific rural exception is not needed at this time.

Comment: Many commenters state that existing fraud and abuse laws adequately address abuses arising out of affiliations. For example, the commenters stated that the Stark regulations do not allow a physician who has a financial relationship (ownership or compensation) with a DME supplier to refer a patient to that DME supplier for CPAP, unless an exception applies. In addition, commenters stated that under many State regulations a physician cannot have a substantial ownership interest in a DMEPOS supplier and still refer Medicare patients for DME. The commenters also state that fraud and abuse is prevented by other Medicare provisions, such as those limiting coverage of CPAP to a 12-week period to identify beneficiaries diagnosed with OSA who benefit from CPAP.

Response: We disagree. While Stark and other statutes and rules, including the Federal anti-kickback statute, afford some protections, we believe this regulation to be necessary in order to further protect Medicare beneficiaries from potential abusive practices and to further reduce the Medicare program's vulnerability to fraud and abuse. We believe that the payment prohibition for CPAP in this rule will be applied to a broader set of CPAP supplier relationships than would be prohibited under Stark. We here address additional CPAP supplier relationships that do not

necessarily depend on a relationship with the beneficiary's treating physician who makes a referral, for example, a relationship between a sleep test provider and a DME supplier when the provider of the sleep test is not the beneficiary's treating physician who made the referral for the test.

Comment: One commenter stated that this proposal is unlawful. First, the commenter stated that general rulemaking authority cannot support a ''Stark-like'' proposal such as the one under consideration. Further, the commenter states that the preamble lacks sufficient facts or data to support the statutory predicate under section 1871(a)(1) that the rule must be ''necessary to carry out the administration'' of the Medicare program. The commenter summarizes their concerns by stating that the general grant of rulemaking authority is not plenary. The commenter also stated that the rule is inconsistent with the Stark statute and it's implementing regulations, which the commenter asserted would not preclude a physician from selling a CPAP device to his or her patient if the physician is enrolled as a DME supplier and personally furnishes all of the services associated with the provision of the CPAP. In addition, the commenter concludes that this rule is in direct contradiction to the Stark law because, unlike the Stark law, this rule does not contain an exception for referrals made by a physician who has an ownership or investment interest in a ''rural provider.''

Response: We do not agree. Our authority for promulgating this rule is supported by two different provisions in the Act. First, we believe that section 1871(a)(1) of the Act, which authorizes the Secretary to ''prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title,'' provides sufficient authority for this regulation. We believe that the prevention of fraud and abuse in the provision of CPAP devices is essential to the efficient administration of the Medicare program. While the use of unattended HSTs will provide more beneficiaries with access to diagnosis and treatment of OSA, we are concerned that the increased number of unattended HSTs will in turn increase the potential for a test provider's affiliation with a CPAP supplier to lead to overutilization as we discussed above. We believe that the administration of the Medicare program includes a responsibility to protect the program and its beneficiaries from the harmful effects of fraud and abuse. Second, we also believe that section 1834(j)(1)(B)(ii)(IV) of the Act, which requires suppliers of equipment and supplies to ''meet such other requirements as the Secretary may specify,'' provides sufficient authority for this regulation.

We also disagree with the commenter's assertion that a physician's furnishing of CPAP can easily escape the purview of Stark and that this rule therefore conflicts with the Stark law. As we stated in the ''Phase III'' Stark final rule, although personally performed services are not a ''referral'' for Stark purposes, ''the dispensing of CPAP equipment by a physician would almost always constitute a ''referral'' * * *, as would the dispensing of CPAP equipment by anyone else affiliated with the referring physician, such as a nurse or physician assistant'' (72 FR 51020). This is because a referring physician claiming to personally provide DME must personally furnish the CPAP equipment as well as personally perform all activities necessary to satisfy the DME supplier standards. Thus, in all but the rarest of circumstances, the prohibition promulgated under this final rule does not conflict with the Stark prohibition as applied to physicians who refer for and furnish CPAP in their own medical practices. Moreover, given our general rulemaking authority and our authority under section 1834(j)(1)(B)(ii)(IV) of the Act, we are not prevented from regulating the provision of CPAP in those unusual circumstances in which Stark is not implicated because there has been no ''referral.''

Similarly, we do not agree with the commenter's assertion that this rule conflicts with the Stark prohibition because it does not contain an exception for referrals made by a physician who has an ownership or investment interest in a ''rural provider.'' Under the Stark statute, section 1877(d)(2) of the Act, there ''shall not be considered to be an ownership or investment interest * * * [i]n the case of designated health services [including DME, such as CPAP] furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if * * * substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area.'' Thus, Stark is not implicated in those circumstances. Nevertheless, we are not precluded from using other authority to limit or prohibit payment for items and services that are provided in a manner that does not implicate Stark. Notwithstanding Stark, we have authority under sections 1871(a)(1) and 1834(j)(1)(B) of the Act to issue this rule.

Comment: One commenter stated concerns that the rule will limit appropriately trained and qualified DMEPOS suppliers' ability to furnish home sleep tests. The association claims that the rule creates unnecessary and artificially high barriers to DMEPOS suppliers' ability to furnish services that are uniquely within their area of expertise. The commenter stated that the DME business model is premised on the ability to furnish medical equipment to patients in their homes and DMEPOS suppliers may be the only providers with the immediate capacity to furnish HST to Medicare beneficiaries.

Response: Only the physician treating the beneficiary can order a HST and prescribe CPAP therapy. We expect that the sleep test would be interpreted by a physician, and we do not believe CPAP suppliers should be paid for supplying CPAP equipment when an affiliated physician has interpreted the HST or ordered the equipment. We are not persuaded that DME suppliers have any uniquely valuable expertise in the provision of diagnostic testing.

Comment: Many commenters claimed the regulation will result in an under availability of CPAP equipment and services in many communities. One commenter explained that IDTFs are now permitted to utilize HST to diagnose OSA, but point out that the vast majority of IDTFs do not have the resources and infrastructure needed to deliver or pick-up HST equipment to and/or from the beneficiary's home. The commenter requested that CMS furnish a detailed analysis on beneficiary access to CPAP supplies and services locally before implementing such a provision.

Response: This rule does not prohibit IDTFs from establishing and maintaining sufficient resources and infrastructure to deliver or pick up HSTs, so long as the DME supplier who will be furnishing the CPAP to the beneficiary as a result of the HST is not the same DME supplier that the IDTF has affiliated with for purposes of delivering or picking up the HSTs or performing other functions related to providing the HST. In addition, the exception we are providing for attended facility-based PSG is sufficient to maintain beneficiary access at historical levels before the 2008 NCD.

Comment: One commenter stated that the mission of all nonprofit healthcare systems includes furnishing care for the under and un-insured populations. The commenter stated that healthcare systems would no longer furnish sleep tests to the under and uninsured if the healthcare system is prohibited from furnishing CPAP devices to Medicare beneficiaries.

Response: It is not clear to us why a nonprofit would refuse to offer HSTs to

the under- or uninsured simply because the nonprofit entity cannot use an affiliated DME supplier to furnish a CPAP device prescribed after the HST. We note that health care entities can continue to provide CPAP when prescribed as a result of an attended facility-based PSG.

Comment: One commenter points to guidance issued in mid 2002, where CMS recognized a separation between a hospital system and its ownership of a DME business (otherwise referred to as a Hospital-based supplier). By enacting this provision, the commenter concludes that CMS would no longer recognize this separation. The commenter concludes that this provision, if enacted, would result in other prohibitions for follow-up care following a diagnostic test.

Response: We disagree with the commenter's conclusion, and we note that the final rule's exemption of attended facility-based PSG would likely apply to many hospital affiliated sleep programs.

Comment: Several commenters stated that there is a clear conflict of interest for the provider of the test to also profit from the provision of the CPAP therapy.

Response: We appreciate the supportive comments.

Comment: Several commenters wrote that physicians who work for hospitals are under increasing pressure to generate revenue by conducting more tests and prescribing CPAP through a hospital owned DME supplier. Other commenters claim that bonus payments are made to physician's who prescribe CPAP through a hospital owned DME supplier. These commenters favor the payment prohibition.

Response: We appreciate the overall concerns expressed by the commenters about pressure on physicians, but we wish to minimize the disruption to programs that were in place prior to the March 2008 NCD expansion of coverage. We believe that an exemption for attended facility-based PSG is a reasonable balance between beneficiary access and protection at this time.

Comment: Several commenters support a payment prohibition where the diagnostic test facilities are not permitted to provide the CPAP and related supplies. According to the commenters, the DMEPOS suppliers claim to possess a higher degree of sophistication surrounding CPAP technologies and related supplies by focusing exclusively on the technologies rather than on the sleep diagnostics.

Response: We appreciate the supportive comment on the proposed regulation. However we have been persuaded for reasons described above to except attended facility-based PSG from the payment prohibition for CPAP.

Comment: Several commenters stated that hospital-owned DME qualifies as a monopoly, and results in an unfair competitive advantage for hospitals and large sleep centers. The commenters favor the payment prohibition and state that such a prohibition is good for small businesses.

Response: Business monopoly is beyond the scope of this regulation and we will not discuss it here.

Comment: Several commenters stated that the term ''affiliate'' is ambiguous, and that the proposed rule is vague and overly broad in its use of the terms ''affiliate'' and ''directly or indirectly''. The commenters requested that CMS provide a clear definition of ''affiliate''. The commenters stated that without clear definitions from CMS it is impossible to discern what types of affiliations CMS intends to preclude under the rule or how the proposed rule would apply to any given set of circumstances. One commenter recommended that a definition of affiliate be common ownership of greater than 50 percent of the supplier of the CPAP device.

Response: We define ''affiliate'' as a person or organization that is related to another person or organization through a compensation arrangement or some type of ownership.

We have defined a provider of sleep test as an individual or entity that directly or indirectly administers and/or interprets the test and/or furnishes the sleep test device. By indirect we mean that one or more intermediary actors are used to accomplish the sleep test to its end. For example, if a DME supplier contracted with a sleep test provider to furnish HST, that supplier would indirectly provide the HST. Directly providing the test means there are no intermediary actors—no intervening persons or entities between them.

Comment: One commenter requested that sleep labs be permitted to develop criteria to gauge the competency of the DME. Further, the commenter requested that sleep labs be permitted to use such criteria to discriminate against DME companies who fail to perform at an acceptable level of competency.

Response: We believe that this concern can be addressed through the development and implementation of accreditation standards. Ideally, we would like to require that all entities furnishing sleep tests in any settings in addition to supplying CPAP be accredited. Once we are made aware of appropriate accrediting models, we will readdress the issue in future rulemaking.

Based on section 1871(a)(1) of the Act, which provides the Secretary with the authority to ''prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title,'' and section 1834(j)(1)(B)(ii)(IV), which requires suppliers of equipment and supplies to ''meet such other requirements as the Secretary may specify,'' and due to our concerns with respect to the potential for unnecessary utilization of sleep tests, we shall prohibit payment to the supplier of the CPAP device when such supplier or its affiliate is directly or indirectly the provider of the HST that is used to diagnose a Medicare beneficiary with OSA.

We considered several options. We considered whether a narrower prohibition could reasonably accomplish the purposes of this regulation at this time. Exceptions for providers that offer integrated sleep management programs were considered. We also considered allowing an exception for nationally accredited disease management programs but we are unaware of any current model that would encompass accreditation for both OSA diagnosis and CPAP supply under a single accreditation certificate.

After reviewing the public comments, we are finalizing the prohibition in § 424.57 as proposed but with an exception for attended facility-based PSG. Excepting facility-based PSG from the prohibition on providing CPAP would not except HST performed by the same entity, that is, the exception is at the test level not the facility level. We plan to solicit public input on accreditation models that might support future exceptions to this prohibition. We add additional definitions for ''affiliate'', ''attended facility-based polysomnogram,'' and clarify the definitions of ''Continuous positive airway pressure (CPAP)'' and ''Sleep test''.

3. Beneficiary Signature for Nonemergency Ambulance Transport Services

In the CY 2008 PFS final rule with comment period (72 FR 66406), we created an additional exception to the beneficiary signature requirements, applicable for emergency ambulance transports, in § 424.36(b)(6). The exception allows ambulance providers and suppliers to sign on behalf of the beneficiary, at the time of transport (that is, the time during which the beneficiary is picked up and dropped off at the receiving facility), provided that certain documentation requirements are met. To take advantage of the exception at § 424.36(b)(6), an

ambulance provider or supplier must maintain in its files: (1) A contemporaneous statement, signed by an ambulance employee who is present during the trip, that the beneficiary was mentally or physically incapable of signing (and that no other authorized person was available and or willing to sign); (2) documentation as to the date, time and place of transport; and (3) either a signed contemporaneous statement from the receiving facility that documents the name of the beneficiary and the date and time the beneficiary was received by that facility, or a secondary form of verification from the facility that is received at a later date.

In the CY 2008 PFS final rule with comment period (72 FR 66324), we clarified that, apart from the new exception in § 424.36(b)(6), where a beneficiary is unable to sign a claim at the time the service is rendered, ambulance providers and suppliers are required to use reasonable efforts to follow-up with the beneficiary and obtain his or her signature before submitting the claim with a signature from one of the individuals or entities specified in § 424.36(b)(1) through (b)(5). We further clarified that only providers of services, and not ambulance suppliers, can take advantage of § 424.36(b)(5), which states that a representative of the provider or of the nonparticipating hospital may sign on behalf of the beneficiary if the provider or nonparticipating hospital was unable to have a claim signed in accordance with § 424.36(b)(1) through (b)(4) (72 FR 66322).

Subsequent to publication of the CY 2008 PFS final rule with comment period, ambulance provider and supplier stakeholders requested that we extend the exception in § 424.36(b)(6) to nonemergency ambulance transports in instances where the beneficiary is physically or mentally incapable of signing. These stakeholders stated that there are many nonemergency transports for which a beneficiary is physically or mentally incapable of signing a claim form. For example, stakeholders asserted that beneficiaries residing in long term care facilities often need to be transported for nonemergency medical treatment, yet may be incapable of signing the claim due to physical or mental ailments, such as Alzheimer's disease or other forms of dementia. In these instances, there may be no other individual who is immediately available and authorized to sign the claim as specified in § 424.36(b).

Because we do not anticipate an increased risk of fraud or program abuse if the exception in § 424.36(b)(6) is extended to include nonemergency transports, we proposed to revise § 424.36(b)(6) to refer specifically to nonemergency transports. We also proposed to add language to § 424.36(a) to clarify that, apart from the use of the exception in § 424.36(b)(6), providers and suppliers must make reasonable efforts to obtain the beneficiary's signature before relying on one of the exceptions in § 424.36(b). We note that § 424.36(b)(5) specifies that a provider may not invoke the exception to sign a claim on behalf of a beneficiary unless it is unable to have one of the persons specified in § 424.36(b)(1) through (b)(4) sign the claim. Finally, given that most claims are submitted electronically, we proposed to amend § 424.36(a) to define ''claim'' for purposes of the beneficiary signature requirements as the claim form itself or a form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

We received comments that urged us to eliminate entirely the beneficiary signature requirement where a beneficiary is mentally or physically incapable of signing a claim and no other person authorized to sign a claim on behalf of the beneficiary is available or willing to sign at the time of transport. In addition, the commenters stated that the proposed documentation requirements would be costly and burdensome to ambulance providers and suppliers. Several commenters objected to our proposal to amend § 424.36(a) to clarify that, apart from the use of the exception in § 424.36(b)(6), providers and suppliers must make reasonable efforts to obtain the beneficiary's signature before relying upon one of the exceptions in 424.36(b).

We are adopting our proposals, with modification. Specifically, we are amending the exception in § 424.36(b)(6) to include nonemergency ambulance transports. We are also amending § 424.36(a) to define ''claim'' for purposes of the beneficiary signature requirements, as the claim form itself, or a form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary. We are revising § 424.36(b)(6)(ii)(C)(2) to include secondary forms of verification from either a hospital or a facility.

The following is a summary of the comments we received and our responses.

Comment: The majority of commenters stated that it is a burden on ambulance providers and suppliers to obtain a signature for nonemergency ambulance transports when a beneficiary is mentally incapable of signing the ''waiver.'' The commenters contended that asking for additional documentation to verify that a patient was transported creates a financial burden on the ambulance provider. One commenter stated that its billing office has to do more mailings, follow-up calls and faxes to get a ''waiver'' completed, and that spouses are reluctant to sign the form for fear that they will be responsible for the ambulance transport bill. The commenter also stated that the forms are confusing to its ambulance crew and that hospital and rehabilitation representatives are reluctant to sign forms. One commenter suggested that checking hospital and rehabilitation bills would be an easier way to document a patient transport, whereas another commenter suggested that we should abolish the signature requirement entirely.

Response: We note that whereas several commenters referred to a ''waiver'' of the signature requirement of § 424.36, in fact § 424.36 sets forth a signature requirement and alternative means of satisfying the signature requirement. That is, § 424.36 generally requires that the beneficiary sign the claim, unless the beneficiary is deceased or unavailable to sign the claim, in which case other individuals or entity representatives (as enumerated in § 424.36(b), (c) and (d)) may sign the claim. We are adopting our proposal to amend § 424.36(a) to clarify that ''the claim'' includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual signing on behalf of the beneficiary that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary. The purpose of the beneficiary signature is to verify that the services were in fact rendered and were rendered as billed.

Our proposal does not impose any new burdens on ambulance providers or suppliers, but rather offers an optional, alternative method, for satisfying the beneficiary signature requirement. We do not agree with the commenters that it is a significant burden on ambulance providers and suppliers to comply with the proposed signature and documentation requirements in order to meet the proposed exception for nonemergency ambulance transports when a beneficiary is incapable of signing a claim form; however, those

ambulance providers and suppliers that believe that the signature and documentation requirements of the new exception at § 424.36(b)(6) are burdensome may avail themselves of the other means specified in § 424.36 for satisfying the beneficiary signature requirement.

In response to the assertion that the forms are confusing, we reiterate that we did not create any new forms for ambulance personnel or facility staff to sign. Ambulance providers or suppliers may use whatever forms they wish (such as the patient care trip report, etc.) for capturing the signature and documentation requirements specified in § 424.36(b)(6). In response to the assertion that spouses are reluctant to sign a form for fear that they will be responsible for the ambulance transport bill, signing of the claim form (or such other form used as a proxy for the claim form) does not make a person financially liable to pay the provider or supplier. However, if a beneficiary or the beneficiary's authorized representative refuses to sign the claim form, the ambulance company may bill the beneficiary directly for the transport service. In addition, if the transport service is deemed not medically necessary, and thus is not covered by Medicare, the beneficiary may be held responsible for payment (subject to the limitation of liability provisions of section 1879 of the Act and our regulations at §§ 411.404).

We are not persuaded to adopt the suggestion that we eliminate entirely the beneficiary signature requirement for ambulance transports. We are concerned that there may be an increased risk of fraud or program abuse if we were to remove the signature requirement. Moreover, we did not propose to eliminate the signature requirement and therefore may lack the authority to abolish the requirement through this final rule even if we were otherwise inclined to do so. With respect to the suggestion that we should check hospital and rehabilitation bills to document a patient transport (which is tantamount to suggesting that we eliminate the signature requirement), we do not agree that it should be the program's responsibility, at the time of processing the claim, to guess whether the beneficiary would have authorized the claim if asked, or to have to secure documentation from providers and suppliers (which, to the extent that they have not furnished the transport, may not be required to supply us with such documentation and may even be precluded by privacy laws from supplying us with such documentation). Accordingly, we believe providers and suppliers should go on record, at the time of submitting the claim, that the beneficiary (or someone authorized on his behalf) authorized the filing of the claim.

Comment: Several commenters noted that, in light of our proposal to expand the (b)(6) exception to include nonemergency ambulance transports as well as emergency ambulance transports, the signature requirements may apply when a beneficiary is being transported from or to skilled nursing facilities, hospitals and other permissible destinations. Therefore, the commenters requested that we revise § 424.36(b)(6)(ii)(C)(2), which makes reference to ''the hospital registration/admission sheet'', ''the hospital log'', or ''other internal hospital records,'' and replace ''hospital'' with ''facility.''

Response: We agree with the commenter that there may be nonemergency transports where the beneficiary is being transported from or to skilled nursing facilities, hospitals and other permissible destinations. Thus, we are revising § 424.36(b)(6)(ii)(C)(2) to replace ''hospital'' with ''hospital or other facility''.

Comment: One commenter requested that we clarify whether secondary forms of verification must be signed by a representative of the receiving facility. In response to a similar request for clarification in the CY 2008 PFS final rule (72 FR 66323) we stated that secondary forms of verification did require a signature; however, this requirement was not included in the text of § 424.36(b)(6)(ii)(C)(2), as finalized in the CY 2008 PFS final rule. The commenter also stated that hospitals are moving toward electronic recordkeeping, and urged us to clarify that secondary forms of documentation used to verify transport do not need to be signed by a representative of the facility, provided that the form of documentation obtained is an official facility record that clearly indicates the name of the patient, and the date and time the patient was received by or transported from that facility.

Response: We acknowledge that, although the preamble language in the CY 2008 PFS final rule stated that all forms of secondary documentation used to verify transport need to be signed by a representative of the receiving facility, the regulation text at § 424.36(b)(6), as published in the 2008 CY PFS final rule, did not include this specific requirement. We are clarifying § 424.36(b)(6)(ii)(C)(2)to provide that secondary forms of documentation used to verify transport do not need to be signed by a representative of the receiving facility if the form of documentation obtained is an official hospital or facility record, (such as the facility or hospital registration/admissions sheet, patient medical record, facility or hospital log, or other facility or hospital record), and it documents the beneficiary's name, date, and time the beneficiary was received by that facility.

Comment: Several commenters objected to our proposal to clarify § 424.36(a) to state that a provider or supplier must make ''reasonable efforts to locate and obtain the beneficiary's signature'' before a provider or supplier could rely upon one of the exceptions set forth in § 424.36(b)(1) through (5).

Response: We are not adopting our proposal because, having reexamined the issue, we believe that the current language in § 424.36(b)(5) provides adequate protection for the beneficiary and the Medicare program. Prior to, and during the course of, the CY 2008 PFS rulemaking, we were alerted to the fact that some ambulance providers and suppliers were signing the claim on behalf of the beneficiary simply because the beneficiary was not able to sign the claim *at the time of transport.* We clarified in the preamble to the CY 2008 PFS final rule with comment period that signing the claim on behalf of the beneficiary simply because the beneficiary was not able to sign the claim at the time of transport was not proper and, further, that only providers (and not suppliers) are eligible to use the exception at § 424.36(b)(5). Our decision to make an exception to the requirement that reasonable efforts must be made to obtain the signature of the beneficiary, by creating a new exception at § 424.36(b)(6) in the CY 2008 PFS final rule with comment period for emergency ambulance transports, and in this final rule for nonemergency ambulance transports, and to allow the provider or supplier to sign the claim on behalf of the beneficiary *at the time of the service,* provided certain safeguards are met, was a deliberate departure from the general rule. However, because we amended § 424.36(b)(5) in the CY 2008 PFS final rule with comment period to state that, before relying on that exception, providers must ''mak[e] reasonable efforts to locate and obtain the signature of one of the individuals specified in paragraph (b)(1), (2), (3) or (4) of this section,'' rather than to state that the provider must first make reasonable efforts to locate and obtain the signature of the *beneficiary,* we are concerned that we might create confusion or add an unneeded degree of complexity if we were to finalize our proposal to amend § 424.36(a) to state

that a provider or supplier must make reasonable efforts to locate and obtain the *beneficiary's* signature before a provider or supplier could rely upon one of the exceptions set forth in § 424.36(b)(1) through (5). By requiring providers and suppliers to not sign claims on behalf of the beneficiary under § 424.36(b)(5) without having first made reasonable efforts to procure the signature of the beneficiary or an authorized individual, we address our core concerns. It is true that, as clarified, our regulations allow providers and suppliers to procure the signature of an authorized individual in a situation where the beneficiary may be only temporarily unable to sign the claim, but, on balance, we believe it is preferable, for the sake of convenience, to give providers and suppliers some flexibility as to whether they obtain the signature of the beneficiary or that of an authorized individual. With respect to *ambulance* providers and suppliers, the matter of making reasonable efforts to locate and obtain the signature of the beneficiary or another authorized individual should largely be moot. Ambulance providers and suppliers should be able to rely on the exception at § 424.36(b)(6) to sign the claim in the case of both emergency and nonemergency transports, provided they meet the documentation requirements therein. To the extent that ambulance providers and suppliers do not wish to, or are unable to, comply with the documentation requirements of § 424.36(b)(6), they may obtain the signature of an authorized individual specified at § 424.36(b)(1) through (b)(4) (including in the situation where one of the authorized individuals is available and willing to sign at the time of transport). Moreover, an ambulance provider (but not a supplier), may rely on the exception at § 424.36(b)(5) to, itself, sign the claim, after having made reasonable efforts (including over a reasonable period of time) to locate and obtain the signature of either the beneficiary or an authorized individual.

Comment: Several commenters requested that we make the new exception in § 424.36(b)(6) for nonemergency transports retroactive to January 1, 2008. Commenters also asked us to clarify in this final rule and/or in guidance on the CMS Web site that we will not take any adverse action against an ambulance provider or supplier that made good faith (but unsuccessful) attempts to comply with the beneficiary signature requirement rules prior to January 1, 2009. The commenters stated that, despite multiple attempts to obtain the required signatures from the beneficiary or the beneficiary's authorized representative, many ambulance providers and suppliers have been unsuccessful, and thus, they are holding claims for nonemergency transports. The commenters also asserted that ambulance providers and suppliers have experienced difficulty in obtaining signatures from facility representatives because of concerns that their signature would render the facility financially liable for the transport.

Response: We are not making the new exception in § 424.36(b)(6) for nonemergency ambulance transports retroactive to January 1, 2008, and are not making an exception for good faith efforts to comply with the regulation as it existed prior to this final rule with comment period. There would be significant legal issues if we were to make the rule retroactive to January 1, 2008 or to waive the requirements as they existed prior to this final rule. Moreover, apart from the legal constraints, we are not persuaded that either course of action is warranted. The CY 2008 PFS final rule did not create any new burden for ambulance providers and suppliers (and, to the contrary, made it easier for ambulance providers and suppliers to comply with the beneficiary signature requirement for emergency transports). It did, however, clarify our longstanding policy that providers and suppliers must make reasonable efforts to obtain the beneficiary's signature before submitting the claim and that it was not sufficient for *providers* to submit the claim (utilizing the exception at § 424.36(b)(5)) simply because the beneficiary was able to sign the claim at the time of transport. We also clarified that only providers, and not suppliers, may utilize the exception at § 424.36(b)(5), consistent with the plain language of the exception. To the extent that, following the November 27, 2007 final rule, ambulance providers and suppliers have found it difficult to obtain the beneficiary's signature for nonemergency transports (because they had not previously been following our rules), we have addressed their concerns in two ways. First, on July 24, 2008, we placed guidance on the CMS Web site at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/Guidance_On_Beneficiary_Signature_Requirements_for_Ambulance_Claims.pdf* that reiterated our position that ambulance providers and suppliers may utilize the exception at § 424.36(b)(4), which allows facilities to sign on behalf of the beneficiary, and explained that such facilities do not assume liability for payment of the services simply by signing on behalf of the beneficiary. Second, in this final rule we are finalizing our proposal to expand the exception in § 424.36(b)(6) to nonemergency transports. The new exception is effective for ''claims'' filed on or after January 1, 2009. Therefore, if claims have been held and are still within the timely filing limit, as specified in § 424.44, the claims may be submitted to Medicare for payment in accordance with the new exception.

Comment: A commenter recommended that the existing language in § 424.36(b)(6)(ii)(A) be modified to state that, in the case of an emergency transport, the general crew signature on an emergency ambulance incident report is sufficient to meet the requirements of § 424.36(b) and that a separate crew signature is not required. The commenter suggested, as an alternative, that if we determine that the signature of an ambulance employee present during the transport is necessary, it should be sufficient if the employee signature on the incident report is obtained ''after the fact,'' rather than contemporaneous with the transport. The commenter stated that it is necessary that we allow signatures obtained after the transport because the ambulance crew's primary concern is taking care of the patient, not doing paperwork, such as a signed incident report.

Response: We are not persuaded to modify the requirement in § 424.36(b)(6)(ii)(A) to state that the general crew signature on an incident report is sufficient and that a separate crew signature is not required. We believe that the commenter's suggestion that any member of the general crew be permitted to sign the incident report as evidence that the service was rendered as billed would not satisfy our integrity concerns, because the general crew member would have no direct knowledge regarding the transport services. It is also our understanding that the ambulance crew completes a trip report that describes the condition of the beneficiary, treatment, origin/destination, etc. Therefore, we believe it would be a minimal burden upon the ambulance crew signing the incident or trip report to prepare a statement detailing why the beneficiary is unable to sign a claim form at the time of transport. We also emphasize that § 424.36(b)(6)(ii)(A) requires that a contemporaneous statement signed by an ambulance employee present during the trip be obtained. A contemporaneous statement, rather than one obtained after the fact, is necessary to meet our integrity concerns, that is,

to verify that the trip took place as claimed on the bill.

Comment: Several commenters suggested that we eliminate the terms ''emergency and nonemergency ambulance transport services'' in § 424.36(b)(6) and replace those words with ''ambulance services.''

Response: We are not persuaded to revise § 424.36(b)(6) in the manner suggested by the commenters. Although readers familiar with the **Federal Register** publications of the CY 2008 PFS final rule and the CY 2009 PFS final rule would realize that ''ambulance services'' would refer to both emergency and nonemergency transports, we wish the regulation text that will appear in the CFR to be clear on its own, particularly to readers who may be accessing the regulation years from now. Therefore, we believe it is preferable to retain the proposed language ''emergency and nonemergency ambulance transport services'' so as to leave no doubt that both emergency and nonemergency transports are covered by the exception in § 424.36(b)(6).

4. Solicitation of Comments and Data Pertaining to Physician Organ Retrieval Services

Since 1987, we have limited the amount an Organ Procurement Organization (OPO) may reimburse a physician for cadaveric kidney donor retrieval services. Chapter 27 of the Provider Reimbursement Manual (CMS–Pub. 15–1) limits the payment to a physician for cadaveric kidney retrieval to $1,250 per donor (one or two kidneys). Although the payments made to physicians for organ retrieval services associated with other types of organ transplants have increased, kidney retrieval rates have remained at $1,250. We have received several requests to change the amount we pay for kidney retrievals. To date, we do not have data upon which to base a change in payment.

In order to determine fair and reasonable payment for cadaveric organ retrieval services, we solicited public comments and data that are reflective of organ retrieval service costs. We did not limit our solicitation to costs associated with kidney retrieval services, but rather stated that we are interested in receiving comments and data pertaining to retrieval services for all types of organs. We indicated that we may use this information to determine the extent to which a recalculation of the payment for cadaveric organ retrieval services furnished by a physician is warranted and to inform any future rulemaking on this subject. Any future rulemaking would provide for notice and public comment.

We received four timely public comments in response to our request for information and data for use in updating the organ retrieval physician payment amount included in organ acquisition costs. The following is a summary of the comments we received and our responses.

Comment: The commenters believed that the kidney retrieval rate of $1,250 per donor is insufficient and three of the commenters recommended that we increase that limit by either the Consumer Price Index for all urban consumers (CPI–U) or the Medicare Economic Index. Two commenters stated that little or no data on actual organ retrieval services exists, and that any rulemaking without such data would be inappropriate. The commenters stated that due to the extreme variability associated with these services, they had serious concerns as to the feasibility of establishing an accurate cost or payment for organ retrieval using an approach like that employed by the AMA's Relative Value Scale Update Committee (RUC). According to the commenters, there are specific factors impacting the cost of organ retrieval including donor evaluation, travel and wait time, dry runs and other risks and costs. These factors contribute to the great variability in measuring the time and expense associated with organ retrieval services. These commenters offered to assist us in establishing a process to collect data for the purpose of updating the organ retrieval rates. One commenter stated that the retrieval rate should be paid per kidney and not per donor.

Response: We thank the commenters who responded to our solicitation of comments and appreciate the offer that some made to be involved in future efforts to design a revised payment method. We are not inclined to propose that the base organ retrieval rate for kidneys and other organs simply be increased by an indexed amount (such as the CPI–U) because we believe the base payment amounts for retrieval of the various organs may need to be updated. Therefore, we are again soliciting information from the transplant community. Specifically we would like to obtain information on the physician effort and resources required to procure an organ. These resources include surgical time, dry runs (number and percentage of retrievals in which an organ is not recovered), travel and wait times, as well as the incremental time required for extended criteria donors and donors after cardiac death. Additionally, because currently we limit kidney retrieval physician reimbursement to $1,250 per donor, we would need resource information to determine the difference in procuring one kidney or a pair of kidneys from a single donor in order to determine a payment on a per kidney basis as suggested by a commenter.

5. Revision to the ''Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges'' Final Rule

In the June 27, 2008 **Federal Register**, we published the ''Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges'' final rule. In § 405.874(b)(2), we stated, ''The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. A revocation based on Federal exclusion or debarment is effective with the date of the exclusion or debarment.''

During the 30 days after CMS or our contractor mails a revocation notice to a provider or supplier, the provider or supplier is afforded the opportunity to submit a corrective action plan. A corrective action plan gives a provider or supplier an opportunity to provide evidence that demonstrates that the provider or supplier is in compliance with Medicare requirements. Moreover, a provider or supplier can use a corrective action plan to correct the deficiency without filing an appeal under 42 CFR part 498, and remain in the Medicare program when the provider demonstrates that the provider or supplier is in compliance with Medicare requirements and the Medicare contractor accepts the corrective action plan. In those situations where a provider or supplier submits an acceptable corrective action plan, the provider or supplier maintains their billing privileges and the revocation determination is not implemented.

We maintain that providers or suppliers are able to provide sufficient evidence through a corrective action plan that demonstrates that they are in compliance with Medicare requirements when CMS or our contractor imposes a revocation based on certain types of adverse actions such as a Federal exclusion or debarment. Accordingly, consistent with revoking billing privileges with the date of exclusion or debarment, we believe that similarly situated revocations such as felony convictions and license suspension or revocation do not lend themselves to a

corrective action plan and that the revocation should be effective with the date of the felony conviction or the license suspension or revocation. Moreover, we maintain that when CMS or our contractor determines that a provider or supplier, including a DMEPOS supplier, is no longer operating at the practice location provided to Medicare on a paper or electronic Medicare enrollment application that the revocation should be effective with the date that CMS or our contractor determines that the provider or supplier is no longer operating at the practice location.

Further, while we do not believe that revocations based on felony convictions, license suspension or revocation, or a revocation based on a provider or a supplier no longer being operational at a specific practice location, lend themselves to a corrective action plan, we believe that these providers and suppliers should be afforded appeal rights in 42 CFR part 498. We believe that the appeals process will permit a provider or supplier who believes that CMS or our contractor has made an incorrect decision regarding revocation based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or when we have determined that the provider or supplier is no longer operating at the practice location the opportunity to have CMS or our contractor reconsider its initial revocation determination.

Accordingly, we proposed to revise § 405.874(b)(2) from, '' The revocation of provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. A revocation based on Federal exclusion or debarment is effective with the date of the exclusion or debarment.'' to ''The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on an exclusion or debarment Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.''

In addition, to ensure consistency, we proposed to revise § 424.535(f) (redesignated as § 424.535(g)) from, ''Revocation becomes effective within 30 days of the initial revocation notification.'' to ''Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.''

We believe that these changes will ensure that providers and suppliers are afforded due process rights under 42 CFR part 498, but also ensure that Medicare is not making or continuing to make payments to providers and suppliers who are no longer eligible to receive payments.

We solicited comments on whether we should establish an expedited reconsideration process for providers and suppliers for when we issue a revocation for the following reasons: (1) Federal debarment or exclusion, (2) felony conviction, (3) license suspension or revocation, or (4) when CMS or our contractor determines that the provider is not operational at the practice location provided to Medicare and the provider or supplier furnishes sufficient evidence to demonstrate that CMS or our contractor made a factual error when issuing the initial revocation determination.

In addition, we solicited comments on whether CMS or our contractors should consider processing expedited reconsiderations within a specified time period such as 30 days of the date the provider or supplier furnishes sufficient evidence to make a reconsideration determination.

The following is a summary of the comments we received and our responses.

Comment: Several commenters recommended that we withdraw our proposed changes to the appeals process.

Response: We disagree with these commenters because we continue to believe that we should not make further payments to physicians and NPPs who have had their State medical license suspended or revoked, were convicted of a felony as described in § 424.535(a)(3), were excluded or debarred from participating in a Federal program, or were determined by CMS or its contractor not to be operational.

Comment: One commenter urged CMS to require contractors to send revocation notices in an effective manner that would establish a date of receipt and the recipient.

Response: While this comment is outside the scope of the proposed rule, Medicare contractors are instructed to mail revocation notices to the correspondence address of the provider.

Comment: One commenter recommended that we create an expedited reconsideration process of not more than 30 days in cases where revocation is based on CMS/contractor error.

Response: While we have considered establishing an expedited reconsideration process for those cases in which Medicare revoked billing privileges due to a Federal exclusion or debarment, a felony conviction as described in § 424.535(a)(3), a State license suspension or revocation, or the practice location is determined by CMS or our contractor not to be operational, we do not believe that an expedited reconsideration process is warranted.

Comment: One commenter stated that our proposal to make revocation effective with limited notice and appeal rights in certain situations is a violation of due process.

Response: While we agree that physicians, NPPs and physician and NPP organizations will receive limited notice when CMS or our contractor revokes Medicare billing privileges due to State licensure suspension/revocation, Federal debarment or exclusion, felony convictions as described in § 424.535(a)(3), or when a practice location is found to no longer to be in operation, we disagree with this commenter's statement that we are violating due process rights. Physicians, NPPs, and physician and NPP organizations are afforded identical appeal rights as any other provider or supplier whose Medicare billing privileges were revoked.

Comment: One commenter stated that retroactive revocation creates a situation where Medicare denies payment for services physicians have furnished in good faith reduces the time available for appeal and then locks the physician out of Medicare for at least a year.

Response: We disagree with this commenter. Whenever a physician or NPP's State medical license is suspended or revoked, is convicted of felony as described in § 424.535(a)(3), excluded or debarred from participating the Federal exclusion or debarment, or is determined by CMS or our contractor not to be operational, we believe that the payments to these practitioners should immediately cease.

Comment: One commenter suggested, at the very least, current rights of appeal should be preserved for all proposed denials and we should actively research the performance of its contractors in auditing clinicians who make ''all or substantially all of their clinical encounters in the patient's home,'' and give provider feedback a defined role in the evaluation and subsequent award of contracts to intermediaries.

Response: This comment is outside the scope of this proposed rule and can not be addressed in this final rule.

After reviewing public comments, we are finalizing § 405.874(b)(2) to state ''The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction as described in § 424.535(a)(3), license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.'' We are also finalizing § 424.535(f) (redesignated as § 424.535(g)) to state ''Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocations, or if the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.''

We believe that these changes will ensure that providers and suppliers are afforded due process rights under 42 CFR part 498, but also ensure that Medicare is not making or continuing to make payments to providers and suppliers who are no longer eligible to receive payments.

We continue to believe that revocations such as felony convictions and license suspensions or revocations are determinations that do not lend themselves to a corrective action plan and that the revocation should be effective with the date of the felony conviction or the license suspension or revocation action. Moreover, we maintain that when CMS or our contractor determines that a provider or supplier, including a DMEPOS supplier, is no longer operating at the practice location provided to Medicare on a paper or electronic Medicare enrollment application that the revocation should be effective with the date that CMS or our contractor determines that the provider or supplier is no longer operating at the practice location.

Further, while we do not believe that revocations based on felony convictions, license suspension or revocations, or a revocation based on a provider or a supplier no longer being operational at a specific practice location, lend themselves to a corrective action plan, we believe that these providers and suppliers should be afforded appeal rights in 42 CFR part 498. We believe that the appeals process will permit a provider or supplier who believes that CMS or our contractor has made an incorrect decision regarding revocation based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or when we have determined that the provider or supplier is no longer operating at the practice location the opportunity to have CMS or our contractor reconsider its initial revocation determination except for those revocation determinations imposed under § 424.535(a)(2), (a)(3), and (a)(5).

6. Physician Resource Use Feedback Program

a. General Background

CMS' Office of the Actuary estimates that the Medicare PFS allowed charges have grown approximately 55 percent from 2000 to 2007.[1] The Medicare Payment Advisory Commission (MedPAC) reports that since 2000, total Medicare spending for physicians' services has climbed more than 9 percent per year.[2] In addition to these rapid increases in cost, the Dartmouth Atlas (*http://www.dartmouthatlas.org/*) shows that there is significant geographic variation in the amount of services Medicare beneficiaries receive, with little or no relationship to outcomes.[2] We are implementing value-based purchasing (VBP) initiatives in response to these concerning trends. VBP ties payment to performance through the use of incentives based on measures of quality and cost of care. The implementation of VBP will transform CMS from a passive payer of claims to an active purchaser of higher quality, more efficient health care for Medicare beneficiaries. Our VBP initiatives include hospital pay for reporting (the Reporting Hospital Quality Data for the Annual Payment Update program), physician pay for reporting (the Physician Quality Reporting Initiative), home health pay for reporting, the Hospital VBP Plan Report to Congress, and various VBP demonstration programs across payment settings, including the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration.

In its March 2005 Report to Congress, MedPAC recommended that CMS use Medicare claims data to measure physicians' resource use and share the results confidentially with physicians to educate them about how their resource use compares with aggregated peer performance. MedPAC envisioned that resource use measurement and feedback could encourage physicians to reduce the volume and intensity of the services they provide without sacrificing quality of care, thereby improving efficiency.[3]

In response to this MedPAC recommendation, we launched a study to develop resource use reports (RURs), in early 2006, with an initial focus on high cost imaging services. In Stage I of this study, we developed RURs for physician referral and utilization patterns for echocardiograms, along with a concentration on echocardiograms for patients with congestive heart failure. We worked with two healthcare systems in

[1] CMS Office of the Actuary.

[2] Assessing Alternatives to the Sustainable Growth Rate System. Medicare Payment Advisory Commission Report to Congress. March 2007. *http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf.*

[3] Medicare Payment Policy. Medicare Payment Advisory Commission Report to Congress. March 2005. Chapter 3. *http://www.medpac.gov/documents/Mar05_EntireReport.pdf.*

Madison, WI and Cleveland, OH to recruit physicians for the study. We used Medicare fee-for-service (FFS) claims data for the recruited physicians to populate RURs. Based on the feedback received during stage I, we redesigned the RURs (stage II) and focused on magnetic resonance imaging and computerized tomography imaging. For stage II, the RURs were modified to incorporate clinical guidelines into the reports. The construct of the RURs included in stages I and II of the study is similar to the RURs that are described, in detail, in section 6.c. of this final rule.

Building on its March 2005 recommendation, MedPAC subsequently released an additional report on the topic of measuring physician resource use. In its June 2006 Report to Congress, MedPAC focused on commercial episode grouper products. In that report, MedPAC addressed such issues as: risk adjustment, attribution (assignment) of cost per episode to individual physicians, and variation in resource use across geographic areas. MedPAC tested two commercially available episode grouper products, Episode Treatment Groups (ETGs) and Medical Episode Groups (MEGs), using Medicare fee-for-service claims data.[4] The ETG product is owned by Ingenix and ''identifies and classifies an entire episode of care regardless of whether the patient has received medical treatment as an outpatient, inpatient, or both.'' [5] The MEG product is owned by Thomson and ''groups inpatient, outpatient, and pharmaceutical claims into clinically homogenous units of analysis called episodes that describe a patient's complete course of care for a single illness or condition.'' [6]

In 2006, we awarded a contract to Acumen LLC, to explore how the ETGs and MEGs handle Medicare FFS claims data. In addition to Acumen's technical episode grouper analysis, we are also pursuing a contract with Kennell, LLC to analyze selected claims grouping algorithms within each of these commercial episode grouper products. Both of these research contracts are currently underway.

The Government Accountability Office (GAO) has also addressed physician resource use. In their April 2007 report, GAO compared the resource use of physician practices with that of their peers and specifically focused on outliers. In their report, GAO recommended that CMS develop a system to identify physicians with inefficient practice patterns and provide confidential feedback to improve efficiency.[7]

A number of other entities have also been developing approaches to measuring and reporting on physician resource use, including the National Quality Forum, the National Committee for Quality Assurance, the Quality Alliance Steering Committee, and the AQA-Alliance.

b. Statutory Authority

Section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We have titled this initiative the physician resource use feedback program.

Under section 1848(n)(1)(B) of the Act, resource use may be measured on an: (i) Episode basis, (ii) per capita basis, or (iii) on both an episode and a per capita basis. In addition, to the extent practicable, data for reports shall be based on the most recent data available. Section 1848(n)(4) authorizes the Secretary to focus the application of the program as appropriate, such as focusing the program on: (1) Physician specialties that account for a certain percentage of all spending for physicians' services; (2) physicians who treat conditions that have a high cost, of a high volume, or both; (3) physicians who use a high amount of resources compared to other physicians; (4) physicians practicing in certain geographic areas; or (5) physicians who treat a minimum number of individuals. In addition, section 1848(n)(5) authorizes the Secretary to exclude certain information regarding a service from a report with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service. Finally, under section 1848(n)(6), to the extent practicable, the Secretary shall make appropriate adjustments to the data used to prepare RURs, such as adjustments to take into account variations in health status and other patient characteristics.

c. Implementation of Section 1848(n)(1)(B)

In April 2008, we awarded a contract to Mathematica Policy Research to assist in the development of physician resource use measures and confidential feedback reports. The purposes of the contract were to: (1) Develop meaningful, actionable, and fair measures of resource use for physician practices with the ultimate goal of using the measures in CMS' VBP initiatives; and (2) provide feedback and education to encourage more efficient provision of services. The Mathematica contract contains the following tasks: (1) Development of resource use measures based on both an episode of care (ETG & MEG) and per capita analysis; (2) risk adjustment of Medicare FFS claims data for patient severity of illness; (3) development of methodologies to attribute both episodes and total cost of care for a beneficiary to individual physicians and multiple physicians; (4) development of benchmarks for peer comparison; (5) populate RURs with Medicare FFS data for several medical specialties; (6) recruit physicians to confidentially share the feedback reports; and (7) submit all documentation and production programming logic to allow for a possible national dissemination of RURs to physicians. The work performed and derived from this contract is the basis for establishing the program required under section 1848(n) of the Act, which we will refer to as the ''Physician Resource Use Feedback Program.''

The Physician Resource Use Feedback Program will consist of multiple phases. Under this approach, each phase of the program will inform future phases of the Program. The tasks listed above comprise phase I of the feedback program. To date, CMS has disseminated RURs in two program sites: Baltimore, MD (August 2008) and Boston, MA (September 2008). Baltimore was selected as a program site due to its close proximity to the CMS central office and Boston was selected as a program site due to its high per capita Medicare costs and utilization

[4] Increasing the Value of Medicare. Medicare Payment Advisory Commission Report to Congress. June 2006. Chapter 1. *http://www.medpac.gov/documents/Jun06_EntireReport.pdf.*

[5] Ingenix Product Sheet. *http://www.ingenix.com/content/attachments/ETG_ProductSheet.pdf.*

[6] Thomson Product Sheet. *http://home.thomsonhealthcare.com/uploadedFiles/docs/MEG_HP_TH10002.pdf.*

[7] Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency. April 2007. *http://www.gao.gov/new.items/d07307.pdf.*

rates.[8] We refer readers to a detailed discussion of the Baltimore and Boston program sites below. Any additional Phase I activities completed for the Physician Resource Use Feedback Program will be similar to activities completed in Baltimore and Boston, including the same methodologies for: (1) Choosing additional program sites, (2) recruitment of physicians, and (3) construction of RURs. We are implementing Phase I of the Physician Resource Use Feedback Program on an interim final basis with comment period and it is CMS' intent to propose subsequent phases of the program through rulemaking.

As indicated above, section 1848(n)(1)(B) of the Act requires that the physician resource feedback program address resources measured on: (1) An episode basis; (2) a per capita basis; or (3) both an episode and a per capita basis. The RURs used in the Baltimore program site used a per capita analysis for measuring cost of care and the RURs used in the Boston program site used both a per capita and an episode of care analysis for measuring cost of care. Accordingly, we are implementing this approach to resource measurement on an interim final basis and solicit comments on this approach, as well as the following additional questions:

- Are per capita resource use measures meaningful and actionable?
- Are episode-based resource use measures meaningful and actionable?
- Are composite measures of resource use that combine episodes of care valuable?

We also provided the Baltimore and Boston physicians with a cost of service category breakdown (for example, imaging services, inpatient admissions, or outpatient services) for both the per capita and episode of care analyses. We are finalizing this approach and welcome public comment on including cost of service categories to capture Medicare FFS claims data, as well as other ways to capture data in the Physician Resource Use Feedback Program. In particular, we are soliciting comment on the following:

- What cost of service categories are most meaningful and actionable?

Section 1848(n)(3) of the Act, requires that, to the extent practicable, the data for the reports shall be based on the most recent data available. In Phase I of the Physician Resource Use Feedback Program, we are using Medicare FFS claims data from 2004–2007, which is currently the most recent data available. The per capita analysis used in both Baltimore and Boston included Medicare FFS claims data for calendar year 2005. The episode of care analysis used in Boston included Medicare FFS claims data for calendar years 2004–2006. Typically, when an episode of care analysis is used, one calendar year of data is used as a focal year (in this case 2005) and the prior year (2004) and following year (2006) are also included to ensure the episode captures any services that may occur just outside of a calendar year. We are implementing and soliciting comment on this approach to data for Phase I, as well as seeking comments on the following:

- How many years of data should be included for a per capita analysis?
- How many years of data should be included for an episode of care analysis?

As explained above, under section 1848(n)(4) of the Act, the Secretary may focus the application of the program as appropriate, including focusing on physicians who treat conditions that are high cost, a high volume, or both. CMS has identified several priority conditions that are high cost, high volume, or both through an analysis of Medicare FFS claims data. The reports disseminated in the Baltimore and Boston program sites included the following conditions: (i) congestive heart failure; (ii) chronic obstructive pulmonary disorder; (iii) prostate cancer; (iv) cholecystitis; (v) coronary artery disease with acute myocardial infarction flare-up; (vi) hip fracture; (vii) community-acquired pneumonia; and (viii) urinary tract infections.

Under section 1848(n)(4) of the Act, we also are permitted to focus the application as appropriate on physician specialties that account for a certain percentage of all spending for physicians' services. Based upon the high cost and high volume conditions selected above, CMS identified the several medical specialties as being the most relevant specialties for treating those conditions. The RURs disseminated in the Baltimore and Boston program sites included the following physician specialties: internal medicine, cardiology, gastroenterology, general practice, orthopedic surgery, medical oncology, urology, pulmonology, family practice, and primary care. We are implementing the focus of Phase I of the Program on the above conditions and medical specialties on an interim final basis and we welcome public comments on the selected conditions and medical specialties, as well as any additional conditions and medical specialties to include in the feedback program.

To select physicians, CMS recruited participants for the Baltimore and Boston program sites based on self-designated medical specialty. Both the Baltimore and Boston sites included physicians from all of the medical specialties listed above. Once physicians agreed to participate in the Baltimore and Boston program sessions, CMS used Medicare physician identifiers to find Medicare FFS claims data to populate individual physician RURs for the participating physicians. Approximately 50 physicians participated in a 60-minute individual in-depth session with one interviewer that covered approximately 4 different RUR designs. Each one-on-one physician/interviewer session educated the physician on his/her individual Medicare FFS resource utilization. In the cases where Medicare FFS data was available, a de-identified report of real data was used for educational purposes. The RURs contained all of the elements discussed throughout section 6.c of this final rule. In particular, we are soliciting public comments on the following:

- Do physicians prefer paper or electronic feedback reports?
- How do physicians prefer to provide comments on or ask questions about the RURs?
- What other types of the outreach/educational efforts are useful in helping physicians understand resource use?

As mentioned previously, section 1848(n)(4) of the Act permits us to focus the program as appropriate, such as focusing the program on physicians practicing in certain geographic areas. The RURs disseminated in Baltimore included a geographic benchmark for all physicians treating one condition (listed above) in the Baltimore-Washington, DC metro area, as defined by zip codes. The Baltimore program site also used hospital service area (HSA) as a geographic benchmark. The HSA was based upon all hospitals in the Baltimore-Washington, DC metro area that physicians typically refer beneficiaries to for a particular condition. The Boston program site also used the HSA benchmark and used the state of Massachusetts as a benchmark. We welcome public comment on the selected geographic benchmarks implemented for those areas, as well as any additional geographic benchmarks that could be included in the Physician Resource Use Feedback Program.

Section 1848(n)(4) of the Act also permits us to focus the program as appropriate, such as on physicians who use a high amount of resources compared to other physicians. The RURs disseminated in Baltimore and Boston contained distribution curves

[8] Dartmouth Atlas of Healthcare. 2005 Medicare reimbursement figures derived from Hospital Service Area (HSA).

that defined peer groups of physicians for one condition using the specialty and geographic benchmarks mentioned above. Within each peer group, a physician was identified as a high cost outlier if he/she fell within the 90th percentile of cost or higher. In addition, to including a high cost benchmark, the Baltimore and Boston RURs included a low cost (10th percentile) benchmark and a median cost (50th percentile) benchmark. We are implementing this approach and welcome public comment on the cost benchmarks, as well as any additional cost benchmarks that could be included in the program. Further, we are soliciting public comment on which benchmarks (specialty, geography, and cost) are most likely to motivate changes in resource use.

In order to identify a high cost outlier, attribution of cost must be assigned to a physician. In the Baltimore and Boston program sessions, CMS provided RURs that contained several different methodologies for attribution or assignment of costs to physicians. The following five attribution rules were included: (i) Physician billing the most Evaluation and Management (E&M) visits and billing for at least 10 percent of the total cost for a beneficiary or an episode of care; (ii) physician billing the most established E&M visits (chronic conditions only); (iii) assign all cost to each physician billing for any E&M or procedure; (iv) assign cost to each physician in proportion to billed visits; and (v) assign cost to the physician billing the first E&M visit (acute episodes only). In our continued distribution of RURs through phase I, we will continue to update and refine our attribution rules. We are soliciting comments on this approach and the following:

- What criteria should be taken into account to ensure equity when considering attribution rules?

Finally, although the statute authorizes the Secretary to focus the application of the program as appropriate, on physicians who treat a minimum number of individuals and authorizes us to provide feedback to groups of physicians, as determined appropriate by the Secretary, we did not exercise these optional provisions in the Baltimore and Boston program sites and are not finalizing these in Phase I of the program. In addition, section 1848(n)(6) of the Act also requires that adjustments, to the extent practicable, take into account variations in health status and other patient characteristics. This type of adjustment was not practicable due to the complexity of risk adjustment tasks, coupled with the short implementation time from passage of MIPPA legislation to the start date of the Baltimore and Boston program sites. We welcome public comment on factors to consider for establishing minimum thresholds, risk adjustment methodologies, and measuring group practice level resource use.

III. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Provisions

The following section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). Except as noted otherwise within this final rule with comment period, we consider these provisions to be self-implementing. We are revising our policies and regulations as described below in order to conform then to the statutory amendments.

A. Section 101: Improvements to Coverage of Preventive Services

1. Improvements to Coverage of Preventive Services

Over the past 25 years, the Congress has added specific preventive and screening services to the voluntary Part B program. Most of the preventive or screening services that are already covered under Medicare are described in 42 CFR part 410, subpart B, and also as exceptions to statutory exclusions in § 411.15. These preventive and screening services include the following:

- Pneumococcal, influenza, and hepatitis B vaccinations (§ 410.57 and § 410.63);
- Pap smear (section 1861(nn) of the Act);
- Screening mammography (§ 410.34);
- Colorectal cancer screening tests (§ 410.37);
- Screening pelvic exams (§ 410.56);
- Prostate cancer screening tests (§ 410.39);
- Glaucoma screening exams (§ 410.23);
- Ultrasound screening for abdominal aortic aneurysms (AAA) (§ 410.19);
- Cardiovascular disease screening tests (§ 410.17);
- Diabetes screening tests (§ 410.18); and
- The initial preventive physical examination (IPPE) (§ 410.16).

Section 101(a) of the MIPPA provides for coverage under Part B of ''additional preventive services'', which are determined to meet certain requirements, effective for services furnished on or after January 1, 2009. Section 101(a) of the MIPPA provides the Secretary with the authority to add coverage of ''additional preventive services'', and specifies the process and the criteria that are to be used in making determinations regarding the coverage of such services under the Part B program. As provided in the law, this new coverage allows payment for ''additional preventive services'' not otherwise described in Title XVIII of the Act, if the Secretary determines through the national coverage determination (NCD) process (as defined in section 1869(f)(1)(B) of the Act) that the new services meet statutory requirements for coverage.

Specifically, section 101(a) of the MIPPA defines ''additional preventive services,'' as services not otherwise described in title XVIII that identify medical conditions or risk factors and that the Secretary determines are—

(1) Reasonable and necessary for the prevention or early detection of an illness or disability;

(2) Recommended with a grade of A or B by the United States Preventive Services Task Force; and

(3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The U.S. Preventive Services Task Force (USPSTF) is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services, under the sponsorship of HHS' Agency for Healthcare Research and Quality (AHRQ). The USPSTF grades the strength of the evidence from ''A'' (strongly recommends), ''B'' (recommends), ''C'' (no recommendation for or against), ''D'' (recommends against), or ''I'' (insufficient evidence to recommend for or against).

In addition, section 101(a) provides that in making national coverage determinations (NCDs) for the coverage of a new service, the Secretary ''may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.''

We plan to evaluate the preventive services not otherwise described in title XVIII of the Act and that have been recommended with a grade A or B by the USPSTF and determine whether to open an NCD on one or more of them. USPSTF currently has 15 to 20 preventive services with a Grade A or B recommendation that may be appropriate for the Medicare population. These services can be found on its Web site at *http://*

www.preventiveservices.ahrq.gov. We may exclude reviewing any one of these services if: (1) There is an existing Medicare screening or preventive benefit for that particular service; (2) the service does not appear to be appropriate for the Medicare population (for example, pediatric services). We invite public requests on the services on the USPSTF list that CMS should consider for an NCD using the procedures described at *http://www.cms.hhs.gov/DeterminationProces/02_howtorequestanNCD.asp*.

The NCD process consists of three major steps: (1) Initiation; (2) review; and (3) completion. We initiate the NCD process by ''opening'' the NCD. This is announced to the public by posting a ''tracking sheet'' on the CMS Coverage Web site with an initial 30-day public comment period. The public will have another opportunity to comment on the NCD when the proposed decision is published. After taking into consideration all of the public comments and evidence, a final decision will be made public. Development of a complete, formal request for an NCD can be initiated either by an outside party or internally by CMS staff.

We are establishing new § 410.64, Additional Preventive Services, to reflect these statutory requirements. To conform the regulations to the statutory requirements of the MIPPA, we are also adding new paragraph § 411.15(k)(15) for ''additional preventive services.''

Payment of Co-Insurance

Section 101(a)(2) of the MIPPA establishes payment rules under Part B if the Secretary makes a NCD for an additional preventive service under section 1861(ddd) of the Act. The amount of the Part B payment and the amount of the beneficiary's Part B coinsurance will depend on the nature of the new preventive service. For instance, if the additional preventive service is a clinical diagnostic laboratory test, Medicare pays on a fee schedule basis and the amount paid is 100 percent. There is no beneficiary coinsurance. For all other additional preventive services, Medicare will pay 80 percent of the lesser of the actual charge for the service or the amount of the fee schedule. The beneficiary would be responsible for the remaining 20 percent as coinsurance. We will specifically identify the type of service and the accompanying payment levels in our implementing instructions that will be issued contemporaneously with each NCD.

2. Revisions to Initial Preventive Physical Examination (IPPE)

Section 101(b) of the MIPPA also amended section 1861(ww)(1) of the Act which establishes an IPPE for individuals who are newly enrolled in the voluntary Part B program. This benefit was originally effective on January 1, 2005, and is implemented at § 410.16. Section 101(b) of the MIPPA revises the benefit by the following:

(1) Adding the measurement of an individual's body mass index as part of the IPPE;

(2) Upon the individual's consent, adding end-of-life planning to the IPPE services; and

(3) Removing the electrocardiogram from the list of mandated services that must be included in the IPPE benefit, and making it an educational, counseling, and referral service to be discussed with the individual and ordered by the physician, if necessary.

Section 101(b) of the MIPPA also amended section 1861(ww)(1) of the Act by defining the term ''end-of-life planning'' to mean verbal or written information regarding (1) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions, and (2) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

We are amending § 410.16(a)(4) (the physical exam element) of the IPPE benefit so that it includes the measurement of an individual's body mass index. We are amending § 410.16(a)(5) to omit the electrocardiogram as a mandatory part of the IPPE benefit, and add the electrocardiogram to the list of education, counseling, and referral services described in § 410.16(a)(7) of the IPPE benefit.

We are also amending § 410.16(a)(5) by inserting in the place of the term ''electrocardiogram'' the language ''end-of-life planning'' and noting the need for the consent of the individual to have this discussion.

We are also amending § 410.16(a) of the IPPE benefit by adding a definition of the term ''end-of-life planning'' to reflect the statutory definition of that term as described above.

Section 101(b) of the MIPPA also amended section 1861(ww)(1) of the Act (the IPPE benefit) by adding the ''additional preventive services'' benefit to the list of screening and preventive services for which physicians and other qualified nonphysician practitioners must provide ''education, counseling and referral.'' The Congress also extended the time period that newly eligible Part B beneficiaries can obtain the IPPE benefit from 6 months to the first 12 months after the effective date of their first Part B coverage period. Therefore, we are amending § 410.16(a)(7) to reflect the additional education, counseling and referral responsibilities that physicians and other practitioners will have under the IPPE benefit for the electrocardiogram and the ''additional preventive services'' that may be covered in the future.

As mentioned above, the Congress extended the eligibility period for beneficiaries from 6 months to 1 year as provided in section 1862(a)(1)(K) of the Act. This statute is effective for services furnished on or after January 1, 2009. We are revising the present definition of the term ''eligible beneficiary'' in § 410.16(a) to read as follows: ''Eligible beneficiary'' means an individual who receives his or her IPPE not more than 1 year after the effective date of his or her first Medicare Part B coverage period.

3. Payment for IPPE

In order to implement section 101(b) of the MIPPA, beginning January 1, 2009, we will pay for an IPPE performed not later than 12 months after the date of the beneficiary's initial enrollment in Medicare Part B. We will pay for one IPPE per beneficiary per lifetime. The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009.

The section 101(b) of the MIPPA also removes the screening electrocardiogram (EKG) as a mandatory requirement as identified in section 1861(ww)(1) of the Act as part of the IPPE. The MIPPA requires that there be education, counseling, and referral for an EKG, as appropriate, for a once-in-a lifetime screening EKG performed as a result of a referral from an IPPE as stated in revised § 410.16. Effective for beneficiaries who receive the IPPE on or after January 1, 2009, the screening EKG will be billable with G code(s) when it is a result of a referral from an IPPE. Billing instructions for physicians, qualified NPPs, and providers will be issued.

We are implementing the following G codes to identify these services:

- G0402: *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.*
- G0403: *Electrocardiogram, routine ECG with at least 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.*

• G0404: *Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.*

• G0405: *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.*

The 4 existing G codes (G0344, G0366, G0367, and G0367) will be active until December 31, 2008, for beneficiaries who have the IPPE prior to January 1, 2009.

Work RVUs: We believe the additional work of performing a measurement of an individual's body mass index and, upon consent of an individual, the discussion of end-of-life planning, as described in the coverage section, represent minimal work. A simple tool is used to determine body fat based on an individual's height and weight that applies to both adult men and women. End-of-life planning as previously described is verbal or written information given to the beneficiary regarding advance directive preparation and a discussion regarding whether the physician is willing to follow an individual's wishes made in an advance directive.

Therefore, for CY 2009, we are retaining the current work RVUs for the new IPPE G code (G0402) which involves equivalent resources and work intensity to those services contained in CPT evaluation and management (E/M) code 99203, *new patient, office or other outpatient visit*. However, we are interested in receiving comments on suggested valuations of this service to reflect the resources required. We will also retain the work RVUs for the new EKG G codes which are equivalent to those for CPT codes 93000, 93005 and 93010. In addition, we note that the policy for reporting a medically necessary E/M service furnished at the same IPPE visit will still apply. CPT codes 99201 through 99215 may be used depending on the circumstances and appended with CPT modifier ''25'' identifying the E/M visit as a significant, separately identifiable service from the IPPE code G0402.

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

Additionally, since section 101(b) of the MIPPA provides that the Medicare Part B deductible will not apply for the IPPE performed on or after January 1, 2009 (as defined in section 1861(ww)(1) of the Act), we are revising § 410.160(b) to include an exception from the Medicare Part B deductible for the IPPE as described in § 410.16 (Initial preventive physical examination: Conditions for and limitations on coverage). The co-insurance continues to apply.

B. Section 131: Physician Payment, Efficiency, and Quality Improvements

Section 131 of the MIPPA includes a number of provisions that impact the quality reporting system defined in section 1848(k) of the Act. For ease of reference, we have named this quality reporting system, the ''Physician Quality Reporting Initiative'' (PQRI). Although the new MIPPA amendments that pertain to the PQRI, including those provisions that pertain to PQRI beyond 2009, are generally described below, the scope of this final rule with comment period is limited to the 2009 PQRI. The 2009 PQRI, including our implementation of the new MIPPA amendments as they pertain to the 2009 PQRI, is discussed in detail in section II.O1. of this final rule with comment period. This final rule with comment period does not address nor does it attempt to implement any of the new MIPPA amendments as they pertain to the PQRI in 2010 and beyond. The new MIPPA amendments as they pertain to the PQRI in 2010 and beyond will be addressed through future notice and comment rulemaking.

Section 131(b)(1) of the MIPPA amends section 1848(k)(2) of the Act to add new paragraph (C), which provides that for the purposes of reporting quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, the quality measures (including electronic prescribing measures) shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) as added by the MIPPA. Section 1848(k)(2)(C) of the Act also provides that for the 2010 and future years of the PQRI, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under subsection 1890(a), as added by the MIPAA, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA-Alliance.

Paragraph (D) of section 1848(k)(2) of the Act, as added by section 131(b)(1) of the MIPPA, requires that for each quality measure (including an electronic prescribing quality measure) adopted by the Secretary for the PQRI in 2009 and subsequent years, the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to the services they furnish. Additional discussion of the requirements of section 1848(k)(2)(D) of the Act as they pertain to the 2009 PQRI can be found in section II.O1. of this final rule with comment period.

Section 131(b)(2) of the MIPPA redesignates section 101(c) of the MIEA-TRHCA, as amended by the MMSEA, as subsection (m) of the Act. Section 1848(m)(1) of the Act authorizes the Secretary to make incentive payments for satisfactorily reporting data on quality measures for covered professional services furnished by eligible professionals during the reporting period for the PQRI in 2007 through 2010. In addition to the 1.5 percent incentive payment already authorized for the 2007 and 2008 PQRI, section 1848(m)(1)(B) of the Act, as redesignated by section 131(b)(2) of the MIPPA and amended by section 131(b)(3)(B) of the MIPPA, authorizes the Secretary, for the 2009 and 2010 PQRI, to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges submitted not later than 2 months after the end of the reporting period for all covered professional services furnished during the reporting period for 2009 and 2010, respectively.

Section 1848(m)(3)(A) of the Act, as redesignated by section 131(b)(3)(C) of the MIPPA and amended by section 131(b)(3)(D)(iii) of the MIPPA, specifies that for 2009 and subsequent years, the PQRI quality measures shall not include electronic prescribing measures. Therefore, as discussed further in section II.O1. of this final rule with comment period, we are not including measure #125, Health Information Technology: Adoption/Use of Medication e-Prescribing, in the final set of 2009 PQRI quality measures.

Section 1848(m)(3)(C) of the Act, as added by section 131(b)(3)(D)(iv) of the MIPPA, requires that ''by January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures'' for the PQRI ''if,

in lieu of reporting measures under section 1848(k)(2)(C) of the Act the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.'' Section 1848(m)(3)(C) of the Act also provides for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project, and provides that incentive payments made to a group practice for satisfactorily submitting data on quality measures for the PQRI shall be made in lieu of the incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. The requirements at section 1848(m)(3)(c) of the Act also apply to successful electronic prescribers (as defined in section 1848(m)(B)(ii) of the Act), which are described generally in section III.D. and in detail in section II.O2. of this final rule with comment period.

Section 1848(m)(3)(D) of the Act, as added by section 131(b)(3)(D)(iv) of the MIPPA, authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures for the PQRI and for submitting data on electronic prescribing quality measures for years after 2009.

Section 1848(m)(5)(D)(iii) of the Act, as redesignated by section 131(b)(2) of the MIPPA and amended by section 131(b)(3)(E) of the MIPPA, provides that if the Secretary has determined an eligible professional (or group practice) has not reported measures applicable to covered professional services of such professional (or group practice), the Secretary shall not pay the incentive payment, and that if an incentive payment has already been made to an eligible professional (or group practice), the Secretary shall recoup such payments from the eligible professional (or group practice).

Subparagraph (G) of section 1848(m)(5) of the Act, as added by section 131(b)(3)(E)(v) of the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of: (1) The eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI; and (2) the eligible professionals (or group practices) who are successful electronic prescribers.

Section 1848(m)(6)(C) of the Act, as redesignated by section 131(b)(2) of the MIPPA and amended by section 131(b)(3)(F) of the MIPPA, defines ''reporting period'' for the 2008 through 2011 PQRI to be the entire year and authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such ''revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.''

Section 131(b)(4) of the MIPPA amends section 1848(k)(3)(B) of the Act to include a qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act) in the definition of an ''eligible professional'' beginning with the 2009 PQRI.

Section 131(b)(6) of the MIPPA provides that none of the amendments made by subsection 131(b) or section 132 of the MIPPA shall affect the operation of the provisions of section 1848(m) of the Act, with regard to 2007 or 2008.

Further discussion of these MIPPA provisions as they relate to the 2009 PQRI can be found in section II.O1. of this final rule with comment period.

In addition to the provisions that impact the PQRI, section 131(a) of the MIPPA amended section 1848(d)(8) of the Act to extend the 6-month increase in the CY 2008 CF to the entire year and added section 1848(d)(9) of the Act which provided that the update to the single CF for CY 2009 shall be 1.1 percent. This subsection further specified that the CFs for CY 2010 and subsequent years must be computed as if these increases had never applied. Further discussion of these MIPPA provisions as they relate to the PFS update and CF for 2009 can be found in sections VII. and IX. of this final rule with comment period.

C. Section 131(c): Physician Resource Use Feedback Program

Section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. In addition, section 131(c) of the MIPPA outlines the general components and aspects of the program, but provides the Secretary broad discretion with regard to implementation and development of the program. Given the timing of the passage of MIPPA and the deadline for implementing a program, we believe it would be contrary to the public interest to delay implementation and therefore, we will implement the physician feedback program on an interim final basis and provide opportunity for public comment. We refer readers to section II.S.6. of this final rule with comment period for a detailed discussion and implementation of section 131(c) of the MIPPA.

D. Section 132: Incentives for Electronic Prescribing

Section 132(a)(1) of the MIPPA amends section 1848(m) of the Act, as redesignated by section 131(b)(2) of the MIPPA, to authorize for 2009 through 2013 incentives to eligible professionals or group practices who are ''successful electronic prescribers.'' For 2009 and 2010, the Secretary is authorized to provide successful electronic prescribers an incentive payment equal to 2.0 percent of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period for all covered professional services furnished during the 2009 and 2010 reporting periods, respectively. Reduced incentive payments apply to subsequent years through 2013. Section 132(b) of the MIPAA amends section 1848(a) of the Act such that a payment differential applies to those who are not successful electronic prescribers starting in 2012. During 2012 or any subsequent year, if the eligible professional is not a successful electronic prescriber for the reporting period, the fee schedule amount for covered professional services furnished by such professional during the year shall be reduced by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014 and each subsequent year.

Section 132(a)(2) of the MIPPA amends section 1848(m)(3) of the Act, as redesignated by section 131(b)(2) of the MIPPA, to authorize the Secretary to identify successful electronic prescribers for a reporting period using one of two possible standards: One based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any electronic prescribing quality measures that have been established under the physician reporting system under subsection

1848(k) (which, as noted previously, we have named ''PQRI'' for ease of reference) and are applicable to services furnished during a reporting period, as amended by section 131(b) of the MIPPA, and one based on the electronic submission by the eligible professional of a sufficient number of prescriptions under the Medicare Prescription Drug Benefit Program (Part D) during the reporting period. If the Secretary decides to use the latter standard, the Secretary is authorized to use Part D drug claims data to assess whether a ''sufficient'' number of prescriptions have been submitted by eligible professionals. We do not intend to use this latter standard for 2009. However, to the extent that we intend to use this latter standard in future years, we will address how we plan to define ''sufficient'' through notice and comment rulemaking. Section 1848(m)(3)(B) of the Act, as added by section 132(a)(2)(B) of the MIPPA, also requires that to the extent practicable, in determining whether eligible professions meet the requirements to be identified as successful electronic prescribers, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e) of the Act.'' The 2009 electronic prescribing incentive reporting period and the criteria that will be used by CMS to identify successful electronic prescribers for 2009 are described in detail in section II.O2. of this final rule with comment period.

Section 132(a)(1) of the MIPPA also amends section 1848(m) of the Act, as redesignated by section 131(b)(2) of the MIPPA, to provide for an exemption from both the incentive payment and the payment differential for a particular reporting period of certain eligible professionals. The Secretary is authorized to choose between two possible standards for the exemption: One based upon whether the allowed charges to which the electronic prescribing quality measure applies are less than 10 percent of the total allowed charges for all covered professional services furnished by the eligible professional during the reporting period; and one based on whether the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can again be assessed using Part D drug claims data). We do not intend to use this latter standard for 2009. However, to the extent that we intend to use this latter standard in future years, we will address how we plan to define ''sufficient'' through notice and comment rulemaking. For 2009, the criteria for exemption from the incentive payments for electronic prescribing are described in section II.O2. of this final rule with comment period.

Section 132(b) of the MIPPA also amends section 1848(a) of the Act to authorize the Secretary to apply a hardship exception on a case-by-case basis to exempt eligible professionals from the payment differential that applies to those who are not successful electronic prescribers by 2012. Since this hardship exception does not apply until 2012, we will address the parameters that we intend to apply to determine hardship through future notice and comment rulemaking.

E. Section 133(b): Expanding Access to Primary Care Services

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN.

The 5-Year Review of work RVUs would have resulted in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the CF or RVUs. In CY 2007 and CY 2008, we met the 5-Year Review BN requirement by making a separate adjustment to the work RVUs.

Section 133(b) of the MIPPA amends section 1848(c)(2)(B) of the Act to specify that the BN adjustor for the 5-Year Review must be applied to the conversion factor beginning with CY 2009. Further discussion of this MIPPA provision as it relates to the CY 2009 PFS can be found in section IX. of this final rule with comment period.

F. Section 134: Extension of Floor on Medicare Work Geographic Adjustment Under the Medicare Physician Fee Schedule

In accordance with section 103 of the MMSEA, the 1.000 work GPCI floor was set to expire as of July 1, 2008. Section 134(a) of the MIPPA extended the 1.000 work geographic practice cost index (GPCI) floor from July 1, 2008 through December 31, 2009. Additionally, section 134(b) of the MIPPA sets a permanent 1.500 work GPCI floor in Alaska, beginning January 1, 2009. As such, the CY 2009 GPCIs and summarized GAFs reflect these statutorily mandated work GPCI floors.

G. Section 136: Extension of Treatment of Certain Physician Pathology Services Under Medicare

The TC of physician pathology services refers to the preparation of the slide involving tissue or cells that a pathologist will interpret. In contrast, the pathologist's interpretation of the slide is the PC service. If the PC service is furnished by the hospital pathologist for a hospital patient, it is separately billable. If the independent laboratory's pathologist furnishes the PC service, it is usually billed with the TC service as a combined service.

In the CY 2000 PFS final rule, we stated that we would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital inpatients (64 FR 59380, 59408 through 59409). Prior to this proposal, any independent laboratory could bill the Medicare contractor under the PFS for the TC of physician pathology services for hospital inpatients. At the request of commenters on the final rule that independent laboratories and hospitals needed sufficient time to negotiate arrangements, we delayed the implementation of that rule until 2001.

Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA) established the billing exception that allowed certain qualified independent laboratories to continue to bill the Medicare contractor under the PFS for the TC of physician pathology services furnished to a hospital patient. In order to bill in this manner, an independent laboratory must have had an arrangement with a hospital in effect as of July 22, 1999 under which the laboratory furnished the TC of the physician pathology service to a hospital patient and submitted claims to the Medicare contractor for payment. This provision was initially effective for 2 years, 2001 through 2002.

Through subsequent legislation (that is, section 732 of the MMA, section 104 of the MIEA–TRHCA, section 104 of the MMSEA, and section 136 of the MIPPA), this provision has been extended through December 31, 2009. If the independent laboratory did not qualify under this provision, then it must continue to bill the hospital and receive payment from that hospital. As a result of this provision, the TC of physician pathology services could be paid differently depending on the status of the laboratory.

H. Section 141: Extension of Exceptions Process for Medicare Therapy Caps

1. Background

Section 1833(g)(1) of the Act applies an annual per beneficiary combined cap beginning January 1, 1999, on outpatient physical therapy and speech-language pathology services, and a similar separate cap on outpatient occupational therapy services. These caps apply to expenses incurred for the respective therapy services under Medicare Part B, with the exception of outpatient hospital services.

The exceptions process for the therapy caps, originally authorized by section 5107 of the DRA, was extended from January 1, 2006 through December 31, 2007 by section 201 of the MIEA–TRHCA. Section 105 of the MMSEA provided for a further extension of this exceptions process through the first 6 months of CY 2008 (that is, January 1, 2008 through June 30, 2008).

2. MIPPA Provision for Cap Exceptions

Section 141 of the MIPPA extends the exceptions process for therapy caps from July 1, 2008 through December 31, 2009.

Section 1833(g)(2) of the Act provides that, for CY 1999 through CY 2001, the caps were $1500, and for the calendar years after 2001, the caps are equal to the preceding year's cap increased by the percentage increase in the Medicare Economic Index (MEI) (except that if an increase for a year is not a multiple of $10, it is rounded to the nearest multiple of $10). The annual, per beneficiary therapy cap for 2009 will be $1840 for physical therapy and speech-language pathology services combined and $1840 for occupational therapy services, separately. The MIPPA does not create a separate cap for SLP services.

I. Section 143: Speech-Language Pathology Services

1. Background

Currently, therapy services [physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP)] may be billed by providers, such as hospitals, and by suppliers, such as physicians or NPPs. Physical therapists and occupational therapists may also independently enroll as suppliers of Medicare services, and may bill and receive payment for their services furnished in private practice. Prior to enactment of the MIPPA, the statute did not allow SLPs to enroll independently and to be paid directly.

The amendments made by section 143 of the MIPPA provide the authority for CMS to enroll speech-language pathologists as suppliers of Medicare services, and for speech-language pathologists to begin billing Medicare for outpatient SLP services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services.

In general, section 143 of the MIPPA amends the statute to give speech-language pathology services the meaning given the term ''physical therapy services'' in section 1861(p) of the Act. This provides the authority to enroll speech-language pathologists and to pay them for their services in the same way as physical therapists that are separately enrolled. Section 143 made conforming changes to the scope of benefits in section 1832(a)(2)(C) of the Act to include outpatient speech-language pathology services furnished in a private practice. Section 143 of the MIPPA also makes the following changes to the Act:

- Section 1832(a)(2)(C) of the Act is amended to specifically include outpatient speech-language pathology services in the scope of benefits for which payment may be made.
- Section 1833(a)(8) of the Act is amended to describe outpatient SLP services as separate and distinct services from PT.
- Section 1833(g)(1) is amended to separately describe outpatient SLP services, but the amendments do not create a separate therapy cap for SLP services. The cap for PT and SLP combined is $1840 per beneficiary in CY 2009.
- Section 1835(a) of the Act is amended to specify that payment may be made for outpatient SLP services to a provider of services, including a clinic, rehabilitation agency or public health agency that meets the requirements described in the amended section 1861(p)(4)(A) and (B) of the Act.
- Section 1861(p) of the Act is amended to remove from the definition of ''outpatient physical therapy services'' SLP services furnished by or under arrangements or supervision of a provider. These SLP services are deleted from the definition of outpatient physical therapy services because SLP services are now defined separately under section 1861(ll)(2) of the Act.
- Section 1861(s)(2)(D) of the Act is amended to add outpatient SLP services as medical and other health services, along with outpatient PT and OT.
- Section 1862(a)(20) of the Act is amended to add SLP services to the list of therapy services for which Medicare payment cannot be made if furnished as an incident to a physician's professional services unless standards and conditions specified by the Secretary (other than licensing) are met, as such standards and conditions would apply to such services if furnished by a therapist.
- Section 1866 of the Act is amended to include SLP services in the description of services that can be considered furnished by a provider of services when furnished by a clinic, rehabilitation agency, or public health agency that meets certain requirements.
- Section 1877 of the Act is amended to include outpatient SLP services in the list of designated health services for the purpose of the prohibition on certain physician referrals. (See section VI.B. of this preamble for a discussion of these changes.)

2. Implementation of the MIPPA

Section 143 of the MIPPA amends the statute to treat speech-language pathologists (SLP) and speech-language pathology services in a similar manner to physical therapists and physical therapy services. Physical therapists are permitted to enroll in Medicare and to furnish and bill for their services in private practice. To conform SLP regulations to those for PT, we are adding provisions for services furnished by SLPs in private practice to § 410.62(c) using language similar to the provisions of § 410.59 and § 410.60 that apply to OT and PT enrollment. In § 410.62, we are redesignating the paragraph (c) as paragraph (d). The current paragraph (d) is deleted since this language is covered in § 410.60.

The amendments made by section 143 of the MIPPA concerning SLP enrollment, billing and payment are generally self-implementing and we are revising our regulations accordingly as noted above consistent with our policies for PTs.

Section 410.62(c) contains a list of requirements that SLPs must meet. The regulations require that an SLP be legally authorized to engage in SLP private practice in the State where he or she practices. The SLP must practice only within the scope of practice allowed by the State. Section 410.62(c)(1)(ii) describes the various practice types in which an individual SLP may provide services.

Section 410.62(c)(1)(iii)(A) requires that SLPs in private practice must bill Medicare for services furnished in the State where they are licensed, in the locations where the practice is operated, at a time when the practice is operating. The space must be owned, leased or rented by the practice and used for the exclusive purpose of operating the practice during those hours the practice

is furnishing services to beneficiaries. Private practice services may be furnished at a patient's home, but not at an institution that is a hospital, CAH or SNF.

Section 410.62(c)(iv) also requires that SLPs must treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

3. Operational Issues

We will revise our manual instructions to reflect that SLPs can now enroll and be paid directly by Medicare for services furnished on or after July 1, 2009. SLPs who wish to enroll in Medicare may submit their Medicare enrollment application to their local Medicare contractor on or after June 2, 2009. Before submitting a Medicare enrollment application, SLPs are required to obtain a National Provider Identifier, if they do not currently have one. For general information on the Medicare provider enrollment process, please see the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

To educate the public about this change, we will discuss the new enrollment instructions during an upcoming Physician and Allied Health Professionals Open Door Forum. In the coming months, we will also revise our manual instructions and issue a MLN Matters article and listserv messages to inform the public that SLPs may enroll as suppliers of Medicare services and begin billing Medicare for outpatient SLP services furnished in private practice beginning July 1, 2009. We also plan to contact national associations and request that they notify their members about these changes. Finally, we will require our Medicare contractors to contact SLPs via bulletins or listserv announcements about these changes.

J. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment

1. Payment Rules for Oxygen and Oxygen Equipment

a. Overview

The general Medicare payment rules for durable medical equipment (DME) are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

Specific rules regarding payment for oxygen and oxygen equipment are set forth in section 1834(a)(5) of the Act and § 414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary oxygen contents (stationary and portable) and stationary oxygen equipment falling under the class described in § 414.226(c)(1)(i). Equipment in this class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

We also pay a monthly add-on payment to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in § 414.226(c)(1)(ii) and (iii). Equipment in these classes includes portable liquid oxygen systems, portable gaseous oxygen systems, portable oxygen concentrators, and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both liquid and gaseous oxygen systems (stationary and portable) require on-going delivery of oxygen contents.

b. Provisions of the Deficit Reduction Act of 2005 (DRA)

Section 5101(b) of the DRA amended section 1834(a)(5) of the Act, limiting monthly payments to suppliers for oxygen equipment to 36 months of continuous use. At the end of this 36-month period, suppliers must transfer title to oxygen equipment rented on or after January 1, 2006 to the beneficiary. Payments for oxygen contents continue after title to the equipment has been transferred.

On November 9, 2006, we issued a final rule (71 FR 65884) to implement these changes. We amended § 414.226 to clarify that the monthly payments for items falling under the classes now described in § 414.226(c)(1)(i) thru (iii) are made for periods of continuous use not to exceed 36 months. We revised the rules regarding a period of continuous use for the rental of DME in § 414.230 of our regulations to clarify the continuous use determination.

We also added a new paragraph (f) to § 414.226 of our regulations, requiring a supplier to transfer title to the oxygen equipment to the beneficiary on the first day after the 36th continuous month in which payment is made for the equipment.

In addition, we revised § 414.226 of our regulations to allow monthly payments to suppliers for furnishing gaseous or liquid oxygen contents for use with either beneficiary-owned stationary equipment or beneficiary-owned portable equipment.

Section 5101(b) of the DRA also authorized payments for maintenance and servicing of beneficiary-owned oxygen equipment if the Secretary determined such payments to be reasonable and necessary. In keeping with the longstanding Medicare policy to pay for maintenance and servicing of DME that is owned by the beneficiary, we determined that paying for necessary repairs and periodic maintenance and servicing of beneficiary-owned oxygen equipment was reasonable and necessary to ensure that oxygen equipment owned by beneficiaries continued to function properly. Without these payments, we were concerned that there was little incentive for suppliers to maintain this equipment, because the equipment was no longer owned by the supplier. Our regulations setting forth this payment amount are discussed in more detail in section III.J.2.c. below in this section.

In the November 2006 final rule, we established other safeguards for beneficiaries receiving oxygen and oxygen equipment, which are set forth at § 414.210(e)(5) and § 414.226(g). Section 414.210(e)(5) requires suppliers—after transferring title to oxygen equipment—to furnish replacement equipment at no cost to the beneficiary or the Medicare program if the item furnished by the supplier does not last for the entire reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1). Per § 414.210(f), if oxygen equipment has been in continuous use by the beneficiary for the equipment's reasonable useful lifetime, the beneficiary may elect to obtain new equipment. Section 414.210(f)(1) of our regulations states the reasonable useful lifetime for equipment is determined through program instructions. In the absence of program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain replacement oxygen equipment, payment is made in accordance with § 414.226(a). Section 414.226(g)(2) prohibits suppliers from replacing oxygen equipment prior to the expiration of the 36-month rental period unless a specific exception applies. This

was intended to protect the beneficiary from the supplier changing the beneficiary's equipment in order to maximize Medicare payments. For example, the supplier may want to move a beneficiary from a portable oxygen concentrator to portable gaseous equipment for which Medicare makes additional payments after the 36-month rental period ends.

Section 414.226(g)(4) provides that, by no later than 2 months before the date on which the supplier must transfer title to oxygen equipment to the beneficiary, the supplier must disclose to the beneficiary: (1) Whether, in the case of oxygen transfilling equipment and stationary or portable oxygen concentrators, it can maintain and service the equipment after the beneficiary acquires title to it; and (2) whether, in the case of stationary or portable gaseous or liquid oxygen systems, it can continue to deliver oxygen contents to the beneficiary after the beneficiary acquires title to the equipment.

c. Medicare Improvements for Patients and Providers Act (MIPPA) Section 144(b)—Repeal of Transfer of Ownership of Oxygen Equipment

Section 144(b) of the MIPPA repeals the requirement that the supplier transfer title to oxygen equipment to the beneficiary after the 36-month rental period. In its place, section 144(b) establishes a 36-month rental cap and amends section 1834(a)(5)(F) of the Act by adding three new payment rules and supplier requirements for furnishing oxygen and oxygen equipment after the 36-month rental period. Each of these provisions is discussed below.

2. Provisions of the Final Rule with Comment Period

a. Furnishing Oxygen Equipment After the Rental Cap

As discussed above, section 144(b)(1) of the MIPPA amends section 1834(a)(5)(F)(ii)(I) of the Act, replacing the transfer of title provision with a 36-month rental cap. Under this new provision, the supplier that furnishes oxygen equipment during the 36-month rental period must continue to furnish the oxygen equipment after the 36-month rental period. The supplier is required to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Section 144(b) does not provide any exceptions to the requirement that the supplier continue furnishing the equipment during any period of medical need. For example, if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, we interpret this provision to require that the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility is not transferred to another supplier. It is important to note that our current regulation at § 414.226(g)(1)(ii) does not apply this same requirement to situations in which the beneficiary relocates during the 36-month rental period. We welcome comments from interested parties on whether this requirement should be changed in light of the repeal of transfer of ownership of oxygen equipment and other recently enacted provisions of the MIPPA.

We are revising § 414.226(f) to conform our regulations to this new requirement. We are deleting the transfer of ownership requirement and adding the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment.

The language of the statute mandates that the supplier shall continue to furnish oxygen equipment after the 36-month rental period ''during *any* period of medical need'' rather than ''during *the* period of medical need'' for the remainder of the reasonable useful lifetime of the equipment. We interpret this to mean that the supplier is responsible for continuing to furnish the equipment at any time following the 36-month rental period and before the end of the equipment's reasonable useful lifetime, for any period of medical need, including multiple periods of medical need that are separated by periods when interruptions in the use of the equipment occur.

For example, if, following the 36-month rental period and before the end of the equipment's reasonable useful lifetime, the beneficiary is admitted to a hospital as an inpatient and then discharged from the hospital 3 weeks later, our interpretation requires the supplier to furnish the oxygen equipment for the period leading up to the hospital admission and for the period immediately following the hospital discharge through the end of the equipment's reasonable useful lifetime. The supplier's responsibility to continue furnishing the equipment is not affected by the length of a break in medical need or by the number of any such breaks in medical need that occur after the 36-month rental period and before the end of the equipment's reasonable useful lifetime. Therefore, we are revising § 414.230 to specify that a new period of continuous use will not begin following the 36-month rental period until the end of the equipment's reasonable useful lifetime. The supplier is responsible for furnishing the equipment after the 36-month rental period for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. If a break in medical need occurs following the 36-month rental period, the supplier must resume furnishing the oxygen equipment after the break ends and the beneficiary once again has a medical need for the oxygen equipment. In such a case, the supplier is responsible for furnishing the item for no additional rental payments until the end of the equipment's reasonable useful lifetime. If the equipment's reasonable useful lifetime (which is determined based on the date the equipment is first delivered rather than the age of the equipment) ends during a break in medical need, the supplier is under no obligation to continue furnishing the equipment once the beneficiary again has medical need for the oxygen. However, in accordance with § 414.210(f), the beneficiary may elect to obtain new equipment in these situations where the reasonable useful lifetime of the equipment ends during a break in need. If the beneficiary elects to obtain new equipment, a new 36-month rental period and a new reasonable useful lifetime (currently 5 years for oxygen equipment) begin.

We note that, in accordance with section 5101(b)(2)(B) of the DRA, the rental period for beneficiaries receiving oxygen equipment on December 31, 2005, began on January 1, 2006. However, in accordance with § 414.210(f)(1), the reasonable useful lifetime of durable medical equipment, including oxygen equipment, begins on the date that the equipment is first delivered to the beneficiary. The reasonable useful lifetime of oxygen equipment furnished to beneficiaries on December 31, 2005, was not adjusted to begin anew on January 1, 2006, to correspond with the start of the 36-month rental period. Therefore, in these situations, the equipment's reasonable useful lifetime may end at any point during or after the 36-month rental period.

For example, if oxygen equipment was delivered to a beneficiary on May 1, 2003, and the beneficiary continued to use the equipment beyond January 1, 2006, the 36-month rental period for the equipment would begin on January 1, 2006, and end on December 31, 2008. However, because the reasonable useful

lifetime of the equipment ended on April 30, 2008, the beneficiary could have elected to obtain new oxygen equipment on May 1, 2008, prior to the end of the 36-month rental period for the equipment. In another example, if oxygen equipment was delivered to a beneficiary on July 1, 2004, and the beneficiary continued to use the equipment beyond January 1, 2006, the 36-month rental period for the equipment began on January 1, 2006, and will end on December 31, 2008. In this case, the reasonable useful lifetime of the equipment would end on June 30, 2009, and the beneficiary could elect to obtain new oxygen equipment on July 1, 2009, only 6 months after the end of the 36-month rental period for the equipment. In these situations, a new 36-month rental period and a new reasonable useful lifetime (for the new equipment) would begin after the end of the existing equipment's reasonable useful lifetime if the beneficiary elects to obtain new equipment.

We are also revising § 414.210(e)(1), (2), (e)(4) and (e)(5) to delete regulatory text which relates to beneficiary ownership of oxygen equipment. In addition, we are deleting § 414.210(e)(3) because beneficiaries will no longer own oxygen tanks and cylinders. Because § 414.210(e)(3) is being deleted, we are redesignating § 414.210(e)(4) and § 414.210(e)(5) as § 414.210(e)(3) and § 414.210(e)(4), respectively.

We are also modifying § 414.226 to state that the protection against supplier replacement of oxygen equipment, unless an exception applies, continues to be in effect after the 36-month rental period ends. Specifically, we are revising § 414.226(g)(2) to indicate that this prohibition applies until the expiration of the reasonable useful lifetime established for the equipment. As discussed in the November 9, 2006 final rule (71 FR 65894), we believe this is a necessary safeguard for the beneficiary against changes in equipment made by the supplier in order to maximize payments resulting from moving from one payment class or modality to another. Finally, we are deleting § 414.226(g)(4) because the transfer of ownership of oxygen equipment provision has been repealed, rendering this provision inapplicable.

b. Payment for Oxygen Contents After the Rental Cap

Section 144(b)(1) of the MIPPA amends section 1834(a)(5)(F)(ii)(II) of the Act and requires us to continue to make payments to suppliers for furnishing oxygen contents after the 36-month rental cap for oxygen equipment ends. Under this provision, an oxygen supplier that furnished liquid or gaseous oxygen equipment during the 36-month rental period, and is required by section 1834(a)(5)(F)(ii)(I) of the Act to continue furnishing the equipment after the 36-month rental period ends, will receive payment for furnishing oxygen contents necessary for use with liquid or gaseous oxygen equipment after the 36-month rental period. Section 1834(a)(5)(F)(ii)(II) of the Act establishes the payment amount for the oxygen contents as that set forth in section 1834(a)(9) of the Act.

We are revising § 414.226(d) and (f) to specify that payment shall be made for oxygen contents for use with supplier-owned liquid or gaseous oxygen equipment furnished after the 36-month rental period. An oxygen supplier that furnishes liquid or gaseous oxygen equipment during a 36-month rental period must continue to furnish both the oxygen equipment and contents for any period of medical need for the remainder of the reasonable useful lifetime of the liquid or gaseous oxygen equipment established in accordance with § 414.210(f)(1).

This requirement is necessary because liquid and gaseous oxygen systems (stationary and portable) require on-going delivery of oxygen contents in tanks or cylinders to furnish oxygen to the patient. When read in conjunction with section 1834(a)(5)(F)(ii)(II) of the Act, we interpret the mandate in section 1834(a)(5)(F)(ii)(I) of the Act to include oxygen contents, as well as oxygen equipment, given the nature of this benefit and the requirement that Medicare continue to pay for oxygen contents following the 36-month rental period.

As noted in section III.J.2.a. of this final rule with comment period, we are revising § 414.226(f) to specify that the supplier must make arrangements for the beneficiary to continue receiving the equipment if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment. Likewise, for the reasons set forth in section III.J.2.a. above, we are revising § 414.226(f) to specify that, in the case of liquid or gaseous equipment (stationary and portable) the supplier must make arrangements for the beneficiary to continue receiving oxygen contents if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the liquid or gaseous equipment (stationary and portable). The supplier must make arrangements for the beneficiary to continue receiving the oxygen contents and equipment at his or her new residence.

c. Maintenance and Servicing of Supplier-Owned Oxygen Equipment After the Rental Cap

Section 1834(a)(5)(F)(ii)(III) of the Act, as amended by section 144(b)(1) of the MIPPA, authorizes payments for maintenance and servicing of supplier-owned oxygen equipment after the 36-month rental period if the Secretary determines that such payments are reasonable and necessary. Section 5101(b)(1) of the DRA previously authorized payment for reasonable and necessary maintenance and servicing of beneficiary-owned oxygen equipment.

i. Current Payment for Maintenance and Servicing of Oxygen Equipment

In the August 3, 2006 proposed rule for implementing section 5101(b) of the DRA (71 FR 44082), we discussed the fact that it is longstanding Medicare policy to pay for repair (fixing or mending) of beneficiary-owned DME if such services are necessary to keep the equipment functioning. It is also longstanding Medicare policy to pay for non-routine maintenance of beneficiary-owned DME (that is, extensive maintenance that must be performed by skilled technicians). These policies were discussed in the November 9, 2006 final rule (71 FR 65918) and are set forth in § 414.210(e)(1) and sections 40 and 50 of chapter 20 of the Medicare Claims Processing Manual (Pub. 100–04). In keeping with these longstanding Medicare policies, we proposed to pay for both services when performed on beneficiary-owned oxygen equipment following passage of the DRA (see the proposed rule published on August 3, 2006 (71 FR 44082)).

In response to the August 3, 2006 proposed rule, we received public comments concerning the safe use and maintenance and servicing of oxygen equipment once the supplier transferred title of the equipment to the beneficiary. Commenters raised concerns that beneficiaries would be unable to properly maintain their equipment and that unless Medicare paid for maintenance and servicing of beneficiary-owned equipment, suppliers would not have any incentive to provide these services.

In response to these concerns, we finalized our proposal to pay for necessary repairs and non-routine maintenance of beneficiary-owned oxygen equipment (See 71 FR 65917 through 65919) in accordance with the rules set forth at § 414.210(e). In addition, we revised § 414.210(e) to allow for payment for general

maintenance and servicing of beneficiary-owned oxygen equipment other than liquid or gaseous equipment (stationary and portable).

Section 414.210(e)(2) authorized payment for 30 minutes of labor for general maintenance and servicing of beneficiary-owned oxygen transfilling equipment and stationary or portable oxygen concentrators every 6 months, beginning 6 months after transfer of title to the equipment to the beneficiary. Medicare also made payment for parts replaced during the general maintenance and servicing of the beneficiary-owned oxygen equipment. As indicated in the November 9, 2006 final rule (71 FR 65917), we consider this payment for general maintenance and servicing to be an important beneficiary safeguard. The maintenance and servicing payments encourage suppliers to keep beneficiary-owned oxygen equipment in good repair which ensures the safety of the beneficiary.

The payment authorized by § 414.210(e)(2) did not apply to liquid or gaseous oxygen equipment (stationary or portable) because we believe the supplier should ensure that the tanks and cylinders are functioning properly at the time it is furnishing oxygen contents.

Also, in response to concerns regarding the safe use and disposal of beneficiary-owned oxygen tanks and cylinders, we revised § 414.210(e)(3) to allow payment for pick up of beneficiary-owned oxygen tanks and cylinders that are no longer medically necessary.

ii. Revisions as a Result of the MIPPA

(1) Findings Related to Non-Routine Maintenance and Servicing (Including Repair)

Section 1834(a)(5)(F)(ii)(III), as amended by section 144(b)(1) of the MIPPA, authorizes similar payments for maintenance and servicing of supplier-owned oxygen equipment furnished after the 36-month rental period if we determine such payments are reasonable and necessary. Based on a careful review of this issue, as discussed below, we have determined that at this time it is not reasonable and necessary to pay for non-routine maintenance and servicing (including repair) of supplier-owned oxygen equipment. Given that the supplier owns the equipment, we believe that the supplier should be responsible for maintaining their equipment in working order as they did during the 36-month rental period.

In addition, oxygen equipment is largely reliable equipment which requires minimal maintenance and servicing during the first 5 years of use. Warranties covering 5 years are generally available for the top selling brands of oxygen equipment and as discussed in the November 9, 2006 final rule (71 FR 65917), we understand from manufacturers that such products are generally dependable. The Department of Veterans Affairs (VA) has reported to us that, based on their experience, oxygen concentrators will usually operate for 5 years without the need for significant repair or replacement of costly parts. The VA purchases and maintains oxygen equipment, including oxygen concentrators, for veterans through its Veterans Integrated Service Network (VISN).

In a September 2006 report entitled ''Medicare Home Oxygen Equipment: Cost and Servicing,'' (OEI–09–04–00420), the Office of Inspector General (OIG) of the Department of Health and Human Services similarly found that only minimal servicing and maintenance for oxygen concentrators and portable equipment is necessary. The OIG also found that suppliers train beneficiaries to perform routine maintenance of the equipment. As noted in that report, services performed by suppliers during visits to the homes of beneficiaries to perform maintenance and servicing of oxygen concentrators include checking the flow rate prescribed by the physician and checking the concentration of oxygen delivered by the unit.

Moreover, the OIG found that only 22 percent of Medicare beneficiaries use oxygen equipment for 36 months or more. Therefore, oxygen equipment is returned to suppliers before the end of the 36-month rental period in approximately 78 percent of cases, and suppliers are then able to furnish the equipment to other beneficiaries, starting new 36-month periods of rental payments for the same equipment. Based on current Medicare fee schedule amounts, during a 5-year period in which a supplier rents an oxygen concentrator to multiple beneficiaries, each using the equipment for less than 36 months, the supplier is paid $11,957 for furnishing the oxygen concentrator, the average cost of which was found by the OIG to be $587. Even in the minority of cases in which beneficiaries use oxygen equipment for more than 36 months, the supplier is paid $7,174 for furnishing the equipment. Given this level of reimbursement, it is reasonable to assume that each Medicare beneficiary should be receiving a fairly new piece of oxygen equipment. If the supplier chooses instead to provide older equipment to the beneficiary, we expect that the supplier, and not Medicare or the beneficiary, should be responsible for performing any non-routine maintenance and servicing (including repair) of the supplier-owned equipment to ensure that it continues to function properly during the 5-year reasonable useful lifetime of the equipment.

(2) Finding Related to Routine Maintenance and Servicing

We have determined at this time that it is not reasonable and necessary to make payments for repair or non-routine maintenance and servicing (including repair) of supplier-owned oxygen equipment. We have made an initial determination that payments for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing during these visits are reasonable and necessary for the safety of the beneficiary. Therefore, for CY 2009 only, we are revising § 414.210(e)(2), which provides payment for general maintenance and servicing of certain beneficiary-owned oxygen equipment, to apply to routine maintenance and servicing of supplier-owned oxygen concentrators and transfilling equipment furnished after the 36-month rental period consistent with our authority in section 1834(a)(5)(F)(ii)(III) of the Act. Based on our preliminary analysis, we believe that payments in CY 2009 for periodic inspection and general maintenance and servicing of oxygen concentrators and transfilling equipment are reasonable and necessary for the safety of beneficiaries. Therefore, for CY 2009 only, we will make payments when the supplier performs a routine maintenance and servicing visit following each period of continuous use of 6 months after the 36-month rental period ends. Determining a period of continuous use is governed by § 414.230, which we discussed in section III.J.2.a. above.

Payments for a routine maintenance and servicing visit in CY 2009 will be made when the beneficiary is at home or at a temporary residence (for example, a vacation residence). For each visit, we believe that it is appropriate to provide payment for 30 minutes of labor for general maintenance and servicing of oxygen equipment other than liquid or gaseous equipment (stationary and portable). As we indicated in the November 9, 2006 final rule for implementing section 5101(b) of the DRA (71 FR 65917), we believe that payment for 30 minutes of labor will adequately compensate suppliers for general maintenance and servicing visits based on findings by the OIG in their

September 2006 report (OEI–09–04–00420) that many routine maintenance activities performed by suppliers on concentrators could be performed within that timeframe.

We expect that the primary purpose of the periodic visit would be to check the supplier-owned oxygen equipment to ensure that it will continue to function properly for the succeeding 6-month period of continuous use and does not need to be replaced. We are revising § 414.210(e)(2) to permit payment in CY 2009 for general maintenance and servicing of supplier-owned oxygen equipment beginning 6 months after the end of the 36-month rental period.

As a result, we will make payments under § 414.210(e)(2) only for an actual visit to the beneficiary's home or temporary residence. This provision is generally consistent with the additional maintenance and servicing payments established at § 414.210(e)(2) after the enactment of the DRA, except that, in light of the repeal of transfer of title for oxygen equipment provisions, separate payment will not be made for parts replaced during the routine maintenance and servicing visit. If parts need to be replaced in order to make supplier-owned equipment suitable for the beneficiary, we believe that the supplier should be responsible for replacing the parts on equipment from their inventory in order to meet the beneficiary's medical need for oxygen.

We will make payments for general maintenance and servicing of oxygen concentrators and transfilling equipment as discussed above. However, we welcome comments from interested parties on this issue, especially regarding whether these payments should continue past CY 2009 in light of the OIG's findings that only minimal maintenance and servicing of oxygen equipment is necessary and that suppliers continue to own the equipment.

K. Section 145: Clinical Laboratory Tests

Outpatient clinical laboratory services are paid under the clinical laboratory fee schedule (CLFS) in accordance with section 1833(h) of the Act. Section 1833(h)(2)(A)(i) of the Act specifies that the fee schedules are adjusted annually, to become effective on January 1 of each year, by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) (CPI–U). The Congress has frozen the update to zero percent for CYs 2004 through 2008. The freeze on the annual update expires beginning January 1, 2009.

For the period beginning January 1, 2009, the update factor for the clinical lab fee schedule would be 5.0 percent. However, section 145(b) of the MIPPA reduces this increase by 0.5 percent for each of the years 2009 through 2013. Therefore, for the period January 1, 2009, through December 31, 2009, payments under the Clinical Laboratory Fee Schedule will be increased by 4.5 percent.

L. Section 146: Improved Access to Ambulance Services

Section 146(a) of the MIPAA modifies section 1834(l)(13) of the Act to specify that, effective for ground ambulance claims furnished during the period July 1, 2008, the ambulance fee schedule through December 31, 2009 amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports which originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent; and
- For covered ground ambulance transports which do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

We are revising § 414.610(c)(1) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase, and does not require any substantive exercise of discretion on the part of the Secretary. We note that in adding language to § 414.610(c)(1) to set forth this statutory requirement, we have also divided it into 2 paragraphs for purposes of clarity.

In addition, section 146(b)(1) of the MIPPA specifies that any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2009. Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently redesignated as urban, we have re-established the ''rural'' indicator on the zip code file for air ambulance services effective July 1, 2008. We are revising § 414.610 to add a new paragraph (h) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of a rural indicator, and does not require any substantive exercise of discretion on the part of the Secretary.

M. Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth Services

Section 1834(m)(4)(C) of the Act defines a telehealth ''originating site'' to mean only those sites described in the statute at which an eligible telehealth individual is located at the time the service is furnished via a telecommunications system. The statute requires originating sites to be located in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)); in a county that is not included in a Metropolitan Statistical Area; or in an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000. Previously, the statute described the following originating sites: the office of a physician or practitioner; a critical access hospital (as defined in section 1861(mm)(1) of the Act); a rural health clinic (as defined in section 1861(aa)(2) of the Act); a Federally qualified health center (as defined in section 1861(aa)(4) of the Act); and a hospital (as defined in section 1861(e) of the Act).

Section 149 of the MIPPA amended section 1834 of the Act to add certain entities as originating sites for payment of telehealth services. As explained further below, MIPPA also amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

With respect to a telehealth service, subject to section 1833(a)(1)(U) of the Act, we pay a facility fee to the originating site. The originating site facility fee is a separately billable Part B payment, and we pay it to eligible originating sites outside of other payment methodologies. As discussed in section X. of this final rule with comment period, the originating site facility fee for CY 2009 is $23.72.

Other than adding certain entities as originating sites for payment of telehealth services, the MIPPA did not change the existing telehealth eligibility criteria, or payment and billing requirements related to telehealth services. Therefore, for the telehealth originating sites added by section 149 of

the MIPPA, we are adopting policies similar to existing policies with respect to the provision of, and payment for, telehealth services in the various originating sites. We are adopting these policies for CY 2009 on an interim final basis, and will respond to any comments and finalize our policies in subsequent rulemaking.

Telehealth is a delivery mechanism for otherwise payable Part B services. We pay distant site physicians or practitioners for Medicare telehealth services only if the service is separately payable under the PFS when furnished in a face-to-face encounter at that location. For example, we pay distant site physicians or practitioners for furnishing services via telehealth only if such services are not included in a bundled payment to the facility that serves as the originating site.

The regulations relating to the Medicare telehealth provisions under section 1834(m) of the Act are at § 410.78, which specifies the conditions of payment for telehealth services, and § 414.65, which specifies the payment rules for telehealth services. (See also the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270, and the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190 for more information on Medicare telehealth services and for updated instructions for billing the originating site facility fee.)

As noted previously, the telehealth originating site facility fee is a separately billable Part B payment that is payable outside of any other payment methodology. Renal Dialysis Centers, Community Mental Health Centers, and SNFs are all paid based under different payment systems.

Renal Dialysis Centers

Section 149 of the MIPPA added hospital-based or CAH-based renal dialysis centers (including satellites) to the list of originating sites for Medicare telehealth services. As defined in § 405.2102, a renal dialysis center is a hospital unit or satellite approved to furnish outpatient maintenance dialysis services required for the care of end-stage renal disease (ESRD) dialysis patients. Independent renal dialysis facilities are not authorized in the law to serve as originating sites for Medicare telehealth services. Medicare pays for outpatient maintenance dialysis services based on a case-mix adjusted composite rate which includes the cost of some drugs, laboratory tests, and other items and services routinely furnished to dialysis patients. Medicare pays separately for physicians' professional services, separately billable laboratory tests, and separately billable drugs furnished in ESRD facilities. When a hospital-based or CAH-based renal dialysis center (or their satellite) serves as the originating site for a Medicare telehealth service, the originating site facility fee is payable in addition to any case-mix adjusted composite rate or, as explained further below, any monthly capitation payment (MCP) amount. The originating site facility fee is a separately billable Part B payment.

The Medicare composite rate for ESRD facilities includes payment for social and dietetic services to meet the needs of the ESRD patient. To prevent duplicate payment for services that the renal dialysis center is required to furnish directly, and for which payment is included in the case-mix adjusted composite rate, we will not pay separately for the services of clinical social workers (CSW), registered dietitians, and nutrition professionals furnished via telehealth to ESRD outpatients in renal dialysis centers.

Physicians and practitioners managing ESRD facility patients are paid a monthly rate (the MCP) for most outpatient maintenance dialysis-related physician services furnished to a Medicare ESRD beneficiary. The MCP amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary.

When the MCP is billed for ESRD-related services with 2 or 3 visits per month or for ESRD-related services with 4 or more visits per month, some of the visits may be furnished as a telehealth service. However, at least one visit per month is required to be furnished by the physician or practitioner in person to examine the vascular access site. A clinical examination of the vascular access site must be furnished once per month face-to-face (not as a telehealth service) by a physician, nurse practitioner, or physician's assistant.

Consistent with existing policy, non-ESRD-related physicians' services may be furnished via telehealth by the physician or practitioner who furnishes renal care or by another physician or practitioner. These are services that are not incidental to services furnished during a dialysis session or office visits necessitated by the renal condition. The physician or practitioner must provide documentation that the illness is not related to the renal condition and that the additional visits are medically necessary. The Medicare contractor's medical staff determines whether additional reimbursement is warranted for treatment of the unrelated illness. Medicare does not pay separately for ESRD-related services furnished via telehealth that are covered by the MCP. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 8, Section 140, for more information on Medicare policy regarding the monthly capitation payment method for physicians' services.)

Community Mental Health Centers

Section 149 of the MIPPA added community mental health centers (CMHCs), as defined in section 1861(ff)(3)(B) of the Act, to the list of originating sites for Medicare telehealth services. The Medicare statute recognizes CMHCs as ''providers of services'' for purposes of furnishing partial hospitalization programs (PHP). PHPs are structured and intensive programs consisting of a group of mental health services paid on a per diem basis under the OPPS. A CMHC receives a per diem payment for each PHP day, which consists of a minimum of three PHP services. The HCPCS codes that are eligible for PHP services and count towards the number of PHP service units required to receive the per diem payment were originally defined in the April 7, 2000, OPPS final rule with comment period (65 FR 18454).

The Medicare telehealth originating site facility fee is not a PHP service and, as such, it does not count towards the number of PHP services for purposes of determining payment to a CMHC for partial hospitalization services. The originating site facility fee is not bundled into the per diem payment for partial hospitalization. With respect to a Medicare telehealth service furnished by a physician or practitioner to a beneficiary at a CMHC, the originating site facility fee is separately payable under Part B.

Consistent with existing policy, physicians and practitioners furnishing services to beneficiaries in CMHCs can bill Medicare Part B for telehealth services as long as the service would be separately payable under the PFS when furnished in a face-to-face encounter at that location. However, as noted above, PHP services furnished via telehealth will not be included in the count of services used to determine whether the CMHC should receive a PHP per diem payment. Rather, in order to avoid duplicate payment, the facility is paid for its role in furnishing telehealth services through the originating site facility fee. Regardless of whether the CMHC has provided the minimum number of PHP services to receive a per diem payment, CMHCs can bill and receive payment for the originating site facility fee with respect to a Medicare telehealth service that would otherwise

be eligible for payment at the CMHC. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 4, Section 260, for more information on Medicare payment policy regarding partial hospitalization program services.)

The PHP per diem payment includes the services of clinical social workers (CSWs) and other support staff trained to work with psychiatric patients. CSW services furnished under a PHP are included in the partial hospitalization rate. To prevent duplicate payment for services that the CMHC is required to furnish and that are paid to the CMHC through the PHP per diem payment, Medicare does not pay separately for the services of CSWs furnished via telehealth to beneficiaries receiving partial hospitalization services in a CMHC.

Skilled Nursing Facilities

Section 149 of the MIPPA added skilled nursing facilities (SNFs), as defined in section 1819(a) of the Medicare statute, to the list of originating sites for Medicare telehealth services. For residents in a covered Part A SNF stay, the SNF receives a bundled per diem payment under the SNF PPS for all covered skilled nursing facility services as defined under section 1888(e)(2)(A) of the statute. The conforming amendment in section 149(b) of the MIPPA amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) of the Medicare statute from the definition of ''covered skilled nursing facility services'' that are paid under the SNF PPS. Therefore, when a SNF serves as the originating site for Medicare telehealth services, the SNF can receive separate payment for a telehealth originating site facility fee even in those instances where it also receives a bundled per diem payment under the SNF PPS for a resident's covered Part A stay. Moreover, not only would the originating site facility fee be separately billable outside of the SNF PPS, but so would those professional services (furnished at the distant site) that meet the criteria specified in section 1834(m)(2)(A) of the Act for payment as Medicare telehealth services. As indicated previously, under section 1834(m)(2)(A) of the Act, telehealth is a delivery mechanism for *otherwise payable* Part B services; that is, services which would be separately payable under Part B if ''* * * furnished *without* the use of a telecommunications system'' (emphasis added). This means that distant site professional services can qualify for separate telehealth payment *only* to the extent that they are not already included within a bundled payment to the facility that serves as the originating site. Thus, services furnished to a SNF resident from the distant site by a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or qualified psychologist would be separately billable as telehealth services, as the services of all of these practitioner types are excluded from payment under the SNF PPS under section 1888(e)(2)(A)(ii) of the Act. However, the services of other practitioners such as clinical social workers (CSWs), registered dietitians, and nutrition professionals are subject to SNF consolidated billing when furnished to the SNF's Part A resident. In order to avoid duplicate payment, telehealth services furnished by these practitioners would be separately billable telehealth services only in those cases where the SNF resident who receives them is not in a covered Part A stay.

Thus, for services that SNF residents receive during the course of a covered Part A stay, the MIPPA's designation of a SNF as a telehealth setting effectively leaves unchanged the scope of the bundled per diem payment that the SNF PPS makes for the covered stay itself. Accordingly, the use of telehealth as a vehicle for service delivery would not serve to bundle types of services (such as those of physicians) that are otherwise separately payable under Part B when furnished to such residents, nor would it serve to unbundle types of services (such as those of CSWs) that are otherwise included within the bundled SNF PPS payment.

In order to reflect this conforming amendment, we are revising the implementing regulations at § 411.15(p)(2) to include an additional clause, which specifies that types of services that would otherwise be excluded from SNF consolidated billing when furnished in a face-to-face encounter are also excluded when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act. Consistent with the preceding discussion, this revision serves to clarify that a type of service (such as a physician service) that is otherwise excluded from SNF consolidated billing does not become subject to that provision merely by virtue of being furnished via telehealth. Similarly, we are including a conforming change in the regulations at § 489.20(s) that specify compliance with consolidated billing as a requirement under the SNF's Medicare provider agreement.

N. Section 153: Renal Dialysis Provisions

The following changes affecting payment to ESRD facilities for ESRD services are effective January 1, 2009:

- Under section 153(a)(1) of the MIPPA, the ESRD composite rate is increased by 1.0 percent for dialysis services furnished on or after January 1, 2009, and before January 1, 2010. This will require us to update the adjusted drug add-on adjustment as explained in section H of the preamble of this final rule.
- Section 153(a)(2) of the MIPPA requires that the composite rate paid to hospital-based facilities be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2009. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities. Accordingly, we are revising § 413.174, which describes the methodology for ESRD composite rates for hospital-based and independent facilities, to conform to the statutory requirement. These MIPPA provisions are self-implementing and require no substantive exercise of discretion on the part of the Secretary. They are discussed further in section II. H of the preamble of this final rule with comment period.

IV. Potentially Misvalued Services Under the Physician Fee Schedule

A. Valuing Services Under the Physician Fee Schedule

As explained in the CY 2009 PFS proposed rule (73 FR 38582), the AMA RUC provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued under the 5-Year Review of Work. On an ongoing basis, the RUC's PE Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE RVUs.

There has been considerable concern expressed by the Medicare Payment Advisory Commission (MedPAC), the Congress, and other stakeholders in accurate pricing under the PFS. Despite the large increase in work RVUs for many medical visits during the last 5-Year Review of physician work, there continues to be concern that the presence of many overvalued procedures within the PFS disadvantages primary care services and creates distortions in the PFS. Critics have stated the relative imbalance in the

number of codes for which the work RVUs are increased rather than decreased in the three 5-Year Reviews of work RVUs.

The RUC has created the 5-Year Review Identification Workgroup to respond to these concerns regarding the valuation of codes. The workgroup identified some potentially misvalued codes through several vehicles, namely, identifying codes with site of service anomalies, high intra-service work per unit time (IWPUT), and services with high volume growth.

In the proposed rule, we indicated we would address the RUC's recommendations from the February and April 2008 meetings for codes with site of service anomalies in the CY 2009 PFS final rule with comment period in a manner consistent with the way we address other RUC recommendations and that the values for these services would be published as interim values for CY 2009.

In addition to the RUC's work, we believe that there are certain steps we can take to help address the issue of potentially misvalued services. A discussion of these steps are outlined below.

1. Updating High Cost Supplies

In the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update high-cost supplies over $150 every 2 years. In order to obtain the typical price in the marketplace, we outlined examples of acceptable documentation and stated that we would not accept documentation that did not include specific pricing information. We also noted that if acceptable documentation was not received within the proposed rule's 60-day comment period, we would use prices from the Internet, retail vendors, and supply catalogs to determine the appropriate cost; and, that we would use the lowest price identified by these sources. Table 25 in the proposed rule lists the top 65 high-cost supplies over $150 which needed specialty input for price updates.

Comment: We received many comments on our proposed process. Some commenters expressed support for our proposal but others thought the process was flawed and burdensome. Some commenters stated that the third year of the 4-year transition of the PE RVUs to the bottom up methodology is an inappropriate time to update pricing and also believed that the repricing of only the high-cost supplies over $150 is unfair. MedPAC and others recommended that we use an independent entity to update this pricing information in order to capture the ''average transaction prices'' that reflect the discounts and rebates offered by the manufacturers. Some commenters submitted data on the high-cost supplies listed on the table. Of the 65 high cost supplies listed, we received data on 53.

Response: Although we received some data in response to our request for information on the top 65 high cost supplies over $150, much of what we received was not complete and did not represent typical market prices. Many specialty societies submitted quotes and list prices from manufacturers for the premier models of many supply items. Where there are less expensive alternatives for certain supply items, most commenters did not report this information so we could not determine what a typical price would be. We received no pricing information for some items and commenters explained the absence of some prices by saying a particular product was no longer being manufactured. In other cases, we received incomplete pricing information, for example, a typical stent size was not indicated.

We appreciate the many thoughtful comments we received on the proposed process for updating high-cost supplies and believe this is an important area to consider when evaluating potentially overvalued services. However, we have decided not to finalize the proposed process at this time, and not to revise the prices for the supplies listed in the table. We plan to research the possibility of using an independent contractor to assist us in obtaining accurate pricing information. We plan to study the limitations of the data we received and determine how to revise our proposed process to elicit better data. We will propose a revised process in future rulemaking.

2. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Non-Surgical Procedures

In the CY 2009 PFS proposed rule, we stated that we plan to perform data analysis on non-surgical CPT codes that are often billed together (for example, 60 to 70 percent of the time). This would determine if there are inequities in PFS payments that are a result of variations between services or in the comprehensiveness of the codes used to report the services or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that clinical labor activities, supplies and equipment may not be performed or furnished twice when multiple procedures are performed. We stated that we would consider developing a proposal either to bundle additional services or expand application of the MPPR to additional procedures.

Comment: MedPAC requested that we consider duplicative physician work, as well as PE, in any expansion of the MPPR. Several specialty groups noted that the AMA RUC has already taken action to identify frequently occurring code pairs. The commenters support the AMA RUC's recommendation that CMS analyze data to identify nonsurgical CPT codes that are billed together 90 to 95 percent of the time. Other commenters did not believe a broad-based application of the MPPR to non-surgical services was appropriate.

Response: Based on the comments received, we will continue to work with the AMA RUC, MedPAC, and the specialty societies to determine whether there are additional services that should be either bundled or subjected to a MPPR.

B. Requested Approaches for the RUC To Utilize

In the CY 2009 PFS proposed rule, we identified methods that the AMA RUC could undertake to assist in identifying potentially misvalued services including reviewing: (1) The Fastest Growing Procedure Codes; (2) the Harvard-Valued Codes; and (3) PE RVUs (see 73 FR 38586).

Comment: We received many comments on this issue from various specialty groups and medical societies. Some commenters supported our proposed approaches and looked forward to participating in the process, while others expressed concern. Some specialty societies are opposed to our selection of the fastest growing procedure codes based solely on their rate of growth and total spending and cautioned CMS to consider the clinical justification for increased utilization before making any decisions to reduce the payment rates for these services.

The AMA and the AMA RUC both look forward to working with CMS on the review of the fastest growing procedure codes and have developed plans to address these codes. The AMA RUC noted that there are 2,856 services that contain Harvard-based time inputs that have not been surveyed since the Harvard studies. The AMA RUC conducted an analysis of Harvard-valued services with utilization above 10,000 services per year, which resulted in a list of 296 distinct services. The AMA RUC believes it would be effective to limit any review to these 296 services or fewer. The AMA RUC also noted that of the 296 services identified, 23 have

already been identified by another screen and are being reviewed.

MedPAC supports our plan to review the fastest growing procedures codes, services often furnished together, and the Harvard-valued codes and believes it is consistent with their previous recommendations to CMS. MedPAC disagrees with the process for identifying misvalued services. MedPAC believes that it is our responsibility to identify potentially misvalued services and that we should establish a standing panel of experts to help identify overvalued services and to review AMA RUC recommendations.

The AMA RUC, MedPAC and other specialty societies requested that we clarify the timing of the 5-Year Review of PE RVUs. The AMA RUC believes that the increases to PE RVUs for some codes are not attributable to the direct inputs of the codes under the PE methodology transition. Rather, the AMA RUC believes the increases are attributable to our acceptance and incorporation of supplemental survey data for certain specialties. MedPAC supports the review of PE inputs for the fastest growing procedure codes. MedPAC also requests that CMS and the AMA RUC review the PE inputs of high-volume codes, particularly those whose inputs are not based on physician surveys.

Response: We look forward to continuing to work with the AMA RUC in reviewing these issues and receiving alternative approaches for identifying misvalued codes from the specialty societies. We are aware that these approaches are long-term and will require time and effort from the AMA RUC and specialty societies to complete these reviews. We also believe the outlined approaches will address MedPAC's concerns. In selecting these codes and reviewing the AMA RUC's recommendations regarding misvalued codes we have taken into consideration whether there is a clinical rationale for increased utilization, and we will continue to take this into consideration in future reviews.

C. AMA RUC Review of Potentially Misvalued Codes

The AMA RUC started to review potentially misvalued codes using various screens, including codes with site of service and high IWPUT anomalies and high volume and a new technology designation, at the 2008 AMA RUC meetings. Review of the identified clinical services revealed 204 codes. Of those codes, 48 were recommended for a reduction in valuation; 38 were recommended to maintain the same valuation; 105 were referred to CPT for further code clarification; and 13 were recommended for an increase in valuation.

All of these codes were reviewed and revalued by the AMA RUC; other than the codes referred to CPT, we have agreed to accept the valuation for these codes for CY 2009, including the conforming changes to the PE inputs for these codes, as applicable. We recognize that many of the site of service anomaly code changes included deletion or modification of hospital days, office visits, intraservice time, and discharge day management services. We have concerns that the methodology used by the AMA RUC to review the services may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs. We also have concerns about the methodology used to value the high IWPUT and new technology codes. We note that the high volume codes have been referred to CPT.

Although we have some questions or concerns with certain aspects of the AMA RUC reviews of these codes, we believe the AMA RUC-recommended valuations are still a better representation of the resources used to furnish these services than the current valuations. We will continue to examine the AMA RUC recommendations and will consider whether it would be appropriate to propose further changes in future rulemaking.

During the review of the above-noted potentially misvalued codes, the AMA RUC identified three codes that they believed needed review for purposes of the PE inputs only including CPT codes 52214, 52224, and 94770. CPT codes 52214 and 52224 were identified by the high volume growth screen. As a result, the AMA RUC identified a duplication of the PE inputs that included supplies and equipment for both the laser and electrocautery techniques and recommended this duplication be eliminated. After a review of the PE inputs in October 2008, the AMA RUC recommended that the electrocautery PE inputs be deleted. We agree with this recommendation and have made these changes in the PE database.

CPT code 94770 was identified through the high IWPUT screen. In reviewing this diagnostic procedure, the AMA RUC and the specialty society agreed that this test is currently being used inappropriately in the nonfacility setting. The AMA RUC agreed with the specialty society that this procedure is medically appropriate only in the facility setting (provided at the patient's bedside) and that it should not be valued in the nonfacility setting. Therefore, the AMA RUC recommended that all of the PE inputs be removed from the nonfacility setting. We have accepted the AMA's RUC recommendation and we have changed the PE database to reflect these changes.

Table 26 includes codes identified in the screens identified above, as well as other CMS requests.

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
11043	Debride tissue/ muscle.	CPT	Agree	3.04	X					
11044	Debride tissue/ bone.	CPT	Agree	4.11	X					
14000	Skin tissue re-arrangement.	6.19	Agree	6.19	X					
14001	Skin tissue re-arrangement.	8.58	Agree	8.58	X					
14020	Skin tissue re-arrangement.	7.02	Agree	7.02	X					
14021	Skin tissue re-arrangement.	9.52	Agree	9.52	X					
14040	Skin tissue re-arrangement.	8.44	Agree	8.44	X					

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
14041	Skin tissue rearrangement.	10.63	Agree	10.63	X					
14060	Skin tissue rearrangement.	9.07	Agree	9.07	X					
14061	Skin tissue rearrangement.	11.25	Agree	11.25	X					
14300	Skin tissue rearrangement.	CPT	Agree	13.26	X					X
15570	Form skin pedicle flap.	10.00	Agree	10.00	X					
15572	Form skin pedicle flap.	9.94	Agree	9.94	X					
15574	Form skin pedicle flap.	10.52	Agree	10.52	X					
15576	Form skin pedicle flap.	9.24	Agree	9.24	X					
15740	Island pedicle flap graft.	CPT	Agree	11.57	X					X
17106	Destruction of skin lesions.	3.61	Agree	3.61		X				
17107	Destruction of skin lesions.	4.68	Agree	4.68		X				
17108	Destruction of skin lesions.	6.37	Agree	6.37		X				
19357	Breast reconstruction.	CPT	Agree	20.57	X					
20005	Incision of deep abscess.	CPT	Agree	3.55	X					
20900	Removal of bone for graft.	3.00	Agree	3.00	X					
20902	Removal of bone for graft.	4.58	Agree	4.58	X					
21015	Resection of facial tumor.	CPT	Agree	5.59	X					
21025	Excision of bone, lower jaw.	9.87	Agree	9.87	X					
21557	Remove tumor neck/chest.	CPT	Agree	8.91	X					
21935	Remove tumor, back.	CPT	Agree	18.38	X					
22554	Neck spine fusion.	CPT	Agree	17.54					X	
22851	Apply spine prosth device.	CPT	Agree	6.70						X
22900	Remove abdominal wall lesion.	CPT	Agree	6.14	X					
23076	Removal of shoulder lesion.	CPT	Agree	7.77	X					
23120	Partial removal, collar bone.	7.23	Agree	7.23	X					
23410	Repair rotator cuff, acute.	11.23	Agree	11.23	X					
23412	Repair rotator cuff, chronic.	11.77	Agree	11.77	X					
23415	Release of shoulder ligament.	9.07	Agree	9.07	X					
23420	Repair of shoulder.	13.35	Agree	13.35	X					
25116	Remove wrist/forearm lesion.	7.38	Agree	7.38	X					
25310	Transplant forearm tendon.	7.94	Agree	7.94	X					
26080	Explore/treat finger joint.	CPT	Agree	4.36	X					

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
27048	Remove hip/pelvis lesion.	CPT	Agree	6.44	X					
27062	Remove femur lesion/bursa.	5.66	Agree	5.66	X					
27244	Treat thigh fracture.	18.00	Agree	18.00		X				
27245	Treat thigh fracture.	18.00	Agree	18.00		X				
27250	Treat hip dislocation.	3.82	Agree	3.82	X	X				
27615	Remove tumor, lower leg.	CPT	Agree	12.93	X					
27619	Remove lower leg lesion.	CPT	Agree	8.47	X					
27640	Partial removal of tibia.	CPT	Agree	12.10	X					
27641	Partial removal of fibula.	CPT	Agree	9.73	X					
27650	Repair achilles tendon.	9.00	Agree	9.00	X					
27654	Repair of achilles tendon.	10.32	Agree	10.32	X					
27690	Revise lower leg tendon.	8.96	Agree	8.96	X					
27691	Revise lower leg tendon.	10.28	Agree	10.28	X					
28120	Part removal of ankle/heel.	5.64	Agree	5.64	X					
28122	Partial removal of foot bone.	7.56	Agree	7.56	X					
28296	Correction of bunion.	8.16	Agree	8.16	X					
28725	Fusion of foot bones.	11.97	Agree	11.97	X					
28730	Fusion of foot bones.	12.21	Agree	12.21	X					
28825	Partial amputation of toe.	5.85	Agree	5.85	X					
29220	Strapping of low back.	CPT	Agree	0.64						X
29888	Knee arthroscopy/surgery.	14.14	Agree	14.14	X					
33213	Insertion of pulse generator.	CPT	Agree	6.36						X
35470	Repair arterial blockage.	CPT	Agree	8.62						X
35474	Repair arterial blockage.	CPT	Agree	7.35						X
35490	Artherectomy, percutaneous.	CPT	Agree	11.06						X
35491	Artherectomy, percutaneous.	CPT	Agree	7.60						X
35492	Artherectomy, percutaneous.	CPT	Agree	6.64						X
35493	Artherectomy, percutaneous.	CPT	Agree	6.64						X
35494	Artherectomy, percutaneous.	CPT	Agree	10.42						X
35495	Artherectomy, percutaneous.	CPT	Agree	9.47						X
36248	Place catheter in artery.	CPT	Agree	1.01						X
36415	Routine venipuncture.	CPT	Agree	0.00					X	
36820	Av fusion/forearm vein.	14.39	Agree	14.39	X					
36821	Av fusion direct any site.	12.00	Agree	12.00	X					

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
36825	Artery-vein autograft.	10.00	Agree	10.00	X					
36834	Repair A–V aneurysm.	CPT	Agree	11.11	X					
37760	Ligation, leg veins, open.	CPT	Agree	10.69	X					
38542	Explore deep node(s), neck.	7.85	Agree	7.85	X					
42145	Repair palate, pharynx/uvula.	9.63	Agree	9.63	X					
42415	Excise parotid gland/lesion.	17.99	Agree	17.99	X					
42420	Excise parotid gland/lesion.	20.87	Agree	20.87	X					
42440	Excise submaxillary gland.	7.05	Agree	7.05	X					
45170	Excision of rectal lesion.	CPT	Agree	12.48	X					
47525	Change bile duct catheter.	1.54	Agree	1.54		X				
49420	Insert abdom drain, temp.	CPT	Agree	2.22	X					
49421	Insert abdom drain, perm.	CPT	Agree	5.87	X					
49507	Prp i/hern init block > 5 yr.	9.97	Agree	9.97	X					
49521	Rerepair ing hernia, blocked.	12.36	Agree	12.36	X					
49587	Rpr umbil hern, block > 5 yr.	7.96	Agree	7.96	X					
50605	Insert ureteral support.	CPT	Agree	16.66						X
51102	Drain bl w/cath insertion.	2.70	Agree	2.70	X					
51726	Complex cystometrogram.	CPT	Agree	1.71					X	
51772	Urethra pressure profile.	CPT	Agree	1.61					X	X
51795	Urine voiding pressure study.	CPT	Agree	1.53					X	
51797	Intra-abdominal pressure test.	CPT	Agree	0.80					X	
52341	Cysto w/ureter stricture tx.	5.35	Agree	5.35	X					
52342	Cysto w/up stricture tx.	5.85	Agree	5.85	X					
52343	Cysto w/renal stricture tx.	6.55	Agree	6.55	X					
52344	Cysto/uretero, stricture tx.	7.05	Agree	7.05	X					
52345	Cysto/uretero w/up stricture.	7.55	Agree	7.55	X					
52346	Cystouretero w/renal strict.	8.58	Agree	8.58	X					
52400	Cystouretero w/congen repr.	8.66	Agree	8.66	X					
52500	Revision of bladder neck.	7.99	Agree	7.99	X					
52640	Relieve bladder contracture.	4.73	Agree	4.73	X					
53445	Insert uro/ves nck sphincter.	15.21	Agree	15.21	X					
54405	Insert multi-comp penis pros.	14.39	Agree	14.39	X					
54410	Remove/replace penis prosth.	15.00	Agree	15.00	X					

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
54530	Removal of testis.	8.35	Agree	8.35	X					
55866	Lapro radical prostetectomy.	CPT	Agree	32.25			X			X
56620	Partial removal of vulva.	7.35	Agree	7.35	X					
57155	Insert uteri tandems/ovoids.	CPT	Agree	6.79	X					
57287	Revise/remove sling repair.	10.97	Agree	10.97	X					
57288	Repair bladder defect.	12.00	Agree	12.00			X			
60220	Partial removal of thyroid.	12.29	Agree	12.29	X					
60225	Partial removal of thyroid.	14.67	Agree	14.67	X					
61885	Insrt/redo neurostim 1 array.	7.37	Agree	7.37	X					
62263	Epidural lysis mult sessions.	6.41	Agree	6.41	X					
62350	Implant spinal canal cath.	6.00	Agree	6.00	X					
62355	Remove spinal canal catheter.	4.30	Agree	4.30	X					
62360	Insert spine infusion device.	4.28	Agree	4.28	X					
62361	Implant spine infusion pump.	5.60	Agree	5.60	X					
62362	Implant spine infusion pump.	6.05	Agree	6.05	X					
62365	Remove spine infusion device.	4.60	Agree	4.60	X					
63075	Neck spine disk surgery.	CPT	Agree	19.47					X	
63650	Implant neuroelectrodes.	7.15	Agree	7.15	X					
63660	Revise/remove neuroelectrode.	CPT	Agree	6.87	X					X
63685	Insrt/redo spine n generator.	6.00	Agree	6.00	X					
63688	Revise/remove neuroreceiver.	5.25	Agree	5.25	X					
64416	N block cont infuse, B plex.	CPT	Agree	3.85	X					
64446	N block inj, sciatic, cont inf.	CPT	Agree	3.61	X					X
64448	N block inj, fem, cont inf.	CPT	Agree	3.36	X					X
64449	N block inj, lumbar plexus.	CPT	Agree	3.24	X					
64470	Inj paravertebral C/T.	CPT	Agree	1.85						X
64472	Inj paravertebral C/T add on.	CPT	Agree	1.29						X
64475	Inj paravertbral L/S.	CPT	Agree	1.41						X
64476	Inj paravertbral L/S add on.	CPT	Agree	0.98						X
64483	Inj foramen epidural l/s.	CPT	Agree	1.90						X
64484	Inj foramen epidural add-on.	CPT	Agree	1.33						X

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
64555	Implant neuroelectro-des.	CPT	Agree	2.29						X
64573	Implant neuroelectro-des.	8.15	Agree	8.15	X					
64581	Implant neuroelectro-des.	CPT	Agree	14.15	X					
64622	Destr paravertebrl nerve l/s.	CPT	Agree	3.02						X
64623	Destr paravertebral n add-on.	CPT	Agree	0.99						X
64626	Destr paravertebrl nerve c/t.	CPT	Agree	3.82						X
64627	Destr paravertebral n add-on.	CPT	Agree	1.16						X
64708	Revise arm/leg nerve.	6.22	Agree	6.22	X					
64712	Revision of sci-atic nerve.	CPT	Agree	7.98	X					
64831	Repair of digit nerve.	9.00	Agree	9.00	X					
65285	Repair of eye wound.	14.43	Agree	14.43	X					
66982	Cataract sur-gery, complex.	14.83	Agree	14.83		X				
67210	Treatment of retinal lesion.	CPT	Agree	9.35		X				
67220	Treatment of choroid lesion.	CPT	Agree	14.19		X				
67225	Eye photodynamic ther add-on.	0.47	Agree	0.47			X			
67228	Treatment of retinal lesion.	CPT	Agree	13.67		X				
68810	Probe nasolacrimal duct.	2.09	Agree	2.09	X					
69930	Implant coch-lear device.	17.60	Agree	17.60	X					
72192	Ct pelvis w/o dye.	CPT	Agree	1.09						X
72194	Ct pelvis w/o & w/dye.	CPT	Agree	1.22					X	X
74170	Ct abdomen w/ o & w/dye.	CPT	Agree	1.40					X	
74175	Ct angio abdom w/o & w/dye.	CPT	Agree	1.90						X
75790	Visualize A–V shunt.	CPT	Agree	1.84					X	
75992	Artherectomy, X-Ray exam.	CPT	Agree	0.54						X
75993	Artherectomy, X-Ray exam.	CPT	Agree	0.36						X
75994	Artherectomy, X-Ray exam.	CPT	Agree	1.31						X
75995	Artherectomy, X-Ray exam.	CPT	Agree	1.31						X
75996	Artherectomy, X-Ray exam.	CPT	Agree	0.36						X
76513	Echo exam of eye, water bath.	CPT	Agree	0.66						X

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
77427	Radiation tx management, x5.	CPT	Agree	3.70	X					
77782	High intensity brachytherapy.	CPT	Agree	2.04						X
78465	Heart image (3d), multiple.	CPT	Agree	1.46					X	
78478	Heart wall motion add-on.	CPT	Agree	0.50					X	
78480	Heart function add-on.	CPT	Agree	0.30					X	
78483	Heart, first pass, multiple.	CPT	Agree	1.47						X
92270	Electro-oculography.	CPT	Agree	0.81				X	X	
92541	Spontaneous nystagmus test.	CPT	Agree	0.40					X	
92542	Positional nystagmus test.	CPT	Agree	0.33					X	
92544	Optokinetic nystagmus test.	CPT	Agree	0.26					X	
92545	Oscillating tracking test.	CPT	Agree	0.23					X	
92557	Comprehensive hearing test.	CPT	Agree	0.60					X	
92567	Tympanometry	CPT	Agree	0.20					X	
92568	Acoustic refl threshold tst.	CPT	Agree	0.29					X	
92569	Acoustic reflex decay test.	CPT	Agree	0.20					X	
92620	Auditory function, 60 min.	1.50	Agree	1.50				X		
92621	Auditory function, + 15 min.	0.35	Agree	0.35				X		
92625	Tinnitus assessment.	1.15	Agree	1.15				X		
92626	Eval aud rehab status.	1.40	Agree	1.40				X		
92627	Eval aud status rehab add-on.	0.33	Agree	0.33				X		
92640	Aud brainstem implt programg.	1.76	Agree	1.76				X		
93236	ECG monitor/report, 24 hours.	CPT	Agree	0.00						X
93350	Echo transthoracic.	1.46	Agree	1.46	X					
93526	Rt & Lt heart catheters.	CPT	Agree	5.98					X	
93539	Injection, cardiac cath.	CPT	Agree	0.40					X	
93540	Injection, cardiac cath.	CPT	Agree	0.43					X	
93543	Injection for heart x-rays.	CPT	Agree	0.29					X	
93544	Injection for aortography.	CPT	Agree	0.25					X	
93545	Inject for coronary x-rays.	CPT	Agree	0.40					X	
93555	Imaging, cardiac cath.	CPT	Agree	0.81					X	
93556	Imaging, cardiac cath.	CPT	Agree	0.83					X	
93620	Electrophysiology evaluation.	CPT	Agree	11.57					X	
93621	Electrophysiology evaluation.	CPT	Agree	2.10					X	

TABLE 26—AMA RUC RECOMMENDATIONS FOR POTENTIALLY MISVALUED CODES—Continued

CPT code	Descriptor	AMA RUC rec	CMS decision	2009 WRVU	Site of service screen	High IWPUT screen	New tech	Shift from PE to work	Other CMS request	High volume
94681	Exhaled air analysis, o2/co2.	CPT	Agree	0.20						X
97802	Medical nutrition, indiv, in.	0.53	Agree	0.53					X	
97803	Med nutrition, indiv, subseq.	0.45	Agree	0.45					X	
G0179	MD recertification HHA PT.	CPT	Agree	0.45						X
G0181	Home health care supervision.	CPT	Agree	1.73						X

Note: The RUC reviewed and recommended work RVUs for 6 audiology codes (CPT codes 92620, 92621, 92625, 92626, 92627, and 92640) with which we have agreed. Under Medicare, audiology services are provided under the diagnostic test benefit. We recognize that some of the work descriptors include ''counseling,'' ''the potential for remediation,'' and the establishment of ''interventional goals.'' We do not believe those aspects fit within the diagnostic test benefit but are interested in receiving comments on this issue.

V. Refinement of Relative Value Units for Calendar Year 2009 and Response to Public Comments on Interim Relative Value Units for 2008

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Sections IV.B. and IV.C. of this final rule with comment describe the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to the RVUs and billing status codes reflected in Addendum B are effective for services furnished beginning January 1, 2009.

B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule

The CY 2008 PFS final rule with comment period (72 FR 66365) contained the work RVUs for Medicare payment for existing procedure codes under the PFS and interim RVUs for new and revised codes beginning January 1, 2008. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we address comments on the interim work RVUs published in the CY 2008 PFS final rule with comment period, and our establishment of the work RVUs for new and revised codes for the CY 2009 PFS.

C. Interim 2008 Codes

1. Orthopedic Fracture Treatment Codes

Orthopedic fracture treatment codes were originally part of the third 5-Year Review of work RVUs. The codes were referred by the AMA RUC to the AMA's CPT Editorial Panel for further clarification because it was unclear whether the previous valuation for these codes included the circumstance when both internal and external fixation is applied to the fracture site. The CPT Editorial Panel agreed the codes needed further clarification and removed the reference relating to external fixation from the codes.

As a result, the AMA RUC examined the various families of fracture codes and recommended increased work RVUs for most of the codes. The codes were submitted to CMS as part of the new and revised codes for CY 2008. Although we agreed with the work RVU recommendations and rank order listing of the codes in each family, the increase in valuation of the services created BN issues within certain fracture code families. In order to retain BN within these families of codes, the work RVUs associated with each code were adjusted. That is, the work RVUs were adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for each family would be the same as the sum of the current work RVUs (weighted by projected frequency of use) for each family of codes.

Comment: Some commenters believed these codes should have been considered as part of the 5-Year review process and the increase in work RVUs should have been absorbed through the BN work adjuster. The commenters also disagreed with the application of BN and noted that this created rank order anomalies. The commenters requested that if BN is applied, it should be implemented across the entire fracture family of codes, which would include codes that have not been surveyed (Harvard valued codes).

Response: The commenters did not submit sufficient information to demonstrate that the application of BN created rank order anomalies for these codes. We note that the base codes for each fracture family of codes could be submitted to the AMA RUC for re-valuation. This would enable the codes within the family, several of which have not undergone an AMA RUC review, to be properly aligned in comparison to the base codes within each family.

2. Cardiac MRI Codes

For CY 2008, the CPT Editorial Panel created eight new Cardiac Magnetic Resonance Imaging (MRI) codes and deleted five existing Cardiac MRI codes due to technological changes and advances in MRI scanning. We established a national noncoverage determination (NCD) for MRI when blood flow velocity measurement is a component, or comprises all, of the service. As a result, we assigned a status indicator of ''N'' (Noncovered) to four of the new CPT codes (75558, 75560, 75562, and 75564).

Comment: Some commenters expressed disappointment that these four new MRI codes were designated as noncovered and stated that they did not believe the existing NCD for MRI is applicable to flow and velocity measurements.

Response: We have reviewed the information submitted by the commenters and the national noncoverage determination. We have determined that the existing NCD for MRI is applicable to these codes because blood flow/velocity quantification is considered to be a component of these services, which according to the NCD is not considered reasonable and

necessary, and therefore, is noncovered. Any changes in coverage would have to occur through the NCD process.

3. Non-Face-to-Face Physician and Qualified Healthcare Professional Services

For CY 2008, the CPT Editorial Panel created eight new codes (CPT codes 98966, 98967, 98968, 98969, 99441, 99442, 99443, and 99444) to describe Evaluation and Management (E/M) services furnished by a physician or qualified healthcare professional via telephone or online, for which the AMA RUC and the AMA's Health Care Professionals Advisory Committee provided work and PE valuations. We assigned a status indicator of ''N'' (Noncovered) to these services because: (1) These services are non-face-to-face; and (2) the code descriptors include language that recognizes the provision of services to parties other than the beneficiary for whom Medicare does not provide coverage (for example, a guardian).

Comment: Some commenters requested that we reconsider the assignment of an N status for these codes. The commenters believed that failure to provide incentives and funding for these codes affects the alignment of quality of care between providers.

Response: We have considered the commenters' request. However, we will continue to recognize these services as noncovered because they are not furnished in a face-to-face setting (nor are they furnished as Medicare telehealth services), and the code descriptors include language that recognizes the provision of services to a noncovered entity.

In the CY 2008 PFS final rule with comment period (73 FR 66371), we also responded to the AMA RUC recommendations on the PE inputs for the new and revised CPT codes for 2008. In addition to the PE comments discussed in section II.A.2. of this final rule with comment period, we received the following comments concerning PE inputs:

Comment: The specialty societies and the AMA RUC provided clarification and pricing information concerning direct PE inputs for CPT Code 43760, *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.*

Response: We have revised the PE database to reflect this information.

Comment: Several commenters questioned the PE RVUs for CPT code 68816, *Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation,* believing it to be undervalued. In particular, one commenter stated that the payment for this service is less than a specific supply item.

Response: We have reviewed the PE inputs for this service and determined that they accurately represent the inputs recommended by the AMA RUC. The difference in the actual costs of the direct PE inputs and the payment amount for this service is due to the application of the uniform BN adjustment that is applied to all direct inputs as part of the bottom-up PE methodology.

D. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2009 (Includes Table Titled ''AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes'')

One aspect of establishing RVUs for 2008 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 PFS (57 FR 55951) and in section III.B. of the CY 1997 PFS final rule (61 FR 59505), we established a process, based on recommendations received from the AMA RUC, for establishing interim work RVUs for new and revised codes.

We received work RVU recommendations for 128 new and revised CPT codes from the AMA RUC this year. We reviewed the AMA RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received AMA RUC recommendations and agreed with the majority of the relative relationships reflected in the AMA RUC values. Table 27: AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes lists the new or revised CPT codes, and their associated work RVUs, that will be interim in CY 2009. Table 27 includes the following information:

- A ''#'' identifies a new code for CY 2009.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the PC of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- AMA RUC recommendations. This column identifies the work RVUs recommended by the AMA RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the AMA RUC recommendation. Codes for which we did not accept the AMA RUC recommendation are discussed in greater detail following this table.
- 2009 Work RVUs. This column establishes the interim 2009 work RVUs for physician work.

TABLE 27—AMA RUC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2009 CPT CODES

CPT [1] code		Mod	Descriptor	AMA RUC work RVU recommendation	CMS decision	2009 WRVU
#20696	*		COMP MULTIPLANE EXT FIXATION	17.32	Agree	17.32
#20697	*		COMP EXT FIXATE STRUT CHANGE	0.00	Agree	0.00
#22856	*		CERV ARTIFIC DISKECTOMY	23.90	Agree	23.90
#22861	*		REVISE CERV ARTIFIC DISC	33.21	Agree	33.21
#22864	*		REMOVE CERV ARTIF DISC	29.25	Agree	29.25
#27027			BUTTOCK FASCIOTOMY	12.90	Agree	12.90
#27057			BUTTOCK FASCIOTOMY W/DBRDMT	14.77	Agree	14.77
27215			TREAT PELVIC FRACTURE(S)	10.45	Agree (a)	10.45
27216			TREAT PELVIC RING FRACTURE	15.73	Agree (a)	15.73
27217			TREAT PELVIC RING FRACTURE	14.65	Agree (a)	14.65
27218			TREAT PELVIC RING FRACTURE	20.93	Agree (a)	20.93
#35535			ARTERY BYPASS GRAFT	38.00	Agree	38.00
#35570			ARTERY BYPASS GRAFT	29.00	Agree	29.00

TABLE 27—AMA RUC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2009 CPT CODES—Continued

CPT [1] code		Mod	Descriptor	AMA RUC work RVU recommendation	CMS decision	2009 WRVU
#35632			ARTERY BYPASS GRAFT	36.00	Agree	36.00
#35633			ARTERY BYPASS GRAFT	38.98	Agree	38.98
#35634			ARTERY BYPASS GRAFT	35.20	Agree	35.20
#41512			TONGUE SUSPENSION	6.75	Agree	6.75
#41530			TONGUE BASE VOL REDUCTION	4.38	Agree	4.38
#43273	*		ENDOSCOPIC PANCREATOSCOPY	2.24	Agree	2.24
#43279	*		LAP MYOTOMY, HELLER	22.00	Agree	22.00
#46930			DESTROY INTERNAL HEMORRHOIDS	1.56	Agree	1.56
#49652			LAP VENT/ABD HERNIA REPAIR	12.80	Agree	12.80
#49653			LAP VENT/ABD HERN PROC COMP	16.10	Agree	16.10
#49654			LAP INC HERNIA REPAIR	14.95	Agree	14.95
#49655			LAP INC HERN REPAIR COMP	18.00	Agree	18.00
#49656			LAP INC HERNIA REPAIR RECUR	15.00	Agree	15.00
#49657			LAP INC HERN RECUR COMP	22.00	Agree	22.00
#55706	*		PROSTATE SATURATION SAMPLING	6.15	Agree	6.15
#61796			SRS, CRANIAL LESION SIMPLE	15.50	Disagree	10.79
#61797			SRS, CRAN LES SIMPLE, ADDL	3.48	Agree	3.48
#61798			SRS, CRANIAL LESION COMPLEX	19.75	Disagree	10.79
#61799			SRS, CRAN LES COMPLEX, ADDL	4.81	Agree	4.81
#61800			APPLY SRS HEADFRAME ADD-ON	2.25	Agree	2.25
#62267			INTERDISCAL PERQ ASPIR, DX	3.00	Agree	3.00
#63620	*		SRS, SPINAL LESION	15.50	Disagree	10.79
#63621	*		SRS, SPINAL LESION, ADDL	4.00	Agree	4.00
64416			N BLOCK CONT INFUSE, B PLEX	1.81	Agree	1.81
64446			N BLK INJ, SCIATIC, CONT INF	1.81	Agree	1.81
64448			N BLOCK INJ FEM, CONT INF	1.63	Agree	1.63
64449			N BLOCK INJ, LUMBAR PLEXUS	1.81	Agree	1.81
#64455			N BLOCK INJ, PLANTAR DIGIT	0.75	Agree	0.75
#64632			N BLOCK INJ, COMMON DIGIT	1.20	Agree	1.20
#65756			CORNEAL TRNSPL, ENDOTHELIAL	16.60	Agree	16.60
#65757			PREP CORNEAL ENDO ALLOGRAFT	1.44	Disagree	[2]
#77785		26	HDR BRACHYTX, 1 CHANNEL	1.42	Agree	1.42
#77786		26	HDR BRACHYTX, 2–12 CHANNEL	3.25	Agree	3.25
#77787		26	HDR BRACHYTX OVER 12 CHAN	4.89	Agree	4.89
#78808			IV INJ RA DRUG DX STUDY	0.18	Agree	0.18
#90951			ESRD SERV, 4 VISITS P MO, <2	18.46	Agree	18.46
#90952			ESRD SERV, 2–3 VSTS P MO, <2	[2]	Agree	[2]
#90953			ESRD SERV, 1 VISIT P MO, <2	[2]	Agree	[2]
#90954			ESRD SERV, 4 VSTS P MO, 2–11	15.98	Agree	15.98
#90955			ESRD SRV 2–3 VSTS P MO, 2–11	8.79	Agree	8.79
#90956			ESRD SRV, 1 VISIT P MO, 2–11	5.95	Agree	5.95
#90957			ESRD SRV, 4 VSTS P MO, 12–19	12.52	Agree	12.52
#90958			ESRD SRV 2–3 VSTS P MO 12–19	8.34	Agree	8.34
#90959			ESRD SERV, 1 VST P MO, 12–19	5.50	Agree	5.50
#90960			ESRD SRV, 4 VISITS P MO, 20+	5.18	Agree	5.18
#90961			ESRD SRV, 2–3 VSTS P MO, 20+	4.26	Agree	4.26
#90962			ESRD SERV, 1 VISIT P MO, 20+	3.15	Agree	3.15
#90963			ESRD HOME PT, SERV P MO, <2	10.56	Agree	10.56
#90964			ESRD HOME PT SERV P MO, 2–11	9.14	Agree	9.14
#90965			ESRD HOME PT SERV P MO 12–19	8.69	Agree	8.69
#90966			ESRD HOME PT, SERV P MO, 20+	4.26	Agree	4.26
#90967			ESRD HOME PT SERV P DAY, <2	0.35	Agree	0.35
#90968			ESRD HOME PT SRV P DAY, 2–11	0.30	Agree	0.30
#90969			ESRD HOME PT SRV P DAY 12–19	0.29	Agree	0.29
#90970			ESRD HOME PT SERV P DAY, 20+	0.14	Agree	0.14
#93228	*		REMOTE 30 DAY ECG REV/REPORT	0.52	Agree	0.52
#93229	*		REMOTE 30 DAY ECG TECH SUPP	0.00	Disagree	[2]
#93279	*	26	PM DEVICE PROGR EVAL, SNGL	0.65	Agree	0.65
#93280	*	26	PM DEVICE PROGR EVAL, DUAL	0.77	Agree	0.77
#93281	*	26	PM DEVICE PROGR EVAL, MULTI	0.90	Agree	0.90
#93282	*	26	ICD DEVICE PROG EVAL, 1 SNGL	0.85	Agree	0.85
#93283	*	26	ICD DEVICE PROGR EVAL, DUAL	1.18	Disagree	1.05
#93284	*	26	ICD DEVICE PROGR EVAL, MULT	1.25	Agree	1.25
#93285	*	26	ILR DEVICE EVAL PROGR	0.52	Agree	0.52
#93286	*	26	PRE-OP PM DEVICE EVAL	0.30	Agree	0.30
#93287	*	26	PRE-OP ICD DEVICE EVAL	0.45	Agree	0.45
#93288	*	26	PM DEVICE EVAL IN PERSON	0.43	Agree	0.43
#93289	*	26	ICD DEVICE INTERROGATE	0.92	Disagree	0.78

TABLE 27—AMA RUC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2009 CPT CODES—Continued

CPT [1] code		Mod	Descriptor	AMA RUC work RVU recommendation	CMS decision	2009 WRVU
#93290	*	26	ICM DEVICE EVAL	0.43	Agree	0.43
#93291	*	26	ILR DEVICE INTERROGATE	0.43	Agree	0.43
#93292	*	26	WCD DEVICE INTERROGATE	0.43	Agree	0.43
#93293	*	26	PM PHONE R-STRIP DEVICE EVAL	0.32	Agree	0.32
#93294	*	26	PM DEVICE INTERROGATE REMOTE	0.65	Agree	0.65
#93295	*	26	ICD DEVICE INTERROGAT REMOTE	1.38	Disagree	1.17
#93296	*		PM/ICD REMOTE TECH SERV	0.00	Agree	0.00
#93297	*		ICM DEVICE INTERROGAT REMOTE	0.52	Agree	0.52
#93298	*		ILR DEVICE INTERROGAT REMOTE	0.52	Agree	0.52
#93299	*		ICM/ILR REMOTE TECH SERV	0.00	Disagree	(2)
#93306	*	26	TTE W/DOPPLER, COMPLETE	1.30	Agree	1.30
#93351	*		STRESS TTE COMPLETE	1.75	Agree	1.75
#93352	*		ADMIN ECG CONTRAST AGENT	0.19	Agree	0.19
#95803	*	26	ACTIGRAPHY TESTING	1.00	Disagree	(2)
#95992			CANALITH REPOSITIONING PROC	0.75	Agree (b)	(3)
#96360			HYDRATION IV INFUSION, INIT	0.17	Agree	0.17
#96361			HYDRATE IV INFUSION, ADD-ON	0.09	Agree	0.09
#96365			THER/PROPH/DIAG IV INF, INIT	0.21	Agree	0.21
#96366			THER/PROPH/DIAG IV INF ADDON	0.18	Agree	0.18
#96367			TX/PROPH/DG ADDL SEQ IV INF	0.19	Agree	0.19
#96368			THER/DIAG CONCURRENT INF	0.17	Agree	0.17
#96369			SC THER INFUSION, UP TO 1 HR	0.21	Agree	0.21
#96370			SC THER INFUSION, ADDL HR	0.18	Agree	0.18
#96371			SC THER INFUSION, RESET PUMP	0.00	Agree	0.00
#96372			THER/PROPH/DIAG INJ, SC/IM	0.17	Agree	0.17
#96373			THER/PROPH/DIAG INJ, IA	0.17	Agree	0.17
#96374			THER/PROPH/DIAG INJ, IV PUSH	0.18	Agree	0.18
#96375			TX/PRO/DX INJ NEW DRUG ADDON	0.10	Agree	0.10
#96376			TX/PRO/DX INJ NEW DRUG ADON	0.00	Agree	0.00
#96379			THER/PROP/DIAG INJ/INF PROC	0.00	Agree	0.00
#99460			INIT NB EM PER DAY, HOSP	1.17	Agree	1.17
#99461			INIT NB EM PER DAY, NON-FAC	1.26	Agree	1.26
#99462			SBSQ NB EM PER DAY, HOSP	0.62	Agree	0.62
#99463			SAME DAY NB DISCHARGE	1.50	Agree	1.50
#99464			ATTENDANCE AT DELIVERY	1.50	Agree	1.50
#99465			NB RESUSCITATION	2.93	Agree	2.93
#99466			PED CRIT CARE TRANSPORT	4.79	Agree	4.79
#99467			PED CRIT CARE TRANSPORT ADDL	2.40	Agree	2.40
#99468			NEONATE CRIT CARE, INITIAL	18.46	Agree	18.46
#99469			NEONATE CRIT CARE, SUBSQ	7.99	Agree	7.99
#99471			PED CRITICAL CARE, INITIAL	15.98	Agree	15.98
#99472			PED CRITICAL CARE, SUBSQ	7.99	Agree	7.99
#99475			PED CRIT CARE AGE 2–5, INIT	11.25	Agree	11.25
#99476			PED CRIT CARE AGE 2–5, SUBSQ	6.75	Agree	6.75
#99478			IC, LBW INF < 1500 GM SUBSQ	2.75	Agree	2.75
#99479			IC LBW INF 1500–2500 G SUBSQ	2.50	Agree	2.50
#99480			IC INF PBW 2501–5000 G SUBSQ	2.40	Agree	2.40

New CPT code.
[1] All CPT codes copyright 2008 American Medical Association.
[2] Medicare Contractor Priced.
[3] Bundled.
* New Code for Re-Examination at the next 5-Year Review.
(a) See code discussion in section E, Discussion of Codes and RUC Recommendations.
(b) RUC-recommended work RVU accepted but coverage status of code is Bundled.

Table 28: AMA RUC Anesthesia Recommendations and CMS Decisions for New 2009 CPT Codes lists the new CPT codes for anesthesia and their base units that will be interim in CY 2009. Table 28 includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- AMA RUC recommendations. This column identifies the base units recommended by the AMA RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the AMA RUC recommendation.
- 2009 Base Units. This column establishes the CY 2009 base units for these services.

TABLE 28—AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED/REVIEWED CPT CODES

*CPT [1] code	Description	RUC recommendation	CMS decision	2009 base units
#00211	ANESTH, CRAN SURG, HEMOTOMA	10.00	Agree	10.00
#00567	ANESTH, CABG W/PUMP	18.00	Agree	18.00

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

E. Discussion of Codes and AMA RUC Recommendations

The following is an explanation of our rationale for not accepting particular AMA RUC-recommended work RVUs. It is arranged by type of service in CPT order and refers only to work RVUs.

1. Pelvic Bone Fracture Codes

For CY 2009, the CPT Editorial Panel revised the following four CPT codes to report pelvic bone fractures as being unilateral, and reportedly, to clarify the nature of ring fractures as follows:

- 27215, *Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed.*
- 27216, *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, (includes ipsilateral ilium, sacroiliac joint and/or sacrum).*
- 27217, *Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral includes internal fixation when performed (includes ipsilateral pubic symphysis and/or superior/inferior rami).*
- 27218, *Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum.*

The AMA RUC reviewed these codes and agreed with the specialty society that revisions to the code descriptors were editorial because these services were previously valued as typically unilateral with internal fixation. The AMA RUC recommended maintaining the current work RVUs for these codes: 10.45 work RVUs for CPT code 27215; 15.73 work RVUs for CPT code 27216; 14.65 work RVUs for CPT code 27217; and 20.93 work RVUs for CPT code 27218.

We do not agree with CPT and the AMA RUC that the pelvis is a unilateral structure and that the code descriptor change was editorial. The pelvis is formed by adjoining the ilium, ischium, pubis, and sacrum together. Clinically, it is a single anatomic entity and has been referenced as a single anatomic entity. We believe the previous code descriptors more accurately describe the structure of the pelvis and subsequent treatment of fractures. Therefore, we created four G codes to be used with pelvic bone fracture repairs that may occur on one side or both sides of the pelvis consistent with CY 2008 descriptors. We believe the following codes represent these services more appropriately:

- G0412, *Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed.*
- G0413, *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum).*
- G0414, *Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami).*
- G0415, *Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum).*

We have decided to assign the same work RVU values for the G codes as for the corresponding CPT codes: 10.45 work RVUs for G0412; 15.73 work RVUs for G0413; 14.65 work RVUs for G0414; and 20.93 work RVUs for G0415. For CY 2009, we will not recognize CPT codes 27215, 27216, 27217, and 27218 as covered services under the PFS and have assigned a status indicator of ''I'' (Not valid for Medicare purposes, Medicare recognizes another code).

2. Stereotactic Radiosurgery Codes

The CPT Editorial Panel made a significant revision to the stereotactic radiosurgery codes for cranial and spinal stereotactic radiosurgery (SRS) codes, for which the AMA RUC provided recommended work and PE valuations. For CY 2009, the CPT Editorial Panel deleted CPT code 61793, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator), one or more sessions,* and created seven new codes for cranial and spinal lesions to replace CPT code 61793. We believe that the deleted CPT code 61793 accurately describes a complete course of stereotactic radiosurgery, inclusive of all lesions and anatomic sites.

Delivery of radiation as a therapeutic modality consists of many components, including planning, physics, dosimetry, simulation, treatment delivery, and management. Regardless of the clinical background or training received by the clinician, we believe the work involved in providing radiation therapy services or radiosurgery radiation therapy is similar, and that the work relative values should be similar. Currently, CPT code 77432, *Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session),* with 7.92 work RVUs, is used by providers when managing certain pre- and post-delivery-related services of stereotactic radiation. CPT code 77432 includes treatment-related services of all cranial lesions during one session. We have been informed that CPT code 77421, *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy,* with 0.39 work RVUs, often is used, in association with CPT code 77432, when appropriate.

The specialty societies and the AMA RUC, in general, used open surgical codes as comparators during the RUC process. For example, for CPT code 61797, the comparison code was CPT code 63048, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]),*

single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure), instead of a more equivalent stereotactic radiation treatment code.

Therefore, we disagree with the work RVUs for the following CPT codes: 61796, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion;* 61797, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple;* 61798, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion;* 61799, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex;* 63620, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion;* and 63621, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion.*

We believe that the more appropriate comparison for the replacement codes for CPT code 61793 is with CPT codes 77432 plus 77421. The AMA RUC recommended that CPT codes 61796, 61798, and 63620 include a half-day discharge day and two 99213 office visits. We include those recommended values within our valuation of these services.

Therefore, the new work values for these codes would be as follows: 10.79 work RVUs for CPT codes 61796, 61798, and 63620. For the add-on CPT codes 61797, 61799, and 63621, the specialty societies and the AMA RUC used open surgical codes as comparison codes. As noted above, we do not believe that such codes provide the correct comparison, which led to an inappropriate valuation of these codes. Although we disagree with the methodology and valuation of the add-on codes, we will accept the values as recommended on an interim basis. We urge the AMA RUC, to the extent that the type of specialty involved played a part in the valuation of these codes, to place an emphasis on the type of work performed, not the specialty provider.

3. Endothelial Keratoplasty

The CPT Editorial Panel created two CPT codes (65756, *Keratoplasty (corneal transplant); endothelial and 65757, Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)* to describe the physician service of endothelial keratoplasty, which is a new surgical method of repairing certain types of diseased corneas that in the past would have required a full thickness corneal transplant (also called penetrating keratoplasty). The AMA RUC recommended 16.60 work RVUs for CPT code 65756 and 1.44 work RVUs for CPT code 65757. We have accepted the AMA RUC recommended work RVUs for CPT code 65756; however, we have decided to have Medicare contractors price CPT code 65757. We recognize that it is difficult to assess the intensity and work of the other backbench transplant codes and have generally contractor priced them. We also recognize that this service is one of short duration and high intensity. The intra-service work per unit time (IWPUT) may not be of the greatest accuracy in evaluating this service.

4. Cardiac Monitoring

The CPT Editorial Panel made significant revisions to the cardiac device monitoring (CDM) codes, for which the AMA RUC provided work and PE valuations. The CDM codes describe services that generally fall into three categories: Interrogation of devices (retrieval and evaluation of stored device data); programming of devices (retrieval and evaluation of stored device data and programming of the device); and remote monitoring of devices (solely technical services for monitoring, basic analysis and assemblage of device data).

We agree with the majority of the AMA RUC-recommended valuations. However, we question the recommended values of the increments between some codes within families and across families of pacemakers, implantable cardioverter defibrillators (ICDs), implantable loop recorders, and implantable cardiovascular monitoring systems. CPT codes 93279 through 93281 (0.65 to 0.90 work RVUs, with a work RVU difference between the codes of 0.12 to 0.13) describe the programming of pacemakers according to the number of leads. CPT codes 93282 through 93284 (0.85 to 1.25 work RVUs, with a work RVU difference between the codes of 0.07 to 0.33) describe the programming of ICDs according to the number of leads. We note that the recommended difference in the work RVUs between CPT code 93279 (single lead programming pacemaker code) and CPT code 93282 (single lead ICD code) is 0.20 work RVUs, and that the difference between CPT code 93281 (multiple lead programming pacemaker code) and CPT code 93284 (multiple lead ICD code) is 0.35 work RVUs. The AMA RUC primarily used a comparison methodology to determine the value of the pacemaker codes and the surveyed 25th percentile to determine the value of the implantable cardioverter defibrillator (ICD) codes. Even though different methodologies were utilized to develop the recommended values, we do not understand why the increments between various levels of the pacemaker programming codes are not also the appropriate increment between the various levels of ICD programming codes. Therefore, we are not accepting these recommendations and instead will establish work RVUs that maintain the same incremental difference between levels of programming codes. This change will help to ensure consistency and relativity within all cardiac device monitoring codes. The specific changes to the codes are discussed below.

In addition, we believe that although the surveyed 25th percentile of 1.18 work RVUs was chosen for valuation of CPT code 93283, the increment of 0.33 work RVUs between CPT codes 93282 and 93283 is excessive. Therefore, we believe that the appropriate value for CPT code 93283 is 1.05 work RVUs, slightly below the 25th percentile. We believe that an appropriate comparison CPT code for 93283 is CPT code 93890 (*Transcranial Doppler study of the intracranial arteries; vasoreactivity study*) which has a work RVU of 1.00. CPT code 93286 (0.30 work RVUs) describes periprocedural programming of a pacemaker. CPT code 93287 (0.45 work RVUs) describes periprocedural programming of an ICD. These codes have recommended work RVU differences of 0.15 work RVUs and 0.30 work RVUs between the pacemakers and ICDs for a single service and for services pre- and postsurgery, respectively. CPT code 93288 (0.43 work RVUs) describes in person interrogation of pacemakers. CPT Code 93289 (0.92 work RVUs, which was developed by means of a crosswalk to a 99213 office visit) describes in person interrogation of an ICD, a work RVU difference of 0.49 RVUs between the pacemakers and ICDs.

As noted above, the work RVU difference between programming pacemakers and ICDs varies from 0.20 to 0.35. Therefore, we believe that the appropriate value for CPT code 93289 should be 0.78 (0.43 (the work value of CPT code 93288) plus 0.35 (the largest difference between pacemaker and ICD programming codes families)). Appropriate comparisons are CPT codes 99231 (Subsequent hospital care) which has a work RVU of 0.76, and CPT code 93015 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or

pharmacological stress; with physician supervision, with interpretation and report) which has a work RVU of 0.75. Therefore, we believe a work RVU of 0.78 is appropriate for CPT code 93289.

The AMA RUC-recommended work RVUs of 0.65 for CPT code 93294, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)*, was determined by multiplying 1.5 (the average number of transmissions per 90 days) times the work RVU for CPT code 93288 (0.43). The AMA RUC-recommended work RVUs of 1.38 for CPT code 93295, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)*, was determined by multiplying 1.5 (the average number of transmissions per 90 days) times the work RVU for CPT code 93289 (0.92). Because we are adjusting the work value for CPT code 93289 to 0.78, using the RUC-recommended methodology, the adjusted work value for CPT code 93295 is 1.17.

We note that certain CDM codes were not reviewed by the RUC. For example, CPT codes 93230, *Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation*, and 93233, *Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; physician review and interpretation*, currently have work RVUs of 0.52 each. Some of the newly valued CDM codes that provide payment for 30 days of work (for example, CPT codes 93268, *Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation*, and 93272, *Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation*, also have work RVUs of 0.52. We urge the AMA RUC to assess the work valuation of CPT codes 93230 and 93233 in the future in light of the valuation of the other new similar codes.

The adjusted work RVUs are as follows: 1.05 work RVUs for CPT code 93283; 0.78 work RVUs for CPT code 93289; and 1.17 work RVUs for CPT code 93295.

5. Mobile Cardiovascular Telemetry and Implantable Loop Monitoring

The CPT Editorial Panel created two new codes 93228 and 93229 for mobile cardiovascular telemetry and a new code 93299 related to implantable cardiovascular monitoring systems or implantable loop recorder systems. The AMA RUC recommended 0.52 work RVUs for CPT code 93228 and only direct cost inputs for CPT code 93229 and 93299. These services were previously billed using unlisted codes, which were contractor priced. CPT code 93228 represents the professional aspect of the mobile cardiovascular telemetry service and CPT code 93229 represents the technical aspect. We have accepted the AMA RUC recommended work RVUs for CPT code 93228. However, we will continue to contractor price CPT codes 93229 and 93299 in order to provide additional time to better understand the direct cost inputs for this service and to allow us to collect actual utilization data under the new code.

6. Canalith Repositioning

The CPT Editorial Panel created and the AMA RUC valued a new code (CPT code 95992, *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*) for canalith repositioning, which is described as ''therapeutic maneuvering of the patients' body and head designed to use the force of gravity. By using this type of maneuvering, the calcium crystal debris that is in the semi-circular canal system is redeposited into a neutral part of the end organ where it will not cause vertigo.'' This is a procedure that has been performed for several years. Previously this maneuver was billed by physicians as part of an E&M service and by nonphysician practitioners, primarily therapists, under a number of CPT codes, including 97112, *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*, which has 0.45 work RVUs. Therapists usually bill 2 units of service. The RUC recommended work RVUs for this service is 0.75.

We believe a status indicator of ''B'' (Bundled Code, payments for covered services are always bundled into payment for other services not specified) is most appropriate because this service is currently being paid for as part of an E&M service. (**Note:** Because neurologists and physical therapists are the predominant providers of this service to Medicare patients (each at 22 percent) it has been assigned as a ''sometimes therapy'' service under the therapy code abstract file.)

F. Additional Coding Issues

1. Reduction in the Technical Component (TC) Payment for Imaging Services Paid Under the PFS to the Outpatient Department (OPD) Amount

Effective January 1, 2007, section 5102(b)(1) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) capped the TC of most imaging services paid under the PFS to the amount paid under the Outpatient Prospective Payment System (OPPS) (71 FR 69659).

The list of codes subject to of OPPS cap has been revised to reflect new and deleted CPT codes for 2009. CPT Codes 78890 and 78891 have been deleted and have been removed from the list. The following new CPT codes have been added to the list:

- 93306, *Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography*.

The complete list of codes subject to the OPPS cap is in Addendum I.

2. Moderate (Conscious) Sedation Codes (CPT Codes 99143 to 99150)

In 2006, the moderate sedation codes were adopted by the CPT. We did not accept the AMA RUC-recommended work values for these codes, but stated that they would be contractor priced under the PFS. At that time, we indicated that we would continue to review this issue.

In August 2008, the AMA RUC convened a workgroup to review the moderate sedation codes. The workgroup examined national claims data provided to them by CMS to determine if any further action was necessary for these codes. The workgroup concluded its work in September 2008. It recommended that CMS again consider assigning the previously AMA RUC-recommended work values to both the pediatric and adult moderate sedation codes.

Comment: Although not specifically discussed in the CY 2009 PFS proposed rule, we received comments concerning the pricing of these codes. Commenters requested that CMS assign the status

indicator of ''A'' to these codes under the PFS Database and include the AMA RUC-recommended RVUs for these codes. Another commenter requested that we implement the AMA RUC recommendations for the pediatric conscious sedation codes which are represented by CPT codes 99143 and 99150.

Response: When these codes were established by the CPT, the physician specialties that were surveyed by the AMA RUC to recommend work RVUs were the pediatricians, emergency medicine physicians, spine surgeons, and oral and maxillofacial surgeons. Our review of Medicare national claims data shows that these codes are most often utilized by anesthesiologists and interventional pain management physicians. We continue to have concerns about the utilization of these codes and will continue to review them under the Medicare program.

We will also continue contractor pricing of these codes under the PFS. Regarding the AMA RUC-recommended work values for the moderate sedation codes, which we have not accepted, we note that RUC-recommended values for these codes were included in the CY 2006 PFS final rule with comment period (70 FR 70282).

3. Inpatient Dialysis Services (CPT Codes 90935, 90937, 90945, and 90947)

Although not discussed in the CY 2009 PFS proposed rule, we received comments requesting that CMS apply the increases in work RVUs for E&M services recommended by the AMA RUC for each CPT code with a global period of 10 and 90 days as part of the 2007 PFS proposed and final rules to the inpatient dialysis family of services.

Comment: Some commenters believed that the outpatient and inpatient dialysis services that use E&M codes as ''building blocks'' or components of their valuation should have the full increases for the E&M codes incorporated into their values as well.

Response: Increases in E&M codes were not applied to the inpatient dialysis services because these codes do not have a global period of 10 or 90 days. The AMA RUC recommendations were specifically for codes with global periods of 10 or 90 days. We suggest that the specialty society work with the AMA RUC using the existing process to address this issue.

4. New Codes for Re-Examination at the Next 5-Year Review

As part of its annual recommendation, the AMA RUC includes a list identifying new CPT codes which will be reexamined at the next 5-Year Review of Work RVUs. New CPT codes that have been added to this list are identified with an asterisk (*) on Table 27: AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes.

5. Comments Received on New CPT Codes for CY 2009

We received comments on new CPT codes for CY 2009 including Category III codes. Since these are new codes for CY 2009, they are subject to comment as part of this final rule. **Note:** Category III codes are contractor priced under the PFS.

H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2009

We have developed a process for establishing interim PE RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the AMA RUC recommends the PE direct inputs (the staff time, supplies and equipment) associated with each new code. CMS reviews the recommendations in a manner similar to our evaluation of the recommended work RVUs. The AMA RUC recommendations on the PE inputs for the new and revised CY 2009 codes were submitted to CMS as interim recommendations.

We have accepted, in the interim, the PE recommendations submitted by the RUC for the codes listed in Table 27: AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes and Table 26 except as noted below in this section.

1. CPT Code Series 93279 Through 93292

The AMA RUC PE recommendations for cardiac monitoring services in the CPT code series 93279 through 93292 recommended that we include a ''pacemaker monitoring system'' as the necessary equipment to be used in each code of the 14 CPT code series 93279 through 93292. Because the specialty did not list a price along with the equipment item we reviewed the equipment used in the existing services that were used to crosswalk to the new codes. We found that the existing services are each assigned the pacemaker follow-up system (including software and hardware), CMS equipment code EQ198 and, as such, we have assigned this equipment item to each of the 14 new services on an interim basis.

The RUC recommended that a ''pacemaker interrogation system'' be used for the two CPT codes 93293 and 93296. However, the PE database does not contain an equipment item with this description. Because we noted a 100 percent crosswalk from existing CPT code 93733 that utilizes the pacemaker follow-up system to the new CPT code 93293, we have assigned, on an interim basis, the pacemaker follow-up system to CPT codes 93293 and 93296 (a ''new'' service without a crosswalk).

We ask commenters to provide documentation to us as to the type and cost of equipment that is used in furnishing these services in the physician office and other information to support any suggested changes from the prior inputs.

2. CPT Code 41530

The AMA RUC recommended PE direct inputs for CPT code 41530, *Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session,* include a disposable pulse oximeter finger probe. We did not accept the addition of this item to the PE database for this or any other procedure because, as we have discussed in the CY 2004 PFS proposed and final rules (68 FR 49037 and 63206), we continue to treat the pulse oximeter probe as reusable.

3. CPT Code 46930

In the AMA RUC PE recommendations for CPT code 46930, *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency),* the specialty society requested that we add a light guide to the existing price of $3,087.50, for the infrared coagulator and provided the list price of $730 for this item. In addition, the specialty society requested that a sheath (pricing information provided by the specialty at $10.50) for the light guide be included as a typical supply for this procedure. We have reviewed the components of the existing infrared coagulator in the PE database and note its price of $3087.50 includes an infrared power unit and a hand applicator. Using our existing pricing information, we have added the price of $572 for the indicated (6mm x 220mm) light guide (the price resulting from averaging the costs of the Teflon and Sapphire tips) to the infrared coagulator for a total price of $3,659. We did not accept the AMA RUC-recommended sheath to cover the light guide that the specialty proposed to add to the PE database for this service and 4 other procedures as we do not believe it to be typically used in furnishing these services. Because the

light guide was not a component of the infrared coagulator item at the time we re-priced our entire equipment file for CY 2005, and because this same equipment item is used for 4 other endoscopy procedures—including CPT codes 46606, 46608, 46610, and 46612—we ask commenters to provide us with information and documentation as to whether the light guide is typical to any of these 5 procedures. Additionally, we also invite comments about the typical use of the sheath in relationship to the light guide. In the interim, while we await comments, we have assigned the new equipment price including the light guide to the new CPT code 46930 as well as the four other procedures that employ this infrared coagulator for CY 2009.

4. CPT Code 64632

For CPT code 64632, *Destruction by neurolytic agent; plantar common digital nerve,* the AMA RUC recommended that supply code SH062, a sclerosing solution for injection, be used as a proxy for the neurolytic agent needed to perform this procedure. We are concerned about the appropriateness of this substitution suggested by the specialty society. The society stated that it was not able to find pricing for either phenol or 4 percent ethyl alcohol, which the society believes are the commonly used analytics for this procedure. We ask commenters to provide us documentation for pricing of the phenol or 4 percent ethyl alcohol that are appropriately used in furnishing this service. In the interim, we will accept the recommendation to use the $2.029 sclerosing solution as the proxy for the analytic agent.

5. CPT Code Series 90951 Through 90966

For the End-Stage Renal Disease (ESRD) Services including new CPT codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965 and 90966, the AMA RUC recommended PE direct inputs (36 minutes of clinical labor for the pre-service period and an additional 6 minutes in the post period for CPT codes 90960, 90961, 90962 and 90966) for the monthly capitation payments. For CPT codes 90967, 90968, 90969, and 90970, the ESRD codes representing per-day payments, the AMA RUC PE recommendations included 1.2 minutes of clinical labor per day. Prior to accepting these PE recommendations, we have asked the AMA RUC to review the PE inputs at an upcoming meeting to make certain that they accurately reflect the typical direct resources required for these services. In the interim, we will continue to use the established PE RVUs for these services. In addition, for CPT codes 90960 and 90961, we will ask the RUC to review the physician times for these services.

6. CPT Code 93306

The AMA RUC recommended PE direct inputs for CPT code 93306, *Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography.* However, the AMA RUC did not recommend any changes to the PE direct inputs for the related echocardiography codes 93307, 93320 and 93325. Prior to accepting this recommendation, we have asked the AMA RUC to review the PE inputs 93307, 93320 and 93325 to ensure that they are consistent with the recommended direct inputs for 93306. In the interim, we will continue to use the established PE RVUs for these services.

7. CPT Code 93351

The AMA RUC recommended PE inputs for CPT code 93351, *Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring with physician supervision,* includes three new equipment items with pricing information proposed by the specialty society. These new equipment items include an ultrasound machine, an echocardiography exam table, and a dual image viewing and reporting system. We did not accept the recommended ultrasound machine valued at $325,000 which appears to be a newer model than that currently used in a similar procedure and priced at $248,000 in the PE database. We also did not accept the echocardiography exam table ($11,095) because we do not believe it to be the typical equipment item found in the physician's office. In place of these two new items, we assigned those PE inputs from the PE database that are typical to similar services—the $248,000 ultrasound machine and a $1,915 stretcher. We ask commenters to provide us with documentation as to the type and cost of equipment that is used in furnishing the procedure in the physician office setting along with a rationale for suggested changes from the existing inputs.

We have included the ''dual'' echocardiography image viewing and reporting system, although we accepted the base unit price of $85,000 in place of the $173,000 price provided by the specialty. This basic system is sufficient to manage, import, export, archive, and review and report digital exams; and, it contains an additional work station that is designed to function concurrently with a second ultrasound machine. Because this unit is designed for the concurrent use of two ultrasound units (a connection for managing the images from a third unit can be added for an additional fee), we ask commenters to provide us with the typical scenario as to whether one, two, or three ultrasound units will be connected to this image management system. We also ask commenters for information as to the amount of time that this dual image management system is in use for this procedure. In the interim, we have assigned the 7 minutes from the AMA RUC PE recommendation that is indicated for the cardiac sonographer to enter the ECG and echo report elements into reporting system.

8. CPT Code 95803

CPT code 95803, *Actigraphy, testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording),* requires the patient to wear a home monitor for 24 hours a day for 3 to 14 days. The RUC PE recommendations did not include the typical number of days the home monitor would be in use. They also did not include the necessary equipment used to analyze the data. Therefore, we seek comment on the typical number of days for this service. We will continue to contractor price this service for 2009.

VI. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act specifies that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Speech-Language Pathology Services

As we stated in section III.I. of this final rule with comment period, section 143 of the MIPPA amended section 1877(h)(6) of the Act to specify that ''outpatient speech-language pathology services'' are DHS, effective July 1, 2009. We note that, in the ''Phase I'' physician self-referral final rule, we defined the DHS category of ''physical therapy services'' to include speech-language pathology services because the statutory definition of ''outpatient physical therapy services'' (section 1861(p) of the Act) included speech-language pathology services (66 FR at 925). To conform the language of the regulations to MIPPA, we are revising two of the definitions at § 411.351. First, we are revising the definition of ''Designated health services (DHS)'' by adding the word ''outpatient'' before the phrase ''speech-language pathology services'' in paragraph (2). Second, we are revising the definition of ''Physical therapy, occupational therapy, and speech-language pathology services'' by:

- Removing the phrase ''speech-language pathology'' in the heading of the definition and wherever it occurs within the introductory paragraph and adding, in its place, the phrase ''outpatient speech-language pathology'';
- Deleting the parenthetical ''(including speech-language pathology services)'' from paragraph (1) of the description of physical therapy services;
- Deleting sub-paragraph (1)(iv), which describes physical therapy services as including ''Speech-language pathology services that are for the diagnosis and treatment of speech, language, and cognitive disorders that include swallowing and other oral-motor dysfunctions;'' and
- Adding the following new paragraph to describe outpatient speech-language pathology services: ''(3) Outpatient speech-language pathology services, meaning those services as described in section 1861(ll)(2) of the Act that are for the diagnosis and treatment of speech, language, and cognitive disorders that include swallowing and other oral-motor dysfunctions''.

Consistent with the provisions of section 143 of the MIPPA, these changes will be effective July 1, 2009.

C. Annual Update to the Code List

1. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§ 411.355(h)).

The Code List was last updated in the CY 2008 PFS final rule with comment period (72 FR 66222) and in a subsequent correction notice (73 FR 2568).

2. Response to Comments

We received no public comments relating to the Code List that became effective January 1, 2008.

3. Revisions Effective for 2009

The updated, comprehensive Code List effective January 1, 2009 appears as Addendum J in this final rule with comment period and is available on our Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp#TopOfPage*. Additions, deletions, and revisions to the Code List conform the Code List to the most recent publications of CPT and HCPCS.

Tables 29, 30, and 31 identify the additions, deletions, and revisions, respectively, to the comprehensive Code List that was published in Addendum I of the CY 2008 PFS final rule (72 FR 66574 through 66578) and revised in a subsequent correction notice (73 FR 2568).

Tables 29 and 30 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

In Table 29, we specify additions that generally reflect new CPT and HCPCS codes that become effective January 1, 2009, or that became effective since our last update. Also, we are adding CPT code 0183T (Low frequency, non-contact, non-thermal ultrasound) to the category of Physical Therapy, Occupational Therapy, and Outpatient Speech-Language Pathology Services. The AMA added this code to the CPT for 2008, but we inadvertently failed to add this code to our Code List.

Table 30 reflects the deletions necessary to conform the Code List to the most recent publications of CPT and HCPCS. It also reflects our decision to delete CPT codes 78000, 78001, and 78003 from the Radiology and Certain Other Imaging Services category of the Code List because we realized that these codes do not involve imaging and, therefore, should not be included in that category.

Also in the category of Radiology and Certain Other Imaging Services and as shown in Table 31, we are making revisions to our qualifying language included in brackets for CPT codes 93320, 93321 and 93325. Our revisions reflect changes made by the AMA for the CPT 2009 that specify with which codes CPT codes 93320, 93321, and 93325 may be used. Additionally, we found that we had previously failed to include certain CPT codes with which CPT code 93325 may be used. Thus, we are revising our qualifying language in brackets for CPT 93325 to clarify that it is considered a DHS when used in conjunction with CPT codes 76825, 76826, 76827, 76828, 99903, 93304, and 93308.

We will consider comments regarding the codes listed in Tables 29, 30, and 31. Comments will be considered if we receive them by the date specified in the ''DATES'' section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

TABLE 29—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1] HCPCS CODES

CLINICAL LABORATORY SERVICES	
0194T	Procalcitonin (PCT).
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
0183T	Wound ultrasound.
95992	Canalith repositioning proc.
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
93306	TTE w/Doppler, complete.
A9580	Sodium fluoride F–18.
RADIATION THERAPY SERVICES AND SUPPLIES	
0190T	Place intraoc radiation src.
0197T	Intrafraction track motion.
61796	SRS, cranial lesion simple.
61797	SRS, cran les simple, addl.
61798	SRS, cranial lesion complex.
61799	SRS, cran les complex, addl.
61800	Apply SRS headframe add-on.
63620	SRS, spinal lesion.
63621	SRS, spinal lesion, addl.
77785	HDR brachytx, 1 channel.
77786	HDR brachytx, 2–12 channel.
77787	HDR brachytx over 12 chan.
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J1750	Inj iron dextran.
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[No additions].	

[1] CPT codes and descriptions only are copyright 2008 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 30—DELETIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1]/HCPCS CODES

CLINICAL LABORATORY SERVICES	
0026T	Measure remnant lipoproteins.
0041T	Detect ur infect agnt w/cpas.
0043T	Co expired gas analysis.
0058T	Cryopreservation, ovary tiss.
0059T	Cryopreservation, oocyte.
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
0029T	Magnetic tx for incontinence.
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
0028T	Dexa body composition study.
78000	Thyroid, single uptake.
78001	Thyroid, multiple uptakes.
78003	Thyroid, suppress/stimul.

TABLE 30—DELETIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1]/HCPCS CODES—Continued

78890	Nuclear medicine data proc.
78891	Nuclear med data proc.
RADIATION THERAPY SERVICES AND SUPPLIES	
61793	Focus radiation beam.
77781	High intensity brachytherapy.
77782	High intensity brachytherapy.
77783	High intensity brachytherapy.
77784	High intensity brachytherapy.
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J1751	Iron dextran 165 injection.
J1752	Iron dextran 267 injection.
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[No deletions].	

[1] CPT codes and descriptions only are copyright 2008 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 31—REVISIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1] HCPCS CODES

CLINICAL LABORATORY SERVICES	
[No revisions].	
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
[No revisions].	
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
93320	Doppler echo exam, heart [if used in conjunction with 93303–93304].
93321	Doppler echo exam, heart [if used in conjunction with 93303, 93304, 93308].
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827, 76828, 93303, 93304, 93308].
RADIATION THERAPY SERVICES AND SUPPLIES	
[No revisions].	
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[No revisions].	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[No revisions].	

[1] CPT codes and descriptions only are copyright 2008 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

VII. Physician Fee Schedule Update for CY 2009

A. Physician Fee Schedule Update

The PFS update is set under a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA-TRHCA provided a 1-year increase in the CY 2007 conversion factor (CF) and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that was applicable for the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

If section 101 of the MMSEA had not been enacted, the CY 2008 CF update would have been –10.1 percent (0.89896), as published in the CY 2008 PFS final rule with comment period (72 FR 66383). For CY 2009, the Medicare Economic Index (MEI) is equal to 1.6 percent (1.016). The update adjustment factor (UAF) is –7.0 percent (0.930). Our calculations of these figures are explained below in this section. If section 131 of the MIPPA had not been enacted, the CY 2009 CF update would have been the –15.1 percent (0.84941), which is the product of the published CY 2008 update (0.89896), the MEI (1.016), and the UAF (0.930). Consistent with section 131 of the MIPPA, however, the update for CY 2009 is 1.1 percent.

B. The Percentage Change in the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is authorized by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973, may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes.

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has CY 2000 base year weights,

is comprised of two broad categories: (1) Physician's own time; and (2) physician's PE.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

Table 32 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2009 update. For CY 2009, the increase in the MEI is 1.6 percent, which includes a 1.4 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.6 percent increase in physician's own time and a 2.4 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 6.0 percent, and employee benefits, which increased 4.3 percent.

TABLE 32—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CY 2009 [1]

Cost categories and price measures	CY 2000 weights [2]	CY 2009 percent changes
Medicare Economic Index Total, productivity adjusted [3]	N/A	1.6
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector [3]	N/A	1.4
Medicare Economic Index Total, without productivity adjustment	100.000	3.0
1. Physician's Own Time [4]	52.466	3.6
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.8
b. Fringe Benefits: Employment Cost Index, benefits, private Nonfarm [4]	9.735	2.7
2. Physician's Practice Expense [4]	47.534	2.4
a. Nonphysician Employee Compensation	18.653	3.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.4
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation	4.845	4.3
b. Office Expense: Consumer Price Index for Urban Areas (CPI–U), housing	12.209	3.1
c. Drugs and Medical Materials and Supplies	4.319	4.1
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI–U, medical equipment and supplies (equally weighted)	2.011	1.4
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	6.0
d. Professional Liability Insurance: Professional liability insurance Premiums [5]	3.865	−2.7
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.5
f. Other Expenses	6.433	2.3

[1] The rates of historical change are estimated for the 12-month period ending June 30, 2008, which is the period used for computing the CY 2009 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 5, 2008.

[2] The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] These numbers may not sum due to rounding and the multiplicative nature of their relationship.

[4] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found on the BLS Web site at *http://stats.bls.gov*.

[5] Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2008).

C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the percentage change in the MEI and the update adjustment factor (UAF). The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

The PFS update is set under a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that was applicable for the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between

the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• *Cumulative Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2009 in this case), the current CY (that is, CY 2008) and the preceding CY (that is, CY 2007) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year are initially estimated and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the final revision to 2007 allowed expenditures in this final rule with comment). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 33 shows annual and cumulative allowed and actual expenditures for physicians' services from April 1, 1996, through the end of the current CY, including the short periods in 1999 when we transitioned to a CY system. Also shown is the SGR corresponding with each period. The calculation of the SGR is discussed in detail below in this section.

TABLE 33—ANNUAL AND CUMULATIVE ALLOWED AND ACTUAL EXPENDITURES FOR PHYSICIANS' SERVICES FROM APRIL 1, 1996 THROUGH THE END OF THE CURRENT CALENDAR YEAR

Period	Annual allowed expenditures ($ in billions)	Annual actual expenditures ($ in billions)	Cumulative allowed expenditures ($ in billions)	Cumulative actual expenditures ($ in billions)	FY/CY SGR
4/1/96–3/31/97	[1] $48.9	$48.9	$48.9	$48.9	N/A.
4/1/97–3/31/98	50.5	49.5	99.4	98.4	FY 1998 = 3.2%.
4/1/98–3/31/99	52.6	50.8	152.0	149.2	FY 1999 = 4.2%.
1/1/99–3/31/99	13.3	13.2	([2])	149.2	FY 1999 = 4.2%.
4/1/99–12/31/99	42.1	39.7	([3])	188.9	FY 2000 = 6.9%.
1/1/99–12/31/99	55.3	52.9	194.0	188.9	FY 1999/2000.
1/1/00–12/31/00	59.3	58.4	253.4	247.3	CY 2000 = 7.3%.
1/1/01–12/31/01	62.0	66.7	315.4	314.1	CY 2001 = 4.5%.
1/1/02–12/31/02	67.2	71.5	382.6	385.6	CY 2002 = 8.3%.
1/1/03–12/31/03	72.1	78.8	454.6	464.4	CY 2003 = 7.3%.
1/1/04–12/31/04	76.8	87.7	531.5	552.1	CY 2004 = 6.6%.
1/1/05–12/31/05	80.1	92.4	611.5	644.5	CY 2005 = 4.2%.
1/1/06–12/31/06	81.3	94.1	692.8	738.6	CY 2006 = 1.5%.
1/1/07–12/31/07	84.1	93.9	776.9	832.4	CY 2007 = 3.5%.
1/1/08–12/31/08	86.8	94.4	863.7	926.8	CY 2008 = 3.2%.
1/1/09–12/31/09	93.2	NA	956.9	NA	CY 2009 = 7.4%.

[1] Allowed expenditures in the first year (April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: *http://www.cms.hhs.gov/SustainableGRatesConFact/.* We expect to update the Web site with the most current information later this month.

[2] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

[3] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

Consistent with section 1848(d)(4)(E) of the Act, Table 33 includes our final revision of allowed expenditures for CY 2007, a recalculation of allowed expenditures for CY 2008, and our initial estimate of allowed expenditures for CY 2009. To determine the UAF for CY 2009, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2008 and the CY 2009 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2008 and CY 2009 SGRs and CY 2008 and CY 2009 allowed expenditures. Because we have incomplete actual expenditure data for CY 2008, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years.

We note that Table 33 contains updated actual expenditures for each time period from April 1, 1997 through December 31, 2008. We discovered that fifteen procedure codes were inadvertently omitted from the measurement of actual expenditures beginning in 1998. An additional 6 codes were omitted from the measurement of actual expenditures in 2005 and 2006 only, but have been included in actual expenditures since 2007. Therefore, the measurement of actual expenditures for FY 1998 and each subsequent time period was lower than it should have been. We will be making no changes to PFS payments made for services furnished prior to CY 2009. However, under section 1848(d) of the Act, we must include these codes in the measurement of actual expenditures for historical, current, and future periods. The inclusion of these additional actual expenditures will have no effect on the 2009 update. Also, we estimate that the inclusion of the additional expenditures for these codes will not increase the number of years that we expect the maximum reduction in the physician fee schedule update to apply under current law. This correction is consistent with the actions taken in 2001 when we discovered that another set of codes inadvertently had not been included in the measurement

of actual expenditures (66 FR 55314). As discussed in detail below, consistent with section 1848(f)(3) of the Act, in this final rule with comment, we are making our preliminary estimate of the CY 2009 SGR, a revision to the CY 2008 SGR, and our final revision to the CY 2007 SGR. All of the inadvertently excluded codes were taken into consideration for purposes of estimating the SGRs for these 3 years.

We are using figures from Table 33 in the following statutory formula:

$$UAF_{09} = \frac{Target_{08} - Actual_{08}}{Actual_{08}} \times 0.75 + \frac{Target_{4/96\text{-}12/08} - Actual_{4/96\text{-}12/08}}{Actual_{08} \times SGR_{09}} \times 0.33$$

UAF_{09} = Update Adjustment Factor for CY 2009 = −26.6 percent
$Target_{08}$ = Allowed Expenditures for CY 2008 = $86.8 billion
$Actual_{08}$ = Estimated Actual Expenditures for CY 2008 = $94.4 billion
$Target_{4/96–12/08}$ = Allowed Expenditures from 4/1/1996–12/31/2008 = $863.7 billion
$Actual_{4/96–12/08}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2008 = $926.8 billion
SGR_{09} = 7.4 percent (1.074)

$$\frac{\$86.8 - \$94.4}{\$94.4} \times 0.75 + \frac{\$863.7 - \$926.8}{\$94.4 \times 1.074} \times 0.33 = -26.6\%$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.07 or greater than 0.03. Since −0.266 is less than −0.07, the UAF for CY 2009 will be −0.07.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to −0.07 makes the UAF equal to 0.93.

VIII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate (SGR)

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real GDP per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2009 SGR, a revision to the CY 2008 SGR, and our final revision to the CY 2007 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified) or the equivalent services processed by the Medicare Administrative Contractors:

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, NPs, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- MNT services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.

- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device.

Comment: We received over 40 comments from organizations representing physicians, practitioners, and beneficiaries concerning the SGR and the physician update. Many commenters expressed relief that, as a result of the MIPPA, the 0.5 percent update in effect for the first half of 2008 was extended to the entire year, and the mid-year 2008 rate reduction of −10.6 percent was retroactively replaced with the rates in effect from January through June 2008. They were further relieved that in lieu of the estimated −15 percent update that would otherwise have applied for 2009, the MIPPA specified a 1.1 percent update for CY 2009. However, these commenters remain concerned about the estimated negative update for CY 2010 of approximately −21 percent, followed by multiple years of negative physician updates of approximately −5 percent. Commenters described how they believe the SGR and update formulas are flawed, and they urged us to work with the Congress to develop a new methodology. Some commenters suggested using our administrative authority to lessen the negative impact by removing drugs from the SGR, accounting for NCDs in the allowed expenditures targets, and reducing the productivity adjustment to the MEI.

Response: Ultimately, the formula for the SGR and the physician update are dictated by statute. We are required to follow this methodology when calculating the payment rates under the PFS. We look forward to working with the Congress, the physician community, and other interested parties as we continue to analyze appropriate alternatives to the current system that could ensure appropriate payments while promoting high quality care, without increasing Medicare costs.

Comment: Many commenters emphasized that we must implement the 1.1 percent update using the current 2008 CF as the base rate. Some requested that we include explanations of the calculations used to implement the 1.1 percent conversion factor update and how we changed the application of 5-Year Review BN. Many commenters requested that we provide examples showing how these changes affect different categories of services.

Response: Per the MIPPA, the 1.1 percent physician update is applied to the CY 2008 CF. Later in this section, we explain the calculations used for the CY 2009 CF, including how we implemented both the 1.1 percent update and the change in the application of 5-Year Review BN.

For the impact of these changes by specialty, see the Regulatory Impact Analysis in section XVI. of this final rule with comment period. In that section, we also include the overall impact of this final rule with comment period on selected procedures.

C. Preliminary Estimate of the SGR for 2009

Our preliminary estimate of the CY 2009 SGR is 7.4 percent. We first estimated the CY 2009 SGR in March 2008, and we made the estimate available to the MedPAC and on our Web site. Table 34 shows the March 2008 estimate and our current estimates of the factors included in the CY 2009 SGR.

TABLE 34—2009 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	2.1 percent (1.021)	2.1 percent (1.021).
Enrollment	−0.2 percent (0.998)	−0.2 percent (0.998).
Real Per Capita GDP	1.8 percent (1.018)	1.2 percent (1.012).
Law and Regulation	−2.9 percent (0.971)	4.2 percent (1.042).
Total	0.7 percent (1.007)	7.4 percent (1.074).

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.021 \times 0.998 \times 1.012 \times 1.042 = 1.074$). A more detailed explanation of each figure is provided in section VIII.F.1 of this preamble.

D. Revised Sustainable Growth Rate for 2008

Our current estimate of the CY 2008 SGR is 3.2 percent. Table 35 shows our preliminary estimate of the CY 2008 SGR that was published in the CY 2008 PFS final rule with comment period (72 FR 66379) and our current estimate.

TABLE 35—2008 SGR CALCULATION

Statutory factors	Estimate from CY 2008 final rule	Current estimate
Fees	1.9 percent (1.019)	1.4 percent (1.014).
Enrollment	−0.7 percent (0.993)	−3.2 percent (0.968).
Real Per Capita GDP	1.7 percent (1.017)	1.6 percent (1.016).
Law and Regulation	−2.9 percent (0.971)	3.5 percent (1.035).
Total	−0.1 percent (0.999)	3.2 percent (1.032).

A more detailed explanation of each figure is provided in section VIII.F.2 of this preamble.

E. Final Sustainable Growth Rate for 2007

The SGR for 2007 is 3.5 percent. Table 36 shows our preliminary estimate of the 2007 SGR from the CY 2007 PFS final rule with comment period (71 FR 69757), our revised estimate from the CY 2008 PFS final rule with comment period (72 FR 66380) and the final figures determined using the best available data as of September 1, 2008.

TABLE 36—2007 SGR CALCULATION

Statutory factors	Estimate from CY 2006 final rule	Estimate from CY 2007 final rule	Final
Fees	2.2 percent (1.022)	1.9 percent (1.019)	2.0 percent (1.020).
Enrollment	−0.9 percent (0.991)	−2.6 percent (0.974)	−2.0 percent (0.980).
Real per Capita GDP	2.0 percent (1.020)	1.9 percent (1.019)	1.8 percent (1.018).
Law and Regulation	−1.5 percent (0.985)	2.0 percent (1.020)	1.7 percent (1.017).
Total	1.8 percent (1.018)	3.2 percent (1.032)	3.5 percent (1.035).

A more detailed explanation of each figure is provided in section VIII.F.3. of this final rule.

E. Calculation of 2009, 2008, and 2007 Sustainable Growth Rates

1. Detail on the CY 2009 SGR

All of the figures used to determine the CY 2009 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2009

This factor is calculated as a weighted-average of the CY 2009 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 81.7 percent of total allowed charges included in the SGR in CY 2009 and are updated using the MEI. The MEI for CY 2009 is 1.6 percent. Diagnostic laboratory tests are estimated to represent approximately 7.7 percent of Medicare allowed charges included in the SGR for CY 2009. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U), which is 5.0 percent for CY 2009. However, section 145 of the MIPPA reduces the increase applied to clinical laboratory tests by 0.5 percent for CY 2009 through CY 2013. Therefore, for CY 2009, diagnostic laboratory tests will receive an update of 4.5 percent. Drugs are estimated to represent 10.6 percent of Medicare allowed charges included in the SGR in CY 2009. We estimated a weighted-average change in fees for drugs included in the SGR (using the ASP+6 percent pricing methodology) of 3.9 percent for CY 2009.

Table 37 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2009.

TABLE 37—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2009

	Weight	Update
Physician	0.817	1.6
Laboratory	0.077	4.5
Drugs	0.106	3.9
Weighted-average	1.000	2.1

We estimate that the weighted-average increase in fees for physicians' services in CY 2009 under the SGR (before applying any legislative adjustments) will be 2.1 percent.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees From CY 2008 to CY 2009

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2008 to CY 2009. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. We estimate that the average number of Medicare Part B fee-for-service enrollees will decrease by 0.2 percent from CY 2008 to CY 2009. Table 38 illustrates how this figure was determined.

TABLE 38—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2008 TO CY 2009

[Excluding beneficiaries enrolled in MA plans]

	2008	2009
Overall	41.662 million	42.425 million.
Medicare Advantage (MA)	9.592 million	10.431 million.
Net	32.070 million	31.995 million.
Percent Increase		−0.2 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in Medicare Advantage (MA) plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2009 becomes known.

• Factor 3—Estimated Real Gross Domestic Product per Capita Growth in 2009

We estimate that the growth in real GDP per capita from CY 2008 to CY 2009 will be 1.2 percent (based on the

10-year average GDP over the 10 years of 2000 through 2009). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in 2009.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2009 Compared With CY 2008

The statutory and regulatory provisions that will affect expenditures in CY 2009 relative to CY 2008 are estimated to have an impact on expenditures of 4.2 percent. These include the DRA provision reducing payments for imaging services, the MMSEA provision regarding the PQRI bonuses payable in 2009, and the MIPPA provisions regarding the change in cost sharing for mental health services, the physician update, and the change in application of BN to the CF. The details of the MIPPA provisions are discussed in section III. of this final rule with comment period.

2. Detail on the 2008 SGR

A more detailed discussion of our revised estimates of the four elements of the 2008 SGR follows.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2008

This factor was calculated as a weighted-average of the 2008 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the PFS account for approximately 81.9 percent of total allowed charges included in the SGR in CY 2008. These services were updated using the CY 2008 MEI of 1.8 percent. We estimate that diagnostic laboratory tests represent approximately 7.7 percent of total allowed charges included in the SGR in CY 2008. Medicare payments for these tests are updated by the CPI–U. However, section 628 of the MMA specifies that diagnostic laboratory tests will receive an update of 0.0 percent from CY 2004 through CY 2008. We estimate that drugs represent 10.4 percent of Medicare-allowed charges included in the SGR in CY 2008. We estimate a weighted-average change in fees for drugs included in the SGR of −0.5 percent for CY 2008.

Table 39 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2008.

TABLE 39—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2008

	Weight	Update
Physician	0.819	1.8
Laboratory	0.077	0.0
Drugs	0.104	−0.5
Weighted-average	1.000	1.4

After considering the elements described in Table 39, we estimate that the weighted-average increase in fees for physicians' services in 2008 under the SGR (before applying any legislative adjustments) will be 1.4 percent. Our estimate of this factor in the CY 2008 PFS final rule with comment period was 1.9 percent (72 FR 66380). The decrease in the estimate is due to the availability of some actual data.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees From CY 2007 to CY 2008

We estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) decreased by 3.2 percent in CY 2008. Table 40 illustrates how we determined this figure.

TABLE 40—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2007 TO CY 2008

[Excluding beneficiaries enrolled in MA plans]

	2007	2008
Overall	41.055 million	41.662 million.
Medicare Advantage (MA)	7.926 million	9.592 million.
Net	33.129 million	32.070 million.
Percent Increase		−3.2 percent.

Our estimate of the −3.2 percent change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2008 compared to CY 2007, is lower than our original estimate of −0.7 percent in the CY 2008 PFS final rule with comment period (72 FR 66381). While our current projection based on data from 8 months of 2008 is lower than our original estimate of −0.7 percent when we had no actual data, it is still possible that our final estimate of this figure will be different once we have complete information on CY 2008 fee-for-service enrollment.

• Factor 3—Estimated Real Gross Domestic Product per Capita Growth in CY 2008

We estimate that the growth in real GDP per capita will be 1.6 percent for CY 2008 (based on the 10-year average GDP over the 10 years of CY 1999 through CY 2008). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2008 economic performance becomes available to us in 2009.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2008 Compared With CY 2007

The statutory and regulatory provisions that will affect expenditures in CY 2008 relative to CY 2007 are estimated to have an impact on expenditures of 3.5 percent. These include the DRA provision reducing payments for imaging services, the MIEA–TRHCA provisions regarding the 2007 PQRI reporting bonuses payable in 2008, and the MIPPA provisions regarding the physician update and the bonus payments for mental health services. The details of the MIPPA provisions are discussed in section III of this final rule with comment period.

3. Detail on the CY 2007 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2007 SGR follows.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2007

This factor was calculated as a weighted-average of the CY 2007 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the PFS accounted for approximately 82.8 percent of total Medicare-allowed charges included in the SGR for CY 2007 and are updated using the MEI. The MEI for CY 2007 was 2.1 percent. Diagnostic laboratory tests represented approximately 7.4 percent of total CY 2007 Medicare allowed charges included in the SGR and are updated by the CPI–U. However, section 628 of the MMA specifies that diagnostic laboratory tests will receive an update of 0.0 percent from CY 2004 through CY 2008. Drugs represented approximately 9.7 percent of total Medicare-allowed charges included in the SGR for CY 2007. We estimate a weighted-average change in fees for drugs included in the SGR of 2.1 percent for 2007. Table 41 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2007.

TABLE 41—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2007

	Weight	Update
Physician	0.828	2.1
Laboratory	0.074	0.0
Drugs	0.097	2.1
Weighted-average	1.000	2.0

After considering the elements described in Table 41, we estimate that the weighted-average increase in fees for physicians' services in CY 2007 under the SGR (before applying any legislative adjustments) was 2.0 percent. This figure is a final one based on complete data for CY 2007.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees From CY 2006 to CY 2007

We estimate the decrease in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2006 to CY 2007 was −2.0 percent. Our calculation of this factor is based on complete data from CY 2007. Table 42 illustrates the calculation of this factor.

TABLE 42—AVERAGE NUMBER OF MEDICARE PART B FROM CY 2006 TO CY 2007

[Excluding beneficiaries enrolled in MA Plans]

	2006	2007
Overall	40.360 million	41.055 million.
Medicare Advantage (MA)	6.550 million	7.926 million.
Net	33.811 million	33.129 million.
Percent Increase		−2.0 percent.

• Factor 3—Estimated Real Gross Domestic Product per Capita Growth in 2007

We estimate that the growth in real per capita GDP was 1.8 percent in 2007 (based on the 10-year average GDP over the 10 years of CY 1998 through CY 2007). This figure is a final one based on complete data for CY 2007.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2007 Compared With CY 2006

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2007 relative to CY 2006 is 1.7 percent. These include the DRA provision reducing payments for imaging services and the MIEA–TRHCA 1-year adjustment to the CF.

IX. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2009

The CY 2009 PFS CF is $36.0666. The CY 2009 national average anesthesia CF is $20.9150.

A. Physician Fee Schedule Conversion Factor

The PFS CF for a year is calculated in accordance with section 1848(d)(1)(A) of the Act by multiplying the previous year's CF by the PFS update. The formula for calculating the PFS update is set forth in section 1848(d)(4)(A) of the Act. In general, the PFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI times the update adjustment factor (UAF), which is calculated as specified under section 1848(d)(4)(B) of the Act. However, section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008,

and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the MMSEA increase in the CY 2008 CF that was applicable to the first half of the year to the entire year, provided a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

If section 101 of the MMSEA had not been enacted, the CY 2008 CF update would have been −10.1 percent (0.89896), as published in the CY 2008 PFS final rule with comment period (72 FR 66383). For CY 2009, the percentage increase in the MEI is equal to 1.6 percent (1.016). The UAF is −7.0 percent (0.930). If section 131 of the MIPPA had not been enacted, the CY 2009 CF update would have been −15.1 percent, which is the product of the published CY 2008 update (0.89896), the percentage increase in the MEI (1.016), and the UAF (0.930).

Section 131 of the MIPPA provided a 1.1 percent increase in the CY 2009 CF. Consistent with section 131 of the MIPPA, the update for CY 2009 is 1.1 percent.

Budget Neutrality Adjustment: Section 133(b) of the MIPPA

Section 1848(c)(2)(B)(i) of the Act requires that we review the RVUs no less often than every 5 years. Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN.

The most recent 5-Year Review of the work RVUs was implemented in 2007 and 2008. We estimated that the 5-Year Review of work RVUs, including the refinement to the work RVU changes for the additional codes and the increases in the work of anesthesia services, would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustment. In CY 2007, we met the BN requirement by applying a separate BN adjustment factor to the work RVUs of −10.06 percent. In CY 2008, due to subsequent changes related to the 5-Year Review of work, the separate BNF for work RVUs was −11.94 percent.

Section 133(b) of the MIPPA requires the Secretary, instead of continuing to apply the BN adjustment required as a result of the 5-Year Review of work to the work RVUs, to apply the required BN adjustment to the CF beginning with CY 2009. Shifting the 11.94 percent separate work adjustment to the CF requires a reduction to the CF of 6.41 percent (0.9359). (Work RVUs represent slightly over half of PFS payments; PE and malpractice RVUs comprise the rest.) Payments for the work portion of the PFS will increase as a result of this change. However, this increase will be offset in the aggregate by the decrease to the CF. Therefore, this increase is budget neutral prior to the interaction with section 5102 of the DRA (see below for a discussion of the interaction with section 5102 of the DRA.) For the impact by specialty of section 133(b) of the MIPPA, see the Regulatory Impact Analysis in section XVI. of this final rule with comment period.

Section 5102(b)(1) of the DRA amended section 1848(b) of the Act and added paragraph (4), requiring that the payment for the TC of certain imaging services (including the technical portion of the global fee) cannot exceed the payment for the same service under the Outpatient Prospective Payment System (OPPS). In general, if the payment for these services as calculated using PFS RVUs would exceed the payment for the same service under the OPPS, we cap the TC of the PFS payment amount at the OPPS payment amount. Section 5102(a)(3) amended section 1848(c)(2)(B) of the Act and added clause (v) to exempt certain reduced expenditures from the BN provision. Section 5102(b)(2) added subclause (II), which specifically excluded savings generated by the OPPS imaging services cap from the PFS BN requirement. (For further discussion of section 5102 of the DRA, see the CY 2007 PFS final rule with comment period (71 FR 69659).)

The separate work BN adjustor did not impact payment for the TC of imaging services, since this portion of the service does not have work RVUs. When the BN adjustment is made to the CF as required under section 133(b) of MIPPA, however, the adjustment does lower payments for the TC of imaging services. Because the reduction to the CF lowers the payments for the TC of imaging services, there are less aggregate savings resulting from the OPPS payment cap under section 5102 of the DRA with the BN adjustment to the CF than there are with the separate work BN adjustment. This is because services will be paid at the OPPS rate both before and after the application of the BN adjustment, resulting in no BN savings from these services. We estimate that the reduction in aggregate savings will be approximately $0.2 billion in 2009. In other words, Medicare expenditures in the aggregate will increase by $0.2 billion relative to what would have occurred in the absence of section 133(b) of the MIPPA.

As stated earlier, section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN. We estimate that CY 2009 RVU changes would result in a decrease in Medicare physician expenditures. Therefore, we are increasing the CF by 1.0008 to offset this estimated decrease in Medicare physician expenditures due to the CY 2009 RVU changes.

We illustrate the calculation of the CY 2009 PFS CF in Table 43.

TABLE 43—CALCULATION OF THE CY 2009 PFS CF

CY 2008 Conversion Factor	$38.0870.
CY 2009 CF Update	1.1 percent (1.011).
CY 2009 CF Budget Neutrality Adjustment	0.08 percent (1.0008).
5-Year Review Budget Neutrality Adjustment	−6.41 percent (0.9359).
CY 2009 Conversion Factor	$36.0666.

Payment for services under the PFS will be calculated as follows:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

B. Anesthesia Conversion Factor

We calculate the anesthesia CF in Table 44. Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia CF to simulate changes to RVUs. More specifically, if there is an

adjustment to the work, PE, or malpractice RVUs, these adjustments are applied to the respective shares of the anesthesia CF as these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services.

As explained above, section 133(b) of the MIPPA provided for the application of the 2007–2008 5-Year work review BN adjustor to the PFS CF for years beginning with CY 2009. To make this change for the anesthesia CF, we recalculated the adjustments to the anesthesia CF for CY 2007 and CY 2008 by removing the BN adjustor for work, which had been applied to calculate the CF for each of these years. The adjustor for the work BN is applied as a separate adjustment to the anesthesia CF as it is similarly applied to the PFS CF. In addition, for the calculation of the CY 2008 anesthesia CF, we recognized the 32 percent increase in anesthesia work adopted under the third 5-Year Review of work. We also applied the adjustments that were made in CY 2007 and CY 2008 for anesthesia PE and anesthesia malpractice. (The anesthesia CFs shown in the Table 44 for 2007 and 2008 are not the rates used to pay claims for services furnished in those calendar years, but are recalculated anesthesia CFs showing the removal of the work BN adjustor.)

TABLE 44—CALCULATION OF THE CY 2009 ANESTHESIA CONVERSION FACTOR

CY 2006 Anesthesia CF	$17.7663
2007 Adjustment without BN adjustor	0.9874
CY 2007 Anesthesia CF	$17.5424
2007 Adjustment without BN adjustor	1.2528
2008 Legislative Update Factor	0.5% (1.0050)
CY 2008 Anesthesia CF	$22.0871
2009 MIPPA CF Adjustor	0.9359
2009 MIPAA Update (1.1%)	1.0110
2009 Combined Adjustment to Anesthesia CF	1.0008
CY 2009 Anesthesia CF	$20.9150

X. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2009 is 1.6 percent.

Therefore, for CY 2009, the payment amount for HCPCS code Q3014, Telehealth originating site facility fee, is 80 percent of the lesser of the actual charge or $23.72.

The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 45.

TABLE 45—THE MEDICARE TELEHEALTH ORIGINATING SITE FACILITY FEE AND MEI INCREASE BY THE APPLICABLE TIME PERIOD

Facility fee	MEI increase (percent)	Period
$20.00	N/A	10/01/2001–12/31/2002
$20.60	3.0	01/01/2003–12/31/2003
$21.20	2.9	01/01/2004–12/31/2004
$21.86	3.1	01/01/2005–12/31/2005
$22.47	2.8	01/01/2006–12/31/2006
$22.94	2.1	01/01/2007–12/31/2007
$23.35	1.8	01/01/2008–12/31/2008
$23.72	1.6	01/01/2009–12/31/2009

XI. Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)—Services Excluded From Coverage

A. Low Vision Aid Exclusion

1. Background

Section 1862(a)(7) of the Act excludes payment under Medicare Part A and Part B where ''expenses are for * * * eyeglasses (other than eyewear described in section 1861(s)(8) of the Act) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes * * *'' Section 411.15(b) excludes from coverage, eyeglasses and contact lenses, except for—

- Post-surgical prosthetic lenses customarily used during convalescence for eye surgery in which the lens of the eye was removed (for example, cataract surgery);
- Prosthetic lenses for patients who lack the lens of the eye because of congenital absence or surgical removal; and
- One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

From as early as 1980, we have clarified that we viewed closed circuit visual aid systems and other low vision devices to be subject to the eyeglass coverage exclusion at section 1862(a)(7) of the Act. On July 16, 1980, we conveyed from the Acting Director, Office of Coverage Policy, Bureau of Program Policy, Health Care Financing Administration, to the Regional Administrator, San Francisco, an example of this clarification. We stated in a memorandum that closed circuit visual aid systems, in providing magnification serve the same function as eyeglasses, coverage of which is specifically excluded by Medicare law

(section 1862(a)(7) of the Act). This document explained that section 1862(a)(7) of the Act is an overriding statutory coverage exclusion which would apply even if these devices were determined to meet Medicare's definition of durable medical equipment. Moreover, the Medicare Appeals Council has recognized that video magnifiers, or closed circuit televisions (CCTVs), are subject to the eyeglass coverage exclusion at section 1862(a)(7) of the Act. However, we have never issued a regulation or national coverage decision (NCD) that specifically states that the eyeglass exclusion at section 1862(a)(7) of the Act applies to low vision aids.

2. Provisions of the Proposed Rule

In the Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) proposed rule (hereinafter referred to as the May 1, 2006 proposed rule (71 FR 25654, at 25659 and 25687)), we proposed to revise § 411.15(b), which provides certain specific exceptions to the eyeglass coverage exclusion, to expressly state the scope of the eyeglass exclusion. In proposing this revision, we were mindful that three United States District courts found that the Act does not prohibit payment for video magnifiers. (*Collins* v. *Thompson,* No 2:03-cv-265-FtM-29SPC (M.D. Fla. June 4, 2004); *Davidson* v. *Thompson,* No. Civ. 04–32 LFG (D.N.M. 2004); *Currier* v. *Thompson,* 369 F. Supp. 2d 65 (D. Me. 2005)). We also noted that the *Currier* case recognized that the statute was ambiguous, and the Supreme Court has recognized that a prior judicial construction of an ambiguous statute does not categorically control an agency's contrary construction (*National Cable & Telecommunications Association* v. *Brand X Internet Services,* 545 U.S. 967, 982 (2005)).

We have a longstanding practice of denying claims for low visions aids and have stated in both judicial and administrative processes our position that low vision aids fall within the statutory eyeglass exclusion. The purpose of this final regulation is not to withdraw coverage of low vision aids but to codify in regulations our longstanding practice of not covering these devices.

In the May 1, 2006 proposed rule, we proposed to clarify under proposed § 411.15(b) that the scope of the eyeglass coverage exclusion encompasses all devices irrespective of their size, form, or technological features that use one or more lenses to aid vision or provide magnification of images for impaired vision. This proposed regulatory provision would clarify that the statute does not support the interpretation that the term ''eyeglasses'' only applies to lenses supported by frames that pass around the nose and ears. The underlying technology and the function of eyeglasses are to use lenses to assist persons with impaired vision. *Dorland's Illustrated Medical Dictionary* (28th Ed. 1994) defines ''eyeglass'' simply as a ''lens for aiding sight.'' Low vision aids depend on the use of a lens to aid vision. For example, computers can use lenses to enlarge print to help individuals who need visual assistance in reading. The Cleveland Clinic on its Web site, under the heading of ''Coping with Vision Loss'', lists examples of popular low vision aids. The examples include telescopic glasses, lenses that filter light, magnifying glasses, hand magnifiers, close-circuit television, and reading prisms.

We interpret the eyeglass exclusion at section 1862(a)(7) of the Act as encompassing all of the various types of devices that use lenses for the correction of vision unless there is a statutory exception that allows for coverage, or the existing regulatory exceptions that remain unchanged at § 411.15(b) allow coverage. For example, section 1861(s)(8) of the Act provides for one pair of conventional eyeglasses or contact lenses after each cataract surgery with insertion of an intraocular lens.

We noted that if the term ''eyeglasses'' as used at section 1862(a)(7) of the Act was interpreted to refer only to the exclusion of payment for lenses supported by frames that pass around the nose and ears, then the eyeglass exclusion would not apply to contact lenses and there would have been no reason for the Congress to make an exception to section 1862(a)(7) of the Act for contact lenses. However, the Congress enacted the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) (OBRA 90). Section 4153(b)(2)(B) of the OBRA 90 provides for an exception to section 1862(a)(7) of the Act that allows coverage of contact lenses furnished after cataract surgery with the insertion of an intraocular lens.

Considering sections 1862(a) and 1861(s) of the Act together indicates that the eyeglass exclusion also applies to contact lenses, except for contact lenses furnished under the specific conditions noted in section 1861(s) of the Act, that being, after each cataract surgery with the insertion of an intraocular lens. By applying the eyeglass exclusion to contact lenses, we believe that not only does the plain language of the statute reinforce our interpretation that the exclusion encompasses the use of any device that uses a lens to aid vision, and is not limited to just lenses supported by frames that pass around the nose and ears, but that this interpretation best captures the Congress' intent.

Also, when referring to ''conventional eyeglasses,'' section 1861(s)(8) of the Act is affirming that the term ''eyeglasses'' has a wider application than ''conventional eyeglasses'' and the terms ''conventional eyeglasses'' and ''eyeglasses'' are not synonymous in the statute. Moreover, the statute uses the terms ''eyewear'' and ''contact lenses'' in reference to the eyeglass exclusion, further suggesting that these terms are not synonymous.

Our interpretation of the term eyeglasses is consistent with the regulatory language used for the optional benefit in the Medicaid program under § 440.120(d) for eyeglasses. Section 1905(a)(12) of the Act defines the term ''medical assistance'' to include eyeglasses as an optional service. The Medicaid regulations implementing this section of the statute defines eyeglasses to mean ''lenses, including frames, and other aids to vision * * *'' Therefore, in setting program parameters, both Medicaid and Medicare are consistently interpreting in regulations a statutory reference to eyeglasses as including low vision aids.

Although the technology of using lenses to aid low vision may continue to be improved with new innovations, such as contact lenses, progressive lenses, and low vision aids, this does not exempt the new technology from the eyeglass exclusion. The adaptation of the vision aid technology does not change the essential nature of the device: a video magnifier is a device that utilizes a lens to enhance vision. We believe this interpretation is consistent with the decision in *Warder* v. *Shalala,* 149 F 3d 73 (1st Cir. 1998), in which the United States Court of Appeals for the First Circuit held, in part, that the Secretary's classification of a seating system as DME, even though it was a technologically advanced seating system, was supported by the Medicare statute and regulations. In reaching this conclusion, the Court stated that the Secretary could conclude that the seating system met the definition of DME, which ''unequivocally includes 'wheelchairs,' '' since the system served the same (as well as additional) functions as a wheelchair. We believe this case affirms the principle that the Secretary has the discretion to interpret the statute and to assign a product to a particular Medicare category even when

this will result in non-coverage determinations by Medicare.

3. Public Comments Received on the Proposed Rule

Comment: Several commenters urged that low vision aids should be covered for individuals with vision loss to help individuals to remain as independent as possible, to ensure quality of life, to conduct activities of daily living safely and effectively, and to avoid placement in assistive living or nursing homes. The commenters believe the use of prescribed low vision aids would help avoid greater expenses to the Medicare program due to reduced illnesses, injuries, and loss of independence. Several commenters indicated that they did not have sufficient funds to obtain these items without Medicare coverage.

Response: We understand and can appreciate the commenters' concerns. However, the Medicare statute does not provide for the coverage of every service or item that may increase an individual's quality of life or which may provide a medical benefit. For example, in addition to excluding eyeglasses from coverage, the Act also generally excludes coverage of dental services, orthopedic shoes, and hearing aids. We understand that eyeglasses aid individuals in conducting activities of daily living; however, the Medicare statute makes only limited exceptions to the statutory eyeglass coverage exclusion, such as for ''conventional eyeglasses and contact lenses,'' in certain cases. Moreover, we believe the appropriate regulatory interpretation of this statutory exclusion is to remain consistent with our longstanding views, and finalize the proposed regulation without modification.

Comment: Some commenters stated that the regulation does not rely on the plain language of the statute. The commenters suggested that eyeglasses and low vision devices are dissimilar: eyeglasses are optical systems to aid the vision of a person who essentially has normal vision, while low vision aids are prosthetic in nature for persons whose vision is impaired in other ways than refractive error. The commenters believe that the regulation fails to distinguish between lenses that correct refractive errors in eyes with normal visual function and lenses and devices that enlarge images to make them visible to eyes with subnormal visual function. The commenters also stated that the regulation is not in accord with certain established case law, that it conflicts with Congressional intent, and ignores other Medicare regulations and definitions that could be used to cover low vision aids as DME or prosthetic devices.

Response: As a general matter, we disagree with the commenters' concerns raised above. First, we continue to believe that our interpretation is consistent with the plain language of the Medicare statute, and alternatively, if the statute is ambiguous to this point, we believe our interpretation best captures the Congress' intent and is a reasonable and permissible interpretation.

Second, eyeglasses and low vision aids are not dissimilar, but the same, in that, they both use lenses to aid poor vision or provide magnification of images for impaired vision. The operative component of the eyeglass is the lens because it is the component that provides visual improvement. It may be useful to consider standard dictionary definitions of the word ''eyeglass.'' For example, the Webster's Third New Int. Dictionary (1976) defines ''eyeglass'' to include the eyepiece of an optical instrument (as in a microscope or telescope). Also, the Webster's New Collegiate Dictionary (8th Ed, 1979) includes eyepiece as its first definition for eyeglass. It defines eyepiece as the lens or combination of lenses at the eye end of an optical instrument.

As can be clearly seen through the dictionary definitions, any type of eyeglass, conventional or otherwise, is a device used for aiding sight. Lenses used with low vision aids *are* for the purpose of improving vision, as are the lenses used with conventional eyeglasses.

While we understand that some may suggest that a more narrow reading of the statutory exclusion may be appropriate, we disagree and believe that our interpretation is a reasonable and permissible construction of the statutory exclusion, and one that best matches the Congress' intent.

In addition to the plain language of the Medicare statutory exclusion itself, language in other sections of the statute further supports our interpretation. For example, in section 1862(a)(7) of the Act, the Congress makes an exception to the eyeglass exclusion for certain conventional eyeglasses and contact lenses used after cataract surgery. This exception indicates that the eyeglass exclusion applies to more than lenses in frames worn around the nose and ears. In referring to the eyeglass exclusion, the Medicare statute uses various terms, such as eyeglasses, eyewear, conventional eyeglasses and contact lenses, which strongly indicates that the eyeglass exclusion applies to more than just conventional eyeglasses. Additional evidence of Congressional intent regarding the meaning of the term ''eyeglasses'' can be found in the conference report accompanying the original legislation in 1965 (S. Rep. No. 89–404, 49). Although the original statutory language referred to eyeglasses, the conference report also referred to contact lenses, suggesting that the Congress did not intend to construe the term narrowly.

We also note that there is nothing in either the Medicare statutory language of the eyeglass coverage exclusion or the accompanying legislative history to suggest that the exclusion is limited to lenses used to correct refractive errors or other types of specific visual problems; rather, it is stated without reference to any particular types of visual problems.

Additionally, to the extent there is some ambiguity (as noted above in our discussion of the *Currier* case, where the court noted that ambiguity exists with respect to this statutory exclusion and low vision aids), the Supreme Court recognizes that a prior judicial construction of an ambiguous statute does not categorically control an agency's contrary construction. As noted above, we understand that some may believe a more narrow interpretation would be appropriate in this instance. We disagree and continue to believe we have interpreted the Medicare statute in a way that best captures the Congress's intent and that our interpretation is a reasonable and permissible reading of the statutory exclusion.

Furthermore, we have followed the necessary procedures set forth under the Administrative Procedures Act for agencies to follow in establishing interpretive rules to ensure that this regulatory clarification of our longstanding Medicare policy has been given the appropriate consideration and review.

Finally, as noted in more detail below, if an item or service falls within a benefit category, it must not be otherwise excluded, in order for coverage to be considered. Thus, whether an item that falls within the scope of statutory exclusion clarified by this regulation falls within a defined Medicare benefit category, does not alter the analysis as to whether the statutory exclusion for eyeglasses may apply.

Comment: Some commenters believe the regulation does not consider advancements in medical technology and would automatically deny coverage for any new technology designed to assist individuals with vision impairments. As a result, the commenters stated this regulation creates a disincentive for manufacturers

and innovators to develop new and progressive vision technology.

Response: We disagree with the commenters that this regulation creates a disincentive for manufacturers and innovators to develop new and progressive vision technology. As noted above, it is true that new medical advancements and new technologies in the area of vision impairment may fall within the scope of the statutory exclusion clarified in this regulation and coverage may be prohibited under Medicare.

We do not automatically deny coverage for technologically improved items or services, instead, as a general matter, we cover technologically improved items or services if all coverage requirements are met. Many items, however, are not covered by Medicare, yet the relevant industries continue to develop and achieve major advancements in technology. For example, while we do not cover dental services or hearing aids, there continue to be advances in the furnishing of dental care and technological advances in the use of hearing aids. In addition, Medicare has had a longstanding history of not covering low vision aids, yet, manufacturers continue to make technological improvements in this area. Moreover, there are existing incentives beyond Medicare reimbursement that will continue to encourage manufacturers and innovators to improve vision technology.

Comment: Other commenters believe it is inconsistent and discriminatory for Medicare to cover wheelchairs to assist individuals with impaired mobility and not to cover low vision aids to assist individuals with impaired vision.

Response: In order to be covered under Medicare, an item or service must fall within one or more benefit categories contained within Part A or Part B, and must not be otherwise excluded from coverage. Wheelchairs, which may assist individuals with impaired mobility, fall within the defined benefit category for durable medical equipment under section 1861(n) of the Act, and are not otherwise excluded from coverage under section 1862(a) of the Act. Low vision aids, on the other hand, are excluded from coverage under section 1862(a)(7) of the Act and we must comply with this provision.

Comment: Some commenters suggested that CMS allow for a more fully vetted process prior to any rule for or against low vision aid coverage.

Response: We are issuing this final regulation in accordance with the requirements of the Administrative Procedures Act (the APA). On May 1, 2006, we issued a proposed rule that discussed the background and rationale pertaining to our proposed provisions to apply the eyeglass coverage exclusion to low vision aids. In accordance with section 1871(b)(1) of the Act, we proposed this regulation pursuant to a 60-day public comment period. After reviewing and considering the public comments, relevant case law, and our existing policies on this issue, we are issuing this final rule without modification. We believe it sets forth a reasonable and permissible interpretation of the Medicare statutory eyeglass coverage exclusion.

Comment: Commenters expressed concern that the use of assistive low vision aids associated with rehabilitative therapy services, which are identified by Medicare-covered Current Procedural Terminology (CPT) codes, such as CPT code 97535, would no longer be covered by Medicare if subjected to the eyeglass exclusion.

Response: Low vision aids are not covered, items based on the statutory eyeglass exclusion. A practitioner is paid for his or her professional services. Supplies and instruments used in providing those services are not paid for separately, rather payment is made based on the practitioner's PEs.

4. Provisions of the Final Rule

After consideration of the public comments received, we are finalizing § 411.15(b) without modification.

B. Replacement of Reasonable Charge Methodology by Fee Schedules for Therapeutic Shoes

We are finalizing proposed § 414.228(c) to codify that the Medicare fee schedule amounts for therapeutic shoes, inserts, and shoe modifications are established in accordance with the methodology specified in sections 1833(o) and 1834(h) of the Act.

Section 627 of the MMA mandated fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005, calculated using the prosthetic and orthotic fee schedule methodology in section 1834(h) of the Act. In accordance with section 627 of the MMA, fee schedule amounts for therapeutic shoes, inserts and shoe modifications were established and added to the DMEPOS fee schedule through program instructions, effective January 1, 2005.

In our May 1, 2006 proposed rule (71 FR 25654), we proposed to add § 414.228(c) to specify that the Medicare fee schedule amounts for therapeutic shoes, inserts, and shoe modifications are established in accordance with the methodology specified in sections 1833(o) and 1834(h) of the Act. Section 627 of the MMA amended section 1833(o)(2) of the Act to require implementation of fee schedule amounts, effective January 1, 2005, for the purpose of determining payment for custom molded shoes, extra-depth shoes, and inserts (collectively, ''therapeutic shoes''). Section 627 of the MMA was initially implemented through program instructions, and on January 1, 2005, Medicare began paying for therapeutic shoes, inserts, and shoe modifications based on fee schedule amounts determined in accordance with section 1834(h) of the Act and 42 CFR part 414, subpart D of our regulations.

We did not receive any comments on our proposal to add § 414.228(c) to 42 CFR part 414, subpart D of our regulations. Therefore, we are finalizing proposed § 414.228(c) regarding the methodology used to establish fee schedule amounts for therapeutic shoes, inserts and shoe modifications.

XII. Provisions of the Final Rule

The provisions of this final rule with comment period restate the provisions of the CY 2009 PFS proposed rule, except as noted elsewhere in the preamble.

XIII. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services, and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for CMS to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the RUC recommendations for valuing these services. By reviewing these RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with furnishing the services. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each carrier establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Section IV.C. of this final rule with comment discusses the identification and review of 204 potentially misvalued codes by a workgroup of the AMA RUC, as well as our review and decisions regarding the AMA RUC workgroup's recommendations. The AMA RUC submitted several recommendations for misvalued codes in May 2008 and the remainder of their recommendations for misvalued codes in October 2008. Due to the timing of the May 2008 AMA RUC recommendations, it was impracticable for CMS to adequately evaluate and solicit public comment prior to this final rule with comment period. We believe it is in the public interest to implement the revised RVUs for the 61 codes that were identified as misvalued, and that have been reviewed and re-evaluated by the AMA RUC workgroup, on an interim final basis for CY 2009. These revisions will establish a more appropriate payment for these services, some of which changed significantly since they were originally valued. The revisions of RVUs for these codes will establish a more appropriate payment that better corresponds to the relative resources associated with furnishing these services. A delay in implementing revised values for these misvalued codes would not only perpetuate the known misvaluation for these services, it would also perpetuate a distortion in the payment for other services under the PFS. Implementing the changes now allows for a more equitable distribution of payments across all PFS services. We believe a delay in implementation of these revisions would be contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to the AMA RUC's recommendation to CMS.

For the reasons described above, we find good cause to waive notice and comment procedures with respect to the misvalued codes identified in Table 26, and to revise RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Sections III. and VI.B. of this final rule with comment period also address certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275) which became law after publication of the CY 2009 PFS proposed rule. Except as noted further below, we consider these provisions to be self-implementing. We are revising our policies and regulations as described in this final rule with comment period in order to conform them to the statutory amendments. Because these revisions are in accordance with explicit statutory amendments, we find that notice and comment procedures are unnecessary for their implementation. Therefore, we find good cause to waive notice and comment procedures with respect to the changes in policy and regulations to effectuate the self-implementing provisions of the MIPPA as described in this final rule with comment period.

Section 131(c) of the MIPPA requires the Secretary to implement a Physician Feedback Program no later than January 1, 2009. Under the program, the Secretary must use claims data to provide confidential reports to physicians that measure resources involved in furnishing care to individuals (and, if determined appropriate, the reports can also include information about the quality of care furnished). Although this provision is self-implementing in certain respects, especially given that many elements of this program are already in place as a result of our previous data analysis and reporting efforts, we would ordinarily engage in notice and comment rulemaking to establish other aspects of this program. To the extent this provision is not self-implementing, we find good cause to waive notice and comment rulemaking because it would be contrary to the public interest to delay implementation of this program. Moreover, we note that the confidential feedback reporting will serve informational purposes and will not affect any rights or obligations under the Medicare program.

Section 144(b) of the MIPPA repeals the requirement that an oxygen supplier transfer title to oxygen equipment to the beneficiary after a 36-month rental period. In its place, section 144(b) of the MIPPA establishes a 36-month rental cap and sets forth new rules for furnishing oxygen and oxygen equipment after the 36-month period. The current oxygen payment regulations reflect the previous transfer of title requirements, and we are revising these rules to reflect the changes set forth in section 144(b) of the MIPPA.

These changes are largely self-implementing. Section 1834(a)(5)(F)(ii)(I) of the Act, as amended by MIPPA, requires suppliers to continue to furnish oxygen equipment following the 36-month rental period, and section 1834(a)(5)(F)(ii)(II) of the Act mandates continued Medicare payments for oxygen contents following the 36-month rental period. When read in conjunction with section 1834(a)(5)(F)(ii)(II) of the Act, we interpret the mandate in section 1834(a)(5)(F)(ii)(I) of the Act to include oxygen contents, as well as oxygen equipment, given the nature of this benefit and the requirement that Medicare continue to pay for oxygen contents following the 36-month rental

period. To the extent these subsections are not self-implementing, we find good cause to waive notice and comment rulemaking as contrary to the public interest, because timely implementation of these provisions is necessary to ensure that beneficiaries' oxygen treatment—which for many beneficiaries includes both oxygen equipment and contents—continues uninterrupted after January 1, 2009.

Subsection 1834(a)(5)(F)(ii)(III) of the Act, as amended by MIPPA, authorizes payments for maintenance and servicing of oxygen equipment furnished after the 36-month rental period if the Secretary determines such payments are reasonable and necessary. As set forth in section III. J. of this preamble, we have determined that certain routine maintenance and servicing payments are reasonable and necessary to protect Medicare beneficiaries from malfunctioning oxygen equipment.

For the reasons described above, we believe the completion of notice and comment rulemaking would prevent the timely implementation of payment for certain maintenance and servicing of oxygen equipment that we have determined to be necessary for the safe use of oxygen equipment by Medicare beneficiaries, and that any such delay would be contrary to the public interest. Therefore, we find good cause to waive the notice of proposed rulemaking with respect to implementation of subsection 1834(a)(5)(F)(ii)(III) of the Act.

Section 149 of the MIPPA amended section 1834(m)(4)(C)(ii) of the Act to add certain entities as originating sites for purposes of Medicare telehealth services effective January 1, 2009: A hospital-based or critical access hospital-based (CAH-based) renal dialysis center (including satellites); a skilled nursing facility (as defined in section 1819(a) of the Act); and a community mental health center (as defined in section 1861(ff)(3)(B) of the Act). Section 149 of the MIPPA also amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) of the Act from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS). Apart from adding certain entities as originating sites for payment of telehealth services, section 149 of the MIPPA did not change the existing telehealth eligibility criteria, or payment and billing requirements related to telehealth services. Thus, the new authority for these entities to serve as originating sites for Medicare telehealth services is largely self-implementing. However, there are some operational and payment issues that arise as to which we would ordinarily engage in notice and comment rulemaking. In section III. M. of this final rule with comment period, we describe certain limitations on the types of services for which a Medicare telehealth payment will be made when these entities serve as the originating site. These requirements are similar to those in place under current policies for the existing list of telehealth originating sites, but are also tailored to address the particular characteristics of the newly added originating sites. It is necessary to address these requirements in a timely manner in order to avoid potential duplicate billing and payment, and to ensure that facilities appropriately furnish the requisite scope of services for which payment is included in their bundled or prospective payment. For the reasons described above, we believe that completion of notice and comment rulemaking prior to adopting these policies would delay timely implementation of policies that are important to quality care and program integrity. Therefore, to the extent these requirements are not self-implementing, we find good cause to waive notice and comment rulemaking as a delay in implementation would be contrary to the public interest.

As detailed above in this section, we are implementing certain aspects of sections 131(c), 144(b), and 149 of the MIPPA as described in sections III.C., III.J., and III.M. (respectively) of this final rule with comment period on an interim final basis for CY 2009, and include a 60-day comment period.

XIV. 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 (COI) 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.

The collection of information section for this final rule with comment period contains the discussion of the information collection requirements as it appeared in the CY 2008 PFS proposed rule (73 FR 38502), with updated information included as necessary. In addition, we have included a new discussion of the information collection requirements associated with the Electronic Prescribing (E-Prescribing) Incentive Program, as detailed in section II.O2. of the preamble of this final rule with comment period.

A. ICRs Regarding Independent Diagnostic Testing Facility (§ 410.33)

Section 410.33(j) initially proposed that a physician or nonphysician practitioner organization furnishing diagnostic testing services, except diagnostic mammography services, must enroll as an IDTF for each practice location furnishing these services. However, we have removed this requirement and the associated paperwork burden from this final rule with comment period.

For mobile units furnishing diagnostic testing services that are not enrolled in the Medicare program to enroll in the program, they must complete a Medicare enrollment application, the CMS–855B, and attachment 2 of the enrollment application. The burden associated with completing and submitting this application is currently approved under OMB control number 0938–0685 with an expiration date of February 28, 2011. We believe that most of these mobile entities are already enrolled as IDTFs, as required in § 410.33(g).

However, we have no way to accurately quantify the burden because we cannot estimate the number of this type of requests that we may receive. We did not receive any public comments to assist us in our burden analysis. We also recognize that we will not be able to determine the number of the IDTFs that are billing only under arrangement with a hospital. Therefore, while we acknowledge that there is a burden associated with this provision, we also acknowledge that we have no way to quantify this provision's burden. For that reason, we are assigning 1 token burden hour to this requirement until such a time that we can conduct an accurate burden analysis for this information collection requirement.

B. ICRs Regarding Exception to the Referral Prohibition Related to Compensation Arrangements (§ 411.357)

As discussed in section II.N.1. of the preamble of this final rule with comment period, we are not finalizing the exception for incentive payment and shared savings programs contained in § 411.357(x). Consequently, we have removed all discussion of the associated information collection requirements.

C. ICRs Regarding Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination or Physician Participation Under Exigent Circumstances (§ 414.917)

Section 414.917(b)(4) states that an approved CAP vendor may appeal a termination by requesting a reconsideration. The burden associated with this requirement is the time and effort necessary to submit a reconsideration request to CMS. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4(a)(2). Information collected as part of an administrative action is not subject to the PRA.

In section II.F.2 of this final rule with comment period, we discuss the postponement of the CAP for CY 2009.

D. ICRs Regarding Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program (§ 424.516)

Section 424.516(d) discusses the reporting requirements for physician groups/organizations, physicians and NPPs. Specifically, the aforementioned providers must report to CMS, within 30 days the information listed in § 424.516(d)(1). Additionally, all other changes in enrollment must be reported within 90 days.

Section 424.516(e) addresses the reporting requirements for all other providers and suppliers. Providers not mentioned in § 424.516(a) through (d) must report to CMS, within 30 days, changes of ownership, including changes in authorized official(s) or delegated official(s). All other changes in enrollment must be reported within 90 days.

The burden associated with the requirements contained in § 424.516(d) through (e) is the time and effort necessary to report the applicable information to CMS. These provisions change the reporting timeframes for the actions but not the burden associated with the requirement. While this requirement is subject to the PRA, we have no way to accurately quantify the number of submissions. Each submission will be reviewed on a case-by-case basis.

Section § 424.516(d) states providers or suppliers are required to maintain ordering and referring documentation, including the NPI, received from a physician or eligible NPP for 7 years from the date of service. As discussed in Section II.I.5 of this final rule with comment period, we are not adopting the proposed record retention requirement of 10 years from the date of service. Physicians and NPPs are currently required to maintain written ordering and referring documentation for 7 years from the date of service within the CMS Program Integrity Manual. The burden associated with these recordkeeping requirements is the time and effort associated with maintaining the aforementioned documentation for 7 years, which is merely the codification of the requirements that already exist. While these requirements are subject to the PRA, we believe the burden is exempt because the requirement is part of a usual and customary business practice. As stated in 5 CFR 1320.3(b)(2), the time, effort, and financial resources necessary to comply with a COI that would be incurred by persons in the normal course of their activities (for example, in compiling and maintaining business records) is not subject to the PRA.

TABLE 46—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control number	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 410.33	0938–0685	400,000	400,000	2.5	1,001,503
Total		400,000	400,000	2.5	1,001,503

This final rule with comment period imposes COI requirements as outlined in the regulation text and specified above. However, this rule also makes reference to several associated information collections that are not discussed in the regulation text which have already received OMB approval.

These include the following:

Part B Drug Payment

Section II.F.1 of the preamble of this final rule with comment period discusses payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The collection of ASP data imposes a reporting requirement on the public. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921, with an expiration date of May 31, 2009.

Competitive Acquisition Program (CAP)

Section II.F.2. of this final rule with comment period discusses the Part B CAP issues. While we are not imposing any new burden, it should be noted that all of the information collection components of the CAP have been reviewed and approved by OMB. They are approved under OMB control numbers 0938–0987, 0938–0955, and 0938–0954 with expiration dates of April 30, 2009, August 31, 2009, and June 30, 2011, respectively.

Physician Quality Reporting Initiative (PQRI)

Section II.O1. of this final rule with comment period discusses the background of the PQRI and provides information about the measures available to eligible professionals who choose to participate in PQRI. Section 1848(k)(1) of the Act requires the Secretary to implement a system for the reporting by eligible professionals of data on quality measures. We are requesting OMB's emergency review and approval of the information collections referenced below. Emergency review and approval is necessary to meet the statutory effective date of January 1, 2009.

As stated in section II.O1.a.ii., eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2009, the eligible professional must meet one of the criteria for satisfactory reporting described in section II.O1.b. of the preamble.

The burden associated with the requirements of this voluntary reporting initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows. Therefore, we will assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP) indicated an average labor cost of $50 per hour. Thus, we estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows to be approximately $150 per eligible professional ($50 per hour × 3 hours). We expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality-data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2009.

Because this is a voluntary program, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI in CY 2009. Preliminary results from the 2007 PQRI (the first year of PQRI reporting) indicate that of approximately 619,000 unique individual eligible professionals, approximately 101,000 unique individual eligible professionals, or 16 percent, attempted to submit PQRI quality measures data in 2007. Therefore, for purposes of conducting a burden analysis for the 2009 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2009 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. Information from the PVRP indicates that the cost associated with this burden ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures, with the cost for the median practice being $0.90.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data are reported. Preliminary results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average, the median number of eligible instances reported on per measure was about 9. Therefore, for this burden analysis, we estimate for each measure on which an eligible professional reports, the eligible professional reports the quality data on 9 cases.

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 186.75 minutes, or 3.1 hours [(0.25 minutes per measure × 3 measures × 9 cases per measure) + 3 hours] to 504 minutes, or 8.4 hours [(12 minutes per measure × 3 measures × 9 cases per measure) + 3 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from $155.67 [($0.21 per measure × 3 measures × 9 cases per measure) + $150] to $421.62 [($10.06 per measure × 3 measures × 9 cases per measure) + $150].

For registry-based reporting, there would be no additional burden for eligible professionals to report data to a registry as eligible professionals more than likely would already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2009 PQRI. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf would need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals.

The burden associated with the registry-based submission requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the

registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

We are not finalizing our proposal to allow eligible professionals to submit clinical quality data extracted from electronic health records (EHRs) for purposes of receiving an incentive payment for the 2009 PQRI.

The Electronic Prescribing (E-Prescribing) Incentive Program

It is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the e-prescribing incentive program in CY 2009. However, if we assume that every eligible professional who attempted to participate in the 2007 PQRI will also attempt to participate in the 2009 E-Prescribing Incentive Program, then we can estimate that approximately 101,000 unique individual eligible professionals will participate in the 2009 E-Prescribing Incentive Program.

Section II.O2. of the preamble discusses the background of a new incentive program that is available to eligible professionals in addition to the PQRI. This incentive program is known as the e-prescribing incentive program. Section II.O2. of the preamble provides information on how eligible professionals can qualify to be considered a successful electronic prescriber in 2009 in order to earn an incentive payment. Similar to the PQRI, the e-prescribing incentive program is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful electronic prescriber described in section II.O2. of this final rule with comment period, they can qualify to receive an incentive payment.

Similar to claims-based reporting for the PQRI, we estimate the burden associated with the requirements of this new incentive program is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the e-prescribing program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into the office work flows. At an average cost of approximately $50 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $50 ($50 per hour × 1 hour).

The quality-data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2009. Based on our experience with the PVRP described above, we estimate that the time needed to perform all the steps necessary to report the e-prescribing measure to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the e-prescribing measure to be $0.90 based on the experience with the PVRP described above.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Based on preliminary results from the 2007 PQRI described above and the fact that the measure's denominator consists of only billing codes for professional services, we estimate that each eligible professional reports the quality data on 60 cases for the e-prescribing measure.

Therefore, we estimate the total annual burden per eligible professional associated with claims-based reporting of the e-prescribing measure to be 165 minutes, or 2.75 hours [(1.75 minutes per measure × 1 measure × 60 cases per measure) + 1 hour]. The total estimated cost per eligible professional to report the e-prescribing measure is estimated to be $104 [($0.90 per measure × 1 measure × 60 cases per measure) + $50].

If you choose to comment on these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: William Parham, CMS–1403–FC, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: CMS Desk Officer, CMS–1403–FC, Fax (202) 395–6974.

XV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XVI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 on regulatory planning and review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866, as amended, directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As indicated in more detail below in this regulatory impact analysis, we estimate that the PFS provisions included in this final rule with comment period will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional

Review Act. Accordingly, we have prepared a RIA that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses and other small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $34.5 million in any 1 year (For further information, see the Small Business Administration's regulation at 70 FR 72577, December 6, 2005.) Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $7 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are about 980,000 physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA, approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that approximately 66,000 entities bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately $10.8 billion in 2007 for which $8.3 billion was for fee-for-service and $2.5 billion was for managed care. However the therapeutic shoe, oxygen and oxygen equipment, and low vision aids provisions in this rule do not have a significant economic impact on a substantial number of small entities. In the case of therapeutic shoes, the regulation is being updated to reflect the fact that fee schedules were implemented on January 1, 2005, in accordance with the requirements of MMA section 627. Since the fees themselves are not impacted by this change, suppliers are likewise not impacted by this change. In the case of oxygen and oxygen equipment, as explained in section S.9. below, it is difficult to estimate the impact of section 144(b) of the MIPPA on small entities and oxygen and oxygen equipment suppliers in general. Nevertheless, we do believe that the net impact on small entities and other suppliers of oxygen and oxygen equipment will be positive rather than negative. This is based on the fact that this change allows suppliers to retain ownership of oxygen equipment in all cases when it is no longer needed by the beneficiary. Prior to this change, suppliers were required to relinquish ownership of oxygen equipment after 36 continuous rental months. While suppliers will be required to continue furnishing the equipment after the 36-month rental period for up to 2 additional years in some cases until the 5 year reasonable useful lifetime of the equipment ends, they will retain ownership of equipment when it is no longer needed and can furnish the equipment to other patients. Although suppliers will not be paid for non-routine maintenance or repair of oxygen equipment they own and furnish to Medicare beneficiaries, the equipment itself is very dependable and requires very little maintenance and servicing, so this change should not significantly impact suppliers. As previously noted, approximately 78 percent of Medicare beneficiaries that need oxygen do not use the oxygen equipment for more than 36 months. The changes mandated by section 144(b) of the MIPPA will have no impact on suppliers or beneficiaries in these cases.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the Small Business Administration's size standards. These are posted on the following Web site: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf*. Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $7 million to $34.5 million or less in any year. We consider a substantial number of entities to be significantly affected if the final rule with comment period has an annual average impact on small entities of 3 to 5 percent or more. Based on our analysis of the 926 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this final rule with comment period for nonprofit facilities will have a 0.7 percent decrease in overall payments relative to current overall payments. The majority of ESRD facilities will experience impacts of less than 3 percent of total revenues. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section XVI.F. of this final rule with comment period complies with the RFA requirements.

For the e-prescribing provisions, physician practices and independent pharmacies are considered small entities.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this rule constitutes our final regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

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. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a metropolitan statistical area and has fewer than 100 beds. We have determined that this final rule with comment period will have minimal impact on small hospitals located in rural areas. Of the 196 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2008, that threshold is approximately $130 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments. Medicare beneficiaries are considered to be part of the private

sector for this purpose. A discussion concerning the impact of this rule on beneficiaries is found later in this section.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. The e-prescribing portions of this rule present a potential Federalism implication. No State categorically bars e-prescribing, but the scope and substance of State laws varies widely among the States. In recent years, many States have more actively legislated in this area. Should a State law be contrary to the Part D e-prescribing standards, or should it restrict the ability to carry out the Medicare Part D e-prescribing program, the MMA provides for preemption of that State law at section 1860D–4(e)(5) of the Act. Section 1860D–4(e)(5) provides:

Relation to State Laws. The standards promulgated under the subsection shall supersede any State law or regulation that—

(A) Is contrary to the standards or restricts the ability to carry out this part; and

(B) Pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered Part D drugs under this part.

For the reasons given above, we have determined that States would not incur any direct costs as a result of this rule. However, as mandated by section 1860D–4(e) of the Act, and under Executive Order 13132, we are required to minimize the extent of preemption, consistent with achieving the objectives of the Federal statute, and to meet certain other conditions. We believe that, taken as a whole, this final rule with comment period would meet these requirements.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this final rule with comment period. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work and PE RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Section 133(b) of the MIPPA requires an alternative application of the BN adjustment that resulted from the 5-Year Review of Work RVUs. The 0.8806 percent BN adjustment that is currently being applied to the work RVUs will be removed from the work RVUs and applied to the physician CF (See the CY 2008 PFS final rule with comment period (72 FR 66389) for further discussion of the BN adjustment that resulted from the 5-Year Review of Work RVUs). See sections III.E. and VII. of this final rule with comment period for more information on the provisions of section 133(b) of the MIPPA. The effect of this change on selected procedures is shown in Table 50.

Table 47 shows the specialty-level impact of the work and PE RVU changes.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2008 with payment rates for CY 2009 using CY 2007 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 47. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 47 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 47.

- Specialty: The physician specialty or type of practitioner/supplier.
- Allowed charges: Allowed charges are the Medicare Fee Schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Work RVU Changes for any new or revised CY 2009 PFS services.
- Impact of PE RVU changes. The impact is shown for both 2009 which is the third year of the 4-year transition using the new methodology and the fully implemented 2010 PE RVUs.
- Combined impact of the work RVUs and PE RVUs for both 2009 and the fully implemented 2010 PE RVUs.

TABLE 47—COMBINED TOTAL ALLOWED CHARGE IMPACT FOR WORK AND PRACTICE EXPENSE RVU CHANGES

	Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes		Combined impact of PE and work changes *	
			2009 (percent)	2009 (PE trans. year 3) (percent)	2010 (PE full implement.) (percent)	2009 (PE trans. year 3) (percent)	2010 (PE full implement.) (percent)
1	TOTAL	$81,669	0	0	0	0	0
2	ALLERGY/IMMUNOLOGY	184	0	1	2	1	2
3	ANESTHESIOLOGY	1,966	0	−1	−1	−1	−1

TABLE 47—COMBINED TOTAL ALLOWED CHARGE IMPACT FOR WORK AND PRACTICE EXPENSE RVU CHANGES—Continued

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes		Combined impact of PE and work changes *	
		2009 (percent)	2009 (PE trans. year 3) (percent)	2010 (PE full implement.) (percent)	2009 (PE trans. year 3) (percent)	2010 (PE full implement.) (percent)
4 CARDIAC SURGERY	400	0	0	0	0	0
5 CARDIOLOGY	7,775	0	−2	−3	−2	−4
6 COLON AND RECTAL SURGERY	136	0	1	1	0	1
7 CRITICAL CARE	224	0	0	0	0	0
8 DERMATOLOGY	2,557	0	2	5	2	5
9 EMERGENCY MEDICINE	2,451	0	0	0	0	0
10 ENDOCRINOLOGY	385	0	0	0	0	0
11 FAMILY PRACTICE	5,354	0	0	1	0	1
12 GASTROENTEROLOGY	1,883	0	2	3	2	3
13 GENERAL PRACTICE	842	0	0	0	0	0
14 GENERAL SURGERY	2,408	0	0	1	1	1
15 GERIATRICS	175	0	0	1	0	1
16 HAND SURGERY	88	0	−1	−2	−1	−2
17 HEMATOLOGY/ONCOLOGY	2,019	0	−1	−1	−1	−1
18 INFECTIOUS DISEASE	561	0	1	2	1	2
19 INTERNAL MEDICINE	10,662	0	0	0	0	0
20 INTERVENTIONAL RADIOLOGY	228	0	−1	−1	−1	−2
21 NEPHROLOGY	1,840	0	−1	−2	−1	−2
22 NEUROLOGY	1,489	0	0	0	0	0
23 NEUROSURGERY	620	−1	0	−1	−1	−2
24 NUCLEAR MEDICINE	79	0	−1	−2	−1	−1
25 OBSTETRICS/GYNECOLOGY	654	0	0	0	0	−1
26 OPHTHALMOLOGY	5,026	0	0	0	0	0
27 ORTHOPEDIC SURGERY	3,454	0	0	0	0	−1
28 OTOLARYNGOLOGY	984	0	−1	−1	−1	−1
29 PATHOLOGY	1,007	0	0	0	0	0
30 PEDIATRICS	72	0	1	1	1	1
31 PHYSICAL MEDICINE	850	0	0	−1	0	−1
32 PLASTIC SURGERY	288	0	0	1	0	1
33 PSYCHIATRY	1,169	0	1	1	1	1
34 PULMONARY DISEASE	1,828	0	1	1	1	1
35 RADIATION ONCOLOGY	1,854	0	−1	−2	−1	−2
36 RADIOLOGY	5,554	0	0	1	0	1
37 RHEUMATOLOGY	521	0	0	−1	0	−1
38 THORACIC SURGERY	431	0	0	0	0	0
39 UROLOGY	2,146	0	0	0	0	0
40 VASCULAR SURGERY	685	0	0	0	0	0
41 AUDIOLOGIST	33	1	−10	−20	−9	−19
42 CHIROPRACTOR	768	0	−1	−1	−1	−1
43 CLINICAL PSYCHOLOGIST	571	0	−2	−4	−2	−3
44 CLINICAL SOCIAL WORKER	378	0	−2	−3	−1	−3
45 NURSE ANESTHETIST	846	0	0	0	0	0
46 NURSE PRACTITIONER	963	0	1	1	1	1
47 OPTOMETRY	867	0	0	0	0	0
48 ORAL/MAXILLOFACIAL SURGERY	38	0	1	2	1	2
49 PHYSICAL/OCCUPATIONAL THERAPY	1,772	0	2	4	2	4
50 PHYSICIAN ASSISTANT	711	0	0	1	0	1
51 PODIATRY	1,727	0	1	3	1	2
52 DIAGNOSTIC TESTING FACILITY	1,186	0	−2	−4	−2	−4
53 INDEPENDENT LABORATORY	878	0	5	9	5	10
54 PORTABLE X–RAY SUPPLIER	87	0	2	4	2	4

* Components may not sum to total due to rounding.

2. Adjustments for Payments for Imaging Services

Section 1848(c)(2)(B)(iv)(II) of the Act as added by section 5102 of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) exempts the estimated savings from the application of the OPPS-based payment limitation on PFS imaging services from the PFS BN requirement. We estimate that the combined impact of the current BN exemptions instituted by such section, the addition of 4 new codes and the removal of 2 codes from the list of services subject to the DRA OPPS cap (See section V. G. Additional Coding Issues), and the payment revisions to OPPS cap amounts would result in no measurable changes in the specialty specific impacts of the DRA provisions.

3. Combined Impact

Table 48 shows the specialty-level impact of the work and PE RVU changes, the impact of the MIPPA provision to apply the BN adjustment to the CF, the MIPPA provision for a 1.1

percent increase to the CF, and the combined impact of all of these changes. Additionally, the impacts in this final rule with comment period rule reflect the use of the updated physician time data from the AMA–RUC, that is, used in step 13 of the detailed description of the PE methodology described in section II.A.1.i. of this final rule with comment period.

As indicated in Table 48, our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2008 with payment rates for CY 2009 using CY 2007 Medicare utilization crosswalked to 2009 services. To the extent that there are year-to-year changes in the volume and mix of services furnished by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 48. These payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician furnishes.

Table 48 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 48.

- Specialty: The physician specialty or type of practitioner/supplier.
- Allowed Charges: Allowed charges are the Medicare Fee Schedule amounts for covered services and include coinsurances and deductibles (which are the financial responsibility of the beneficiary.) These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of the CY 2009 Work and PE RVU changes using the methodology finalized in the CY 2007 PFS final rule with comment period and the revised data sources discussed in this final rule with comment period.
- Impact of section 133(b) of the MIPPA which applies the BN adjustment resulting from the 5-Year Review of work RVUs to the physician CF rather than to the work RVUs.
- Impact of section 131(a)(1) of the MIPPA which provides for a 1.1 update to the Medicare PFS CF.
- Combined impact of the finalized work and PE RVUs, section 133(b) of the MIPPA, and section 131(a)(1) of the MIPPA.

TABLE 48—COMBINED CY 2009 TOTAL ALLOWED CHARGE IMPACT FOR WORK RVU CHANGES, PRACTICE EXPENSE CHANGES, AND MIPPA CHANGES

	Specialty	Allowed Charges (mil)	Work and PE RVU Changes * (percent)	MIPPA 133(b) ** (percent)	MIPPA 131 Update (percent)	Total *** (percent)
1	TOTAL	$81,669	0	0	1	1
2	ALLERGY/IMMUNOLOGY	184	1	−3	1	−1
3	ANESTHESIOLOGY	1,966	−1	3	1	3
4	CARDIAC SURGERY	400	0	1	1	2
5	CARDIOLOGY	7,775	−2	−1	1	−2
6	COLON AND RECTAL SURGERY	136	0	1	1	2
7	CRITICAL CARE	224	0	2	1	3
8	DERMATOLOGY	2,557	2	−2	1	1
9	EMERGENCY MEDICINE	2,451	0	3	1	4
10	ENDOCRINOLOGY	385	0	0	1	2
11	FAMILY PRACTICE	5,354	0	0	1	2
12	GASTROENTEROLOGY	1,883	2	1	1	3
13	GENERAL PRACTICE	842	0	0	1	2
14	GENERAL SURGERY	2,408	1	1	1	3
15	GERIATRICS	175	0	2	1	3
16	HAND SURGERY	88	−1	−1	1	−1
17	HEMATOLOGY/ONCOLOGY	2,019	−1	−2	1	−1
18	INFECTIOUS DISEASE	561	1	2	1	4
19	INTERNAL MEDICINE	10,662	0	1	1	2
20	INTERVENTIONAL RADIOLOGY	228	−1	0	1	0
21	NEPHROLOGY	1,840	−1	1	1	2
22	NEUROLOGY	1,489	0	0	1	1
23	NEUROSURGERY	620	−1	0	1	0
24	NUCLEAR MEDICINE	79	−1	−2	1	−1
25	OBSTETRICS/GYNECOLOGY	654	0	0	1	0
26	OPHTHALMOLOGY	5,026	0	0	1	0
27	ORTHOPEDIC SURGERY	3,454	0	0	1	0
28	OTOLARNGOLOGY	984	−1	−1	1	−1
29	PATHOLOGY	1,007	0	0	1	1
30	PEDIATRICS	72	1	0	1	2
31	PHYSICAL MEDICINE	850	0	1	1	1
32	PLASTIC SURGERY	288	0	0	1	1
33	PSYCHIATRY	1,169	1	2	1	4
34	PULMONARY DISEASE	1,828	1	1	1	3
35	RADIATION ONCOLOGY	1,854	−1	−3	1	−3
36	RADIOLOGY	5,554	0	−1	1	0
37	RHEUMATOLOGY	521	0	−1	1	−1
38	THORACIC SURGERY	431	0	1	1	2
39	UROLOGY	2,146	0	−1	1	0
40	VASCULAR SURGERY	685	0	−1	1	1
41	AUDIOLOGIST	33	−9	−2	1	−10
42	CHIROPRACTOR	768	−1	2	1	2
43	CLINICAL PSYCHOLOGIST	571	−2	3	1	2
44	CLINICAL SOCIAL WORKER	378	−1	3	1	3

TABLE 48—COMBINED CY 2009 TOTAL ALLOWED CHARGE IMPACT FOR WORK RVU CHANGES, PRACTICE EXPENSE CHANGES, AND MIPPA CHANGES—Continued

Specialty	Allowed Charges (mil)	Work and PE RVU Changes * (percent)	MIPPA 133(b) ** (percent)	MIPPA 131 Update (percent)	Total *** (percent)
45 NURSE ANESTHETIST	846	0	4	1	5
46 NURSE PRACTITIONER	963	1	1	1	3
47 OPTOMETRY	867	0	−1	1	0
48 ORAL/MAXILLOFACIAL SURGERY	38	1	−1	1	1
49 PHYSICAL/OCCUPATIONAL THERAPY	1,772	2	0	1	3
50 PHYSICIAN ASSISTANT	711	0	1	1	2
51 PODIATRY	1,727	1	−1	1	1
52 DIAGNOSTIC TESTING FACILITY	1,186	−2	−5	1	−6
53 INDEPENDENT LABORATORY	878	5	−4	1	2
54 PORTABLE X-RAY SUPPLIER	87	2	−4	1	−2

* PE changes are CY 2009 third year transition changes. For fully implemented CY 2010 PE changes, see Table 1.
** Prior to the application of the OPPS imaging caps under DRA 5102.
*** Components may not sum to total due to rounding.

We received comments from individuals and organizations concerning the impact of the proposed rule, which reflected the projected negative update. These commenters stated that the proposed cuts in payment for services, particularly those for interventional pain management, could have a devastating impact on their ability to provide services to Medicare beneficiaries. The commenters also expressed concern that the current PE payment methodology does not accurately reflect the costs needed to provide their services.

As discussed in sections III. and VII. of this final rule with comment period, section 131(a) of the MIPPA provides that the update to the single CF for CY 2009 shall be 1.1 percent. Tables 47 and 48 reflect this change. As required by the statute, payment under the PFS is resource-based. In future rulemaking, we expect to include improvements to the resource-based PE methodology that will include more current specialty specific aggregate cost data obtained through physician specialty practice surveys.

Table 49 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE refer to Addendum A of this final rule with comment period.

TABLE 49—IMPACT OF FINAL RULE WITH COMMENT PERIOD AND ESTIMATED PHYSICIAN UPDATE ON 2009 PAYMENT FOR SELECTED PROCEDURES

CPT/HCPCS	MOD	Description	Facility			Non-facility		
			2008	2009	Percent change	2008	2009	Percent change
11721	.....	Debride nail, 6 or more	$27.42	$27.77	1	$39.61	$40.39	2
17000	.....	Destruct premalg lesion	46.47	48.69	5	67.41	69.97	4
27130	.....	Total hip arthroplasty	1,336.09	1,359.71	2	NA	NA	NA
27244	.....	Treat thigh fracture	1,077.10	1,144.39	6	NA	NA	NA
27447	.....	Total knee arthroplasty	1,435.12	1,456.37	1	NA	NA	NA
33533	.....	CABG, arterial, single	1,854.84	1,892.05	2	NA	NA	NA
35301	.....	Rechanneling of artery	1,045.11	1,067.93	2	NA	NA	NA
43239	.....	Upper GI endoscopy, biopsy	156.92	165.55	5	329.07	323.16	−2
66821	.....	After cataract laser surgery	249.47	251.38	1	266.23	266.53	0
66984	.....	Cataract surg w/iol, 1 stage	626.15	638.74	2	NA	NA	NA
67210	.....	Treatment of retinal lesion	545.79	561.56	3	567.88	580.67	2
71010	.....	Chest x-ray	NA	NA	NA	25.52	24.16	−5
71010	26	Chest x-ray	8.76	9.02	3	8.76	9.02	3
77056	.....	Mammogram, both breasts	NA	NA	NA	104.74	107.48	3
77056	26	Mammogram, both breasts	41.90	44.36	6	41.90	44.36	6
77057	.....	Mammogram, screening	NA	NA	NA	82.65	81.15	−2
77057	26	Mammogram, screening	33.90	35.71	5	33.90	35.71	5
77427	.....	Radiation tx management, x5	177.10	188.27	6	177.10	188.27	6
78465	26	Heart image (3d), multiple	74.27	78.99	6	74.27	78.99	6
88305	26	Tissue exam by pathologist	36.18	37.15	3	36.18	37.15	3
90801	.....	Psy dx interview	125.31	128.04	2	147.02	152.92	4
90862	.....	Medication management	43.80	45.08	3	52.18	55.18	6
90935	.....	Hemodialysis, one evaluation	65.13	66.36	2	NA	NA	NA
92012	.....	Eye exam established pat	43.04	45.80	6	70.08	70.69	1
92014	.....	Eye exam & treatment	66.27	70.33	6	101.69	103.15	1
92980	.....	Insert intracoronary stent	806.30	847.93	5	NA	NA	NA
93000	.....	Electrocardiogram, complete	23.23	20.92	−10	23.23	20.92	−10

TABLE 49—IMPACT OF FINAL RULE WITH COMMENT PERIOD AND ESTIMATED PHYSICIAN UPDATE ON 2009 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT/HCPCS	MOD	Description	Facility			Non-facility		
			2008	2009	Percent change	2008	2009	Percent change
93010		Electrocardiogram report	8.38	9.02	8	8.38	9.02	8
93015		Cardiovascular stress test	103.98	100.27	−4	103.98	100.27	−4
93307	26	Echo exam of heart	47.23	49.77	5	47.23	49.77	5
93510	26	Left heart catheterization	241.09	248.86	3	241.09	248.86	3
98941		Chiropractic manipulation	28.57	30.30	6	33.14	33.90	2
99203		Office/outpatient visit, new	65.51	68.17	4	91.03	91.97	1
99213		Office/outpatient visit, est	41.90	44.72	7	59.80	61.31	3
99214		Office/outpatient visit, est	65.51	69.25	6	89.89	92.33	3
99222		Initial hospital care	116.93	122.63	5	NA	NA	NA
99223		Initial hospital care	171.77	180.33	5	NA	NA	NA
99231		Subsequent hospital care	35.42	37.15	5	NA	NA	NA
99232		Subsequent hospital care	63.22	66.72	6	NA	NA	NA
99233		Subsequent hospital care	90.65	95.58	5	NA	NA	NA
99236		Observ/hosp same date	200.34	207.38	4	NA	NA	NA
99239		Hospital discharge day	92.93	96.30	4	NA	NA	NA
99243		Office consultation	92.93	97.38	5	122.26	124.79	2
99244		Office consultation	145.49	154.00	6	179.01	184.30	3
99253		Inpatient consultation	108.55	114.69	6	NA	NA	NA
99254		Inpatient consultation	156.54	165.55	6	NA	NA	NA
99283		Emergency dept visit	59.03	61.31	4	NA	NA	NA
99284		Emergency dept visit	108.93	114.33	5	NA	NA	NA
99291		Critical care, first hour	204.15	212.07	4	250.99	253.91	1
99292		Critical care, addtl 30 min	102.45	106.04	3	111.98	114.69	2
99348		Home visit, est patient	NA	NA	NA	76.17	79.35	4
99350		Home visit, est patient	NA	NA	NA	155.78	160.86	3
G0008		Admin influenza virus vac	NA	NA	NA	20.57	20.92	2

Table 50 illustrates, for selected commonly provided procedures, how the payment amounts are affected solely by the requirement in section 133(b) of the MIPPA that BN for the 5-Year Review of physician work be applied to the CF instead of through a separate work adjustor. While section 133(b) of the MIPPA does not increase or decrease expenditures in the aggregate for physician services, it will have a differential effect on services depending on the proportion of the PFS payment that is accounted for by work, PE, and malpractice. Physician work accounts for—on average across all PFS services—52.5 percent of total work RVUs. As BN for the 5-Year Review is being moved from the physician work RVUs only to the total payment, any service that has a higher than average proportion of its total payment accounted for by physician work will see its total payment increase solely as a result of section 133(b) of the MIPPA. Conversely, any service where physician work accounts for a lower than average proportion of its total payment, section 133(b) of the MIPPA will result in a reduction in payment. Thus, section 133(b) of the MIPPA results in a payment reduction of 5 percent to CPT code 78565, *Heart Image, 3d, Multiple,* for the global service and 6 percent for the TC only. Physician work is 11 percent of the total RVU for the global and 0 percent of the TC of this service. These percentages are less than the 52.5 percent on average that is attributed to physician work and explains why payment for these services declines as a result of section 133(b) of the MIPPA. Similarly, the nonfacility amount for CPT code 99213 (Office/outpatient visit, est) increases by 0.5 percent because its work RVUs are a slightly higher proportion of its total payment (54 percent) than the 52.5 percent average for all physician services while the facility amount increases even more because its work RVUs as a percent of total RVUs (74 percent) are significantly higher than the proportion on average for all physician services. A hospital visit (CPT code 99223) and an emergency department visit (CPT code 99285) also show higher increases in payment (3 and 4 percent respectively) due to section 133(b) of the MIPPA because physician work RVUs also account for a higher proportion of the total RVUs (76 and 80 percent respectively) than the average for all physician services.

TABLE 50—CY 2009 IMPACT OF PLACING BUDGET NEUTRALITY ADJUSTMENT ON THE CONVERSION FACTOR

[Section 133(b) of the MIPPA]

CPT/HCPCS	Mod	Description	Facility or nonfacility	Physician work as a % of total RVUs	2009 BN on work RVU	2009 BN on CF	Percent change
78465		Heart image (3d), multiple	Nonfacility	11	$509.48	$485.46	−5
78465	TC	Heart image (3d), multiple	Nonfacility	0	432.18	406.47	−6
99213		Office/outpatient visit, est	Nonfacility	54	60.98	61.26	0.5
99213		Office/outpatient visit, est	Facility	74	43.34	44.69	3
99223		Initial hospital care	Facility	76	174.43	180.33	3

TABLE 50—CY 2009 IMPACT OF PLACING BUDGET NEUTRALITY ADJUSTMENT ON THE CONVERSION FACTOR—Continued
[Section 133(b) of the MIPPA]

CPT/HCPCS	Mod	Description	Facility or nonfacility	Physician work as a % of total RVUs	2009 BN on work RVU	2009 BN on CF	Percent change
99285	.....	Emergency dept visit	Facility	80	163.99	170.60	4

B. Telehealth

In section II.D. of this final rule with comment period, we are creating HCPCS codes specific to the telehealth delivery of follow-up inpatient consultations. The new HCPCS codes will be limited to the range of services included in the scope of deleted CPT codes previously approved for telehealth, with the descriptions modified to limit the use of such services for telehealth. Utilization of these codes will allow us to provide payment for follow-up inpatient telehealth consultations, as well as enable us to monitor whether the codes are used appropriately.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately $2 million. Previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that the addition of follow-up inpatient telehealth consultation services to the approved telehealth service list will enable more beneficiaries access to these services, we do not anticipate that this change will have a significant budgetary impact on the Medicare program.

C. Payment for Covered Outpatient Drugs and Biologicals

1. ASP Issues

The changes discussed in section II.F.1. of this final rule with comment period with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures.

2. CAP Issues

In the CY 2009 PFS proposed rule, we proposed minor refinements for the CAP, specifically the annual CAP payment amount update mechanism, the definition of a CAP physician, easing the restriction on the transportation of CAP drugs between practice locations, and the dispute resolution process. After the publication of the CY 2009 PFS proposed rule, further CAP implementation for 2009 was postponed. At this time, we are seeking feedback about the CAP from current and former CAP physicians, potential vendors, and other interested parties. We will assess the information and consider implementing changes to the CAP before proceeding with another bid solicitation.

Our proposed refinements to the CAP are not being finalized in this rule. Therefore, there is no potential impact associated with CAP provisions in the CY 2009 PFS rule.

D. Application of the HPSA Bonus Payment

As discussed in section II.G. of this final rule with comment period, there are no program cost savings or increased expenditures associated with this change; however, we expect that the regulation will increase the number of physicians who receive the bonus automatically, while decreasing the number of physicians required to use a modifier in order to receive the payment. It will also provide assurance to physicians and eligible recipients, for example health care facilities that bill under the CAH II method in qualified areas, that they will receive the HPSA bonus payment throughout the calendar year.

F. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in section II.H. of this final rule with comment period. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2008 payments) to estimated payments under the revisions to the composite rate payment system (CY 2009 payments) as discussed in section II.H. of this final rule with comment period. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2008 payments and 2009 payments.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2008 update of CY 2007 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Due to data limitations, we are unable to estimate current and proposed payments for 96 of the 4954 ESRD facilities that bill for ESRD dialysis treatments.

Table 51 shows the impact of this year's changes to CY 2009 payments to hospital-based and independent ESRD facilities. The first column of Table 51 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of all changes to the ESRD wage index for CY 2009 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in the fourth year of the transition (CY 2009) to aggregate ESRD wage adjusted composite rate payments in the third year of the transition (CY 2008). In the fourth year of the transition (CY 2009), ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate. In the third year of the transition, ESRD facilities receive 75 percent of the CBSA wage adjusted composite rate and 25 percent of the MSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2009 ESRD wage index has been multiplied by a BN adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index. The impacts are similar to those shown in the proposed rule. (See the CY 2009 PFS proposed rule (73 FR 38599) for a

breakout of the effects associated with the change in the wage index floor.)

The fifth column shows the effect of the MIPPA provisions on hospital-based and independent ESRD facilities. Section 153(a) of the MIPPA updated section 1881(b)(12)(G) of the Act and revised payments to ESRD facilities. The revisions that are effective January 1, 2009 include an update of 1 percent to the composite rate component of the payment system and the establishment of a site neutral composite rate to hospital-based and independent dialysis facilities.

The sixth column shows the overall effect of the changes in the composite rate payments to ESRD providers excluding the drug add-on. This column shows the percent change between CY 2009 and CY 2008 composite rate payments to ESRD facilities. The sixth column combines the effects of changes in the wage index (column 4) with the effect of the MIPPA provisions (column 5). This column does not include the drug add-on to the composite rate.

The seventh column shows the overall effect of the changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the difference between the CY 2009 payment with all changes as proposed in this rule and current CY 2008 payment. This payment amount is computed by multiplying the wage adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2007 claims. The CY 2009 payment is the transition year 4 wage-adjusted composite rate for each provider (with the 15.2 percent drug add-on) times dialysis treatments from CY 2007 claims. The CY 2008 current payment is the transition year 3 wage-adjusted composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2007 claims.

The overall impact to ESRD providers in aggregate is 0.4 percent. Most ESRD facilities will see an increase in payments as a result of the MIPPA provisions. However, the site neutral composite rate results in a 2.1 percent decrease in payments to hospital-based ESRD facilities. Since many hospital-based ESRD facilities are nonprofit, there is a 0.7 percent decrease in payments to all nonprofit ESRD facilities.

While the MIPPA provision includes a 1 percent increase to the ESRD composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule is a 0.4 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.7 percent and payments to hospital-based ESRD facilities will decrease 2.1 percent.

TABLE 51—IMPACT OF CY 2009 CHANGES IN PAYMENTS TO HOSPITAL-BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities (both program and beneficiaries)]

1	2	3	4	5	6	7
	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in wage index [1]	Effect of the MIPPA provisions only [2]	Overall effect without drug add-on [3]	Overall effect including drug add-on [4]
All Providers:	4,858	36.4	0.0	0.7	0.7	0.4
Independent	4,303	32.8	0.0	1.0	1.0	0.7
Hospital Based	555	3.7	0.2	−2.1	−1.9	−2.1
By Facility Size:						
Less than 5000 treatments	1,732	5.0	−0.1	0.6	0.5	0.2
5000 to 9999 treatments	1,915	13.9	0.0	0.8	0.8	0.5
Greater than 9999 treatments	1,211	17.6	0.0	0.6	0.6	0.4
Type of Ownership:						
Profit	3,932	29.8	0.0	1.0	0.9	0.7
Nonprofit	926	6.6	0.2	−0.7	−0.5	−0.7
By Geographic Location:						
Rural	1,320	7.6	−0.5	0.6	0.1	−0.1
Urban	3,538	28.8	0.1	0.7	0.8	0.5
By Region:						
New England	154	1.2	1.2	0.5	1.8	1.5
Middle Atlantic	566	4.6	0.1	0.2	0.3	0.0
East North Central	768	5.8	−1.0	0.6	−0.4	−0.7
West North Central	372	2.0	0.0	0.3	0.3	0.0
South Atlantic	1104	8.3	−0.1	0.8	0.8	0.5
East South Central	379	2.7	−1.0	0.9	0.0	−0.3
West South Central	667	5.2	−0.5	0.9	0.3	0.1
Mountain	259	1.6	0.0	0.7	0.7	0.5
Pacific	555	4.6	2.2	0.8	3.0	2.7
Puerto Rico & Virgin Islands	34	0.4	−4.6	0.8	−3.8	−4.1

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments computed using the current wage index are compared to composite rate payments using the CY 2009 wage index changes. This column does not include the drug add-on to the composite rate.

[2] This column shows the effect of the MIPPA provisions which include a 1 percent increase to composite rate and elimination of separate composite rate for hospital-based ESRD providers. These provisions are effective January 1, 2009. This column does not include the drug add-on to the composite rate.

[3] This column shows the percent change between CY 2009 and CY 2008 composite rate payments to ESRD facilities. This column does not include the drug add-on to the composite rate.

[4] This column shows the percent change between CY 2009 and CY 2008 composite rate payments to ESRD facilities. The CY 2009 payments include the CY 2009 wage adjusted composite rate, and the 15.2 percent drug add-on times treatments. The CY 2008 payments to ESRD facilities includes the CY 2008 wage adjusted composite rate and the 15.5 percent drug add-on times treatments.

G. IDTF Issues

We believe that the provisions regarding IDTFs as discussed in Section II.I. of this final rule with comment period will have minimal budgetary impact. We believe that the IDTF enrollment provisions contained in this rule are necessary and will help ensure that beneficiaries receive quality care by making certain that those entities providing mobile diagnostic testing services meet established performance standards and are enrolled in the Medicare program as IDTFs. We maintain that most of these mobile units providing diagnostic testing services are already enrolled as IDTFs as required in § 410.33(g), however we have no way of determining how many of these units are providing mobile diagnostic testing services, yet are not enrolled. We do not believe that beneficiary access to IDTF services will be affected by these requiring mobile units providing diagnostic testing services to enroll in the Medicare program.

H. Physician and Nonphysician Practitioner Enrollment Issues

We believe that the provisions regarding physicians, NPPs, and physician and NPP organizations as discussed in section II.J. of this final rule with comment period will have minimal budgetary impact. The provisions of this final rule supplement, but do not replace or nullify, existing regulations concerning the issuance of physician and NPP billing privileges, and payment for Medicare covered items or services to eligible physicians and NPPs. We have already increased our efforts to seek more uniformity in the enrollment process. However, our experience clearly shows that the best means for preventing payment errors and, in worst cases, abuse by providers and suppliers, is to discourage and prevent their entry into the Medicare program. While some individuals and organizations may perceive our requirements as a barrier to their access to serving Medicare beneficiaries, we do not believe that bona fide physicians, NPP, or physician or NPP organizations will experience any difficulty in obtaining or maintaining Medicare billing privileges.

We expect this final rule with comment period to ensure that the Medicare program has adequate information on those who seek to bill the program for items or services. The primary goal of this provision of the final rule with comment period, through standard enrollment requirements is to allow us to collect and maintain (keep current) a unique and equal data set on all current and future physicians, NPPs, and physician and NPP organizations that are billing or will bill the Medicare program for items or services furnished to Medicare beneficiaries. By achieving this goal, we will be better positioned to protect the Medicare Trust Funds and the Medicare beneficiaries.

This rule will also allow us to develop, implement, and enforce national enrollment procedures to be administered uniformly by all Medicare contractors. Further, we believe that the enrollment provisions contained in this rule are necessary to ensure that beneficiaries receive quality care by making certain that the physicians, NPPs, and physician or NPP organizations providing care meet established standards and are enrolled in the Medicare program.

As a result of currently not having quantifiable data, we cannot effectively derive an estimate of the monetary impacts of these provisions. Accordingly, we sought public comment so that the public may provide any data available that provides a calculable impact or any alternative to the proposed provision. However, no further data was presented by the public in order to provide a calculable impact. We adopted a modified enrollment policy after considering the alternatives that were suggested through the public comment period of the regulatory process which established the effective date of billing privileges for newly enrolling physicians, NPPs, and physician and NPP organizations.

I. Amendment to the Exemption for Computer-Generated Facsimile Transmissions From the NCPDP SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D-Covered Drugs Prescribed to Part D Eligible Individuals

The amendment to the exemption for computer-generated facsimiles from the NCPDP SCRIPT Standard under the Medicare Part D e-prescribing provisions is discussed in section II.K. of this rule. E-prescribing Part D covered drugs to Part D eligible individuals is voluntary for providers and dispensers. The MMA only requires that if prescribers and dispensers choose to e-prescribe, that they use the standards adopted by the Secretary for those specific e-prescribing transactions. The amendment to the exemption for computer-generated faxing from the NCPDP SCRIPT standard only affects pharmacies that already conduct e-prescribing using products that generate facsimiles.

This amendment of the exemption for computer-generated facsimiles to include prescription refill requests sent from dispensers to providers who do not possess the capability to conduct electronic refill request transactions using the NCPDP SCRIPT standard will not affect non-NCPDP SCRIPT enabled prescribers. Prescribers that currently e-prescribe using NCPDP SCRIPT would continue to receive refill requests electronically. Prescribers that currently e-prescribe with computer-generated faxes using a system that can utilize the NCPDP SCRIPT standard will simply turn that function on, and receive refill request transactions using the NCPDP SCRIPT standard in place of the computer-generated facsimiles that they used to receive. Prescribers that do not have the capacity to use NCPDP SCRIPT standard would continue to receive computer-generated facsimiles. Moreover, the amendment would not impose costs on dispensers, as they would be permitted to continue using computer-generated facsimiles with partners that cannot conduct electronic refill request transactions using the NCPDP SCRIPT standard. The amendment will have direct benefits for dispensers. One national drug store chain estimated that its stores generate 150,000 non-EDI prescription refill requests each day. If the computer-generated facsimile exemption were not modified, these dispensers would have to revert to paper/phone calls in instances in which a provider is not able to accept electronic refill requests utilizing the NCPDP SCRIPT standard. One chain pharmacy has relayed that moving forward with the scheduled elimination of the computer-generated faxing exception to the NCPDP SCRIPT standard in all instances other than transmission failures and similar communication problems of temporary or transient nature would result in approximately 105,000 initial paper facsimiles and 45,000 initial phone calls/oral scripts per day. They also consider a 2 percent facsimile failure rate that translates into phone calls, or approximately 2,100 additional phone calls per day. Ten percent of all phone calls require a second call back, or 4,710 call backs per day. Therefore, without further modification of computer-generated facsimiles exception, as of January 1, 2009 this national drug store chain would have to make a total of 51,810 additional phone calls for prescription refill requests per day. They estimate the cost of reverting to paper facsimiles, including purchasing fax machines, labor, paper, printing, hardware, and service costs at over $12.5 million a year. They also estimate the cost per year of phone calls,

including an average of 4 minutes per call, labor, and telecommunication costs, at more than $78 million per year, for a total cost for faxes and phone calls of $88.8 million per year.[9]

Another national drug store chain offered a similar analysis. They estimated that a prescription refill request undertaken by telephone takes 1.43 minutes longer to complete than one initiated by computer-generated facsimile. Without further modification of the computer-generated facsimile exception, as of January 1, 2009 this national drug store chain would have to replace the more than 123 million computer-generated facsimile refill requests that are made each year with phone calls or paper faxes. They estimate that this would result in 9.2 lost hours of staff time per store per week, resulting in $88 million in additional costs, based on a blended payroll rate of pharmacists and staff. Extrapolating this cost across the entire pharmacy industry based on this commenter's market share, they estimated an impending pharmacy industry loss of at least $520 million unless the computer-generated facsimile exception is further modified.[10]

According to industry reports in 2006 approximately 3.309 billion prescriptions [11] were filled by retail dispensers, and according to CMS data, in 2006, approximately 825,000,000 Part D claims (prescription drug events) were finalized and accepted for payment,[12] or approximately 25 percent of the total prescriptions filled that year. Thus, $130 million of the $520 million total loss estimated above would be attributable to Medicare Part D claims. We invite comments on these savings and loss assumptions estimates and assumptions.

We also assume that expanding the computer-generated facsimile exception to allow for computer-generated faxing in instances in which the provider is incapable of receiving electronic refill request transactions using the NCPDP SCRIPT standard would result in improved patient satisfaction through timely prescription refill request authorizations from prescribers and maintenance of existing workflows at both the prescriber and dispenser ends.

Our decision to retain the exemption for computer-generated facsimiles in all instances other than temporary/transient transmission failures will have a positive impact on the industry overall, including small pharmacies and prescribers who are early adopters of e-prescribing and who may still depend on the use of computer-generated facsimiles to communicate. In the CY 2009 PFS proposed rule (73 FR 38601), we discussed the estimated losses that could result if we moved forward with the elimination of the computer-generated faxing exemption to the NCPDP SCRIPT standard in all instances other than temporary/transient transmission failures. We stated that two national chain pharmacies said the proposed elimination of the computer-generated faxing exemption would result in a loss to each chain of approximately $88 million in labor, lost productivity and telecommunications costs. If this cost was extrapolated across the entire pharmacy industry, industry estimated an impending pharmacy industry loss of at least $520 million a year. As Medicare Part D claims account for approximately 25 percent of the total prescriptions filled annually, we estimated that $130 million of that $520 loss would be attributable to Medicare Part D claims. We also considered other alternatives, including eliminating the exemption for computer-generated facsimiles in all instances, with an effective date of January 1, 2009, as detailed in the final rule with comment at 72 FR 66396; and eliminating the exemption for computer-generated facsimiles in all instances except for the prescription refill request transaction and in instances of temporary/transient transmission failures. As we discussed previously in this final rule, we decided against imposing either of those alternatives in light of the advantage of the momentum that will be built by the e-prescribing incentive program under MIPPA, and affording the industry an additional 3 years from the effective date of this final rule to move toward true e-prescribing.

J. CORF Issues

The revisions to the CORF regulations discussed in section II.L. of this final rule with comment period updates the regulations for consistency with the PFS payment rules and make additional changes to the conditions of participation to reflect industry standards. These revisions will help to clarify payment and operational requirements for CORF services and are expected to have minimal impact on Medicare expenditures.

K. Therapy Issues

The revisions to the therapy regulations discussed in section II.M. of this final rule with comment period make technical corrections and update the regulations and are expected to have minimal impact on Medicare expenditures.

L. Physician Self-Referral Provisions

We anticipate that the provisions in section II.N. of this final rule with comment period concerning the anti-markup provisions in § 414.50 will result in savings to the program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any certainty the extent of these savings to the Medicare program.

M1. Physician Quality Reporting Initiative (PQRI)

As discussed section II.O1. of this final rule with comment period, the final 2009 PQRI measures satisfy the requirement of section 1848(k)(2)(B)(iii) of the Act that the Secretary publish in the **Federal Register** by November 15, 2008 a final set of quality measures that the Secretary determines would be appropriate for eligible professionals to use to submit data to the Secretary in 2009. As discussed in section II.O1. of this final rule with comment period, we are also offering options in 2009 for reporting some of the 2009 PQRI measures via submission of data to a clinical registry and options for reporting on measures groups rather than individual measures.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based data submission for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the PQRI on providers. One factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity

[9] CVS/Caremark Discussion Points on E-Fax Ruling Exceptions, January 3, 2007.

[10] December 22, 2007 correspondence from Walgreen's to CMS re: CMS–1385–FC, Final Rule with Comment Period: Amendment of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

[11] *http://www.statehealthfacts.org.*

[12] CMS, November 16, 2007 Proposed Rule, 72 FR 64913.

and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows. Therefore, we will assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP) indicated an average labor cost of approximately $50 per hour. Thus, we estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows to be approximately $150 per eligible professional ($50 per hour × 3 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP, estimates the cost to physicians to perform all the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Eligible professionals are generally required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2009 PQRI will report an average of 3 measures each.

The cost of implementing claims-based reporting of PQRI quality measures data also varies with the volume of claims on which quality data is reported. Preliminary results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average, the median number of eligible instances reported on per measure was about 9. Therefore, for this analysis, we estimate that for each measure, an eligible professional reports the quality data on 9 cases.

Thus, we estimate the cost to each eligible professional associated with claims-based reporting of PQRI quality data codes to range from $155.67 [($0.21 per measure × 3 measures × 9 cases per measure) + $150] to $421.62 [($10.06 per measure × 3 measure × 9 cases per measure) + $150].

M2. Electronic Prescribing (E-Prescribing) Incentive Program

Section II.O2. of this final rule with comment period describes a new incentive program for eligible professionals who are considered successful electronic prescribers. To be considered a successful electronic prescriber, an eligible professional must report on the e-prescribing measure identified in section II.O2. of this final rule with comment period.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program would be minimal since the program consists of only 1 quality measure.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the E-Prescribing Incentive Program on eligible professionals. Similar to claims-based reporting for the PQRI, one factor in the cost to eligible professionals is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into the office work flows. At an average cost of approximately $50 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $50 ($50 per hour × 1 hour).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP, estimates the cost to physicians to perform all the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the e-prescribing measure on a claim to be approximately $0.90.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on preliminary results from the 2007 PQRI described above and the fact that the measure's denominator consists of only billing codes for professional services, we estimate that each eligible professional reports the quality data on 60 cases for the e-prescribing measure.

Thus, we estimate the cost to each eligible professional associated with claims-based reporting of the e-prescribing measure to be $104[($0.90 per measure × 1 measures × 60 cases per measure) + $50].

In addition, the e-prescribing measure requires eligible professionals to have and use a ''qualified'' e-prescribing system. There are currently many commercial packages available for e-prescribing. One study indicated that a mid-range complete electronic medical record costs $2500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs $1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). ''Electronic prescribing: a review of costs and benefits.'' Topics in Health Information Management 24(1): 29–38.). The cost to an eligible professional of obtaining and utilizing an e-prescribing system varies not only by the commercial software package selected but also by the level at which the professional currently employs information technology in his or her practice and the level of training needed.

N. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists

We anticipate that there are no program cost savings or increased expenditures associated with the changes discussed in section II.Q. of this final rule with comment period. However, we expect that the technical correction to the NP qualifications will

make the regulations comport with the agency's intent to require a master's degree in nursing as the minimum educational level for new NPs independently treating beneficiaries and directly billing the Medicare program. Also, the changes to the NP and CNS educational requirement to include the DNP doctoral degree will help to eliminate any concern or confusion for contractors and the nursing industry about whether APNs with doctoral degrees in nursing (but without a master's degree in nursing) meet our program qualifications.

O. Portable X-ray Personnel Qualifications

We anticipate that there are no program cost savings or increased expenditures associated with the changes discussed in section II.R. of this final rule with comment period; however, we expect that the revisions to the regulations will have a positive impact on patient care.

P. Prohibition Concerning Payment of Continuous Positive Airway Pressure (CPAP) Devices

The provisions discussed in section II.S.2 of this final rule with comment period will reduce Medicare Trust Fund vulnerability to fraud and abuse and protect Medicare Beneficiaries from the burden of unnecessary sleep testing and unnecessary exposure to a medical device. This prohibition will have no effect on providers as the majority of providers are not DMEPOS suppliers who would by supplying CPAP devices. Only providers or other entities that perform both unattended out-of-facility sleep testing and supply CPAP machines to beneficiaries they have tested will be impacted which we believe would be very few, if any. For the reasons listed above, this final will have no impact on DMEPOS suppliers because most suppliers only supply the CPAP machines; they do not evaluate patients, order sleep tests, nor do they interpret them.

Q. Beneficiary Signature Requirements for Nonemergency Ambulance Services

We believe that our proposal in section II.S.3. of this final rule with comment period for allowing the ambulance provider or supplier to sign the claim on behalf of the beneficiary with respect to nonemergency transport services, provided that certain conditions are satisfied, will have no budgetary impact.

R. Revision to the ''Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges'' Final Rule

We expect that the provision in section II.S.5. of this final rule with comment period will have an impact on an unknown number of persons and entities; however, we believe that this provision will impact only a small number of suppliers whose billing privileges are revoked due to Federal debarment or exclusion, felony convictions, license suspensions or revocation, or because the supplier is no longer operating at a practice location provided to Medicare. We also believe that while this provision changes the effective date of revocation for certain suppliers that are no longer in compliance with Medicare enrollment requirements, this provision does not expand or change our revocation authority.

As a result of not having quantifiable data for the suppliers that meet the criteria for immediate revocation, we cannot effectively derive an estimate of the monetary impacts of this provision. Accordingly, we sought public comment so that the public may provide any data available that provides a calculable impact or any alternative to the proposed provision. However, no further data was presented by the public in order to provide a calculable impact.

S. MIPPA Provisions

1. Section 101: Improvements to Coverage of Preventive Services

a. Section 101(a) Coverage of Additional Preventive Services

As discussed earlier in the preamble, section 101(a) of the MIPPA provides the Secretary with the authority to add coverage of ''Additional Preventive Services'' and specifies the process and the criteria that are to be used in follow-up determinations regarding the coverage of such services under the Part B Program. As provided in the law, this new coverage allows payment for ''additional preventive services'' not otherwise described in Title XVIII of the Act, if the Secretary determines through the national coverage determination (NCD) process that the new services meet statutory requirements for coverage. We estimate that the new authority to review and add coverage of additional preventive services, if appropriate, will result in an increase in Medicare payments in the next couple of years to physician and other providers for such services. However, based on our experience in adding coverage of other preventive services (for example, the tobacco cessation benefit) we do not expect that the amount of the increase will be more than a modest amount. Since MIPPA refers to the evidence-based preventive services recommended by the USPSTF, costs would be aligned with the most effective screenings, and would avoid use of resources for those services that are not based on available evidence of effectiveness, thus reducing wasted resources.

b. Section 101(b)—Revisions to Initial Preventive Physical Examination (IPPE)

Section 101(b) of the MIPPA expands the eligibility period for beneficiaries using the initial preventive physical examination (IPPE) from 6 to 12 months, waives the Part B deductible, and makes several other changes to the benefit such as adding the measurement of the body mass index (BMI) and end-of-life planning to the list of required services. We estimate that the expansion of these Medicare Preventive services and the waiver of the Part B deductible requirement may increase the number of covered services that are performed in the next several years. As a result, we expect the amendment may result in a small but modest increase in payments to physicians and other qualified practitioners who provide these examinations and for any medically necessary follow-up (tests, counseling or treatment) that occur as a result of the initial preventive physical examination as beneficiaries increase their use of the benefit. The estimated financial impact is shown in Table 52.

TABLE 52—MEDICARE COST ESTIMATES FOR SECTION 101(b) OF THE MIPPA

[In millions]

MIPPA	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Section 101(b)	$5	$5	$5	$5	$5

2. Section 131: Physician Payment, Efficiency, and Quality Improvements; and Section 132: Incentives for Electronic Prescribing

A discussion of the impact of these MIPPA provisons is addressed earlier in this section in conjunction with the other PQRI provisions being implemented (see section XV.M. of this final rule with comment period).

3. Section 131(c): Physician Resource Use Feedback Program

Section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the phased pilot physician feedback program to date.

4. Section 133(b): Expanding Access to Primary Care Services (BN Adjustment)

The impact of this MIPPA provision is addressed in section VII. and previously in this section (XVI.A.) as part of the RVU impact discussion.

5. Section 134: Extension of Floor on Medicare Work Geographic Adjustment Under the Medicare PFS

As discussed in section III.F. of this preamble, section 134 of the MIPPA of 2008 extended the 1.000 work GPCI floor from July 1, 2008, through December 31, 2009. Additionally, the MIPPA sets a permanent 1.500 work GPCI floor in Alaska, beginning January 1, 2009. As a result of this MIPPA provision, 55 (out of 89) PFS localities will receive an increase in their work GPCI. Alaska receives the largest increase (+47.49 percent), followed by Puerto Rico (+10.62 percent), South Dakota (+6.16 percent), North Dakota (+5.60 percent) and the Missouri ''rest of state'' locality (+5.37 percent). The estimated impact for this provision is $400 million for CY 2009.

6. Section 136: Extension of Treatment of Certain

We do not have specific information on the number of independent laboratories that would be affected by section 136 of the MIPPA. We think that most, if not, all independent laboratories have some exposure to this billing practice. The estimated CY 2009 incurred benefit impact of the extension of this practice is $80 million.

7. Section 141: Extension of Exceptions Process for Medicare Therapy Caps

Section 141 of the MIPPA extends the exceptions process for therapy caps from July 1, 2008, through December 31, 2009. The estimated impact of this provision for CY 2009 is $1.69 billion.

8. Section 143: Speech-Language Pathology Services

Amendments made by section 143 of the MIPPA provide the authority to enroll speech-language pathologists as suppliers of Medicare services and for speech-language pathologists to begin billing Medicare for outpatient speech language pathology services furnished in private practice beginning July 1, 2009. The enrollment of speech language pathologists to provide services in outpatient settings is expected to have a minimal impact on Medicare expenditures.

9. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment

The revisions pertaining to oxygen and oxygen equipment in section III.J. of this final rule with comment period reflect changes made by the MIPPA. Prior to the MIPPA, section 1834(a)(5)(F) of the Act limited monthly payments to suppliers furnishing oxygen equipment to 36 months of continuous use. At the end of this 36-month period, suppliers were required to transfer title to oxygen equipment rented on or after January 1, 2006 to the beneficiary. Section 144(b) of the MIPPA repealed the transfer of title provision. In its place, section 144(b) establishes a 36-month rental cap and amends section 1834(a)(5)(F) of the Act by adding additional payment rules discussed previously in this preamble.

These changes may provide an economic benefit to suppliers because they will now retain ownership of oxygen equipment after 36 months of rental payments. If a beneficiary stops needing oxygen after the 36-month rental cap but before the end of the reasonable useful lifetime of the equipment (currently 5 years), the supplier will be able to retrieve the equipment and rent it to another Medicare beneficiary or other customer and receive additional rental payments for the remainder of the equipment's reasonable useful lifetime. It is difficult to estimate the impact of this change, but we believe the impact will be minimal and, therefore, do not believe it will be economically significant.

In addition, our regulations implementing MIPPA may provide a slight financial benefit to Medicare because we have determined that at this time it is not reasonable and necessary to make payments for non-routine maintenance and servicing (including repair) of supplier-owned oxygen equipment. We understand that oxygen equipment is very durable and should need few repairs in the first 5 years. Any costs suppliers may incur in repairs would be offset by the gains they achieve through retaining ownership of the equipment. Taken together, we expect these changes to have a minimal impact on Medicare expenditures.

10. Section 145: Clinical Laboratory Tests

Section 145 of the MIPPA reduces the Clinical Laboratory Fee Schedule update by 0.5 percentage points for each year, CY 2009 through CY 2013, and is estimated to result in an incurred benefit savings of $40 million.

11. Section 146: Improved Access to Ambulance Services

Section 146 of the MIPPA makes certain changes to Medicare payment for ambulance services. Specifically, this section: Increases the payment rate under the Ambulance fee schedule by 2 percent or 3 percent for ground ambulance trips in urban and rural areas, respectively furnished during the period July 1, 2008 through December 31, 2009; and, for air ambulance services furnished during the period beginning on July 1, 2008, and ending on December 31, 2009, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments for ambulance services furnished during such period. This section is estimated to increase Medicare expenditures by $20 million for CY 2009.

12. Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth Services

This provision will increase access to telehealth services through the new authority for certain facilities to serve as originating sites and is expected to have a negligible budgetary impact on Medicare expenditures.

13. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in

section XV.F. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

T. Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

1. Low Vision Aids

We have determined that there will be no impact on Medicare beneficiaries, medical equipment industry, or the Medicare program. This final rule with comment period clarifies a longstanding Medicare practice of not covering low vision aids.

2. Therapeutic Shoes Fee Schedule

The revisions to the therapeutic shoes regulations discussed in section XI.B. of this final rule are expected to have no impact on Medicare expenditures. This final rule with comment period merely codifies in regulations our current practice of paying for therapeutic shoes on a fee schedule basis.

U. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered. For a discussion of the sections that could impact small entities see the following sections: II.A.2. PE Proposals for CY 2009; II.B. GPCIs: Locality Discussion; II.D. Medicare Telehealth Services; II.E. Specific Coding Issues related to PFS; II.F. Part B Drug Payment; II.G. Application of the HPSA Bonus Payment; II.H. Provisions Related to Payment for Renal Dialysis Services Furnished by ESRD Facilities; II.I. IDTF Issues; II.J. Physician and NPP Enrollment Issues; II.K. Amendment to the Exemption for Computer-Generated Facsimile Transmission from the NCPDP SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Covered Drugs Prescribed for Part D Eligible Individuals; II.L. CORF and Rehabilitation Agency Issues; II.N. Physician Self-Referral and Anti-Markup Issues; II.O1. Physician Quality Reporting Initiative and O2. Electronic Prescribing (E-Prescribing) Incentive Program; II.Q. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists; II.R. Portable X-Ray Issue; II.S.2. Prohibition Concerning Payment of Continuous Positive Airway Pressure (CPAP) Devices; II.S.3. Beneficiary Signature for Nonemergency Ambulance Transport Services; II.S 5. Revision to the ''Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges'' Final Rule; II.S.6. Physician Resource Use Feedback Program; II.T. Electronic Prescribing (E–Prescribing) Incentive Program; III.A. Section 101: Improvements to Coverage of Preventive Services: III.I. Section 143: Speech-Language Pathology Services; III.J. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment; III.M. Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth Services; IV. Potentially Misvalued Codes Under PFS; V.E. Discussion of Codes and AMA RUC Recommendations for Which There Was No AMA RUC recommendation or for Which the Recommendation Was Not Accepted; V.G. Additional Coding Issues; and V.H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2009.

V. Impact on Beneficiaries

There are a number of changes made in this final rule with comment period that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the MIPPA provisions related to the IPPE, and the changes with respect to telehealth services will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries.

We do not believe that beneficiaries will experience drug access issues as a result of the changes with respect to Part B drugs and discontinuation of payment for preadministration services associated with IVIG.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2009, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be $468. In addition, the portion of the 2009 standard monthly Part B premium attributable to PFS services is estimated to be $40.10.

To illustrate this point, as shown in Table 47, the 2008 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is $91.03 which means that in 2008 a beneficiary is responsible for 20 percent of this amount, or $18. Based on this rule, the 2009 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 47, is $91.97 which means that, in 2009, the beneficiary coinsurance for this service would be $18.39.

Policies discussed in this rule that do affect overall spending, such as the additions to the list of codes that are subject to the MPPR for diagnostic imaging, would similarly impact beneficiaries' coinsurance.

W. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 53, we have prepared an accounting statement showing the classification of the expenditures associated with this final rule with comment period. This estimate includes the incurred benefit impact associated with the estimated CY 2009 PFS update based on the 2008 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

TABLE 53—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2008 TO CY 2009

Category	Transfers
Annualized Monetized Transfers	Estimated increase in expenditures of $3.00 billion.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.

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

List of Subjects

42 CFR Part 405

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

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Health professionals, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 486

Grant programs—health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-rays.

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 set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 1. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart H—Appeals Under the Medicare Part B Program

■ 2. Section 405.874 as is amended by revising paragraph (b)(2) to read as follows:

§ 405.874 Appeals of CMS or a CMS contractor.

* * * * *

(b) * * *

(2) *Effective date of revocation.* The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

* * * * *

PART 409—HOSPITAL INSURANCE BENEFITS

■ 3. The authority citation for part 409 continues to read as follows:

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

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

■ 4. Section 409.17 is amended by revising paragraph (a)(1) to read as follows:

§ 409.17 Physical therapy, occupational therapy, and speech-language pathology services.

(a) * * *

(1) Except as specified in this section, physical therapy, occupational therapy, or speech-language pathology services must be furnished by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists who meet the requirements specified in part 484 of this chapter.

* * * * *

Subpart C—Posthospital SNF Care

■ 5. Section 409.23 is amended by revising the section heading to read as follows:

§ 409.23 Physical therapy, occupational therapy and speech-language pathology.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 6. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

■ 7. Section 410.16 is amended in paragraph (a) by—

■ A. Revising the definition of ''Eligible beneficiary''.

■ B. Adding the definition of ''End-of-life planning'' in alphabetical order.

■ C. Revising paragraphs (4), (5), and (7) of the definition ''Initial preventive physical examination.''

§ 410.16 Initial preventive physical exam: Conditions for and limitations on coverage.

(a) * * *

Eligible beneficiary means, for the purposes of this section, an individual who receives his or her initial preventive examination not more than 1 year after the effective date of his or her first Medicare Part B coverage period.

End-of-life planning means, for purposes of this section, verbal or written information regarding the following areas:

(1) An individual's ability to prepare an advance directive in the case where

an injury or illness causes the individual to be unable to make health care decisions.

(2) Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

Initial preventive physical exam

* * *

(4) An examination to include measurement of the beneficiary's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history, and current clinical standards.

(5) End-of-life planning as that term is defined in this section upon agreement with the individual.

* * * * *

(7) Education, counseling, and referral, including a brief written plan such as a checklist provided to the individual for obtaining an electrocardiogram, as appropriate, and the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described in sections 1861(s)(10), (jj), (nn), (oo), (pp), (qq)(1), (rr), (uu), (vv), (xx)(1), (yy), (bbb), and (ddd) of the Act.

* * * * *

■ 8. Section 410.33 is amended by adding paragraphs (g)(16) and (17) to read as follows:

§ 410.33 Independent diagnostic testing facility.

* * * * *

(g) * * *

(16) Enrolls for any diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.

(17) Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a hospital service provided under arrangement with that hospital.

* * * * *

■ 9. Section 410.62 is amended by—

■ A. Revising paragraphs (a)(2) and (3).

■ B. Amending the heading of paragraph (b) by removing the phrase, ''*services to certain inpatients*'' and adding in its place ''*services furnished to certain inpatients.*''

■ C. Removing paragraph (d).

■ D. Redesignating paragraph (c) as paragraph (d).

■ E. Adding new paragraph (c).

The revisions and addition read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) * * *

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished by one of the following:

(i) A provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider.

(ii) A speech-language pathologist in private practice as described in paragraph (c) of this section.

(iii) Incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

* * * * *

(c) *Special provisions for services furnished by speech-language pathologists in private practice.*

(1) *Basic qualifications.* In order to qualify under Medicare as a supplier of outpatient speech-language pathology services, each individual speech-language pathologist in private practice must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the State in which he or she practices, and practice only within the scope of his or her license and/or certification.

(ii) Engage in the private practice of speech-language pathology as an individual, in one of the following practice types:

(A) An unincorporated solo practice.

(B) An unincorporated partnership or unincorporated group practice.

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice.

(D) An employee of a physician group.

(E) An employee of a group that is not a professional corporation.

(iii) Bill Medicare only for services furnished in one of the following:

(A) A speech-language pathologist's private practice office space that meets all of the following:

(*1*) The location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services and during the hours that the therapist engages in practice at that location.

(*2*) The space must be owned, leased, or rented by the practice, and used for the exclusive purpose of operating the practice.

(B) A patient's home not including any institution that is a hospital, a CAH, or a SNF.

(iv) Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

* * * * *

■ 10. Section 410.64 is added to read as follows:

§ 410.64 Additional preventive services.

(a) Medicare Part B pays for additional preventive services not otherwise described in this subpart that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following:

(1) Reasonable and necessary for the prevention or early detection of illness or disability.

(2) Recommended with a grade of A or B by the United States Preventive Services Task Force.

(3) Appropriate for individuals entitled to benefits under part A or enrolled under Part B.

(b) In making determinations under paragraph (a) of this section regarding the coverage of a new preventive service, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such services and may take into account the results of such an assessment in making such national coverage determinations.

■ 11. Section 410.75 is amended by revising paragraph (b) to read as follows:

§ 410.75 Nurse practitioners' services.

* * * * *

(b) *Qualifications.* For Medicare Part B coverage of his or her services, a nurse practitioner must be a registered professional nurse who is authorized by the State in which the services are

furnished to practice as a nurse practitioner in accordance with State law, and must meet one of the following:

(1) Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:

(i) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

(ii) Possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.

(2) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and meets the standards in paragraph (b)(1)(i) of this section.

(3) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

* * * * *

■ 12. Section 410.76 is amended by revising paragraph (b)(2) to read as follows:

§ 410.76 Clinical nurse specialists' services.

* * * * *

(b) * * *

(2) Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and

* * * * *

■ 13. Section 410.78 is amended by—

■ A. Revising the introductory text of paragraph (b).

■ B. Adding paragraphs (b)(3)(vi), (vii), and (viii).

The revision and additions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, and follow-up telehealth consultations furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(3) * * *

(vi) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(vii) A skilled nursing facility (as defined in section 1819(a) of the Act).

(viii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Act).

* * * * *

Subpart I—Payment of SMI Benefits

■ 14. Section 410.155 is amended by revising paragraph (b)(1) introductory text to read as follows:

§ 410.155 Outpatient mental health treatment limitation.

* * * * *

(b) * * *

(1) *Services subject to the limitation.* Except as specified in paragraph (b)(2) of this section, services furnished by physicians and other practitioners, whether furnished directly or incident to those practitioners' services, are subject to the limitation if they are furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder (that is, any condition identified by a diagnosis code within the range of 290 through 319) and are furnished to an individual who is not an inpatient of a hospital:

* * * * *

■ 15. Section 410.160 is amended by adding paragraph (b)(9) to read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(b) * * *

(9) Beginning January 1, 2009, initial preventive physical examinations as described in § 410.16.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 16. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart A—General Exclusions and Exclusion of Particular Services

■ 17. Section 411.15 is amended by—

■ A. Revising paragraphs (a)(1) and (b).

■ B. Adding new paragraph (k)(15).

■ C. Redesignating paragraphs (p)(2)(xii), (xiii), (xiv), and (xv) as (p)(2)(xiii), (xiv), (xv), and (xvi) respectively.

■ D. Adding new paragraph (p)(2)(xii).

The revision and additions read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) of this section, or additional preventive services that meet the criteria in § 410.64 of this chapter.

* * * * *

(b) *Low vision aid exclusion*—(1) *Scope.* The scope of the eyeglass exclusion encompasses all devices irrespective of their size, form, or technological features that use one or more lens to aid vision or provide magnification of images for impaired vision.

(2) *Exceptions.* (i) Post-surgical prosthetic lenses customarily used during convalescence for eye surgery in which the lens of the eye was removed (for example, cataract surgery).

(ii) Prosthetic intraocular lenses and one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.

(iii) Prosthetic lenses used by Medicare beneficiaries who are lacking the natural lens of the eye and who were not furnished with an intraocular lens.

* * * * *

(k) * * *

(15) In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in § 410.64 of this chapter.

* * * * *

(p) * * *

(2) * * *

(xii) Services described in paragraphs (k)(15)(i) thorugh (vi) of this section when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act.

* * * * *

■ 18. Section 411.351 is amended by—

■ A. Amending the definition of ''Designated health services (DHS)'' by adding the word ''outpatient'' before the phrase ''speech-language pathology services'' in paragraph (1)(ii).

■ B. Amending the definition of ''Physical therapy, occupational

therapy, and speech-language pathology services'' by—

■ 1. Removing the phrase ''speech-language pathology'' wherever it appears within the heading or introductory text and adding in its place the phrase ''outpatient speech-language pathology.''

■ 2. Removing the parenthetical phrase ''(including speech-language pathology services)'' from the introductory text in paragraph (1).

■ 3. Adding the word ''or'' to follow ''equipment;'' at the end of paragraph (1)(ii).

■ 4. Removing ''; or'' at the end of paragraph (1)(iii) and replacing it with a period.

■ 5. Removing paragraph (1)(iv).

■ 6. Adding a new paragraph (3).

The addition reads as follows:

§ 411.351 Definitions.

* * * * *

Physical therapy, occupational therapy, and outpatient speech-language pathology services * * *

* * * * *

(3) *Outpatient speech-language pathology services*, meaning those services as described in section 1861(ll)(2) of the Act that are for the diagnosis and treatment of speech, language, and cognitive disorders that include swallowing and other oral-motor dysfunctions.

* * * * *

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

■ 20. Section 413.174 is amended by—

■ A. Revising the introductory text of paragraphs (a) and (c).

■ B. Revising paragraph (a)(1).

■ C. Redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4), respectively.

■ D. Adding new paragraph (a)(2).

The revisions and addition read as follows:

§ 413.174 Prospective rates for hospital-based and independent ESRD facilities.

(a) *Establishment of rates.* CMS establishes prospective payment rates for ESRD facilities using the following methodology:

(1) For dialysis services furnished prior to January 1, 2009, the methodology differentiates between hospital-based and independent ESRD facilities;

(2) For dialysis services furnished on or after January 1, 2009—

(i) The composite rate paid to hospital-based facilities for dialysis services shall be the same as the composite rate paid for such services furnished by independent renal dialysis facilities.

(ii) When applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

* * * * *

(c) *Determination of hospital-based facility.* A determination under this paragraph (c) is an initial determination under § 498.3 of this chapter. CMS determines that a facility is hospital-based if the—

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 21. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart B—Physicians and Other Practitioners

■ 22. Section 414.22 is amended by revising paragraphs (b)(5)(i)(A) and (B) to read as follows:

§ 414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(5) * * *

(i) * * *

(A) *Facility practice expense RVUs.* The facility PE RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center.

(B) *Nonfacility practice expense RVUs.* The nonfacility PE RVUs apply to services performed in a physician's office, a patient's home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC.

* * * * *

■ 23. Section 414.50 is amended by—

■ A. Revising the section heading as set forth below.

■ B. Revising paragraph (a).

The revisions read as follows:

§ 414.50 Physician or other supplier billing for diagnostic tests performed or interpreted by a physician who does not share a practice with the billing physician or other supplier.

(a) *General rules.* (1) For services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act), if a physician or other supplier bills for the technical component (TC) or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control as described in § 413.17 of this chapter) and the diagnostic test is performed by a physician who does not share a practice with the billing physician or other supplier, the payment to the billing physician or other supplier (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(i) The performing supplier's net charge to the billing physician or other supplier. For purposes of this paragraph (a)(1) only, with respect to the TC, the performing supplier is the physician who supervised the TC, and with respect to the PC, the performing supplier is the physician who performed the PC.

(ii) The billing physician or other supplier's actual charge.

(iii) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

(2) The following requirements are applicable for purposes of paragraph (a)(1) of this section:

(i) The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

(ii) A performing physician shares a practice with the billing physician or other supplier if he or she furnishes substantially all (which, for purposes of this section, means ''at least 75 percent'') of his or her professional services through such billing physician or other supplier. The ''substantially

all'' requirement will be satisfied if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that:

(A) For the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or

(B) The performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

(iii) A physician will be deemed to share a practice with the billing physician or other supplier with respect to the performance of the TC or PC of a diagnostic test if the physician is an owner, employee or independent contractor of the billing physician or other supplier and the TC or PC is performed in the office of the billing physician or other supplier. The ''office of the billing physician or other supplier'' is any medical office space, regardless of number of locations, in which the ordering physician or other ordering supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the same building (as defined in § 411.351) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in § 411.351 of this chapter), the ''office of the billing physician or other supplier'' is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. The performance of the TC includes both the conducting of the TC as well as the supervision of the TC.

* * * * *

■ 24. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), and individual medical nutrition therapy furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

* * * * *

■ 25. Section 414.67 is amended by adding paragraph (d) to read as follows:

§ 414.67 Incentive payments for Health Professional Shortage Areas.

* * * * *

(d) HPSA bonuses are payable for services furnished by physicians in areas designated as geographic HPSAs as of December 31 of the prior year. Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made should use the AQ modifier to receive the HPSA bonus payment.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

■ 26. Section 414.210 is amended by—

■ A. Revising paragraphs (e)(1) and (2).

■ B. Removing paragraph (e)(3).

■ C. Redesignating paragraphs (e)(4) and (e)(5) as paragraphs (e)(3) and (e)(4), respectively.

■ D. Revising newly redesignated paragraphs (e)(3)(ii), (e)(3)(iii), and (e)(4).

The revisions read as follows:

§ 414.210 General payment rules.

* * * * *

(e) * * *

(1) *General rule.* Except as provided in paragraph (e)(3) of this section, the carrier pays the reasonable and necessary charges for maintenance and servicing of beneficiary-owned equipment. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. Payment is made for replacement parts in a lump sum based on the carrier's consideration of the item. The carrier establishes a reasonable fee for labor associated with repairing, maintaining, and servicing the item. Payment is not made for maintenance and servicing of a rented item other than the maintenance and servicing fee for oxygen equipment described in paragraph (e)(2) of this section or for other durable medical equipment as described in § 414.229(e).

(2) Maintenance and servicing payment for 2009 for certain oxygen equipment furnished after the 36-month rental period. The carrier makes a maintenance and servicing payment for oxygen equipment other than liquid and gaseous equipment (stationary and portable) as follows:

(i) For the first 6-month period following the date on which the 36-month rental period ends, in accordance with § 414.226(a)(1), no payments are made.

(ii) During each succeeding 6-month period, payment may be made for 30 minutes of labor for general maintenance and servicing of the equipment in the beneficiary's home.

(3) *Exception to Maintenance and Servicing Payments.* For items purchased on or after June 1, 1989, no payment is made under the provisions of paragraph (e)(1) of this section for the maintenance and servicing of:

(i) Items requiring frequent and substantial servicing, as defined in § 414.222(a);

(ii) Capped rental items, as defined in § 414.229(a), that are not beneficiary-owned in accordance with § 414.229(d), § 414.229(f)(2), or § 414.229(h); and

(iii) Capped rental items, as defined in § 414.229(a), that are not beneficiary-owned in § 414.229(d), § 414.229(f)(2), or § 414.229(h); and

(iv) Oxygen equipment, as described in § 414.226.

(4) Supplier replacement of beneficiary-owned equipment based on accumulated repair costs. A supplier that transfers title to a capped rental item to a beneficiary in accordance with § 414.229(f)(2) is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if the carrier determines that the item furnished by the supplier will not last for the entire reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1). In making this determination, the carrier may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the item.

* * * * *

■ 27. Section 414.226 is amended by revising paragraphs (d)(3), (d)(4), (f), (g)(1) introductory text, (g)(2) introductory text and (g)(3) and by removing paragraph (g)(4) to read as follows:

§ 414.226 Oxygen and oxygen equipment.

* * * * *

(d) * * *

(3) The fee schedule amount for items described in paragraph (c)(1)(iv) of this section is paid when the beneficiary—

(i) Owns stationary oxygen equipment that requires delivery of gaseous or liquid oxygen contents; or

(ii) Rents stationary oxygen equipment that requires delivery of gaseous or liquid oxygen contents after the period of continuous use of 36 months described in paragraph (a)(1) of this section.

(4) The fee schedule amount for items described in paragraph (c)(1)(v) of this section is paid when the beneficiary—

(i) Owns portable oxygen equipment described in (c)(1)(ii) of this section;

(ii) Rents portable oxygen equipment described in paragraph (c)(1)(ii) of this section during the period of continuous use of 36 months described in paragraph (a)(1) of this section and does not rent stationary oxygen equipment; or

(iii) Rents portable oxygen equipment described in paragraph (c)(1)(ii) of this section after the period of continuous use of 36 months described in paragraph (a)(1) of this section.

* * * * *

(f) *Furnishing oxygen and oxygen equipment after the 36-month rental cap.* (1) The supplier that furnishes oxygen equipment for the 36th continuous month during which payment is made under this section must—

(i) Continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1); or

(ii) Arrange for furnishing the oxygen equipment with another supplier if the beneficiary relocates to an area that is outside the normal service area of the supplier that initially furnished the equipment.

(2) The supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month during which payment is made under this section must—

(i) Continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period of medical need for the remainder of the reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1); or

(ii) Arrange for furnishing the oxygen contents with another supplier if the beneficiary relocates to an area that is outside the normal service area of the supplier that initially furnished the equipment.

(g) * * *

(1) The supplier that furnishes oxygen equipment for the first month during which payment is made under this section must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends or—

* * * * *

(2) Oxygen equipment furnished under this section may not be replaced by the supplier prior to the expiration of the reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1) unless:

* * * * *

(3) Before furnishing oxygen equipment, the supplier must disclose to the beneficiary its intentions regarding whether it will accept assignment of all monthly rental claims for the duration of the rental period. A supplier's intentions could be expressed in the form of a written agreement between the supplier and the beneficiary.

■ 28. Section 414.228 is amended by adding paragraph (c) to read as follows:

§ 414.228 Prosthetic and orthotic devices.

* * * * *

(c) *Payment for therapeutic shoes.* The payment rules specified in paragraphs (a) and (b) of this section are applicable to custom molded and extra depth shoes, modifications, and inserts (therapeutic shoes) furnished after December 31, 2004.

■ 29. Section 414.230 is amended by adding paragraph (h) to read as follows:

§ 414.230 Determining a period of continuous use.

* * * * *

(h) Oxygen equipment furnished after the 36-month rental period. A new period of continuous use does not begin under any circumstance in the case of oxygen equipment furnished after the 36-month rental period in accordance with § 414.226(f) until the end of the reasonable useful lifetime established for such equipment in accordance with § 414.210(f).

Subpart H—Fee Schedule for Ambulance Services

■ 30. Section 414.610 is amended by—

■ A. Revising paragraph (c)(1) introductory text.

■ B. Adding new paragraph (h).

The revision and addition read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(1) *Ground ambulance service levels.* (i) The CF is multiplied by the applicable RVUs for each level of service to produce a service-level base rate. For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in urban areas (both base rate and mileage) are paid based on a rate that is one percent higher than otherwise is applicable under this section, and ambulance services originating in rural areas (both base rate and mileage) are paid based on a rate that is two percent higher than otherwise is applicable under this section. For services furnished during the period July 1, 2008 through December 31, 2009, ambulance services originating in urban areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section, and ambulance services originating in rural areas (both base rate and mileage) are paid based on a rate that is three percent higher than otherwise is applicable under this section.

(ii) The service-level base rate is then adjusted by the GAF. Compare this amount to the actual charge. The lesser of the actual charge or the GAF adjusted base rate amount is added to the lesser of the actual mileage charges or the payment rate per mile, multiplied by the number of miles that the beneficiary was transported. When applicable, the appropriate RAF is applied to the ground mileage rate to determine the appropriate payment rates. The RVU scale for the ambulance fee schedule is as follows:

* * * * *

(h) *Treatment of certain areas for payment for air ambulance services.* Any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2009.

Subpart K—Payment for Drugs and Biologicals Under Part B

■ 31. Section 414.904 is amended by revising paragraphs (b)(2), (c)(2), (d)(3), and (e)(1)(i) to read as follows:

§ 414.904 Average sales price as the basis for payment.

* * * * *

(b) * * *

(2) *Calculation of the average sales price.* (i) For dates of service before April 1, 2008, the average sales price is determined by—

(A) Computing the sum of the products (for each National Drug Code assigned to the drug products) of the manufacturer's average sales price and the total number of units sold; and

(B) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug products.

(ii) For dates of service on or after April 1, 2008, the average sales price is determined by—

(A) Computing the sum of the products (for each National Drug Code assigned to such drug products) of the manufacturer's average sales price, determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code and the total number of units sold; and

(B) Dividing the sum determined under clause (A) by the sum of the products (for each National Drug Code assigned to such drug products) of the total number of units sold and the total number of billing units for the National Drug Code for the billing and payment code.

(iii) For purposes of this subsection and subsection (c), the term billing unit means the identifiable quantity associated with a billing and payment code, as established by CMS.

(c) * * *

(2) *Calculation of the average sales price.* (i) For dates of service before April 1, 2008, the average sales price is determined by—

(A) Computing the sum of the products (for each National Drug Code assigned to the drug product) of the manufacturer's average sales price and the total number of units sold; and

(B) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug product.

(ii) For dates of service on or after April 1, 2008, the average sales price is determined by—

(A) Computing the sum of the products (for each National Drug Code assigned to such drug products) of the manufacturer's average sales price, determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code and the total number of units sold; and

(B) Dividing the sum determined under clause (A) by the sum of the products (for each National Drug Code assigned to such drug products) of the total number of units sold and the total number of billing units for the National Drug Code for the billing and payment code.

(d) * * *

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in CYs 2005, 2006, 2007, 2008 and 2009, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) * * *

(1) * * *

(i) *Treatment of Certain Drugs.* Beginning with April 1, 2008, the payment amount for—

(A) Each single source drug or biological described in section 1842(o)(1)(G) that is treated as a multiple source drug because of the application of section 1847A(c)(6)(C)(ii) is the lower of—

(*1*) The payment amount that would be determined for such drug or biological applying section 1847A(c)(6)(C)(ii); or

(*2*) The payment amount that would have been determined for such drug or biological if section 1847A(c)(6)(C)(ii) were not applied.

(B) A multiple source drug described in section 1842(o)(1)(G) (excluding a drug or biological that is treated as a multiple source drug because of the application of section 1847A(c)(6)(C)(ii)) is the lower of—

(*1*) The payment amount that would be determined for such drug or biological taking into account the application of section 1847A(c)(6)(C)(ii); or

(*2*) The payment amount that would have been determined for such drug or biological if section 1847A(c)(6)(C)(ii) were not applied.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

■ 32. The authority citation for part 415 continues to read as follows:

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

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

§ 415.130 [Amended]

■ 33. In § 415.130(d), the phrase ''December 31, 2007'' is removed and the phrase ''December 31, 2009'' is added in its place.

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

■ 34. The authority citation for part 423 continues to read as follows:

Authority: Sections 1102, 1106, 1860D–1 through 1860D–42, and 1871 of the Social Security Act (42 U.S.C. 1302, 1306, 1395w–101 through 1395w–152, and 1395hh).

■ 35. Section 423.160 is amended by revising paragraph (a)(3)(i) to read as follows:

§ 423.160 Standards for electronic prescribing.

(a) * * *

(3) * * *

(i) Until January 1, 2012, entities transmitting prescriptions or prescription-related information by means of computer-generated facsimile are exempt from the requirement to use the NCPDP SCRIPT Standard adopted by this section in transmitting such prescriptions or prescription-related information. After January 1, 2012, entities transmitting prescriptions or prescription-related information must utilize the NCPSP SCRIPT standard in all instances other than temporary/transient network transmission failures.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 36. The authority citation for part 424 continues to read as follows:

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

Subpart C—Claims for Payment

■ 37. Section 424.36 is amended by revising paragraphs (a), (b)(6) introductory text, and (b)(6)(ii)(C)(*2*) to read as follows:

§ 424.36 Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraphs (b), (c), or (d) of this section apply. For purposes of this section, ''the claim'' includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

(b) * * *

(6) An ambulance provider or supplier with respect to emergency or nonemergency ambulance transport

services, if the following conditions and documentation requirements are met.

* * * * *

(ii) * * *

(C) * * *

(*2*) The requested information from a representative of the hospital or facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment. Secondary forms of verification include a copy of any of the following:

(*i*) The signed patient care/trip report;

(*ii*) The facility or hospital registration/admission sheet;

(*iii*) The patient medical record;

(*iv*) The facility or hospital log; or

(*v*) Other internal facility or hospital records.

* * * * *

■ 38. Section 424.44 is amended by—

■ A. Revising the introductory text of paragraph (a).

■ B. Adding paragraph (e).

The revision and addition read as follows:

§ 424.44 Time limits for filing claims.

(a) *Basic Limits.* Except as provided in paragraph (b) and (e) of this section, the claim must be delivered to the intermediary or carrier as appropriate:

* * * * *

(e) *Exceptions.* Any claims filed by the following suppliers with Medicare billing privileges whose time limits for filing claims are linked to their enrollment status and are governed under § 424.516, § 424.520, and § 424.521 of this subpart:

(1) Physician or nonphysician organizations.

(2) Physicians.

(3) Nonphysician practitioners.

(4) Independent diagnostic testing facilities.

Subpart D—To Whom Payment Is Ordinarily Made

■ 39. Section 424.57 is amended by—

■ A. Amending paragraph (a) by adding the definitions of ''Affiliate'', ''Attended facility-based polysomnogram'', ''Continuous positive airway pressure (CPAP)'' device, and ''Sleep test'' in alphabetical order.

■ B. Adding new paragraph (f).

The additions read as follows:

§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

(a) * * *

Affiliate means a person or organization that is related to another person or organization through a compensation arrangement or ownership.

Attended facility-based polysomnogram means a comprehensive diagnostic sleep test including at least electroencephalography, electro-oculography, electromyography, heart rate or electrocardiography, airflow, breathing effort, and arterial oxygen saturation furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed.

* * * * *

Continuous positive airway pressure (CPAP) device means a machine that introduces air into the breathing passages at pressures high enough to overcome obstructions in the airway in order to improve airflow. The airway pressure delivered into the upper airway is continuous during both inspiration and expiration.

* * * * *

Sleep test means an attended or unattended diagnostic test for a sleep disorder whether performed in or out of a sleep laboratory. The 'provider of the sleep test' is the individual or entity that directly or indirectly administers and/or interprets the sleep test and/or furnishes the sleep test device used to administer the sleep test.

* * * * *

(f) *Payment prohibition.* No Medicare payment will be made to the supplier of a CPAP device if that supplier, or its affiliate, is directly or indirectly the provider of the sleep test used to diagnose the beneficiary with obstructive sleep apnea. This prohibition does not apply if the sleep test is an attended facility-based polysomnogram.

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

■ 40. Section 424.502 is amended by adding the definitions ''Final adverse action'' and ''Physician or nonphysician practitioner organization'' in alphabetical order to read as follows:

§ 424.502 Definitions.

* * * * *

Final adverse action means one or more of the following actions:

(1) A Medicare-imposed revocation of any Medicare billing privileges;

(2) Suspension or revocation of a license to provide health care by any State licensing authority;

(3) Revocation or suspension by an accreditation organization;

(4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(5) An exclusion or debarment from participation in a Federal or State health care program.

* * * * *

Physician or nonphysician practitioner organization means any physician or nonphysician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.

* * * * *

■ 41. Section 424.516 is added to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

(a) *Certifying compliance.* CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with title XVIII of the Act and applicable Medicare regulations.

(2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

(3) Not employing or contracting with individuals or entities that meet either of the following conditions:

(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128A(a)(6) of the Act.

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.

(b) *Reporting requirements Independent Diagnostic Testing Facilities (IDTFs).* IDTF reporting requirements are specified in § 410.33(g)(2) of this chapter.

(c) *Reporting requirements DMEPOS suppliers.* DMEPOS reporting requirements are specified in § 424.57(c)(2).

(d) *Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* Physicians, nonphysician practitioners, and

physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

(1) Within 30 days—

(i) A change of ownership;

(ii) Any adverse legal action; or

(iii) A change in practice location.

(2) All other changes in enrollment must be reported within 90 days.

(e) *Reporting requirements for all other providers and suppliers.* Reporting requirements for all other providers and suppliers not identified in paragraphs (a) through (d) of this section, must report to CMS the following information within the specified timeframes:

(1) Within 30 days for a change of ownership, including changes in authorized official(s) or delegated official(s);

(2) All other changes to enrollment must be reported within 90 days.

(f) *Maintaining documentation.* A provider or supplier is required to maintain ordering and referring documentation, including the NPI, received from a physician or eligible nonphysician practitioner for 7 years from the date of service. Physicians and nonphysician practitioners are required to maintain written ordering and referring documentation for 7 years from the date of service.

■ 42. Section 424.517 is added to read as follows:

§ 424.517 Onsite review.

(a) CMS reserves the right, when deemed necessary, to perform onsite review of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. Site visits for enrollment purposes do not affect those site visits performed for establishing compliance with conditions of participation. Based upon the results of CMS's onsite review, the provider may be subject to denial or revocation of Medicare billing privileges as specified in § 424.530 or § 424.535 of this part.

(1) *Medicare Part A providers.* CMS determines, upon on-site review, that the provider meets either of the following conditions:

(i) Is unable to furnish Medicare-covered items or services.

(ii) Has failed to satisfy any of the Medicare enrollment requirements.

(2) *Medicare Part B providers.* CMS determines, upon review, that the supplier meets any of the following conditions:

(i) Is unable to furnish Medicare-covered items or services.

(ii) Has failed to satisfy any or all of the Medicare enrollment requirements.

(iii) Has failed to furnish Medicare covered items or services as required by the statute or regulations.

(b) [Reserved]

■ 43. Section 424.520 is revised to read as follows:

§ 424.520 Effective date of Medicare billing privileges.

(a) *Surveyed, certified or accredited providers and suppliers.* The effective date for billing privileges for providers and suppliers requiring State survey, certification or accreditation is specified in § 489.13 of this chapter. If a provider or supplier is seeking accreditation from a CMS-approved accreditation organization, the effective date is specified in § 489.13(d).

(b) *Independent Diagnostic Testing Facilities.* The effective date for billing privileges for IDTFs is specified in § 410.33(i) of this chapter.

(c) *DMEPOS suppliers.* The effective date for billing privileges for DMEPOS suppliers is specified in § 424.57(b) of this subpart and section 1834(j)(1)(A) of the Act.

(d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

■ 44. Section 424.521 is added to read as follows:

§ 424.521 Request for payment by physicians, nonphysician practitioners, physician or nonphysician organizations.

(a) Physicians, nonphysician practitioners and physician and nonphysician practitioner organizations may retrospectively bill for services when a physician or nonphysician practitioner or a physician or a nonphysician organization have met all program requirements, including State licensure requirements, and services were provided at the enrolled practice location for up to—

(1) 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

(2) 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

(b) [Reserved]

■ 45. Section 424.530 is amended by—

■ A. Revising the section heading as set forth below.

■ B. Adding paragraphs (a)(6) and (a)(7).

The revision and additions read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(6) *Overpayment.* The current owner (as defined in § 424.502), physician or nonphysician practitioner has an existing overpayment at the time of filing of an enrollment application.

(7) *Payment suspension.* The current owner (as defined in § 424.502), physician or nonphysician practitioner has been placed under a Medicare payment suspension as defined in § 405.370 through § 405.372 of this subchapter.

* * * * *

■ 46. Section 424.535 is amended by—

■ A. Amending paragraph (a)(1) by removing the phrase ''billing privileges.'' and adding in its place ''billing privileges, except for those imposed under paragraphs (a)(2), (a)(3), or (a)(5) of this section.

■ B. Adding paragraphs (a)(9), (a)(10), and (g).

■ C. Revising paragraph (f).

The additions and revision read as follows:

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) * * *

(9) *Failure to report.* The provider or supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart.

(10) *Failure to document.* The provider or supplier did not comply with the documentation requirements specified in § 424.516(f) of this subpart.

* * * * *

(g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony

conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

(h) *Submission of claims for services furnished before revocation.* A physician organization, physician, nonphysician practitioner or independent diagnostic testing facility must submit all claims for items and services furnished within 60 calendar days of the effective date of revocation.

■ 47. Section 424.565 is added to read as follows:

§ 424.565 Overpayment.

A physician or nonphysician practitioner organization, physician or nonphysician practitioner that does not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart is assessed an overpayment back to the date of the final adverse action or change in practice location. Overpayments are processed in accordance with Part 405 Subpart C of this chapter.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 48. The authority citation for part 485 continues to read as follows:

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

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

■ 49. Section 485.58 is amended by revising the introductory text and paragraphs (a)(1)(i) and (e)(2) to read as follows:

§ 485.58 Condition of participation: Comprehensive rehabilitation program.

The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. These services must be furnished by personnel that meet the qualifications set forth in §§ 485.70 and 484.4 of this chapter and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

(a) * * *

(1) * * *

(i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of nonphysician staff;

* * * * *

(e) * * *

(2) *Exceptions.* Physical therapy, occupational therapy, and speech-language pathology services may be furnished away from the premises of the CORF including the individual's home when payment is not otherwise made under Title XVIII of the Act. In addition, a single home environment evaluation is covered if there is a need to evaluate the potential impact of the home environment on the rehabilitation goals. The single home environment evaluation requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

* * * * *

■ 50. Section 485.70 is amended by:

■ A. Revising paragraphs (c), (e), (j) introductory text, (j)(2) and (j)(3).

■ B. Reletting paragraph (k) and redesignating paragraphs (l) and (m) as paragraphs (k) and (l) respectively.

The revisions read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in § 484.4 of this chapter.

* * * * *

(e) A physical therapist and a physical therapist assistant must meet the qualifications in § 484.4 of this chapter.

* * * * *

(j) A respiratory therapist must—

(1) * * *

(2) Have successfully completed a nationally—accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exams, and have passed the registry examination administered by the NBRC, or

(3) Have equivalent training and experience as determined by the National Board for Respiratory Care (NBRC) and passed the registry examination administered by the NBRC.

* * * * *

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

■ 51. Section 485.635 is amended by revising paragraph (e) to read as follows:

§ 485.635 Conditions of participation: Provision of services.

* * * * *

(e) *Standard: Rehabilitation Therapy Services.* Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in § 409.17 of this subpart.

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

■ 52. Section 485.703 is amended by—

■ A. Adding the definition of ''extension location'' in alphabetical order.

■ B. Revising paragraph (2) of the definition of ''rehabilitation agency.''

The addition and revision read as follows:

§ 485.703 Definitions.

* * * * *

Extension location. A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the rehabilitation agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

* * * * *

Rehabilitation agency * * *

(2) Provides at least physical therapy or speech-language pathology services.

* * * * *

■ 53. Section 485.711 is amended by revising the introductory text and paragraphs (b)(3) and (c) to read as follows:

§ 485.711 Condition of participation: Plan of care and physician involvement.

For each patient in need of outpatient physical therapy or speech pathology services, there is a written plan of care established and periodically reviewed by a physician, or by a physical therapist or speech pathologist respectively.

* * * * *

(b) * * *

(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken.

* * * * *

(c) *Standard: Emergency care.* The rehabilitation agency must establish procedures to be followed by personnel

in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

■ 54. Section 485.717 is revised to read as follows:

§ 485.717 Condition of participation: Rehabilitation program.

This condition and standards apply only to a rehabilitation agency's own patients, not to patients of hospitals, skilled nursing facilities (SNFs), or Medicaid nursing facilities (NFs) to which the agency furnishes services. The hospital, SNF, or NF is responsible for ensuring that qualified staff furnish services for which they arrange or contract for their patients. The rehabilitation agency provides physical therapy and speech-language pathology services to all of its patients who need them.

(a) *Standard: Qualification of staff.* The agency's therapy services are furnished by qualified individuals as direct services and/or services provided under contract.

(b) *Standard: Arrangements for services.* If services are provided under contract, the contract must specify the term of the contract, the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

■ 55. The authority citation for part 486 continues to read as follows:

Authority: Secs. 1102, 1138, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320b–8, and 1395hh) and section 371 of the Public Health Service Act (42 U.S.C. 273).

Subpart C—Conditions for Coverage: Portable X-Ray Services

■ 56. Section 486.104 is amended by—

■ A. Revising the introductory text of paragraph (a).

■ B. Revising paragraph (a)(1).

■ C. Adding paragraph (a)(4).

The revision and addition read as follows:

§ 486.104 Condition for coverage: Qualifications, orientation and health of technical personnel.

* * * * *

(a) *Standard-qualifications of technologists.* All operators of the portable X-ray equipment meet the requirements of paragraphs (a)(1), (2), (3), or (4) of this section:

(1) Successful completion of a program of formal training in X-ray technology in a school approved by the Joint Review Committee on Education in Radiologic Technology (JRCERT), or have earned a bachelor's or associate degree in radiologic technology from an accredited college or university.

* * * * *

(4) For those whose training was completed prior to January 1, 1993, successful completion of a program of formal training in X-ray technology in a school approved by the Council on Education of the American Medical Association, or by the American Osteopathic Association is acceptable.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 57. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

Subpart B—Essentials of Provider Agreements

■ 58. Section 489.20 is amended by—

■ A. Redesignating paragraphs (s)(12), (13), (14), and (15) as (s)(13), (14), (15), and (16), respectively.

■ B. Adding new paragraph (s)(12).

The addition reads as follows:

§ 489.20 Basic commitments.

* * * * *

(s) * * *

(12) Services described in paragraphs (s)(1) through (6) of this section when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act.

* * * * *

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

Dated: October 21, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2008.

Michael O. Leavitt,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2009. Addendum B contains the RVUs for work, non-facility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

• An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

• Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier–26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier–26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier–53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for

other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D* = Deleted/discontinued code.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H* = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2009.

6. *Fully implemented non-facility practice expense RVUs.* These are the fully implemented resource-based PE RVUs for non-facility settings.

7. *Transitional non-facility practice expense RVUs.* These are the 2009 resource-based PE RVUs for non-facility settings.

8. *Fully implemented facility practice expense RVUs.* These are the fully implemented resource-based PE RVUs for facility settings.

9. *Transitional facility practice expense RVUs.* These are the 2009 resource-based PE RVUs for facility settings.

10. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2009.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra service time and in some instances in the post service time.

* Codes with these indicators had a 90-day grace period before January 1, 2005.

ADDENDUM B: Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2009

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0062T		C	Rep intradisc annulus;1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0063T		C	Rep intradisc annulus;>1lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T		N	Ct colonography;screen	0.00	0.00	0.00	NA	NA	0.00	XXX
0066T	TC	N	Ct colonography;screen	0.00	0.00	0.00	NA	NA	0.00	XXX
0066T	26	N	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	NA	NA	0.00	XXX
0067T	TC	C	Ct colonography;dx	0.00	0.00	0.00	NA	NA	0.00	XXX
0067T	26	C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	12.88	14.20	NA	NA	0.13	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0140T		C	Exhaled breath condensate ph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0144T		C	CT heart wo dye; qual calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0144T	TC	C	CT heart wo dye; qual calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0144T	26	C	CT heart wo dye; qual calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0145T		C	CT heart w/wo dye funct	0.00	0.00	0.00	NA	NA	0.00	XXX
0145T	TC	C	CT heart w/wo dye funct	0.00	0.00	0.00	NA	NA	0.00	XXX
0145T	26	C	CT heart w/wo dye funct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0146T		C	CCTA w/wo dye	0.00	0.00	0.00	NA	NA	0.00	XXX
0146T	TC	C	CCTA w/wo dye	0.00	0.00	0.00	NA	NA	0.00	XXX
0146T	26	C	CCTA w/wo dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0147T		C	CCTA w/wo, quan calcium	0.00	0.00	0.00	NA	NA	0.00	XXX
0147T	TC	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	NA	NA	0.00	XXX
0147T	26	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0148T		C	CCTA w/wo, strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0148T	TC	C	CCTA w/wo, strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0148T	26	C	CCTA w/wo, strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0149T		C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0149T	TC	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0149T	26	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0150T		C	CCTA w/wo, disease strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0150T	TC	C	CCTA w/wo, disease strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0150T	26	C	CCTA w/wo, disease strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0151T		C	CT heart funct add-on	0.00	0.00	0.00	NA	NA	0.00	XXX
0151T	TC	C	CT heart funct add-on	0.00	0.00	0.00	NA	NA	0.00	XXX
0151T	26	C	CT heart funct add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0170T		C	Anorectal fistula plug rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0193T		C	Rf bladder neck microremodel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0194T		C	Procalcitonin (pct)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0529F		I	Intrvl 3+yrs pts clnscp docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0540F		I	Gluco mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.14	2.15	0.40	0.43	0.10	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
10022		A	Fna w/image	1.27	2.16	2.26	0.44	0.43	0.08	XXX
10040		A	Acne surgery	1.19	1.34	1.26	1.00	0.95	0.05	010
10060		A	Drainage of skin abscess	1.19	1.48	1.41	1.07	1.04	0.12	010
10061		A	Drainage of skin abscess	2.42	2.04	1.99	1.50	1.50	0.26	010
10080		A	Drainage of pilonidal cyst	1.19	2.61	2.74	1.09	1.10	0.11	010
10081		A	Drainage of pilonidal cyst	2.47	3.49	3.64	1.47	1.48	0.24	010
10120		A	Remove foreign body	1.23	1.91	1.98	0.94	0.95	0.12	010
10121		A	Remove foreign body	2.71	3.43	3.46	1.65	1.68	0.33	010
10140		A	Drainage of hematoma/fluid	1.55	2.21	2.10	1.27	1.28	0.19	010
10160		A	Puncture drainage of lesion	1.22	1.82	1.76	1.07	1.07	0.14	010
10180		A	Complex drainage, wound	2.27	3.22	3.17	1.82	1.86	0.35	010
11000		A	Debride infected skin	0.60	0.71	0.68	0.17	0.18	0.07	000
11001		A	Debride infected skin add-on	0.30	0.23	0.23	0.08	0.09	0.04	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	NA	3.43	3.56	0.67	000
11005		A	Debride abdom wall	14.24	NA	NA	4.03	4.43	0.96	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	4.16	4.34	1.28	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	1.40	1.56	0.61	ZZZ
11010		A	Debride skin, fx	4.19	6.82	6.85	2.44	2.49	0.66	010
11011		A	Debride skin/muscle, fx	4.94	7.06	7.35	2.15	2.21	0.74	000
11012		A	Debride skin/muscle/bone, fx	6.87	9.01	9.81	3.30	3.44	1.16	000
11040		A	Debride skin, partial	0.50	0.66	0.62	0.16	0.17	0.06	000
11041		A	Debride skin, full	0.60	0.70	0.69	0.19	0.22	0.10	000
11042		A	Debride skin/tissue	0.80	0.94	0.95	0.25	0.30	0.13	000
11043		A	Debride tissue/muscle	3.04	3.45	3.44	2.58	2.59	0.32	010
11044		A	Debride tissue/muscle/bone	4.11	4.84	4.75	3.60	3.65	0.43	010
11055		R	Trim skin lesion	0.43	0.78	0.73	0.11	0.13	0.05	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.85	0.80	0.16	0.18	0.07	000
11057		R	Trim skin lesions, over 4	0.79	0.96	0.90	0.21	0.23	0.10	000
11100		A	Biopsy, skin lesion	0.81	1.86	1.71	0.41	0.40	0.03	000
11101		A	Biopsy, skin add-on	0.41	0.42	0.40	0.21	0.21	0.02	ZZZ
11200		A	Removal of skin tags	0.79	1.22	1.18	0.90	0.87	0.04	010
11201		A	Remove skin tags add-on	0.29	0.17	0.16	0.12	0.12	0.02	ZZZ
11300		A	Shave skin lesion	0.51	1.18	1.13	0.22	0.22	0.03	000
11301		A	Shave skin lesion	0.85	1.49	1.40	0.41	0.40	0.04	000
11302		A	Shave skin lesion	1.05	1.76	1.64	0.52	0.50	0.05	000
11303		A	Shave skin lesion	1.24	2.02	1.91	0.59	0.57	0.07	000
11305		A	Shave skin lesion	0.67	1.03	0.99	0.21	0.23	0.07	000
11306		A	Shave skin lesion	0.99	1.39	1.32	0.40	0.40	0.07	000
11307		A	Shave skin lesion	1.14	1.70	1.60	0.51	0.51	0.07	000
11308		A	Shave skin lesion	1.41	1.68	1.63	0.52	0.54	0.13	000
11310		A	Shave skin lesion	0.73	1.37	1.31	0.34	0.33	0.04	000
11311		A	Shave skin lesion	1.05	1.64	1.54	0.52	0.51	0.05	000
11312		A	Shave skin lesion	1.20	1.91	1.79	0.60	0.59	0.06	000
11313		A	Shave skin lesion	1.62	2.19	2.10	0.78	0.76	0.10	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.87	1.87	1.91	0.94	0.93	0.06	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.25	2.18	2.15	1.17	1.13	0.10	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.42	2.39	2.36	1.24	1.20	0.13	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.81	2.55	2.52	1.59	1.52	0.17	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.08	2.88	2.84	1.67	1.61	0.21	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.47	3.55	3.44	2.15	2.03	0.32	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.00	1.80	1.79	0.93	0.93	0.09	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.44	2.20	2.17	1.18	1.16	0.13	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.65	2.40	2.37	1.53	1.49	0.16	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.03	2.65	2.64	1.67	1.62	0.20	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.45	2.95	2.92	1.79	1.74	0.25	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.04	3.62	3.59	2.37	2.31	0.44	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.02	1.99	2.05	1.31	1.32	0.08	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.50	2.37	2.37	1.57	1.55	0.13	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.74	2.63	2.61	1.67	1.65	0.16	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.31	2.87	2.89	1.87	1.86	0.22	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.16	3.34	3.38	2.16	2.17	0.30	010
11446		A	Exc face-mm b9+marg > 4 cm	4.75	4.14	4.13	2.77	2.78	0.43	010
11450		A	Removal, sweat gland lesion	3.14	5.09	5.09	2.44	2.34	0.34	090
11451		A	Removal, sweat gland lesion	4.35	6.24	6.35	2.92	2.83	0.53	090
11462		A	Removal, sweat gland lesion	2.92	5.24	5.22	2.47	2.36	0.32	090
11463		A	Removal, sweat gland lesion	4.35	6.58	6.66	3.07	2.98	0.54	090
11470		A	Removal, sweat gland lesion	3.66	5.44	5.35	2.67	2.57	0.40	090
11471		A	Removal, sweat gland lesion	4.81	6.36	6.46	3.03	2.97	0.58	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.58	2.71	2.69	1.16	1.11	0.10	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.02	3.43	3.26	1.55	1.47	0.12	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.22	3.83	3.59	1.74	1.63	0.12	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.77	4.05	3.81	1.94	1.79	0.16	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.12	4.37	4.13	2.02	1.87	0.20	010
11606		A	Exc tr-ext mlg+marg > 4 cm	4.97	5.52	5.17	2.57	2.37	0.36	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	2.83	2.78	1.22	1.15	0.09	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.03	3.49	3.30	1.58	1.50	0.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.36	3.89	3.67	1.81	1.71	0.14	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.06	4.15	3.95	2.04	1.93	0.20	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.57	4.45	4.28	2.17	2.07	0.27	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	4.98	4.91	2.42	2.42	0.45	010
11640		A	Exc face-mm malig+marg 0.5 <	1.62	3.02	2.94	1.31	1.26	0.11	010
11641		A	Exc face-mm malig+marg 0.6-1	2.12	3.61	3.47	1.65	1.63	0.16	010
11642		A	Exc face-mm malig+marg 1.1-2	2.57	4.01	3.87	1.89	1.85	0.19	010
11643		A	Exc face-mm malig+marg 2.1-3	3.37	4.28	4.17	2.18	2.13	0.26	010
11644		A	Exc face-mm malig+marg 3.1-4	4.29	5.06	4.98	2.54	2.53	0.37	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.21	5.94	5.91	3.26	3.32	0.61	010
1170F		I	Fxnl status assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11719		R	Trim nail(s)	0.17	0.36	0.34	0.04	0.05	0.02	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11720		A	Debride nail, 1-5	0.32	0.45	0.42	0.08	0.09	0.04	000
11721		A	Debride nail, 6 or more	0.54	0.53	0.51	0.14	0.16	0.07	000
11730		A	Removal of nail plate	1.10	1.29	1.23	0.29	0.32	0.14	000
11732		A	Remove nail plate, add-on	0.57	0.53	0.51	0.15	0.17	0.07	ZZZ
11740		A	Drain blood from under nail	0.37	0.77	0.71	0.42	0.40	0.04	000
11750		A	Removal of nail bed	2.40	2.87	2.70	1.84	1.82	0.22	010
11752		A	Remove nail bed/finger tip	3.48	4.00	3.75	2.76	2.82	0.35	010
11755		A	Biopsy, nail unit	1.31	1.96	1.87	0.75	0.76	0.14	000
11760		A	Repair of nail bed	1.60	3.35	3.18	1.43	1.52	0.21	010
11762		A	Reconstruction of nail bed	2.91	3.62	3.44	1.68	1.85	0.36	010
11765		A	Excision of nail fold, toe	0.71	2.57	2.38	0.98	0.92	0.08	010
11770		A	Removal of pilonidal lesion	2.63	3.43	3.45	1.54	1.53	0.33	010
11771		A	Removal of pilonidal lesion	5.98	6.69	6.44	3.79	3.68	0.74	090
11772		A	Removal of pilonidal lesion	7.23	7.94	7.85	5.56	5.45	0.89	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11900		A	Injection into skin lesions	0.52	0.91	0.85	0.26	0.25	0.02	000
11901		A	Added skin lesions injection	0.80	1.02	0.93	0.42	0.40	0.03	000
11920		R	Correct skin color defects	1.61	2.35	2.69	1.13	1.12	0.24	000
11921		R	Correct skin color defects	1.93	2.62	2.96	1.28	1.28	0.29	000
11922		R	Correct skin color defects	0.49	0.90	0.96	0.23	0.23	0.07	ZZZ
11950		R	Therapy for contour defects	0.84	0.92	0.98	0.40	0.40	0.06	000
11951		R	Therapy for contour defects	1.19	1.12	1.22	0.52	0.52	0.11	000
11952		R	Therapy for contour defects	1.69	1.64	1.70	0.81	0.78	0.16	000
11954		R	Therapy for contour defects	1.85	1.82	1.98	0.88	0.88	0.25	000
11960		A	Insert tissue expander(s)	11.01	NA	NA	10.72	10.66	1.31	090
11970		A	Replace tissue expander	7.86	NA	NA	6.24	6.22	1.05	090
11971		A	Remove tissue expander(s)	3.21	7.19	7.69	3.95	3.92	0.32	090
11975		N	Insert contraceptive cap	1.48	1.81	1.71	0.50	0.52	0.17	XXX
11976		R	Removal of contraceptive cap	1.78	1.82	1.79	0.50	0.55	0.21	000
11977		N	Removal/reinsert contra cap	3.30	2.44	2.41	1.11	1.15	0.37	XXX
11980		A	Implant hormone pellet(s)	1.48	1.05	1.06	0.50	0.51	0.13	000
11981		A	Insert drug implant device	1.48	1.90	1.85	0.62	0.63	0.12	XXX
11982		A	Remove drug implant device	1.78	2.05	2.03	0.76	0.78	0.17	XXX
11983		A	Remove/insert drug implant	3.30	2.71	2.61	1.43	1.44	0.23	XXX
12001		A	Repair superficial wound(s)	1.72	1.70	1.77	0.73	0.74	0.15	010
12002		A	Repair superficial wound(s)	1.88	1.76	1.83	0.83	0.85	0.17	010
12004		A	Repair superficial wound(s)	2.26	2.03	2.11	0.92	0.94	0.21	010
12005		A	Repair superficial wound(s)	2.88	2.46	2.56	1.06	1.10	0.27	010
12006		A	Repair superficial wound(s)	3.68	2.94	3.06	1.29	1.34	0.35	010
12007		A	Repair superficial wound(s)	4.13	3.35	3.47	1.49	1.58	0.45	010
12011		A	Repair superficial wound(s)	1.78	1.85	1.93	0.75	0.76	0.16	010
12013		A	Repair superficial wound(s)	2.01	2.01	2.08	0.88	0.89	0.18	010
12014		A	Repair superficial wound(s)	2.48	2.24	2.33	0.97	1.00	0.23	010
12015		A	Repair superficial wound(s)	3.21	2.72	2.83	1.11	1.15	0.29	010
12016		A	Repair superficial wound(s)	3.94	3.15	3.26	1.32	1.37	0.37	010
12017		A	Repair superficial wound(s)	4.72	NA	NA	1.47	1.58	0.47	010
12018		A	Repair superficial wound(s)	5.54	NA	NA	2.21	2.23	0.64	010
12020		A	Closure of split wound	2.64	3.62	3.68	1.75	1.80	0.30	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
12021		A	Closure of split wound	1.86	1.83	1.84	1.33	1.35	0.24	010
12031		A	Intmd wnd repair s/tr/ext	2.17	3.88	3.49	1.82	1.61	0.17	010
12032		A	Intmd wnd repair s/tr/ext	2.49	5.18	4.85	2.33	2.20	0.16	010
12034		A	Intmd wnd repair s/tr/ext	2.94	4.55	4.22	2.03	1.89	0.25	010
12035		A	Intmd wnd repair s/tr/ext	3.44	5.24	5.24	2.15	2.16	0.39	010
12036		A	Intmd wnd repair s/tr/ext	4.06	5.29	5.37	2.25	2.33	0.55	010
12037		A	Intmd wnd repair s/tr/ext	4.68	5.86	5.93	2.67	2.75	0.66	010
12041		A	Intmd wnd repair n-hf/genit	2.39	3.85	3.53	1.82	1.65	0.19	010
12042		A	Intmd wnd repair n-hg/genit	2.76	4.47	4.18	2.18	2.00	0.17	010
12044		A	Intmd wnd repair n-hg/genit	3.16	5.31	4.80	1.99	1.90	0.27	010
12045		A	Intmd wnd repair n-hg/genit	3.65	5.02	5.09	2.11	2.16	0.41	010
12046		A	Intmd wnd repair n-hg/genit	4.26	5.89	6.06	2.47	2.55	0.54	010
12047		A	Intmd wnd repair n-hg/genit	4.66	6.41	6.41	2.70	2.80	0.58	010
12051		A	Intmd wnd repair face/mm	2.49	4.08	3.88	1.96	1.84	0.20	010
12052		A	Intmd wnd repair face/mm	2.81	4.84	4.45	2.62	2.32	0.17	010
12053		A	Intmd wnd repair face/mm	3.14	5.32	4.81	2.18	2.02	0.23	010
12054		A	Intmd wnd repair, face/mm	3.47	5.33	4.90	2.08	1.97	0.30	010
12055		A	Intmd wnd repair face/mm	4.44	5.94	5.58	2.13	2.13	0.45	010
12056		A	Intmd wnd repair face/mm	5.25	6.45	6.54	2.64	2.75	0.59	010
12057		A	Intmd wnd repair face/mm	5.97	7.62	7.27	3.10	3.27	0.56	010
13100		A	Repair of wound or lesion	3.14	4.51	4.40	2.58	2.52	0.26	010
13101		A	Repair of wound or lesion	3.93	5.95	5.64	3.07	2.98	0.26	010
13102		A	Repair wound/lesion add-on	1.24	1.35	1.31	0.56	0.56	0.13	ZZZ
13120		A	Repair of wound or lesion	3.32	4.63	4.52	2.68	2.60	0.26	010
13121		A	Repair of wound or lesion	4.36	6.71	6.26	3.74	3.51	0.25	010
13122		A	Repair wound/lesion add-on	1.44	1.37	1.41	0.62	0.62	0.15	ZZZ
13131		A	Repair of wound or lesion	3.80	5.03	4.87	2.96	2.90	0.26	010
13132		A	Repair of wound or lesion	6.48	7.95	7.46	5.11	4.89	0.32	010
13133		A	Repair wound/lesion add-on	2.19	1.92	1.86	1.05	1.05	0.18	ZZZ
13150		A	Repair of wound or lesion	3.82	4.71	4.76	2.79	2.79	0.34	010
13151		A	Repair of wound or lesion	4.46	5.55	5.37	3.33	3.29	0.31	010
13152		A	Repair of wound or lesion	6.34	7.60	7.22	4.09	4.09	0.40	010
13153		A	Repair wound/lesion add-on	2.38	2.07	2.04	1.08	1.10	0.24	ZZZ
13160		A	Late closure of wound	11.84	NA	NA	7.18	7.19	1.54	090
14000		A	Skin tissue rearrangement	6.19	8.60	8.43	5.81	5.74	0.59	090
14001		A	Skin tissue rearrangement	8.58	10.67	10.38	7.25	7.22	0.82	090
14020		A	Skin tissue rearrangement	7.02	9.71	9.46	6.68	6.66	0.64	090
14021		A	Skin tissue rearrangement	9.52	11.78	11.35	8.09	8.16	0.81	090
14040		A	Skin tissue rearrangement	8.44	10.26	9.92	7.15	7.18	0.62	090
14041		A	Skin tissue rearrangement	10.63	12.75	12.24	8.65	8.68	0.73	090
14060		A	Skin tissue rearrangement	9.07	9.79	9.56	7.36	7.40	0.68	090
14061		A	Skin tissue rearrangement	11.25	13.79	13.27	9.28	9.36	0.76	090
14300		A	Skin tissue rearrangement	13.26	13.61	13.02	9.68	9.58	1.16	090
14350		A	Skin tissue rearrangement	10.82	NA	NA	6.84	6.93	1.34	090
15002		A	Wound prep, trk/arm/leg	3.65	4.18	4.18	1.73	1.73	0.49	000
15003		A	Wound prep, addl 100 cm	0.80	0.90	0.90	0.28	0.28	0.11	ZZZ
15004		A	Wound prep, f/n/hf/g	4.58	4.90	4.90	2.14	2.14	0.62	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.23	1.23	0.54	0.54	0.22	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15040		A	Harvest cultured skin graft	2.00	3.86	4.05	1.02	1.05	0.24	000
15050		A	Skin pinch graft	5.37	7.54	7.40	5.01	5.05	0.57	090
15100		A	Skin splt grft, trnk/arm/leg	9.74	9.78	10.51	6.79	7.07	1.28	090
15101		A	Skin splt grft t/a/l, add-on	1.72	2.44	2.77	0.87	0.95	0.24	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.88	8.49	9.06	6.19	6.41	1.31	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	0.91	1.01	0.67	0.70	0.26	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.19	9.04	9.11	6.67	6.86	1.15	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.34	1.40	1.01	1.04	0.33	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	10.96	11.31	11.19	7.55	7.63	1.16	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.36	3.65	1.27	1.42	0.36	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.41	7.84	8.36	5.55	5.76	0.97	090
15131		A	Derm autograft t/a/l add-on	1.50	0.75	0.83	0.58	0.59	0.21	ZZZ
15135		A	Derm autograft face/nck/hf/g	10.91	9.23	9.41	6.92	7.24	1.23	090
15136		A	Derm autograft, f/n/hf/g add	1.50	0.56	0.64	0.42	0.48	0.20	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.30	6.61	7.09	5.45	5.71	1.14	090
15151		A	Cult epiderm grft t/a/l addl	2.00	0.91	1.01	0.73	0.76	0.28	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.38	1.43	1.18	1.15	0.35	ZZZ
15155		A	Cult epiderm graft, f/n/hf/g	10.05	7.11	7.30	5.86	6.15	1.05	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.41	1.45	1.21	1.22	0.36	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.59	1.64	1.30	1.31	0.39	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	4.19	4.11	2.81	2.71	0.55	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.67	0.67	0.53	0.56	0.19	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	4.53	4.77	3.26	3.45	0.82	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.11	1.11	0.87	0.90	0.29	ZZZ
15200		A	Skin full graft, trunk	8.97	10.14	9.98	6.65	6.55	0.98	090
15201		A	Skin full graft trunk add-on	1.32	2.04	2.18	0.55	0.57	0.19	ZZZ
15220		A	Skin full graft sclp/arm/leg	7.95	10.45	10.16	6.82	6.80	0.84	090
15221		A	Skin full graft add-on	1.19	1.99	2.08	0.54	0.55	0.16	ZZZ
15240		A	Skin full grft face/genit/hf	10.15	12.09	11.64	9.06	8.80	0.92	090
15241		A	Skin full graft add-on	1.86	2.52	2.50	0.86	0.87	0.23	ZZZ
15260		A	Skin full graft een & lips	11.39	13.14	12.44	9.58	9.35	0.69	090
15261		A	Skin full graft add-on	2.23	2.95	2.89	1.21	1.26	0.21	ZZZ
15300		A	Apply skinallogrft, t/arm/lg	4.65	3.50	3.43	2.24	2.24	0.49	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0.50	0.49	0.37	0.37	0.14	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	3.76	3.73	2.38	2.42	0.58	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.73	0.72	0.55	0.56	0.21	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	3.54	3.46	2.23	2.24	0.49	090
15331		A	Aply acell grft t/a/l add-on	1.00	0.50	0.49	0.38	0.38	0.14	ZZZ
15335		A	Apply acell graft, f/n/hf/g	4.50	3.26	3.32	2.01	2.13	0.55	090
15336		A	Aply acell grft f/n/hf/g add	1.43	0.62	0.64	0.43	0.46	0.20	ZZZ
15340		A	Apply cult skin substitute	3.76	3.65	3.75	2.63	2.67	0.41	010
15341		A	Apply cult skin sub add-on	0.50	0.62	0.62	0.14	0.16	0.06	ZZZ
15360		A	Apply cult derm sub, t/a/l	3.93	4.64	4.61	3.41	3.34	0.43	090
15361		A	Aply cult derm sub t/a/l add	1.15	0.51	0.53	0.34	0.37	0.14	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.21	4.02	4.16	2.96	3.02	0.46	090
15366		A	Apply cult derm f/hf/g add	1.45	0.59	0.62	0.40	0.45	0.17	ZZZ
15400		A	Apply skin xenograft, t/a/l	4.38	5.26	4.96	4.01	4.02	0.47	090
15401		A	Apply skn xenogrft t/a/l add	1.00	0.99	1.22	0.34	0.36	0.14	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15420		A	Apply skin xgraft, f/n/hf/g	4.89	5.93	5.65	4.63	4.43	0.52	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.16	1.20	0.50	0.53	0.21	ZZZ
15430		A	Apply acellular xenograft	5.93	6.28	6.45	5.76	5.99	0.66	090
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
15570		A	Form skin pedicle flap	10.00	10.39	10.65	6.74	6.76	1.34	090
15572		A	Form skin pedicle flap	9.94	10.35	10.16	7.34	7.14	1.20	090
15574		A	Form skin pedicle flap	10.52	10.72	10.73	7.47	7.57	1.20	090
15576		A	Form skin pedicle flap	9.24	9.75	9.78	6.71	6.77	0.87	090
15600		A	Skin graft	1.95	5.22	5.83	2.74	2.82	0.27	090
15610		A	Skin graft	2.46	5.49	5.30	3.06	3.16	0.35	090
15620		A	Skin graft	3.62	6.38	6.75	3.90	3.90	0.35	090
15630		A	Skin graft	3.95	7.00	7.03	4.33	4.30	0.34	090
15650		A	Transfer skin pedicle flap	4.64	7.70	7.58	4.76	4.63	0.42	090
15731		A	Forehead flap w/vasc pedicle	14.12	12.79	12.79	10.17	10.17	1.28	090
15732		A	Muscle-skin graft, head/neck	19.70	14.87	15.70	11.44	11.66	2.00	090
15734		A	Muscle-skin graft, trunk	19.62	15.76	16.39	12.06	12.17	2.62	090
15736		A	Muscle-skin graft, arm	16.92	13.74	14.90	10.09	10.40	2.46	090
15738		A	Muscle-skin graft, leg	18.92	13.97	15.00	10.52	10.85	2.66	090
15740		A	Island pedicle flap graft	11.57	13.73	12.86	9.70	9.36	0.63	090
15750		A	Neurovascular pedicle graft	12.73	NA	NA	8.86	8.93	1.42	090
15756		A	Free myo/skin flap microvasc	36.74	NA	NA	19.31	19.67	4.62	090
15757		A	Free skin flap, microvasc	36.95	NA	NA	18.53	19.34	3.90	090
15758		A	Free fascial flap, microvasc	36.70	NA	NA	18.62	19.41	4.24	090
15760		A	Composite skin graft	9.68	10.47	10.38	7.21	7.24	0.85	090
15770		A	Derma-fat-fascia graft	8.73	NA	NA	6.78	6.77	1.05	090
15775		R	Hair transplant punch grafts	3.95	3.48	3.68	1.68	1.59	0.52	000
15776		R	Hair transplant punch grafts	5.53	4.91	5.04	2.25	2.40	0.72	000
15780		A	Abrasion treatment of skin	8.50	11.29	11.38	6.62	7.05	0.67	090
15781		A	Abrasion treatment of skin	4.91	8.21	7.91	5.41	5.41	0.34	090
15782		A	Abrasion treatment of skin	4.36	8.99	9.23	5.20	5.55	0.34	090
15783		A	Abrasion treatment of skin	4.33	7.50	7.36	4.75	4.62	0.28	090
15786		A	Abrasion, lesion, single	2.05	3.81	3.70	1.29	1.30	0.11	010
15787		A	Abrasion, lesions, add-on	0.33	0.76	0.84	0.10	0.12	0.04	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	8.69	8.22	3.84	3.66	0.11	090
15789		R	Chemical peel, face, dermal	4.91	9.02	8.81	5.68	5.47	0.20	090
15792		R	Chemical peel, nonfacial	1.86	8.64	8.27	4.45	4.46	0.13	090
15793		A	Chemical peel, nonfacial	3.82	7.99	7.58	4.90	4.78	0.19	090
15819		A	Plastic surgery, neck	10.45	NA	NA	7.06	7.11	0.97	090
15820		A	Revision of lower eyelid	6.09	6.55	6.67	5.37	5.43	0.40	090
15821		A	Revision of lower eyelid	6.66	6.72	6.89	5.45	5.53	0.45	090
15822		A	Revision of upper eyelid	4.51	5.30	5.45	4.19	4.27	0.37	090
15823		A	Revision of upper eyelid	8.12	7.57	7.66	6.32	6.37	0.50	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	16.90	NA	NA	10.13	10.13	2.93	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15832		A	Excise excessive skin tissue	12.65	NA	NA	8.22	8.27	1.66	090
15833		A	Excise excessive skin tissue	11.70	NA	NA	8.02	8.09	1.49	090
15834		A	Excise excessive skin tissue	11.97	NA	NA	7.60	7.64	1.61	090
15835		A	Excise excessive skin tissue	12.79	NA	NA	8.14	8.01	1.60	090
15836		A	Excise excessive skin tissue	10.41	NA	NA	6.96	6.93	1.34	090
15837		A	Excise excessive skin tissue	9.37	8.78	8.74	5.99	6.35	1.18	090
15838		A	Excise excessive skin tissue	8.07	NA	NA	5.65	5.77	0.58	090
15839		A	Excise excessive skin tissue	10.32	10.06	9.77	6.83	6.74	1.22	090
15840		A	Graft for face nerve palsy	14.76	NA	NA	9.22	9.43	1.32	090
15841		A	Graft for face nerve palsy	25.69	NA	NA	14.33	14.53	2.55	090
15842		A	Flap for face nerve palsy	40.68	NA	NA	21.94	22.23	4.94	090
15845		A	Skin and muscle repair, face	14.04	NA	NA	8.78	8.93	0.81	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.38	1.43	0.26	0.27	0.05	XXX
15851		A	Removal of sutures	0.86	1.30	1.39	0.24	0.26	0.06	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.27	0.29	0.09	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.69	0.72	0.27	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.15	NA	NA	5.61	5.61	1.04	090
15922		A	Removal of tail bone ulcer	10.23	NA	NA	7.15	7.19	1.42	090
15931		A	Remove sacrum pressure sore	9.96	NA	NA	5.62	5.65	1.25	090
15933		A	Remove sacrum pressure sore	11.60	NA	NA	7.56	7.65	1.52	090
15934		A	Remove sacrum pressure sore	13.54	NA	NA	7.75	7.84	1.79	090
15935		A	Remove sacrum pressure sore	15.58	NA	NA	9.73	9.90	2.10	090
15936		A	Remove sacrum pressure sore	13.04	NA	NA	7.47	7.67	1.77	090
15937		A	Remove sacrum pressure sore	15.00	NA	NA	9.00	9.22	2.07	090
15940		A	Remove hip pressure sore	10.11	NA	NA	5.83	5.93	1.31	090
15941		A	Remove hip pressure sore	12.24	NA	NA	8.35	8.65	1.66	090
15944		A	Remove hip pressure sore	12.27	NA	NA	8.16	8.29	1.65	090
15945		A	Remove hip pressure sore	13.57	NA	NA	9.10	9.26	1.85	090
15946		A	Remove hip pressure sore	23.80	NA	NA	14.23	14.30	3.17	090
15950		A	Remove thigh pressure sore	7.91	NA	NA	5.40	5.42	1.04	090
15951		A	Remove thigh pressure sore	11.41	NA	NA	7.47	7.59	1.49	090
15952		A	Remove thigh pressure sore	12.14	NA	NA	7.81	7.81	1.60	090
15953		A	Remove thigh pressure sore	13.39	NA	NA	8.74	8.82	1.80	090
15956		A	Remove thigh pressure sore	16.59	NA	NA	9.84	10.10	2.22	090
15958		A	Remove thigh pressure sore	16.55	NA	NA	10.56	10.70	2.26	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.71	0.75	0.24	0.24	0.08	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.08	1.14	0.55	0.56	0.08	000
16025		A	Dress/debrid p-thick burn, m	1.85	1.58	1.63	0.88	0.91	0.19	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.04	2.08	1.02	1.04	0.24	000
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.28	1.36	0.46	000
16036		A	Escharotomy; addÆl incision	1.50	NA	NA	0.49	0.52	0.20	ZZZ
17000		A	Destruct premalg lesion	0.62	1.40	1.29	0.75	0.70	0.03	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.11	0.04	0.04	0.01	ZZZ
17004		A	Destroy premlg lesions 15+	1.82	2.45	2.42	1.42	1.47	0.11	010
17106		A	Destruction of skin lesions	3.61	4.63	4.63	3.02	3.11	0.35	090
17107		A	Destruction of skin lesions	4.68	5.75	6.13	3.63	4.10	0.63	090
17108		A	Destruction of skin lesions	6.37	7.04	7.61	4.44	5.26	0.54	090
17110		A	Destruct b9 lesion, 1-14	0.67	2.10	1.98	1.06	0.97	0.05	010
17111		A	Destruct lesion, 15 or more	0.94	2.39	2.21	1.21	1.11	0.05	010
17250		A	Chemical cautery, tissue	0.50	1.29	1.28	0.38	0.37	0.06	000
17260		A	Destruction of skin lesions	0.93	1.40	1.37	0.73	0.71	0.04	010
17261		A	Destruction of skin lesions	1.19	2.46	2.25	1.09	1.03	0.05	010
17262		A	Destruction of skin lesions	1.60	2.82	2.59	1.31	1.24	0.06	010
17263		A	Destruction of skin lesions	1.81	3.05	2.81	1.41	1.33	0.07	010
17264		A	Destruction of skin lesions	1.96	3.23	2.98	1.47	1.39	0.08	010
17266		A	Destruction of skin lesions	2.36	3.48	3.25	1.65	1.54	0.09	010
17270		A	Destruction of skin lesions	1.34	2.41	2.23	1.12	1.06	0.05	010
17271		A	Destruction of skin lesions	1.51	2.65	2.43	1.26	1.19	0.06	010
17272		A	Destruction of skin lesions	1.79	2.96	2.72	1.41	1.34	0.07	010
17273		A	Destruction of skin lesions	2.07	3.20	2.96	1.55	1.46	0.08	010
17274		A	Destruction of skin lesions	2.61	3.59	3.34	1.81	1.72	0.10	010
17276		A	Destruction of skin lesions	3.22	3.87	3.64	2.05	1.96	0.16	010
17280		A	Destruction of skin lesions	1.19	2.33	2.16	1.05	0.99	0.05	010
17281		A	Destruction of skin lesions	1.74	2.73	2.53	1.37	1.30	0.07	010
17282		A	Destruction of skin lesions	2.06	3.13	2.89	1.54	1.47	0.08	010
17283		A	Destruction of skin lesions	2.66	3.56	3.31	1.83	1.75	0.11	010
17284		A	Destruction of skin lesions	3.23	3.97	3.71	2.11	2.03	0.13	010
17286		A	Destruction of skin lesions	4.45	4.47	4.28	2.61	2.58	0.23	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.65	10.65	3.26	3.26	0.24	000
17312		A	Mohs addl stage	3.30	6.81	6.81	1.73	1.73	0.13	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	9.82	9.82	2.93	2.93	0.22	000
17314		A	Mohs, addl stage, t/a/l	3.06	6.31	6.31	1.61	1.61	0.12	ZZZ
17315		A	Mohs surg, addl block	0.87	1.14	1.14	0.46	0.46	0.03	ZZZ
17340		A	Cryotherapy of skin	0.76	0.43	0.41	0.38	0.37	0.05	010
17360		A	Skin peel therapy	1.44	1.87	1.76	1.05	1.01	0.06	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1.90	1.93	0.29	0.30	0.08	000
19001		A	Drain breast lesion add-on	0.42	0.27	0.26	0.15	0.15	0.04	ZZZ
19020		A	Incision of breast lesion	3.74	6.55	6.51	3.05	2.96	0.45	090
19030		A	Injection for breast x-ray	1.53	2.69	2.74	0.59	0.57	0.09	000
19100		A	Bx breast percut w/o image	1.27	2.06	2.07	0.35	0.37	0.16	000
19101		A	Biopsy of breast, open	3.20	4.34	4.39	1.82	1.84	0.39	010
19102		A	Bx breast percut w/image	2.00	3.48	3.58	0.75	0.73	0.14	000
19103		A	Bx breast percut w/device	3.69	10.03	10.42	1.30	1.29	0.30	000
19105		A	Cryosurg ablate fa, each	3.69	51.22	51.22	1.30	1.30	0.30	000
19110		A	Nipple exploration	4.35	6.32	6.20	3.27	3.17	0.57	090
19112		A	Excise breast duct fistula	3.72	6.21	6.19	3.17	3.06	0.48	090
19120		A	Removal of breast lesion	5.84	5.10	4.97	3.43	3.35	0.73	090
19125		A	Excision, breast lesion	6.59	5.56	5.38	3.71	3.61	0.80	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
19126		A	Excision, addl breast lesion	2.93	NA	NA	0.80	0.85	0.38	ZZZ
19260		A	Removal of chest wall lesion	17.60	NA	NA	10.35	10.58	2.14	090
19271		A	Revision of chest wall	21.86	NA	NA	16.16	16.64	2.63	090
19272		A	Extensive chest wall surgery	24.82	NA	NA	17.33	17.77	3.00	090
19290		A	Place needle wire, breast	1.27	2.90	2.89	0.49	0.47	0.07	000
19291		A	Place needle wire, breast	0.63	1.15	1.16	0.24	0.23	0.04	ZZZ
19295		A	Place breast clip, percut	0.00	2.23	2.35	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	83.86	94.49	1.25	1.32	0.36	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.47	0.51	0.17	ZZZ
19298		A	Place breast rad tube/caths	6.00	21.98	27.10	2.21	2.27	0.43	000
19300		A	Removal of breast tissue	5.20	6.14	6.41	3.86	3.75	0.69	090
19301		A	Partical mastectomy	10.00	NA	NA	4.75	4.43	0.79	090
19302		A	P-mastectomy w/ln removal	13.88	NA	NA	6.34	6.35	1.80	090
19303		A	Mast, simple, complete	15.67	NA	NA	7.20	6.67	1.18	090
19304		A	Mast, subq	7.81	NA	NA	4.98	4.93	1.04	090
19305		A	Mast, radical	17.23	NA	NA	8.26	8.21	1.93	090
19306		A	Mast, rad, urban type	17.85	NA	NA	8.93	8.78	2.08	090
19307		A	Mast, mod rad	17.95	NA	NA	8.98	8.81	2.13	090
19316		A	Suspension of breast	10.98	NA	NA	6.98	7.13	1.64	090
19318		A	Reduction of large breast	15.91	NA	NA	10.14	10.42	2.93	090
19324		A	Enlarge breast	6.65	NA	NA	4.37	4.51	0.84	090
19325		A	Enlarge breast with implant	8.52	NA	NA	6.50	6.52	1.33	090
19328		A	Removal of breast implant	6.35	NA	NA	5.06	5.06	0.91	090
19330		A	Removal of implant material	8.39	NA	NA	6.27	6.22	1.26	090
19340		A	Immediate breast prosthesis	6.32	NA	NA	2.94	2.99	1.06	ZZZ
19342		A	Delayed breast prosthesis	12.40	NA	NA	9.11	9.09	1.84	090
19350		A	Breast reconstruction	8.99	9.83	10.86	6.66	6.81	1.41	090
19355		A	Correct inverted nipple(s)	8.37	7.58	8.26	4.87	4.84	0.92	090
19357		A	Breast reconstruction	20.57	NA	NA	15.60	15.64	2.94	090
19361		A	Breast reconstr w/lat flap	23.17	NA	NA	16.96	15.86	2.93	090
19364		A	Breast reconstruction	42.40	NA	NA	23.22	23.36	6.24	090
19366		A	Breast reconstruction	21.70	NA	NA	10.27	10.62	3.25	090
19367		A	Breast reconstruction	26.59	NA	NA	15.67	15.96	4.04	090
19368		A	Breast reconstruction	33.61	NA	NA	18.65	18.76	5.54	090
19369		A	Breast reconstruction	31.02	NA	NA	16.57	17.07	4.51	090
19370		A	Surgery of breast capsule	8.99	NA	NA	6.87	6.90	1.29	090
19371		A	Removal of breast capsule	10.42	NA	NA	7.80	7.82	1.62	090
19380		A	Revise breast reconstruction	10.21	NA	NA	7.72	7.73	1.44	090
19396		A	Design custom breast implant	2.17	3.66	3.02	0.97	0.98	0.30	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.14	2.73	2.73	1.52	1.58	0.25	010
20005		A	Incision of deep abscess	3.55	3.65	3.62	2.04	2.10	0.46	010
20100		A	Explore wound, neck	10.33	NA	NA	3.41	3.68	1.21	010
20101		A	Explore wound, chest	3.22	6.21	6.15	1.54	1.56	0.44	010
20102		A	Explore wound, abdomen	3.95	6.86	7.03	1.90	1.91	0.49	010
20103		A	Explore wound, extremity	5.31	7.73	7.96	2.87	3.01	0.75	010
20150		A	Excise epiphyseal bar	14.60	NA	NA	8.46	8.12	2.04	090
20200		A	Muscle biopsy	1.46	3.09	3.08	0.72	0.73	0.23	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
20205		A	Deep muscle biopsy	2.35	3.80	3.83	1.14	1.16	0.33	000
20206		A	Needle biopsy, muscle	0.99	5.17	5.52	0.60	0.61	0.07	000
20220		A	Bone biopsy, trocar/needle	1.27	2.70	3.18	0.71	0.73	0.08	000
20225		A	Bone biopsy, trocar/needle	1.87	11.91	15.08	1.08	1.10	0.22	000
20240		A	Bone biopsy, excisional	3.25	NA	NA	2.06	2.19	0.44	010
20245		A	Bone biopsy, excisional	8.77	NA	NA	5.80	6.01	1.31	010
20250		A	Open bone biopsy	5.16	NA	NA	3.59	3.58	1.02	010
20251		A	Open bone biopsy	5.69	NA	NA	3.92	3.99	1.15	010
20500		A	Injection of sinus tract	1.25	1.35	1.58	0.90	1.06	0.12	010
20501		A	Inject sinus tract for x-ray	0.76	2.37	2.51	0.30	0.29	0.04	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.87	2.56	2.66	1.45	1.53	0.21	010
20525		A	Removal of foreign body	3.51	7.02	7.57	2.26	2.35	0.51	010
20526		A	Ther injection, carp tunnel	0.94	0.82	0.86	0.43	0.45	0.13	000
20550		A	Inj tendon sheath/ligament	0.75	0.62	0.65	0.29	0.27	0.09	000
20551		A	Inj tendon origin/insertion	0.75	0.63	0.64	0.29	0.30	0.08	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.58	0.62	0.26	0.24	0.05	000
20553		A	Inject trigger points, =/> 3	0.75	0.65	0.69	0.28	0.26	0.04	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.33	2.33	0.43	000
20600		A	Drain/inject, joint/bursa	0.66	0.66	0.66	0.32	0.32	0.08	000
20605		A	Drain/inject, joint/bursa	0.68	0.73	0.74	0.33	0.34	0.08	000
20610		A	Drain/inject, joint/bursa	0.79	1.06	1.04	0.41	0.42	0.11	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.70	0.70	0.33	0.34	0.10	000
20615		A	Treatment of bone cyst	2.30	2.73	2.93	1.46	1.56	0.20	010
20650		A	Insert and remove bone pin	2.25	2.43	2.42	1.45	1.48	0.31	010
20660		A	Apply, rem fixation device	4.00	1.59	1.96	1.59	1.60	0.59	000
20661		A	Application of head brace	5.14	NA	NA	5.88	5.65	1.14	090
20662		A	Application of pelvis brace	6.26	NA	NA	5.22	5.31	0.56	090
20663		A	Application of thigh brace	5.62	NA	NA	4.79	4.81	0.94	090
20664		A	Halo brace application	9.86	NA	NA	8.12	7.87	1.75	090
20665		A	Removal of fixation device	1.33	1.37	1.57	0.99	1.08	0.19	010
20670		A	Removal of support implant	1.76	6.45	7.74	1.67	1.78	0.28	010
20680		A	Removal of support implant	5.90	8.07	8.27	4.14	4.04	0.56	090
20690		A	Apply bone fixation device	8.65	NA	NA	5.15	4.50	0.59	090
20692		A	Apply bone fixation device	16.00	NA	NA	10.23	8.64	1.05	090
20693		A	Adjust bone fixation device	5.97	NA	NA	4.60	4.83	0.98	090
20694		A	Remove bone fixation device	4.20	5.31	5.78	3.58	3.70	0.71	090
20696		A	Comp multiplane ext fixation	17.32	NA	NA	7.96	7.96	2.86	090
20697		A	Comp ext fixate strut change	0.00	33.08	33.08	0.00	0.00	0.01	000
20802		A	Replantation, arm, complete	42.30	NA	NA	15.88	17.19	3.82	090
20805		A	Replant forearm, complete	51.14	NA	NA	17.36	21.66	4.85	090
20808		A	Replantation hand, complete	62.77	NA	NA	33.56	35.82	6.88	090
20816		A	Replantation digit, complete	31.74	NA	NA	17.18	22.39	4.53	090
20822		A	Replantation digit, complete	26.42	NA	NA	14.09	19.27	4.19	090
20824		A	Replantation thumb, complete	31.74	NA	NA	17.20	22.10	4.62	090
20827		A	Replantation thumb, complete	27.24	NA	NA	15.39	20.72	3.67	090
20838		A	Replantation foot, complete	42.56	NA	NA	18.35	19.38	1.12	090
20900		A	Removal of bone for graft	3.00	6.25	6.81	2.14	3.04	0.94	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
20902		A	Removal of bone for graft	4.58	NA	NA	2.70	3.75	1.30	000
20910		A	Remove cartilage for graft	5.41	NA	NA	4.77	4.89	0.71	090
20912		A	Remove cartilage for graft	6.42	NA	NA	4.98	5.20	0.69	090
20920		A	Removal of fascia for graft	5.42	NA	NA	4.34	4.32	0.66	090
20922		A	Removal of fascia for graft	6.84	7.84	7.78	5.24	5.16	0.70	090
20924		A	Removal of tendon for graft	6.59	NA	NA	5.11	5.32	1.04	090
20926		A	Removal of tissue for graft	5.70	NA	NA	4.54	4.60	0.87	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	0.72	0.78	0.43	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.15	1.23	0.54	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.23	1.31	0.64	ZZZ
20950		A	Fluid pressure, muscle	1.26	3.95	4.68	0.86	0.90	0.20	000
20955		A	Fibula bone graft, microvasc	40.02	NA	NA	20.17	21.25	4.90	090
20956		A	Iliac bone graft, microvasc	40.93	NA	NA	20.70	21.76	7.03	090
20957		A	Mt bone graft, microvasc	42.33	NA	NA	16.53	17.17	7.07	090
20962		A	Other bone graft, microvasc	39.21	NA	NA	21.01	22.45	6.57	090
20969		A	Bone/skin graft, microvasc	45.11	NA	NA	21.91	23.15	4.80	090
20970		A	Bone/skin graft, iliac crest	44.26	NA	NA	22.35	23.17	6.62	090
20972		A	Bone/skin graft, metatarsal	44.19	NA	NA	16.72	17.73	5.32	090
20973		A	Bone/skin graft, great toe	46.95	NA	NA	15.59	18.03	5.56	090
20974		A	Electrical bone stimulation	0.62	1.00	0.93	0.50	0.51	0.11	000
20975		A	Electrical bone stimulation	2.60	NA	NA	1.52	1.57	0.51	000
20979		A	Us bone stimulation	0.62	0.60	0.65	0.21	0.24	0.09	000
20982		A	Ablate, bone tumor(s) perq	7.27	78.58	86.54	2.88	2.91	0.69	000
20985		A	Cptr-asst dir ms px	2.50	1.06	1.06	1.06	1.06	0.48	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.90	NA	NA	6.33	6.53	1.11	090
21015		A	Resection of facial tumor	5.59	NA	NA	4.40	4.56	0.70	090
21025		A	Excision of bone, lower jaw	9.87	10.70	11.11	7.37	7.88	1.32	090
21026		A	Excision of facial bone(s)	5.54	8.75	8.54	5.94	6.05	0.60	090
21029		A	Contour of face bone lesion	8.26	9.57	9.54	6.61	6.72	0.94	090
21030		A	Excise max/zygoma b9 tumor	4.80	7.14	6.95	4.70	4.80	0.54	090
21031		A	Remove exostosis, mandible	3.26	5.93	5.75	3.53	3.56	0.48	090
21032		A	Remove exostosis, maxilla	3.28	6.02	5.86	3.40	3.44	0.47	090
21034		A	Excise max/zygoma mlg tumor	17.17	14.12	14.61	10.41	11.00	1.72	090
21040		A	Excise mandible lesion	4.80	7.24	7.05	4.73	4.74	0.54	090
21044		A	Removal of jaw bone lesion	12.61	NA	NA	8.28	8.58	1.12	090
21045		A	Extensive jaw surgery	18.13	NA	NA	11.08	11.43	1.52	090
21046		A	Remove mandible cyst complex	13.97	NA	NA	11.84	11.88	1.86	090
21047		A	Excise lwr jaw cyst w/repair	19.83	NA	NA	10.70	11.42	2.13	090
21048		A	Remove maxilla cyst complex	14.47	NA	NA	11.64	11.79	1.77	090
21049		A	Excis uppr jaw cyst w/repair	19.08	NA	NA	10.91	11.46	1.59	090
21050		A	Removal of jaw joint	11.54	NA	NA	8.87	9.04	1.47	090
21060		A	Remove jaw joint cartilage	10.91	NA	NA	7.58	7.85	1.38	090
21070		A	Remove coronoid process	8.50	NA	NA	6.49	6.66	1.27	090
21073		A	Mnpj of tmj w/anesth	3.33	5.40	5.40	2.33	2.33	0.43	090
21076		A	Prepare face/oral prosthesis	13.40	8.34	9.37	5.07	6.32	2.00	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21077		A	Prepare face/oral prosthesis	33.70	19.67	22.65	13.25	16.48	4.56	090
21079		A	Prepare face/oral prosthesis	22.31	14.40	16.22	8.66	10.82	3.16	090
21080		A	Prepare face/oral prosthesis	25.06	16.57	18.60	9.61	12.08	3.75	090
21081		A	Prepare face/oral prosthesis	22.85	15.37	17.14	8.93	11.10	3.21	090
21082		A	Prepare face/oral prosthesis	20.84	15.25	16.31	8.76	10.53	3.12	090
21083		A	Prepare face/oral prosthesis	19.27	15.11	16.07	8.19	9.77	2.89	090
21084		A	Prepare face/oral prosthesis	22.48	17.12	18.49	9.43	11.53	2.19	090
21085		A	Prepare face/oral prosthesis	8.99	7.01	7.34	3.69	4.48	1.27	010
21086		A	Prepare face/oral prosthesis	24.88	13.34	15.98	8.99	11.64	3.72	090
21087		A	Prepare face/oral prosthesis	24.88	13.51	16.00	9.14	11.68	3.45	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.56	13.01	12.67	5.20	5.09	0.34	090
21110		A	Interdental fixation	5.80	12.87	12.07	9.64	9.34	0.72	090
21116		A	Injection, jaw joint x-ray	0.81	2.36	2.86	0.23	0.26	0.06	000
21120		A	Reconstruction of chin	4.99	9.58	9.85	6.63	6.86	0.60	090
21121		A	Reconstruction of chin	7.70	10.96	10.68	7.92	7.91	0.90	090
21122		A	Reconstruction of chin	8.59	NA	NA	8.51	8.56	1.07	090
21123		A	Reconstruction of chin	11.22	NA	NA	8.63	9.20	1.40	090
21125		A	Augmentation, lower jaw bone	10.68	66.25	63.64	7.11	7.43	0.79	090
21127		A	Augmentation, lower jaw bone	12.24	86.64	75.85	8.19	8.53	1.52	090
21137		A	Reduction of forehead	10.12	NA	NA	6.68	6.96	1.32	090
21138		A	Reduction of forehead	12.73	NA	NA	8.17	8.53	1.75	090
21139		A	Reduction of forehead	14.90	NA	NA	8.89	9.46	1.18	090
21141		A	Reconstruct midface, lefort	19.27	NA	NA	12.62	12.91	2.36	090
21142		A	Reconstruct midface, lefort	19.98	NA	NA	11.35	11.74	2.39	090
21143		A	Reconstruct midface, lefort	20.75	NA	NA	12.15	12.72	1.66	090
21145		A	Reconstruct midface, lefort	23.64	NA	NA	12.90	13.18	2.85	090
21146		A	Reconstruct midface, lefort	24.54	NA	NA	14.53	14.77	3.10	090
21147		A	Reconstruct midface, lefort	26.14	NA	NA	15.19	15.19	1.85	090
21150		A	Reconstruct midface, lefort	25.78	NA	NA	14.05	14.77	2.56	090
21151		A	Reconstruct midface, lefort	28.84	NA	NA	20.07	20.84	2.31	090
21154		A	Reconstruct midface, lefort	31.05	NA	NA	17.47	18.93	2.49	090
21155		A	Reconstruct midface, lefort	34.98	NA	NA	17.48	19.13	6.66	090
21159		A	Reconstruct midface, lefort	42.90	NA	NA	20.13	22.42	8.20	090
21160		A	Reconstruct midface, lefort	46.95	NA	NA	21.48	23.04	4.14	090
21172		A	Reconstruct orbit/forehead	28.07	NA	NA	14.46	14.32	3.56	090
21175		A	Reconstruct orbit/forehead	33.43	NA	NA	17.24	17.42	4.84	090
21179		A	Reconstruct entire forehead	22.53	NA	NA	12.14	12.67	2.81	090
21180		A	Reconstruct entire forehead	25.46	NA	NA	14.15	14.49	3.49	090
21181		A	Contour cranial bone lesion	10.18	NA	NA	6.33	6.63	1.32	090
21182		A	Reconstruct cranial bone	32.45	NA	NA	16.30	17.04	2.81	090
21183		A	Reconstruct cranial bone	35.57	NA	NA	18.22	18.92	4.48	090
21184		A	Reconstruct cranial bone	38.49	NA	NA	18.12	19.12	5.72	090
21188		A	Reconstruction of midface	22.97	NA	NA	15.97	16.74	1.70	090
21193		A	Reconst lwr jaw w/o graft	18.65	NA	NA	10.40	10.99	2.24	090
21194		A	Reconst lwr jaw w/graft	21.54	NA	NA	12.24	12.65	2.03	090
21195		A	Reconst lwr jaw w/o fixation	18.88	NA	NA	13.00	13.49	1.64	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21196		A	Reconst lwr jaw w/fixation	20.55	NA	NA	14.09	14.53	2.08	090
21198		A	Reconstr lwr jaw segment	15.48	NA	NA	12.08	12.27	1.44	090
21199		A	Reconstr lwr jaw w/advance	16.62	NA	NA	8.04	8.33	1.39	090
21206		A	Reconstruct upper jaw bone	15.36	NA	NA	11.79	12.03	1.33	090
21208		A	Augmentation of facial bones	11.15	33.17	30.53	8.37	8.70	1.09	090
21209		A	Reduction of facial bones	7.58	12.20	11.88	7.51	7.67	0.90	090
21210		A	Face bone graft	11.40	42.97	38.53	7.90	8.28	1.30	090
21215		A	Lower jaw bone graft	11.94	84.06	73.68	8.13	8.46	1.53	090
21230		A	Rib cartilage graft	11.06	NA	NA	6.94	7.23	1.29	090
21235		A	Ear cartilage graft	7.31	10.13	10.08	6.30	6.34	0.61	090
21240		A	Reconstruction of jaw joint	15.77	NA	NA	9.86	10.43	2.25	090
21242		A	Reconstruction of jaw joint	14.32	NA	NA	9.30	9.87	1.79	090
21243		A	Reconstruction of jaw joint	24.03	NA	NA	14.74	15.45	3.26	090
21244		A	Reconstruction of lower jaw	13.35	NA	NA	11.69	11.82	1.25	090
21245		A	Reconstruction of jaw	12.88	14.36	14.41	8.94	9.19	1.19	090
21246		A	Reconstruction of jaw	12.78	NA	NA	7.16	7.65	1.35	090
21247		A	Reconstruct lower jaw bone	24.05	NA	NA	13.57	14.55	2.84	090
21248		A	Reconstruction of jaw	12.54	13.03	12.84	7.97	8.35	1.55	090
21249		A	Reconstruction of jaw	18.57	16.21	16.38	10.22	10.86	2.49	090
21255		A	Reconstruct lower jaw bone	18.14	NA	NA	16.22	16.23	2.39	090
21256		A	Reconstruction of orbit	17.42	NA	NA	10.47	10.83	1.50	090
21260		A	Revise eye sockets	17.74	NA	NA	15.26	14.67	0.97	090
21261		A	Revise eye sockets	33.78	NA	NA	18.95	20.32	3.43	090
21263		A	Revise eye sockets	30.72	NA	NA	17.93	18.26	2.63	090
21267		A	Revise eye sockets	20.45	NA	NA	16.02	17.00	1.71	090
21268		A	Revise eye sockets	26.78	NA	NA	18.06	18.65	3.66	090
21270		A	Augmentation, cheek bone	10.52	11.32	11.43	6.17	6.45	0.72	090
21275		A	Revision, orbitofacial bones	11.65	NA	NA	7.41	7.62	1.29	090
21280		A	Revision of eyelid	6.92	NA	NA	5.76	5.81	0.42	090
21282		A	Revision of eyelid	4.11	NA	NA	4.27	4.33	0.26	090
21295		A	Revision of jaw muscle/bone	1.82	NA	NA	2.33	2.39	0.16	090
21296		A	Revision of jaw muscle/bone	4.67	NA	NA	5.80	5.59	0.34	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	1.91	2.00	0.11	0.12	0.05	000
21315		A	Treatment of nose fracture	1.78	4.59	4.51	1.76	1.79	0.14	010
21320		A	Treatment of nose fracture	1.86	4.22	4.16	1.37	1.44	0.18	010
21325		A	Treatment of nose fracture	4.07	NA	NA	6.83	7.29	0.31	090
21330		A	Treatment of nose fracture	5.68	NA	NA	7.56	8.12	0.56	090
21335		A	Treatment of nose fracture	8.91	NA	NA	8.59	8.87	0.74	090
21336		A	Treat nasal septal fracture	6.56	NA	NA	8.62	8.89	0.55	090
21337		A	Treat nasal septal fracture	3.26	6.08	6.10	3.58	3.58	0.28	090
21338		A	Treat nasoethmoid fracture	6.76	NA	NA	9.72	10.83	0.82	090
21339		A	Treat nasoethmoid fracture	8.39	NA	NA	10.21	11.16	0.96	090
21340		A	Treatment of nose fracture	11.33	NA	NA	7.81	7.97	1.15	090
21343		A	Treatment of sinus fracture	14.11	NA	NA	12.74	13.46	1.47	090
21344		A	Treatment of sinus fracture	21.36	NA	NA	13.72	14.45	2.44	090
21345		A	Treat nose/jaw fracture	8.87	10.38	10.27	6.66	6.81	0.92	090
21346		A	Treat nose/jaw fracture	11.29	NA	NA	11.31	11.56	1.21	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21347		A	Treat nose/jaw fracture	13.37	NA	NA	11.99	13.07	1.47	090
21348		A	Treat nose/jaw fracture	17.36	NA	NA	9.57	9.98	2.49	090
21355		A	Treat cheek bone fracture	4.32	6.12	6.17	3.48	3.49	0.34	010
21356		A	Treat cheek bone fracture	4.70	6.94	7.00	4.12	4.23	0.46	010
21360		A	Treat cheek bone fracture	7.03	NA	NA	5.48	5.61	0.74	090
21365		A	Treat cheek bone fracture	16.52	NA	NA	9.47	9.83	1.70	090
21366		A	Treat cheek bone fracture	18.44	NA	NA	10.09	10.43	2.50	090
21385		A	Treat eye socket fracture	9.46	NA	NA	7.38	7.62	0.97	090
21386		A	Treat eye socket fracture	9.46	NA	NA	6.18	6.42	0.97	090
21387		A	Treat eye socket fracture	10.00	NA	NA	7.35	7.77	1.08	090
21390		A	Treat eye socket fracture	11.07	NA	NA	7.31	7.45	0.90	090
21395		A	Treat eye socket fracture	14.62	NA	NA	8.32	8.52	1.44	090
21400		A	Treat eye socket fracture	1.44	2.83	2.78	2.05	2.01	0.15	090
21401		A	Treat eye socket fracture	3.57	7.58	7.70	3.42	3.45	0.38	090
21406		A	Treat eye socket fracture	7.31	NA	NA	5.42	5.60	0.73	090
21407		A	Treat eye socket fracture	8.91	NA	NA	6.13	6.32	0.94	090
21408		A	Treat eye socket fracture	12.67	NA	NA	7.90	8.17	1.44	090
21421		A	Treat mouth roof fracture	5.80	12.20	11.51	9.09	8.92	0.73	090
21422		A	Treat mouth roof fracture	8.62	NA	NA	7.07	7.34	0.99	090
21423		A	Treat mouth roof fracture	10.71	NA	NA	7.77	8.18	1.27	090
21431		A	Treat craniofacial fracture	7.74	NA	NA	10.12	9.99	0.70	090
21432		A	Treat craniofacial fracture	8.76	NA	NA	6.99	7.27	0.81	090
21433		A	Treat craniofacial fracture	26.13	NA	NA	13.81	14.49	2.79	090
21435		A	Treat craniofacial fracture	20.02	NA	NA	11.95	12.17	1.99	090
21436		A	Treat craniofacial fracture	30.01	NA	NA	16.85	17.23	3.10	090
21440		A	Treat dental ridge fracture	3.28	10.16	9.42	7.56	7.23	0.38	090
21445		A	Treat dental ridge fracture	6.04	12.45	11.81	8.67	8.62	0.78	090
21450		A	Treat lower jaw fracture	3.55	10.47	9.72	7.69	7.51	0.33	090
21451		A	Treat lower jaw fracture	5.46	12.74	11.92	9.54	9.28	0.63	090
21452		A	Treat lower jaw fracture	2.29	11.89	12.20	6.03	5.68	0.27	090
21453		A	Treat lower jaw fracture	6.40	14.65	13.71	11.58	11.40	0.74	090
21454		A	Treat lower jaw fracture	7.17	NA	NA	5.86	5.97	0.82	090
21461		A	Treat lower jaw fracture	9.07	41.13	37.04	12.88	12.86	0.98	090
21462		A	Treat lower jaw fracture	10.77	42.56	38.91	13.57	13.39	1.27	090
21465		A	Treat lower jaw fracture	12.88	NA	NA	8.42	8.79	1.50	090
21470		A	Treat lower jaw fracture	17.24	NA	NA	10.66	11.02	1.97	090
21480		A	Reset dislocated jaw	0.61	1.50	1.57	0.17	0.18	0.06	000
21485		A	Reset dislocated jaw	4.58	11.90	11.00	8.99	8.68	0.51	090
21490		A	Repair dislocated jaw	12.71	NA	NA	8.69	8.96	1.97	090
21495		A	Treat hyoid bone fracture	6.55	NA	NA	10.41	9.93	0.46	090
21497		A	Interdental wiring	4.45	12.21	11.30	9.39	8.97	0.50	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.87	6.50	6.50	3.54	3.62	0.43	090
21502		A	Drain chest lesion	7.43	NA	NA	4.64	4.90	0.97	090
21510		A	Drainage of bone lesion	6.06	NA	NA	4.62	4.89	0.80	090
21550		A	Biopsy of neck/chest	2.08	4.24	4.08	1.79	1.77	0.16	010
21555		A	Remove lesion, neck/chest	4.40	5.78	5.73	3.49	3.42	0.56	090
21556		A	Remove lesion, neck/chest	5.63	NA	NA	4.20	4.18	0.65	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21557		A	Remove tumor, neck/chest	8.91	NA	NA	4.66	4.85	1.08	090
21600		A	Partial removal of rib	7.14	NA	NA	5.96	5.92	0.99	090
21610		A	Partial removal of rib	15.76	NA	NA	8.78	8.83	3.08	090
21615		A	Removal of rib	10.31	NA	NA	5.15	5.55	1.45	090
21616		A	Removal of rib and nerves	12.54	NA	NA	7.58	7.71	1.87	090
21620		A	Partial removal of sternum	7.16	NA	NA	4.95	5.22	0.98	090
21627		A	Sternal debridement	7.18	NA	NA	5.67	5.84	1.02	090
21630		A	Extensive sternum surgery	19.01	NA	NA	10.83	11.11	2.59	090
21632		A	Extensive sternum surgery	19.51	NA	NA	9.87	10.20	2.66	090
21685		A	Hyoid myotomy & suspension	14.89	NA	NA	8.99	9.26	1.06	090
21700		A	Revision of neck muscle	6.23	NA	NA	4.00	4.12	0.32	090
21705		A	Revision of neck muscle/rib	9.83	NA	NA	5.38	5.44	1.43	090
21720		A	Revision of neck muscle	5.72	NA	NA	4.33	3.87	0.91	090
21725		A	Revision of neck muscle	7.10	NA	NA	5.28	5.34	1.21	090
21740		A	Reconstruction of sternum	17.47	NA	NA	8.27	8.35	2.37	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	11.35	NA	NA	5.59	5.74	1.63	090
21800		A	Treatment of rib fracture	0.98	1.33	1.34	1.39	1.38	0.09	090
21805		A	Treatment of rib fracture	2.80	NA	NA	3.35	3.32	0.38	090
21810		A	Treatment of rib fracture(s)	6.92	NA	NA	4.86	4.90	0.94	090
21820		A	Treat sternum fracture	1.31	1.74	1.76	1.80	1.80	0.16	090
21825		A	Treat sternum fracture	7.65	NA	NA	5.52	5.75	1.11	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.08	4.33	4.08	1.88	1.78	0.14	010
21925		A	Biopsy soft tissue of back	4.54	5.37	5.33	3.42	3.38	0.60	090
21930		A	Remove lesion, back or flank	5.06	6.02	5.96	3.81	3.72	0.66	090
21935		A	Remove tumor, back	18.38	NA	NA	8.80	9.02	2.48	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.57	NA	NA	8.59	8.69	1.74	090
22015		A	I&d, p-spine, l/s/ls	12.46	NA	NA	8.61	8.69	1.72	090
22100		A	Remove part of neck vertebra	10.80	NA	NA	8.17	8.03	2.14	090
22101		A	Remove part, thorax vertebra	10.88	NA	NA	8.12	8.05	1.91	090
22102		A	Remove part, lumbar vertebra	10.88	NA	NA	7.93	7.99	1.88	090
22103		A	Remove extra spine segment	2.34	NA	NA	0.97	1.03	0.44	ZZZ
22110		A	Remove part of neck vertebra	13.80	NA	NA	9.59	9.51	2.77	090
22112		A	Remove part, thorax vertebra	13.87	NA	NA	8.60	8.79	2.53	090
22114		A	Remove part, lumbar vertebra	13.87	NA	NA	9.37	9.36	2.64	090
22116		A	Remove extra spine segment	2.32	NA	NA	0.93	0.99	0.50	ZZZ
22206		A	Cut spine 3 col, thor	37.00	NA	NA	18.64	18.64	6.23	090
22207		A	Cut spine 3 col, lumb	36.50	NA	NA	18.47	18.47	6.07	090
22208		A	Cut spine 3 col, addl seg	9.66	3.99	3.99	3.99	3.99	2.07	ZZZ
22210		A	Revision of neck spine	25.13	NA	NA	15.08	15.20	5.46	090
22212		A	Revision of thorax spine	20.74	NA	NA	12.91	13.03	3.91	090
22214		A	Revision of lumbar spine	20.77	NA	NA	12.99	13.22	3.92	090
22216		A	Revise, extra spine segment	6.03	NA	NA	2.49	2.66	1.29	ZZZ
22220		A	Revision of neck spine	22.69	NA	NA	13.43	13.51	5.08	090
22222		A	Revision of thorax spine	22.84	NA	NA	10.22	10.47	4.13	090
22224		A	Revision of lumbar spine	22.84	NA	NA	13.28	13.55	4.19	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22226		A	Revise, extra spine segment	6.03	NA	NA	2.45	2.62	1.29	ZZZ
22305		A	Treat spine process fracture	2.08	2.15	2.20	1.82	1.85	0.39	090
22310		A	Treat spine fracture	3.69	3.05	2.99	2.57	2.52	0.50	090
22315		A	Treat spine fracture	9.91	9.79	9.79	7.49	7.47	1.86	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	NA	13.45	13.47	5.30	090
22319		A	Treat odontoid fx w/graft	25.15	NA	NA	14.07	14.26	6.05	090
22325		A	Treat spine fracture	19.62	NA	NA	12.52	12.44	3.88	090
22326		A	Treat neck spine fracture	20.64	NA	NA	12.40	12.51	4.43	090
22327		A	Treat thorax spine fracture	20.52	NA	NA	12.70	12.65	3.99	090
22328		A	Treat each add spine fx	4.60	NA	NA	1.87	1.97	0.94	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	0.97	0.96	0.36	010
22520		A	Percut vertebroplasty thor	9.17	42.10	47.11	4.27	4.48	1.72	010
22521		A	Percut vertebroplasty lumb	8.60	42.89	46.27	4.04	4.28	1.60	010
22522		A	Percut vertebroplasty addÆl	4.30	NA	NA	1.66	1.67	0.82	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	NA	4.87	5.14	1.72	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	NA	4.71	4.97	1.60	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.80	1.92	0.82	ZZZ
22526		A	Idet, single level	6.07	41.57	41.57	1.91	1.91	1.16	010
22527		A	Idet, 1 or more levels	3.03	34.18	34.18	0.57	0.57	0.58	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	NA	14.22	14.41	4.35	090
22533		A	Lat lumbar spine fusion	24.61	NA	NA	13.99	13.92	3.16	090
22534		A	Lat thor/lumb, addÆl seg	5.99	NA	NA	2.45	2.60	1.25	ZZZ
22548		A	Neck spine fusion	26.86	NA	NA	15.10	15.31	5.61	090
22554		A	Neck spine fusion	17.54	NA	NA	10.87	11.26	4.46	090
22556		A	Thorax spine fusion	24.50	NA	NA	13.36	13.73	4.35	090
22558		A	Lumbar spine fusion	23.33	NA	NA	12.01	12.36	3.16	090
22585		A	Additional spinal fusion	5.52	NA	NA	2.19	2.35	1.25	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	NA	13.38	13.40	4.79	090
22595		A	Neck spinal fusion	20.44	NA	NA	12.82	12.85	4.41	090
22600		A	Neck spine fusion	17.20	NA	NA	11.41	11.38	3.73	090
22610		A	Thorax spine fusion	17.08	NA	NA	11.14	11.23	3.53	090
22612		A	Lumbar spine fusion	23.38	NA	NA	12.99	13.32	4.47	090
22614		A	Spine fusion, extra segment	6.43	NA	NA	2.62	2.81	1.38	ZZZ
22630		A	Lumbar spine fusion	21.89	NA	NA	12.91	13.12	4.73	090
22632		A	Spine fusion, extra segment	5.22	NA	NA	2.11	2.26	1.16	ZZZ
22800		A	Fusion of spine	19.30	NA	NA	11.60	11.92	3.76	090
22802		A	Fusion of spine	31.91	NA	NA	16.85	17.58	6.17	090
22804		A	Fusion of spine	37.30	NA	NA	18.97	19.95	7.00	090
22808		A	Fusion of spine	27.31	NA	NA	14.53	15.01	4.93	090
22810		A	Fusion of spine	31.30	NA	NA	15.32	16.12	5.15	090
22812		A	Fusion of spine	34.00	NA	NA	17.43	18.13	5.30	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	NA	17.12	17.60	6.47	090
22819		A	Kyphectomy, 3 or more	39.18	NA	NA	20.36	20.33	7.67	090
22830		A	Exploration of spinal fusion	11.13	NA	NA	7.26	7.45	2.30	090
22840		A	Insert spine fixation device	12.52	NA	NA	5.09	5.45	2.79	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	NA	5.12	5.48	2.75	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	5.53	5.81	2.86	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22844		A	Insert spine fixation device	16.42	NA	NA	6.90	7.38	3.19	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	4.78	5.12	2.86	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	4.96	5.32	2.96	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	5.58	5.95	3.00	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	2.51	2.69	1.15	ZZZ
22849		A	Reinsert spinal fixation	19.08	NA	NA	10.61	10.92	3.90	090
22850		A	Remove spine fixation device	9.74	NA	NA	6.57	6.69	2.05	090
22851		A	Apply spine prosth device	6.70	NA	NA	2.71	2.88	1.49	ZZZ
22852		A	Remove spine fixation device	9.29	NA	NA	6.34	6.46	1.90	090
22855		A	Remove spine fixation device	15.77	NA	NA	9.40	9.49	3.52	090
22856		A	Cerv artific diskectomy	23.90	NA	NA	13.63	13.63	5.62	090
22857		R	Lumbar artif diskectomy	26.93	NA	NA	13.76	13.76	3.56	090
22861		A	Revise cerv artific disc	33.21	NA	NA	13.54	13.54	5.49	090
22862		R	Revise lumbar artif disc	32.43	NA	NA	13.72	13.72	5.36	090
22864		A	Remove cerv artif disc	29.25	NA	NA	12.22	12.22	7.04	090
22865		R	Remove lumb artif disc	31.55	NA	NA	18.22	18.22	5.18	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	6.14	NA	NA	3.61	3.52	0.76	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.40	7.92	8.09	3.84	3.99	0.68	090
23020		A	Release shoulder joint	9.24	NA	NA	6.66	6.90	1.54	090
23030		A	Drain shoulder lesion	3.44	6.19	6.51	2.43	2.56	0.57	010
23031		A	Drain shoulder bursa	2.76	5.86	6.37	2.05	2.22	0.46	010
23035		A	Drain shoulder bone lesion	9.04	NA	NA	6.57	7.01	1.47	090
23040		A	Exploratory shoulder surgery	9.63	NA	NA	6.93	7.18	1.60	090
23044		A	Exploratory shoulder surgery	7.48	NA	NA	5.66	5.87	1.24	090
23065		A	Biopsy shoulder tissues	2.28	2.92	2.82	1.75	1.72	0.20	010
23066		A	Biopsy shoulder tissues	4.21	7.66	7.68	3.64	3.73	0.63	090
23075		A	Removal of shoulder lesion	2.41	3.66	3.67	1.74	1.76	0.34	010
23076		A	Removal of shoulder lesion	7.77	NA	NA	5.37	5.43	1.13	090
23077		A	Remove tumor of shoulder	18.08	NA	NA	9.86	9.97	2.34	090
23100		A	Biopsy of shoulder joint	6.09	NA	NA	5.14	5.28	1.04	090
23101		A	Shoulder joint surgery	5.63	NA	NA	4.63	4.82	0.96	090
23105		A	Remove shoulder joint lining	8.36	NA	NA	6.27	6.50	1.42	090
23106		A	Incision of collarbone joint	6.02	NA	NA	4.87	5.09	0.99	090
23107		A	Explore treat shoulder joint	8.75	NA	NA	6.43	6.68	1.49	090
23120		A	Partial removal, collar bone	7.23	NA	NA	6.03	6.16	1.23	090
23125		A	Removal of collar bone	9.52	NA	NA	6.61	6.87	1.62	090
23130		A	Remove shoulder bone, part	7.63	NA	NA	6.20	6.45	1.30	090
23140		A	Removal of bone lesion	7.01	NA	NA	4.89	4.99	1.08	090
23145		A	Removal of bone lesion	9.28	NA	NA	6.68	6.88	1.49	090
23146		A	Removal of bone lesion	7.96	NA	NA	5.66	6.04	1.35	090
23150		A	Removal of humerus lesion	8.79	NA	NA	6.42	6.56	1.32	090
23155		A	Removal of humerus lesion	10.72	NA	NA	7.53	7.74	1.81	090
23156		A	Removal of humerus lesion	8.99	NA	NA	6.48	6.72	1.50	090
23170		A	Remove collar bone lesion	7.10	NA	NA	5.02	5.28	1.12	090
23172		A	Remove shoulder blade lesion	7.20	NA	NA	5.34	5.59	1.01	090
23174		A	Remove humerus lesion	9.90	NA	NA	7.44	7.69	1.65	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23180		A	Remove collar bone lesion	8.85	NA	NA	6.55	7.18	1.47	090
23182		A	Remove shoulder blade lesion	8.47	NA	NA	6.50	7.03	1.37	090
23184		A	Remove humerus lesion	9.76	NA	NA	7.12	7.68	1.63	090
23190		A	Partial removal of scapula	7.36	NA	NA	5.46	5.65	1.17	090
23195		A	Removal of head of humerus	10.24	NA	NA	7.17	7.33	1.71	090
23200		A	Removal of collar bone	12.69	NA	NA	7.85	8.09	1.94	090
23210		A	Removal of shoulder blade	13.16	NA	NA	8.42	8.58	2.03	090
23220		A	Partial removal of humerus	15.36	NA	NA	9.34	9.73	2.49	090
23221		A	Partial removal of humerus	18.41	NA	NA	10.42	10.77	3.06	090
23222		A	Partial removal of humerus	25.44	NA	NA	13.94	14.43	3.95	090
23330		A	Remove shoulder foreign body	1.87	3.33	3.42	1.55	1.64	0.24	010
23331		A	Remove shoulder foreign body	7.51	NA	NA	5.98	6.20	1.27	090
23332		A	Remove shoulder foreign body	12.23	NA	NA	8.23	8.52	2.03	090
23350		A	Injection for shoulder x-ray	1.00	2.72	2.91	0.38	0.37	0.06	000
23395		A	Muscle transfer,shoulder/arm	18.29	NA	NA	11.61	11.95	2.94	090
23397		A	Muscle transfers	16.62	NA	NA	10.03	10.39	2.74	090
23400		A	Fixation of shoulder blade	13.73	NA	NA	8.86	9.18	2.30	090
23405		A	Incision of tendon & muscle	8.43	NA	NA	6.09	6.32	1.45	090
23406		A	Incise tendon(s) & muscle(s)	10.90	NA	NA	7.18	7.49	1.88	090
23410		A	Repair rotator cuff, acute	11.23	NA	NA	7.73	8.17	2.17	090
23412		A	Repair rotator cuff, chronic	11.77	NA	NA	7.97	8.47	2.32	090
23415		A	Release of shoulder ligament	9.07	NA	NA	6.82	7.13	1.74	090
23420		A	Repair of shoulder	13.35	NA	NA	9.05	9.52	2.32	090
23430		A	Repair biceps tendon	10.05	NA	NA	6.98	7.27	1.74	090
23440		A	Remove/transplant tendon	10.53	NA	NA	6.98	7.31	1.83	090
23450		A	Repair shoulder capsule	13.58	NA	NA	8.40	8.78	2.33	090
23455		A	Repair shoulder capsule	14.55	NA	NA	8.88	9.29	2.50	090
23460		A	Repair shoulder capsule	15.68	NA	NA	9.71	10.15	2.67	090
23462		A	Repair shoulder capsule	15.60	NA	NA	9.39	9.75	2.60	090
23465		A	Repair shoulder capsule	16.16	NA	NA	9.91	10.25	2.77	090
23466		A	Repair shoulder capsule	15.55	NA	NA	10.39	10.66	2.47	090
23470		A	Reconstruct shoulder joint	17.75	NA	NA	10.54	11.00	2.99	090
23472		A	Reconstruct shoulder joint	22.47	NA	NA	12.69	13.15	3.67	090
23480		A	Revision of collar bone	11.42	NA	NA	7.49	7.83	1.95	090
23485		A	Revision of collar bone	13.79	NA	NA	8.58	8.93	2.34	090
23490		A	Reinforce clavicle	12.04	NA	NA	7.68	7.95	1.47	090
23491		A	Reinforce shoulder bones	14.40	NA	NA	9.09	9.52	2.47	090
23500		A	Treat clavicle fracture	2.13	2.63	2.69	2.69	2.66	0.30	090
23505		A	Treat clavicle fracture	3.74	4.03	4.13	3.64	3.70	0.61	090
23515		A	Treat clavicle fracture	9.53	NA	NA	7.21	7.06	1.28	090
23520		A	Treat clavicle dislocation	2.21	2.74	2.77	2.81	2.80	0.34	090
23525		A	Treat clavicle dislocation	3.67	3.97	4.12	3.48	3.60	0.46	090
23530		A	Treat clavicle dislocation	7.37	NA	NA	4.93	5.19	1.20	090
23532		A	Treat clavicle dislocation	8.08	NA	NA	6.17	6.38	1.38	090
23540		A	Treat clavicle dislocation	2.28	2.60	2.67	2.67	2.60	0.29	090
23545		A	Treat clavicle dislocation	3.32	3.76	3.88	3.27	3.30	0.35	090
23550		A	Treat clavicle dislocation	7.48	NA	NA	5.68	5.87	1.25	090
23552		A	Treat clavicle dislocation	8.70	NA	NA	6.42	6.66	1.46	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23570		A	Treat shoulder blade fx	2.28	2.79	2.85	2.92	2.92	0.36	090
23575		A	Treat shoulder blade fx	4.12	4.57	4.66	4.07	4.14	0.59	090
23585		A	Treat scapula fracture	14.07	NA	NA	8.83	8.56	1.54	090
23600		A	Treat humerus fracture	3.00	4.06	4.19	3.65	3.63	0.48	090
23605		A	Treat humerus fracture	4.94	5.39	5.60	4.63	4.76	0.84	090
23615		A	Treat humerus fracture	12.12	NA	NA	8.32	8.47	1.62	090
23616		A	Treat humerus fracture	18.19	NA	NA	10.88	11.72	3.70	090
23620		A	Treat humerus fracture	2.46	3.40	3.46	3.14	3.11	0.40	090
23625		A	Treat humerus fracture	3.99	4.43	4.56	3.92	4.02	0.67	090
23630		A	Treat humerus fracture	10.39	NA	NA	7.59	7.37	1.27	090
23650		A	Treat shoulder dislocation	3.44	3.20	3.35	2.75	2.76	0.30	090
23655		A	Treat shoulder dislocation	4.64	NA	NA	4.20	4.20	0.69	090
23660		A	Treat shoulder dislocation	7.55	NA	NA	5.82	5.97	1.29	090
23665		A	Treat dislocation/fracture	4.54	4.87	5.00	4.31	4.42	0.71	090
23670		A	Treat dislocation/fracture	12.12	NA	NA	8.20	7.87	1.36	090
23675		A	Treat dislocation/fracture	6.13	6.08	6.28	5.13	5.32	1.01	090
23680		A	Treat dislocation/fracture	12.99	NA	NA	8.57	8.47	1.76	090
23700		A	Fixation of shoulder	2.54	NA	NA	1.93	2.00	0.44	010
23800		A	Fusion of shoulder joint	14.59	NA	NA	9.25	9.56	2.36	090
23802		A	Fusion of shoulder joint	18.17	NA	NA	11.59	11.26	2.71	090
23900		A	Amputation of arm & girdle	20.57	NA	NA	10.25	10.64	3.19	090
23920		A	Amputation at shoulder joint	16.03	NA	NA	9.11	9.33	2.47	090
23921		A	Amputation follow-up surgery	5.61	NA	NA	3.17	3.65	0.78	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.96	4.98	5.33	2.04	2.11	0.43	010
23931		A	Drainage of arm bursa	1.81	4.28	4.70	1.77	1.87	0.28	010
23935		A	Drain arm/elbow bone lesion	6.27	NA	NA	5.07	5.29	1.05	090
24000		A	Exploratory elbow surgery	5.99	NA	NA	4.87	5.02	0.97	090
24006		A	Release elbow joint	9.62	NA	NA	6.77	7.03	1.50	090
24065		A	Biopsy arm/elbow soft tissue	2.10	4.13	3.91	1.95	1.90	0.17	010
24066		A	Biopsy arm/elbow soft tissue	5.26	8.22	8.42	3.97	4.02	0.80	090
24075		A	Remove arm/elbow lesion	3.96	7.12	7.19	3.31	3.34	0.56	090
24076		A	Remove arm/elbow lesion	6.36	NA	NA	4.65	4.72	0.95	090
24077		A	Remove tumor of arm/elbow	11.95	NA	NA	6.96	7.17	1.73	090
24100		A	Biopsy elbow joint lining	4.98	NA	NA	4.34	4.40	0.85	090
24101		A	Explore/treat elbow joint	6.19	NA	NA	5.18	5.38	1.03	090
24102		A	Remove elbow joint lining	8.15	NA	NA	5.93	6.18	1.33	090
24105		A	Removal of elbow bursa	3.67	NA	NA	4.05	4.15	0.61	090
24110		A	Remove humerus lesion	7.46	NA	NA	5.87	6.08	1.28	090
24115		A	Remove/graft bone lesion	10.00	NA	NA	6.98	7.06	1.68	090
24116		A	Remove/graft bone lesion	12.11	NA	NA	7.77	8.11	2.06	090
24120		A	Remove elbow lesion	6.71	NA	NA	5.26	5.44	1.10	090
24125		A	Remove/graft bone lesion	8.02	NA	NA	6.14	6.16	1.06	090
24126		A	Remove/graft bone lesion	8.50	NA	NA	6.35	6.53	1.16	090
24130		A	Removal of head of radius	6.31	NA	NA	5.22	5.44	1.04	090
24134		A	Removal of arm bone lesion	10.10	NA	NA	7.05	7.52	1.64	090
24136		A	Remove radius bone lesion	8.29	NA	NA	5.01	5.58	1.38	090
24138		A	Remove elbow bone lesion	8.33	NA	NA	6.89	7.13	1.34	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24140		A	Partial removal of arm bone	9.43	NA	NA	6.79	7.39	1.51	090
24145		A	Partial removal of radius	7.70	NA	NA	5.83	6.41	1.25	090
24147		A	Partial removal of elbow	7.69	NA	NA	6.40	6.97	1.30	090
24149		A	Radical resection of elbow	15.92	NA	NA	11.09	11.25	2.35	090
24150		A	Extensive humerus surgery	13.70	NA	NA	8.77	9.10	2.33	090
24151		A	Extensive humerus surgery	16.08	NA	NA	9.70	10.18	2.60	090
24152		A	Extensive radius surgery	10.24	NA	NA	6.84	7.08	1.48	090
24153		A	Extensive radius surgery	11.73	NA	NA	7.94	7.37	0.74	090
24155		A	Removal of elbow joint	11.97	NA	NA	7.76	7.94	1.93	090
24160		A	Remove elbow joint implant	7.89	NA	NA	5.97	6.22	1.30	090
24164		A	Remove radius head implant	6.34	NA	NA	5.01	5.21	1.03	090
24200		A	Removal of arm foreign body	1.78	2.67	2.86	1.35	1.42	0.20	010
24201		A	Removal of arm foreign body	4.61	7.71	8.25	3.73	3.86	0.72	090
24220		A	Injection for elbow x-ray	1.31	2.75	2.97	0.52	0.50	0.08	000
24300		A	Manipulate elbow w/anesth	3.86	NA	NA	5.12	5.28	0.65	090
24301		A	Muscle/tendon transfer	10.26	NA	NA	7.09	7.38	1.66	090
24305		A	Arm tendon lengthening	7.51	NA	NA	5.78	6.03	1.15	090
24310		A	Revision of arm tendon	6.03	NA	NA	4.84	5.04	0.96	090
24320		A	Repair of arm tendon	10.74	NA	NA	7.34	7.41	1.74	090
24330		A	Revision of arm muscles	9.67	NA	NA	6.79	7.08	1.60	090
24331		A	Revision of arm muscles	10.83	NA	NA	7.33	7.69	1.78	090
24332		A	Tenolysis, triceps	7.77	NA	NA	6.18	6.34	1.23	090
24340		A	Repair of biceps tendon	7.96	NA	NA	6.08	6.32	1.36	090
24341		A	Repair arm tendon/muscle	9.24	NA	NA	7.65	7.73	1.36	090
24342		A	Repair of ruptured tendon	10.74	NA	NA	7.28	7.61	1.86	090
24343		A	Repr elbow lat ligmnt w/tiss	8.99	NA	NA	7.17	7.43	1.43	090
24344		A	Reconstruct elbow lat ligmnt	14.97	NA	NA	10.20	10.56	2.37	090
24345		A	Repr elbw med ligmnt w/tissu	8.99	NA	NA	7.05	7.31	1.44	090
24346		A	Reconstruct elbow med ligmnt	14.97	NA	NA	10.37	10.64	2.34	090
24357		A	Repair elbow, perc	5.32	NA	NA	4.77	4.98	0.87	090
24358		A	Repair elbow w/deb, open	6.54	NA	NA	5.38	5.59	1.07	090
24359		A	Repair elbow deb/attch open	8.86	NA	NA	6.37	6.37	1.41	090
24360		A	Reconstruct elbow joint	12.53	NA	NA	8.31	8.62	2.06	090
24361		A	Reconstruct elbow joint	14.27	NA	NA	9.14	9.53	2.19	090
24362		A	Reconstruct elbow joint	15.18	NA	NA	9.68	9.80	2.61	090
24363		A	Replace elbow joint	22.47	NA	NA	12.71	12.99	3.02	090
24365		A	Reconstruct head of radius	8.51	NA	NA	6.16	6.44	1.41	090
24366		A	Reconstruct head of radius	9.25	NA	NA	6.48	6.76	1.52	090
24400		A	Revision of humerus	11.19	NA	NA	7.80	8.08	1.93	090
24410		A	Revision of humerus	14.96	NA	NA	9.32	9.59	2.58	090
24420		A	Revision of humerus	13.58	NA	NA	9.31	9.64	2.18	090
24430		A	Repair of humerus	15.07	NA	NA	9.59	9.65	2.22	090
24435		A	Repair humerus with graft	14.74	NA	NA	10.11	10.33	2.28	090
24470		A	Revision of elbow joint	8.81	NA	NA	5.22	5.86	1.48	090
24495		A	Decompression of forearm	8.30	NA	NA	6.68	7.22	1.18	090
24498		A	Reinforce humerus	12.16	NA	NA	7.96	8.30	2.07	090
24500		A	Treat humerus fracture	3.29	4.44	4.55	3.81	3.79	0.50	090
24505		A	Treat humerus fracture	5.25	5.83	6.04	4.90	5.04	0.89	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24515		A	Treat humerus fracture	11.97	NA	NA	8.27	8.57	2.03	090
24516		A	Treat humerus fracture	12.07	NA	NA	7.91	8.23	2.03	090
24530		A	Treat humerus fracture	3.57	4.72	4.85	4.01	4.03	0.57	090
24535		A	Treat humerus fracture	6.96	6.87	7.13	5.94	6.12	1.18	090
24538		A	Treat humerus fracture	9.63	NA	NA	7.40	7.74	1.64	090
24545		A	Treat humerus fracture	12.99	NA	NA	8.58	8.56	1.83	090
24546		A	Treat humerus fracture	14.73	NA	NA	9.42	9.92	2.74	090
24560		A	Treat humerus fracture	2.87	4.06	4.18	3.41	3.36	0.44	090
24565		A	Treat humerus fracture	5.64	5.74	5.97	4.91	5.07	0.93	090
24566		A	Treat humerus fracture	8.86	NA	NA	7.34	7.56	1.30	090
24575		A	Treat humerus fracture	9.53	NA	NA	7.25	7.55	1.87	090
24576		A	Treat humerus fracture	2.94	4.37	4.48	3.69	3.70	0.46	090
24577		A	Treat humerus fracture	5.87	5.96	6.22	5.04	5.25	0.95	090
24579		A	Treat humerus fracture	11.26	NA	NA	7.98	8.21	2.03	090
24582		A	Treat humerus fracture	9.89	NA	NA	8.15	8.41	1.48	090
24586		A	Treat elbow fracture	15.64	NA	NA	9.72	10.12	2.65	090
24587		A	Treat elbow fracture	15.65	NA	NA	9.72	10.07	2.53	090
24600		A	Treat elbow dislocation	4.28	3.71	4.01	3.16	3.25	0.50	090
24605		A	Treat elbow dislocation	5.50	NA	NA	4.99	5.09	0.89	090
24615		A	Treat elbow dislocation	9.72	NA	NA	6.76	7.04	1.60	090
24620		A	Treat elbow fracture	7.07	NA	NA	5.54	5.73	1.07	090
24635		A	Treat elbow fracture	8.64	NA	NA	6.73	8.58	2.29	090
24640		A	Treat elbow dislocation	1.22	1.45	1.55	0.79	0.79	0.12	010
24650		A	Treat radius fracture	2.22	3.41	3.51	2.99	2.94	0.35	090
24655		A	Treat radius fracture	4.48	5.15	5.36	4.40	4.51	0.70	090
24665		A	Treat radius fracture	8.22	NA	NA	6.64	6.88	1.41	090
24666		A	Treat radius fracture	9.74	NA	NA	7.16	7.40	1.62	090
24670		A	Treat ulnar fracture	2.60	3.72	3.83	3.16	3.15	0.41	090
24675		A	Treat ulnar fracture	4.79	5.40	5.56	4.61	4.71	0.81	090
24685		A	Treat ulnar fracture	8.21	NA	NA	6.66	6.89	1.52	090
24800		A	Fusion of elbow joint	11.27	NA	NA	6.95	7.42	1.63	090
24802		A	Fusion/graft of elbow joint	14.18	NA	NA	8.91	9.30	2.38	090
24900		A	Amputation of upper arm	10.04	NA	NA	6.70	6.81	1.53	090
24920		A	Amputation of upper arm	10.02	NA	NA	6.55	6.66	1.61	090
24925		A	Amputation follow-up surgery	7.19	NA	NA	5.73	5.83	1.14	090
24930		A	Amputation follow-up surgery	10.72	NA	NA	6.88	6.99	1.68	090
24931		A	Amputate upper arm & implant	13.32	NA	NA	6.67	6.45	1.90	090
24935		A	Revision of amputation	16.30	NA	NA	7.70	7.80	2.14	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.44	NA	NA	4.01	4.74	0.55	090
25001		A	Incise flexor carpi radialis	3.68	NA	NA	3.96	4.04	0.55	090
25020		A	Decompress forearm 1 space	5.97	NA	NA	6.87	7.57	0.93	090
25023		A	Decompress forearm 1 space	13.69	NA	NA	11.23	12.19	2.04	090
25024		A	Decompress forearm 2 spaces	10.62	NA	NA	7.50	7.51	1.36	090
25025		A	Decompress forearm 2 spaces	17.77	NA	NA	10.45	10.36	1.83	090
25028		A	Drainage of forearm lesion	5.30	NA	NA	6.29	6.77	0.81	090
25031		A	Drainage of forearm bursa	4.18	NA	NA	3.57	4.67	0.63	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25035		A	Treat forearm bone lesion	7.54	NA	NA	5.67	7.67	1.24	090
25040		A	Explore/treat wrist joint	7.41	NA	NA	5.55	6.00	1.15	090
25065		A	Biopsy forearm soft tissues	2.01	4.21	3.97	1.96	1.95	0.15	010
25066		A	Biopsy forearm soft tissues	4.18	NA	NA	3.87	4.68	0.64	090
25075		A	Removal forearm lesion subcu	3.78	NA	NA	3.33	3.98	0.55	090
25076		A	Removal forearm lesion deep	4.97	NA	NA	4.16	5.52	0.74	090
25077		A	Remove tumor, forearm/wrist	9.90	NA	NA	6.29	7.76	1.42	090
25085		A	Incision of wrist capsule	5.55	NA	NA	4.69	5.31	0.85	090
25100		A	Biopsy of wrist joint	3.94	NA	NA	3.76	4.15	0.59	090
25101		A	Explore/treat wrist joint	4.74	NA	NA	4.37	4.76	0.75	090
25105		A	Remove wrist joint lining	5.91	NA	NA	5.06	5.63	0.92	090
25107		A	Remove wrist joint cartilage	7.50	NA	NA	6.46	6.95	0.99	090
25109		A	Excise tendon forearm/wrist	6.81	NA	NA	5.45	5.45	0.96	090
25110		A	Remove wrist tendon lesion	3.96	NA	NA	3.67	4.52	0.62	090
25111		A	Remove wrist tendon lesion	3.44	NA	NA	3.65	3.92	0.53	090
25112		A	Reremove wrist tendon lesion	4.58	NA	NA	4.07	4.38	0.70	090
25115		A	Remove wrist/forearm lesion	9.89	NA	NA	7.50	9.16	1.31	090
25116		A	Remove wrist/forearm lesion	7.38	NA	NA	6.26	8.00	1.11	090
25118		A	Excise wrist tendon sheath	4.42	NA	NA	4.18	4.58	0.68	090
25119		A	Partial removal of ulna	6.10	NA	NA	5.16	5.78	0.96	090
25120		A	Removal of forearm lesion	6.16	NA	NA	5.19	6.93	1.00	090
25125		A	Remove/graft forearm lesion	7.55	NA	NA	6.02	7.75	1.06	090
25126		A	Remove/graft forearm lesion	7.62	NA	NA	5.90	7.70	1.27	090
25130		A	Removal of wrist lesion	5.32	NA	NA	4.82	5.24	0.80	090
25135		A	Remove & graft wrist lesion	6.96	NA	NA	5.76	6.21	1.02	090
25136		A	Remove & graft wrist lesion	6.03	NA	NA	5.15	5.53	1.03	090
25145		A	Remove forearm bone lesion	6.43	NA	NA	5.32	7.02	1.01	090
25150		A	Partial removal of ulna	7.27	NA	NA	5.69	6.33	1.14	090
25151		A	Partial removal of radius	7.57	NA	NA	5.78	7.54	1.18	090
25170		A	Extensive forearm surgery	11.34	NA	NA	7.70	9.59	1.78	090
25210		A	Removal of wrist bone	6.01	NA	NA	5.13	5.56	0.88	090
25215		A	Removal of wrist bones	8.02	NA	NA	6.19	6.85	1.19	090
25230		A	Partial removal of radius	5.28	NA	NA	4.54	4.96	0.79	090
25240		A	Partial removal of ulna	5.22	NA	NA	4.54	5.16	0.81	090
25246		A	Injection for wrist x-ray	1.45	2.69	2.89	0.57	0.54	0.09	000
25248		A	Remove forearm foreign body	5.20	NA	NA	4.07	5.19	0.72	090
25250		A	Removal of wrist prosthesis	6.66	NA	NA	5.41	5.59	1.01	090
25251		A	Removal of wrist prosthesis	9.70	NA	NA	6.82	7.11	1.26	090
25259		A	Manipulate wrist w/anesthes	3.86	NA	NA	5.18	5.33	0.62	090
25260		A	Repair forearm tendon/muscle	7.89	NA	NA	6.44	8.18	1.19	090
25263		A	Repair forearm tendon/muscle	7.90	NA	NA	6.41	8.15	1.18	090
25265		A	Repair forearm tendon/muscle	9.96	NA	NA	7.25	9.04	1.47	090
25270		A	Repair forearm tendon/muscle	6.06	NA	NA	5.10	6.85	0.95	090
25272		A	Repair forearm tendon/muscle	7.10	NA	NA	5.57	7.40	1.11	090
25274		A	Repair forearm tendon/muscle	8.82	NA	NA	6.53	8.33	1.36	090
25275		A	Repair forearm tendon sheath	8.82	NA	NA	6.69	6.93	1.31	090
25280		A	Revise wrist/forearm tendon	7.28	NA	NA	5.68	7.44	1.08	090
25290		A	Incise wrist/forearm tendon	5.34	NA	NA	4.59	7.21	0.82	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25295		A	Release wrist/forearm tendon	6.61	NA	NA	5.39	7.10	1.00	090
25300		A	Fusion of tendons at wrist	8.88	NA	NA	6.79	7.22	1.26	090
25301		A	Fusion of tendons at wrist	8.47	NA	NA	6.35	6.80	1.29	090
25310		A	Transplant forearm tendon	7.94	NA	NA	6.25	7.97	1.21	090
25312		A	Transplant forearm tendon	9.70	NA	NA	6.93	8.71	1.41	090
25315		A	Revise palsy hand tendon(s)	10.56	NA	NA	7.34	9.13	1.58	090
25316		A	Revise palsy hand tendon(s)	12.76	NA	NA	7.97	10.06	1.75	090
25320		A	Repair/revise wrist joint	12.38	NA	NA	10.04	10.40	1.61	090
25332		A	Revise wrist joint	11.60	NA	NA	7.89	8.23	1.84	090
25335		A	Realignment of hand	13.25	NA	NA	8.60	9.37	1.93	090
25337		A	Reconstruct ulna/radioulnar	11.44	NA	NA	8.87	9.44	1.61	090
25350		A	Revision of radius	8.97	NA	NA	6.59	8.46	1.46	090
25355		A	Revision of radius	10.41	NA	NA	7.26	9.12	1.74	090
25360		A	Revision of ulna	8.62	NA	NA	6.42	8.30	1.41	090
25365		A	Revise radius & ulna	12.77	NA	NA	8.20	10.09	2.16	090
25370		A	Revise radius or ulna	13.93	NA	NA	9.31	11.03	2.29	090
25375		A	Revise radius & ulna	13.41	NA	NA	8.67	10.64	2.27	090
25390		A	Shorten radius or ulna	10.58	NA	NA	7.28	9.13	1.65	090
25391		A	Lengthen radius or ulna	14.14	NA	NA	8.86	10.82	2.22	090
25392		A	Shorten radius & ulna	14.44	NA	NA	9.30	10.99	2.11	090
25393		A	Lengthen radius & ulna	16.42	NA	NA	9.95	11.89	2.77	090
25394		A	Repair carpal bone, shorten	10.71	NA	NA	7.39	7.57	1.59	090
25400		A	Repair radius or ulna	11.16	NA	NA	7.50	9.45	1.83	090
25405		A	Repair/graft radius or ulna	14.87	NA	NA	9.30	11.32	2.33	090
25415		A	Repair radius & ulna	13.66	NA	NA	9.07	10.96	2.18	090
25420		A	Repair/graft radius & ulna	16.89	NA	NA	10.39	12.39	2.62	090
25425		A	Repair/graft radius or ulna	13.58	NA	NA	8.65	11.87	2.09	090
25426		A	Repair/graft radius & ulna	16.31	NA	NA	7.86	10.06	2.55	090
25430		A	Vasc graft into carpal bone	9.57	NA	NA	7.16	7.22	1.27	090
25431		A	Repair nonunion carpal bone	10.75	NA	NA	7.19	7.51	1.91	090
25440		A	Repair/graft wrist bone	10.56	NA	NA	7.19	7.77	1.63	090
25441		A	Reconstruct wrist joint	13.15	NA	NA	8.63	8.99	2.08	090
25442		A	Reconstruct wrist joint	10.98	NA	NA	7.74	8.05	1.53	090
25443		A	Reconstruct wrist joint	10.52	NA	NA	7.45	7.80	1.37	090
25444		A	Reconstruct wrist joint	11.28	NA	NA	7.75	8.09	1.72	090
25445		A	Reconstruct wrist joint	9.76	NA	NA	6.88	7.17	1.55	090
25446		A	Wrist replacement	17.16	NA	NA	10.33	10.76	2.48	090
25447		A	Repair wrist joint(s)	10.95	NA	NA	8.08	8.25	1.61	090
25449		A	Remove wrist joint implant	14.80	NA	NA	9.25	9.63	2.22	090
25450		A	Revision of wrist joint	7.94	NA	NA	4.87	6.21	1.36	090
25455		A	Revision of wrist joint	9.57	NA	NA	5.60	6.94	0.96	090
25490		A	Reinforce radius	9.61	NA	NA	6.55	8.37	1.43	090
25491		A	Reinforce ulna	10.03	NA	NA	7.00	8.89	1.60	090
25492		A	Reinforce radius and ulna	12.52	NA	NA	8.37	10.13	2.15	090
25500		A	Treat fracture of radius	2.51	3.29	3.37	2.86	2.83	0.35	090
25505		A	Treat fracture of radius	5.30	5.86	6.04	5.03	5.14	0.90	090
25515		A	Treat fracture of radius	8.64	NA	NA	6.65	6.87	1.59	090
25520		A	Treat fracture of radius	6.35	5.83	6.10	5.28	5.49	1.08	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25525		A	Treat fracture of radius	10.37	NA	NA	7.63	8.24	2.13	090
25526		A	Treat fracture of radius	12.96	NA	NA	9.01	10.16	2.20	090
25530		A	Treat fracture of ulna	2.15	3.46	3.55	2.97	2.95	0.34	090
25535		A	Treat fracture of ulna	5.22	5.65	5.76	4.93	5.04	0.89	090
25545		A	Treat fracture of ulna	7.78	NA	NA	6.37	6.71	1.53	090
25560		A	Treat fracture radius & ulna	2.50	3.37	3.46	2.87	2.81	0.35	090
25565		A	Treat fracture radius & ulna	5.71	5.97	6.17	5.02	5.13	0.93	090
25574		A	Treat fracture radius & ulna	8.64	NA	NA	6.72	6.85	1.21	090
25575		A	Treat fracture radius/ulna	12.10	NA	NA	8.62	8.86	1.82	090
25600		A	Treat fracture radius/ulna	2.69	3.67	3.78	3.17	3.13	0.42	090
25605		A	Treat fracture radius/ulna	7.02	6.90	7.00	6.20	6.22	1.00	090
25606		A	Treat fx distal radial	8.10	NA	NA	6.83	7.38	1.26	090
25607		A	Treat fx rad extra-articul	9.35	NA	NA	7.37	7.37	1.36	090
25608		A	Treat fx rad intra-articul	10.86	NA	NA	8.02	8.02	1.84	090
25609		A	Treat fx radial 3+ frag	14.12	NA	NA	9.96	9.96	2.38	090
25622		A	Treat wrist bone fracture	2.68	3.86	3.97	3.33	3.28	0.41	090
25624		A	Treat wrist bone fracture	4.62	5.65	5.83	4.82	4.89	0.76	090
25628		A	Treat wrist bone fracture	9.51	NA	NA	7.08	7.28	1.37	090
25630		A	Treat wrist bone fracture	2.94	3.73	3.85	3.24	3.17	0.45	090
25635		A	Treat wrist bone fracture	4.47	5.21	5.40	4.42	4.30	0.74	090
25645		A	Treat wrist bone fracture	7.31	NA	NA	5.58	5.86	1.20	090
25650		A	Treat wrist bone fracture	3.12	3.84	3.97	3.46	3.39	0.45	090
25651		A	Pin ulnar styloid fracture	5.68	NA	NA	5.24	5.31	0.86	090
25652		A	Treat fracture ulnar styloid	7.92	NA	NA	6.31	6.50	1.21	090
25660		A	Treat wrist dislocation	4.84	NA	NA	4.32	4.43	0.58	090
25670		A	Treat wrist dislocation	7.98	NA	NA	5.97	6.24	1.28	090
25671		A	Pin radioulnar dislocation	6.32	NA	NA	5.59	5.74	1.00	090
25675		A	Treat wrist dislocation	4.75	4.81	5.04	4.10	4.25	0.62	090
25676		A	Treat wrist dislocation	8.17	NA	NA	6.28	6.55	1.34	090
25680		A	Treat wrist fracture	6.08	NA	NA	4.48	4.55	0.78	090
25685		A	Treat wrist fracture	9.97	NA	NA	6.87	7.12	1.60	090
25690		A	Treat wrist dislocation	5.58	NA	NA	4.97	5.11	0.88	090
25695		A	Treat wrist dislocation	8.40	NA	NA	6.12	6.38	1.32	090
25800		A	Fusion of wrist joint	9.95	NA	NA	6.99	7.53	1.57	090
25805		A	Fusion/graft of wrist joint	11.59	NA	NA	7.96	8.56	1.81	090
25810		A	Fusion/graft of wrist joint	11.75	NA	NA	8.26	8.69	1.68	090
25820		A	Fusion of hand bones	7.52	NA	NA	6.46	6.82	1.22	090
25825		A	Fuse hand bones with graft	9.54	NA	NA	7.82	8.19	1.41	090
25830		A	Fusion, radioulnar jnt/ulna	10.69	NA	NA	10.66	11.63	1.55	090
25900		A	Amputation of forearm	9.46	NA	NA	6.82	8.28	1.30	090
25905		A	Amputation of forearm	9.48	NA	NA	6.51	7.98	1.40	090
25907		A	Amputation follow-up surgery	7.98	NA	NA	5.85	7.35	1.10	090
25909		A	Amputation follow-up surgery	9.20	NA	NA	6.45	7.93	1.44	090
25915		A	Amputation of forearm	17.38	NA	NA	10.07	12.30	2.94	090
25920		A	Amputate hand at wrist	8.92	NA	NA	6.93	7.18	1.35	090
25922		A	Amputate hand at wrist	7.54	NA	NA	5.74	6.08	1.12	090
25924		A	Amputation follow-up surgery	8.70	NA	NA	6.64	7.02	1.32	090
25927		A	Amputation of hand	8.98	NA	NA	8.73	9.49	1.27	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25929		A	Amputation follow-up surgery	7.71	NA	NA	5.25	5.42	1.14	090
25931		A	Amputation follow-up surgery	7.93	NA	NA	8.03	8.91	1.15	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.56	4.00	4.40	1.52	1.55	0.18	010
26011		A	Drainage of finger abscess	2.21	6.17	6.85	1.99	2.08	0.33	010
26020		A	Drain hand tendon sheath	4.97	NA	NA	4.79	4.95	0.73	090
26025		A	Drainage of palm bursa	4.99	NA	NA	4.50	4.67	0.76	090
26030		A	Drainage of palm bursa(s)	6.16	NA	NA	5.06	5.24	0.92	090
26034		A	Treat hand bone lesion	6.49	NA	NA	5.67	5.86	1.01	090
26035		A	Decompress fingers/hand	11.14	NA	NA	8.23	8.16	1.47	090
26037		A	Decompress fingers/hand	7.48	NA	NA	5.59	5.79	1.13	090
26040		A	Release palm contracture	3.38	NA	NA	3.61	3.73	0.53	090
26045		A	Release palm contracture	5.62	NA	NA	4.96	5.14	0.93	090
26055		A	Incise finger tendon sheath	3.00	8.88	10.28	3.83	3.87	0.43	090
26060		A	Incision of finger tendon	2.85	NA	NA	3.14	3.24	0.45	090
26070		A	Explore/treat hand joint	3.73	NA	NA	3.16	3.22	0.48	090
26075		A	Explore/treat finger joint	3.83	NA	NA	3.43	3.52	0.53	090
26080		A	Explore/treat finger joint	4.36	NA	NA	4.38	4.50	0.66	090
26100		A	Biopsy hand joint lining	3.71	NA	NA	3.59	3.74	0.54	090
26105		A	Biopsy finger joint lining	3.75	NA	NA	3.71	3.85	0.59	090
26110		A	Biopsy finger joint lining	3.57	NA	NA	3.64	3.75	0.53	090
26115		A	Removal hand lesion subcut	3.92	9.69	10.57	4.26	4.39	0.59	090
26116		A	Removal hand lesion, deep	5.61	NA	NA	5.37	5.54	0.84	090
26117		A	Remove tumor, hand/finger	8.62	NA	NA	6.32	6.52	1.26	090
26121		A	Release palm contracture	7.61	NA	NA	6.06	6.30	1.17	090
26123		A	Release palm contracture	10.63	NA	NA	8.38	8.52	1.43	090
26125		A	Release palm contracture	4.60	NA	NA	2.00	2.12	0.70	ZZZ
26130		A	Remove wrist joint lining	5.48	NA	NA	4.90	5.02	0.94	090
26135		A	Revise finger joint, each	7.02	NA	NA	5.58	5.81	1.07	090
26140		A	Revise finger joint, each	6.23	NA	NA	5.27	5.47	0.92	090
26145		A	Tendon excision, palm/finger	6.38	NA	NA	5.29	5.49	0.97	090
26160		A	Remove tendon sheath lesion	3.46	8.89	9.79	3.96	4.01	0.49	090
26170		A	Removal of palm tendon, each	4.82	NA	NA	4.42	4.56	0.69	090
26180		A	Removal of finger tendon	5.24	NA	NA	4.84	5.00	0.78	090
26185		A	Remove finger bone	6.32	NA	NA	5.96	6.00	0.81	090
26200		A	Remove hand bone lesion	5.56	NA	NA	4.73	4.90	0.88	090
26205		A	Remove/graft bone lesion	7.82	NA	NA	5.97	6.22	1.20	090
26210		A	Removal of finger lesion	5.21	NA	NA	4.80	4.97	0.79	090
26215		A	Remove/graft finger lesion	7.16	NA	NA	5.60	5.79	0.98	090
26230		A	Partial removal of hand bone	6.38	NA	NA	5.09	5.31	1.01	090
26235		A	Partial removal, finger bone	6.24	NA	NA	5.07	5.27	0.95	090
26236		A	Partial removal, finger bone	5.37	NA	NA	4.68	4.85	0.81	090
26250		A	Extensive hand surgery	7.61	NA	NA	5.86	6.02	1.07	090
26255		A	Extensive hand surgery	12.80	NA	NA	7.38	7.89	1.69	090
26260		A	Extensive finger surgery	7.09	NA	NA	5.48	5.67	1.01	090
26261		A	Extensive finger surgery	9.28	NA	NA	6.72	6.60	1.14	090
26262		A	Partial removal of finger	5.72	NA	NA	4.75	4.91	0.88	090
26320		A	Removal of implant from hand	4.02	NA	NA	3.83	3.96	0.59	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26340		A	Manipulate finger w/anesth	2.62	NA	NA	4.56	4.65	0.39	090
26350		A	Repair finger/hand tendon	6.07	NA	NA	9.44	10.76	0.93	090
26352		A	Repair/graft hand tendon	7.75	NA	NA	9.95	11.33	1.13	090
26356		A	Repair finger/hand tendon	10.22	NA	NA	13.68	14.89	1.21	090
26357		A	Repair finger/hand tendon	8.65	NA	NA	10.43	11.76	1.33	090
26358		A	Repair/graft hand tendon	9.22	NA	NA	10.91	12.38	1.38	090
26370		A	Repair finger/hand tendon	7.17	NA	NA	9.56	10.97	1.12	090
26372		A	Repair/graft hand tendon	8.89	NA	NA	10.54	12.07	1.40	090
26373		A	Repair finger/hand tendon	8.29	NA	NA	10.21	11.70	1.23	090
26390		A	Revise hand/finger tendon	9.31	NA	NA	9.09	10.17	1.40	090
26392		A	Repair/graft hand tendon	10.38	NA	NA	10.99	12.45	1.57	090
26410		A	Repair hand tendon	4.68	NA	NA	7.61	8.71	0.73	090
26412		A	Repair/graft hand tendon	6.37	NA	NA	8.65	9.83	0.97	090
26415		A	Excision, hand/finger tendon	8.40	NA	NA	7.57	8.65	0.98	090
26416		A	Graft hand or finger tendon	9.44	NA	NA	7.10	8.99	0.79	090
26418		A	Repair finger tendon	4.33	NA	NA	8.08	9.16	0.67	090
26420		A	Repair/graft finger tendon	6.83	NA	NA	8.70	9.96	1.07	090
26426		A	Repair finger/hand tendon	6.21	NA	NA	5.23	7.24	0.95	090
26428		A	Repair/graft finger tendon	7.28	NA	NA	9.19	10.39	1.09	090
26432		A	Repair finger tendon	4.07	NA	NA	6.74	7.64	0.64	090
26433		A	Repair finger tendon	4.61	NA	NA	6.95	7.93	0.72	090
26434		A	Repair/graft finger tendon	6.15	NA	NA	7.93	8.85	0.93	090
26437		A	Realignment of tendons	5.88	NA	NA	7.79	8.75	0.89	090
26440		A	Release palm/finger tendon	5.07	NA	NA	8.46	9.73	0.75	090
26442		A	Release palm & finger tendon	9.50	NA	NA	11.79	12.86	1.20	090
26445		A	Release hand/finger tendon	4.36	NA	NA	8.13	9.41	0.65	090
26449		A	Release forearm/hand tendon	8.34	NA	NA	7.43	9.54	1.06	090
26450		A	Incision of palm tendon	3.71	NA	NA	5.17	5.72	0.59	090
26455		A	Incision of finger tendon	3.68	NA	NA	5.14	5.69	0.58	090
26460		A	Incise hand/finger tendon	3.50	NA	NA	5.09	5.62	0.55	090
26471		A	Fusion of finger tendons	5.79	NA	NA	7.72	8.62	0.88	090
26474		A	Fusion of finger tendons	5.38	NA	NA	7.50	8.50	0.76	090
26476		A	Tendon lengthening	5.24	NA	NA	7.32	8.24	0.79	090
26477		A	Tendon shortening	5.21	NA	NA	7.46	8.38	0.81	090
26478		A	Lengthening of hand tendon	5.86	NA	NA	7.86	8.88	0.90	090
26479		A	Shortening of hand tendon	5.80	NA	NA	7.80	8.76	0.92	090
26480		A	Transplant hand tendon	6.76	NA	NA	9.64	11.02	1.02	090
26483		A	Transplant/graft hand tendon	8.36	NA	NA	10.31	11.64	1.26	090
26485		A	Transplant palm tendon	7.77	NA	NA	10.09	11.43	1.15	090
26489		A	Transplant/graft palm tendon	9.74	NA	NA	10.61	11.00	1.26	090
26490		A	Revise thumb tendon	8.48	NA	NA	9.03	10.00	1.21	090
26492		A	Tendon transfer with graft	9.70	NA	NA	9.91	10.86	1.40	090
26494		A	Hand tendon/muscle transfer	8.54	NA	NA	9.14	10.13	1.28	090
26496		A	Revise thumb tendon	9.66	NA	NA	9.62	10.55	1.45	090
26497		A	Finger tendon transfer	9.64	NA	NA	9.58	10.61	1.41	090
26498		A	Finger tendon transfer	14.07	NA	NA	11.67	12.83	2.11	090
26499		A	Revision of finger	9.05	NA	NA	9.35	10.30	1.35	090
26500		A	Hand tendon reconstruction	6.02	NA	NA	7.74	8.69	0.90	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26502		A	Hand tendon reconstruction	7.20	NA	NA	8.40	9.33	1.13	090
26508		A	Release thumb contracture	6.07	NA	NA	7.64	8.67	0.98	090
26510		A	Thumb tendon transfer	5.49	NA	NA	7.63	8.58	0.79	090
26516		A	Fusion of knuckle joint	7.21	NA	NA	8.28	9.29	1.10	090
26517		A	Fusion of knuckle joints	8.96	NA	NA	9.31	10.39	1.41	090
26518		A	Fusion of knuckle joints	9.15	NA	NA	9.40	10.43	1.35	090
26520		A	Release knuckle contracture	5.36	NA	NA	8.80	10.10	0.80	090
26525		A	Release finger contracture	5.39	NA	NA	8.82	10.13	0.81	090
26530		A	Revise knuckle joint	6.76	NA	NA	5.51	5.68	1.04	090
26531		A	Revise knuckle with implant	7.99	NA	NA	6.31	6.52	1.17	090
26535		A	Revise finger joint	5.30	NA	NA	4.17	4.07	0.71	090
26536		A	Revise/implant finger joint	6.44	NA	NA	9.22	9.35	0.96	090
26540		A	Repair hand joint	6.49	NA	NA	8.05	9.03	0.99	090
26541		A	Repair hand joint with graft	8.69	NA	NA	9.14	10.23	1.28	090
26542		A	Repair hand joint with graft	6.84	NA	NA	8.23	9.21	1.02	090
26545		A	Reconstruct finger joint	6.99	NA	NA	8.38	9.34	1.05	090
26546		A	Repair nonunion hand	10.53	NA	NA	11.51	12.42	1.44	090
26548		A	Reconstruct finger joint	8.10	NA	NA	8.81	9.85	1.20	090
26550		A	Construct thumb replacement	21.54	NA	NA	12.38	13.71	2.46	090
26551		A	Great toe-hand transfer	48.23	NA	NA	24.83	26.80	7.98	090
26553		A	Single transfer, toe-hand	47.92	NA	NA	19.98	20.70	2.42	090
26554		A	Double transfer, toe-hand	56.73	NA	NA	25.93	28.90	9.44	090
26555		A	Positional change of finger	16.94	NA	NA	14.31	15.32	2.49	090
26556		A	Toe joint transfer	49.43	NA	NA	17.36	21.41	2.58	090
26560		A	Repair of web finger	5.43	NA	NA	7.29	7.94	0.85	090
26561		A	Repair of web finger	10.98	NA	NA	9.70	10.39	1.45	090
26562		A	Repair of web finger	16.40	NA	NA	13.74	14.62	2.24	090
26565		A	Correct metacarpal flaw	6.80	NA	NA	8.11	9.11	1.00	090
26567		A	Correct finger deformity	6.88	NA	NA	8.21	9.17	1.04	090
26568		A	Lengthen metacarpal/finger	9.15	NA	NA	10.68	11.90	1.49	090
26580		A	Repair hand deformity	19.50	NA	NA	13.41	13.50	2.29	090
26587		A	Reconstruct extra finger	14.36	NA	NA	7.91	8.25	1.53	090
26590		A	Repair finger deformity	18.51	NA	NA	10.06	11.06	2.78	090
26591		A	Repair muscles of hand	3.30	NA	NA	6.17	7.05	0.48	090
26593		A	Release muscles of hand	5.38	NA	NA	7.81	8.66	0.78	090
26596		A	Excision constricting tissue	9.02	NA	NA	7.79	8.07	1.43	090
26600		A	Treat metacarpal fracture	2.48	3.82	3.77	3.48	3.28	0.30	090
26605		A	Treat metacarpal fracture	2.92	4.07	4.20	3.51	3.55	0.49	090
26607		A	Treat metacarpal fracture	5.40	NA	NA	4.16	4.70	0.87	090
26608		A	Treat metacarpal fracture	5.43	NA	NA	5.30	5.55	0.88	090
26615		A	Treat metacarpal fracture	6.91	NA	NA	6.12	5.93	0.86	090
26641		A	Treat thumb dislocation	4.01	4.17	4.28	3.55	3.55	0.39	090
26645		A	Treat thumb fracture	4.47	4.73	4.85	4.06	4.10	0.67	090
26650		A	Treat thumb fracture	5.19	NA	NA	5.44	5.76	0.94	090
26665		A	Treat thumb fracture	7.78	NA	NA	6.46	6.51	0.90	090
26670		A	Treat hand dislocation	3.74	3.53	3.72	2.97	2.97	0.39	090
26675		A	Treat hand dislocation	4.71	5.09	5.20	4.38	4.42	0.77	090
26676		A	Pin hand dislocation	5.60	NA	NA	5.64	5.92	0.91	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26685		A	Treat hand dislocation	6.91	NA	NA	6.11	6.13	1.09	090
26686		A	Treat hand dislocation	8.06	NA	NA	6.17	6.37	1.24	090
26700		A	Treat knuckle dislocation	3.74	3.25	3.39	2.89	2.89	0.35	090
26705		A	Treat knuckle dislocation	4.26	4.69	4.86	4.01	4.09	0.66	090
26706		A	Pin knuckle dislocation	5.19	NA	NA	4.66	4.78	0.81	090
26715		A	Treat knuckle dislocation	6.87	NA	NA	6.10	5.96	0.91	090
26720		A	Treat finger fracture, each	1.70	2.55	2.61	2.28	2.23	0.24	090
26725		A	Treat finger fracture, each	3.39	4.06	4.25	3.41	3.44	0.53	090
26727		A	Treat finger fracture, each	5.30	NA	NA	5.25	5.51	0.84	090
26735		A	Treat finger fracture, each	7.26	NA	NA	6.26	6.10	0.95	090
26740		A	Treat finger fracture, each	1.99	2.96	3.01	2.68	2.69	0.31	090
26742		A	Treat finger fracture, each	3.90	4.28	4.47	3.60	3.68	0.58	090
26746		A	Treat finger fracture, each	9.59	NA	NA	7.36	6.93	0.91	090
26750		A	Treat finger fracture, each	1.74	2.22	2.29	2.23	2.18	0.22	090
26755		A	Treat finger fracture, each	3.15	3.73	3.91	2.95	2.97	0.42	090
26756		A	Pin finger fracture, each	4.46	NA	NA	4.86	5.09	0.71	090
26765		A	Treat finger fracture, each	5.70	NA	NA	5.50	5.24	0.66	090
26770		A	Treat finger dislocation	3.07	2.84	3.00	2.48	2.47	0.27	090
26775		A	Treat finger dislocation	3.78	4.62	4.78	3.89	3.88	0.54	090
26776		A	Pin finger dislocation	4.87	NA	NA	5.02	5.28	0.77	090
26785		A	Treat finger dislocation	6.44	NA	NA	5.84	5.52	0.68	090
26820		A	Thumb fusion with graft	8.33	NA	NA	9.05	10.13	1.30	090
26841		A	Fusion of thumb	7.21	NA	NA	8.76	9.90	1.18	090
26842		A	Thumb fusion with graft	8.37	NA	NA	9.09	10.19	1.32	090
26843		A	Fusion of hand joint	7.67	NA	NA	8.60	9.56	1.15	090
26844		A	Fusion/graft of hand joint	8.86	NA	NA	9.29	10.33	1.33	090
26850		A	Fusion of knuckle	7.03	NA	NA	8.33	9.32	1.06	090
26852		A	Fusion of knuckle with graft	8.59	NA	NA	9.20	10.15	1.22	090
26860		A	Fusion of finger joint	4.76	NA	NA	7.50	8.44	0.73	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	NA	0.75	0.79	0.27	ZZZ
26862		A	Fusion/graft of finger joint	7.44	NA	NA	8.67	9.61	1.10	090
26863		A	Fuse/graft added joint	3.89	NA	NA	1.66	1.78	0.56	ZZZ
26910		A	Amputate metacarpal bone	7.67	NA	NA	8.31	9.06	1.16	090
26951		A	Amputation of finger/thumb	5.85	NA	NA	8.34	8.81	0.71	090
26952		A	Amputation of finger/thumb	6.37	NA	NA	7.90	8.86	0.95	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.84	NA	NA	6.35	6.58	1.22	090
26991		A	Drainage of pelvis bursa	6.97	8.69	9.33	5.04	5.15	1.11	090
26992		A	Drainage of bone lesion	13.37	NA	NA	8.77	9.19	2.17	090
27000		A	Incision of hip tendon	5.66	NA	NA	4.56	4.75	0.98	090
27001		A	Incision of hip tendon	7.05	NA	NA	5.34	5.54	1.24	090
27003		A	Incision of hip tendon	7.70	NA	NA	5.77	5.96	1.12	090
27005		A	Incision of hip tendon	9.96	NA	NA	6.82	7.08	1.73	090
27006		A	Incision of hip tendons	9.99	NA	NA	6.99	7.26	1.70	090
27025		A	Incision of hip/thigh fascia	12.66	NA	NA	8.28	8.37	1.85	090
27027		A	Buttock fasciotomy	12.90	NA	NA	7.57	7.57	1.89	090
27030		A	Drainage of hip joint	13.54	NA	NA	8.36	8.70	2.27	090
27033		A	Exploration of hip joint	13.99	NA	NA	8.73	9.05	2.33	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27035		A	Denervation of hip joint	17.23	NA	NA	8.01	8.84	2.16	090
27036		A	Excision of hip joint/muscle	14.18	NA	NA	9.24	9.45	2.27	090
27040		A	Biopsy of soft tissues	2.89	5.24	5.25	1.96	1.98	0.27	010
27041		A	Biopsy of soft tissues	10.07	NA	NA	6.05	6.21	1.35	090
27047		A	Remove hip/pelvis lesion	7.51	7.01	7.05	4.56	4.62	1.03	090
27048		A	Remove hip/pelvis lesion	6.44	NA	NA	4.70	4.73	0.92	090
27049		A	Remove tumor, hip/pelvis	15.20	NA	NA	8.37	8.40	2.07	090
27050		A	Biopsy of sacroiliac joint	4.65	NA	NA	3.27	3.57	0.60	090
27052		A	Biopsy of hip joint	7.27	NA	NA	5.72	5.77	1.08	090
27054		A	Removal of hip joint lining	9.09	NA	NA	6.64	6.83	1.47	090
27057		A	Buttock fasciotomy w/dbrdmt	14.77	NA	NA	8.32	8.32	1.52	090
27060		A	Removal of ischial bursa	5.78	NA	NA	4.29	4.32	0.80	090
27062		A	Remove femur lesion/bursa	5.66	NA	NA	4.70	4.83	0.93	090
27065		A	Removal of hip bone lesion	6.44	NA	NA	5.21	5.28	1.01	090
27066		A	Removal of hip bone lesion	11.06	NA	NA	7.69	7.89	1.80	090
27067		A	Remove/graft hip bone lesion	14.57	NA	NA	9.43	9.76	1.85	090
27070		A	Partial removal of hip bone	11.44	NA	NA	8.26	8.50	1.75	090
27071		A	Partial removal of hip bone	12.25	NA	NA	8.75	9.12	1.93	090
27075		A	Extensive hip surgery	36.77	NA	NA	17.29	17.81	5.66	090
27076		A	Extensive hip surgery	24.25	NA	NA	13.18	13.54	3.71	090
27077		A	Extensive hip surgery	42.54	NA	NA	20.12	20.81	6.14	090
27078		A	Extensive hip surgery	14.54	NA	NA	9.21	9.42	2.23	090
27079		A	Extensive hip surgery	14.91	NA	NA	7.65	8.14	1.95	090
27080		A	Removal of tail bone	6.80	NA	NA	4.77	4.80	0.93	090
27086		A	Remove hip foreign body	1.89	3.69	3.91	1.53	1.61	0.25	010
27087		A	Remove hip foreign body	8.72	NA	NA	5.91	6.11	1.35	090
27090		A	Removal of hip prosthesis	11.57	NA	NA	7.66	7.96	1.95	090
27091		A	Removal of hip prosthesis	24.15	NA	NA	13.48	13.64	3.85	090
27093		A	Injection for hip x-ray	1.30	3.13	3.47	0.51	0.50	0.13	000
27095		A	Injection for hip x-ray	1.50	3.77	4.27	0.57	0.56	0.14	000
27096		A	Inject sacroiliac joint	1.40	2.54	3.00	0.36	0.35	0.08	000
27097		A	Revision of hip tendon	9.16	NA	NA	6.37	6.40	1.57	090
27098		A	Transfer tendon to pelvis	9.20	NA	NA	5.18	5.66	0.95	090
27100		A	Transfer of abdominal muscle	11.21	NA	NA	7.80	8.03	1.86	090
27105		A	Transfer of spinal muscle	11.90	NA	NA	8.10	8.39	1.73	090
27110		A	Transfer of iliopsoas muscle	13.63	NA	NA	8.74	8.86	2.19	090
27111		A	Transfer of iliopsoas muscle	12.46	NA	NA	7.06	7.60	1.95	090
27120		A	Reconstruction of hip socket	19.10	NA	NA	11.12	11.32	3.09	090
27122		A	Reconstruction of hip socket	15.95	NA	NA	9.78	10.12	2.62	090
27125		A	Partial hip replacement	16.46	NA	NA	9.97	10.16	2.55	090
27130		A	Total hip arthroplasty	21.61	NA	NA	12.31	12.58	3.51	090
27132		A	Total hip arthroplasty	25.49	NA	NA	14.07	14.50	4.05	090
27134		A	Revise hip joint replacement	30.13	NA	NA	15.48	16.10	4.95	090
27137		A	Revise hip joint replacement	22.55	NA	NA	12.31	12.74	3.68	090
27138		A	Revise hip joint replacement	23.55	NA	NA	12.73	13.17	3.85	090
27140		A	Transplant femur ridge	12.66	NA	NA	8.17	8.50	2.12	090
27146		A	Incision of hip bone	18.72	NA	NA	10.77	11.14	2.97	090
27147		A	Revision of hip bone	21.87	NA	NA	12.67	12.85	3.58	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27151		A	Incision of hip bones	23.92	NA	NA	13.48	12.12	3.92	090
27156		A	Revision of hip bones	26.03	NA	NA	13.86	14.45	4.22	090
27158		A	Revision of pelvis	20.89	NA	NA	12.03	11.79	3.17	090
27161		A	Incision of neck of femur	17.74	NA	NA	10.71	11.09	2.95	090
27165		A	Incision/fixation of femur	20.06	NA	NA	12.01	12.27	3.11	090
27170		A	Repair/graft femur head/neck	17.46	NA	NA	10.15	10.46	2.82	090
27175		A	Treat slipped epiphysis	9.29	NA	NA	6.16	6.30	1.46	090
27176		A	Treat slipped epiphysis	12.78	NA	NA	8.48	8.63	2.23	090
27177		A	Treat slipped epiphysis	15.94	NA	NA	10.00	10.25	2.62	090
27178		A	Treat slipped epiphysis	12.78	NA	NA	8.48	8.48	2.09	090
27179		A	Revise head/neck of femur	13.83	NA	NA	8.74	9.07	2.26	090
27181		A	Treat slipped epiphysis	15.98	NA	NA	10.10	10.15	1.57	090
27185		A	Revision of femur epiphysis	9.67	NA	NA	5.45	5.98	2.40	090
27187		A	Reinforce hip bones	14.09	NA	NA	9.00	9.35	2.38	090
27193		A	Treat pelvic ring fracture	5.98	4.73	4.83	4.86	4.93	0.96	090
27194		A	Treat pelvic ring fracture	10.08	NA	NA	6.33	6.67	1.65	090
27200		A	Treat tail bone fracture	1.87	2.05	2.10	2.19	2.19	0.28	090
27202		A	Treat tail bone fracture	7.25	NA	NA	4.93	7.93	1.06	090
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	6.57	6.71	1.98	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	9.48	9.53	2.64	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	9.00	9.31	2.42	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	11.73	11.68	3.49	090
27220		A	Treat hip socket fracture	6.72	5.37	5.47	5.28	5.38	1.07	090
27222		A	Treat hip socket fracture	13.97	NA	NA	8.77	9.09	2.20	090
27226		A	Treat hip wall fracture	15.45	NA	NA	9.36	8.99	2.49	090
27227		A	Treat hip fracture(s)	25.21	NA	NA	13.98	14.37	4.06	090
27228		A	Treat hip fracture(s)	29.13	NA	NA	15.66	16.19	4.67	090
27230		A	Treat thigh fracture	5.69	5.03	5.16	4.96	5.01	0.95	090
27232		A	Treat thigh fracture	11.66	NA	NA	6.36	6.58	1.86	090
27235		A	Treat thigh fracture	12.88	NA	NA	8.27	8.59	2.12	090
27236		A	Treat thigh fracture	17.43	NA	NA	10.55	10.70	2.72	090
27238		A	Treat thigh fracture	5.64	NA	NA	4.77	4.87	0.89	090
27240		A	Treat thigh fracture	13.66	NA	NA	8.59	8.83	2.17	090
27244		A	Treat thigh fracture	18.00	NA	NA	10.79	10.95	2.78	090
27245		A	Treat thigh fracture	18.00	NA	NA	10.82	11.58	3.53	090
27246		A	Treat thigh fracture	4.75	3.98	4.11	4.02	4.13	0.81	090
27248		A	Treat thigh fracture	10.64	NA	NA	6.65	7.05	1.82	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.74	1.72	0.62	000
27252		A	Treat hip dislocation	10.92	NA	NA	6.67	6.88	1.66	090
27253		A	Treat hip dislocation	13.46	NA	NA	8.46	8.82	2.25	090
27254		A	Treat hip dislocation	18.80	NA	NA	10.93	11.23	3.18	090
27256		A	Treat hip dislocation	4.25	2.42	2.70	1.40	1.58	0.46	010
27257		A	Treat hip dislocation	5.35	NA	NA	2.55	2.62	0.69	010
27258		A	Treat hip dislocation	16.04	NA	NA	9.78	10.08	2.65	090
27259		A	Treat hip dislocation	23.03	NA	NA	13.37	13.59	3.75	090
27265		A	Treat hip dislocation	5.12	NA	NA	3.83	4.08	0.63	090
27266		A	Treat hip dislocation	7.67	NA	NA	5.65	5.84	1.29	090
27267		A	Cltx thigh fx	5.38	NA	NA	4.28	4.28	0.89	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27268		A	Cltx thigh fx w/mnpj	7.00	NA	NA	4.93	4.93	1.16	090
27269		A	Optx thigh fx	18.75	NA	NA	9.89	9.89	2.93	090
27275		A	Manipulation of hip joint	2.29	NA	NA	1.83	1.91	0.39	010
27280		A	Fusion of sacroiliac joint	14.49	NA	NA	9.38	9.62	2.54	090
27282		A	Fusion of pubic bones	11.71	NA	NA	6.98	7.26	1.87	090
27284		A	Fusion of hip joint	24.91	NA	NA	10.68	11.73	3.93	090
27286		A	Fusion of hip joint	24.97	NA	NA	13.93	14.43	3.13	090
27290		A	Amputation of leg at hip	24.38	NA	NA	12.52	12.94	3.44	090
27295		A	Amputation of leg at hip	19.54	NA	NA	10.17	10.48	2.96	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.67	8.24	8.72	4.78	4.88	1.04	090
27303		A	Drainage of bone lesion	8.52	NA	NA	6.17	6.39	1.43	090
27305		A	Incise thigh tendon & fascia	6.09	NA	NA	4.65	4.80	1.01	090
27306		A	Incision of thigh tendon	4.66	NA	NA	3.92	4.13	0.85	090
27307		A	Incision of thigh tendons	5.97	NA	NA	4.67	4.86	1.04	090
27310		A	Exploration of knee joint	9.88	NA	NA	6.98	7.14	1.61	090
27323		A	Biopsy, thigh soft tissues	2.30	4.17	4.01	1.96	1.95	0.24	010
27324		A	Biopsy, thigh soft tissues	4.95	NA	NA	3.89	3.97	0.75	090
27325		A	Neurectomy, hamstring	7.09	NA	NA	5.32	5.24	1.09	090
27326		A	Neurectomy, popliteal	6.36	NA	NA	4.87	4.98	1.06	090
27327		A	Removal of thigh lesion	4.52	6.01	6.02	3.62	3.66	0.64	090
27328		A	Removal of thigh lesion	5.62	NA	NA	4.14	4.21	0.84	090
27329		A	Remove tumor, thigh/knee	15.68	NA	NA	8.75	8.84	2.15	090
27330		A	Biopsy, knee joint lining	5.02	NA	NA	4.17	4.28	0.86	090
27331		A	Explore/treat knee joint	5.93	NA	NA	4.88	5.06	1.02	090
27332		A	Removal of knee cartilage	8.34	NA	NA	6.34	6.55	1.43	090
27333		A	Removal of knee cartilage	7.43	NA	NA	5.87	6.08	1.26	090
27334		A	Remove knee joint lining	9.07	NA	NA	6.56	6.79	1.51	090
27335		A	Remove knee joint lining	10.43	NA	NA	7.23	7.49	1.75	090
27340		A	Removal of kneecap bursa	4.23	NA	NA	4.09	4.22	0.72	090
27345		A	Removal of knee cyst	5.98	NA	NA	5.00	5.17	1.00	090
27347		A	Remove knee cyst	6.58	NA	NA	5.43	5.44	0.98	090
27350		A	Removal of kneecap	8.54	NA	NA	6.42	6.64	1.41	090
27355		A	Remove femur lesion	7.89	NA	NA	5.95	6.17	1.32	090
27356		A	Remove femur lesion/graft	9.97	NA	NA	7.05	7.26	1.65	090
27357		A	Remove femur lesion/graft	11.02	NA	NA	7.73	8.00	1.96	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.01	2.14	0.82	ZZZ
27360		A	Partial removal, leg bone(s)	11.34	NA	NA	8.24	8.59	1.84	090
27365		A	Extensive leg surgery	17.93	NA	NA	10.81	11.05	2.80	090
27370		A	Injection for knee x-ray	0.96	2.93	3.14	0.38	0.36	0.08	000
27372		A	Removal of foreign body	5.12	8.31	8.77	4.14	4.28	0.84	090
27380		A	Repair of kneecap tendon	7.34	NA	NA	6.16	6.46	1.24	090
27381		A	Repair/graft kneecap tendon	10.64	NA	NA	7.77	8.12	1.80	090
27385		A	Repair of thigh muscle	8.00	NA	NA	6.45	6.76	1.36	090
27386		A	Repair/graft of thigh muscle	10.99	NA	NA	8.09	8.47	1.86	090
27390		A	Incision of thigh tendon	5.44	NA	NA	4.67	4.79	0.92	090
27391		A	Incision of thigh tendons	7.38	NA	NA	5.71	5.94	1.23	090
27392		A	Incision of thigh tendons	9.51	NA	NA	6.62	6.88	1.57	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27393		A	Lengthening of thigh tendon	6.50	NA	NA	5.11	5.30	1.10	090
27394		A	Lengthening of thigh tendons	8.68	NA	NA	6.31	6.55	1.47	090
27395		A	Lengthening of thigh tendons	12.10	NA	NA	8.20	8.50	2.05	090
27396		A	Transplant of thigh tendon	8.04	NA	NA	6.04	6.30	1.34	090
27397		A	Transplants of thigh tendons	12.46	NA	NA	8.64	8.77	1.83	090
27400		A	Revise thigh muscles/tendons	9.21	NA	NA	6.75	6.89	1.31	090
27403		A	Repair of knee cartilage	8.51	NA	NA	6.23	6.48	1.44	090
27405		A	Repair of knee ligament	8.96	NA	NA	6.60	6.84	1.51	090
27407		A	Repair of knee ligament	10.71	NA	NA	6.94	7.30	1.79	090
27409		A	Repair of knee ligaments	13.57	NA	NA	8.77	9.09	2.25	090
27412		A	Autochondrocyte implant knee	24.53	NA	NA	14.26	14.43	4.36	090
27415		A	Osteochondral knee allograft	19.79	NA	NA	12.24	12.35	4.36	090
27416		A	Osteochondral knee autograft	14.00	NA	NA	8.67	8.67	2.32	090
27418		A	Repair degenerated kneecap	11.46	NA	NA	7.83	8.12	1.89	090
27420		A	Revision of unstable kneecap	10.14	NA	NA	7.10	7.37	1.72	090
27422		A	Revision of unstable kneecap	10.09	NA	NA	7.06	7.35	1.71	090
27424		A	Revision/removal of kneecap	10.12	NA	NA	7.10	7.37	1.71	090
27425		A	Lat retinacular release open	5.28	NA	NA	4.77	4.97	0.90	090
27427		A	Reconstruction, knee	9.67	NA	NA	6.88	7.13	1.63	090
27428		A	Reconstruction, knee	15.33	NA	NA	10.37	10.61	2.43	090
27429		A	Reconstruction, knee	17.24	NA	NA	11.58	11.82	2.71	090
27430		A	Revision of thigh muscles	10.04	NA	NA	7.03	7.29	1.70	090
27435		A	Incision of knee joint	10.68	NA	NA	7.80	7.99	1.70	090
27437		A	Revise kneecap	8.82	NA	NA	6.36	6.60	1.49	090
27438		A	Revise kneecap with implant	11.77	NA	NA	7.75	7.97	1.96	090
27440		A	Revision of knee joint	10.97	NA	NA	7.37	7.04	1.82	090
27441		A	Revision of knee joint	11.42	NA	NA	7.29	7.17	1.89	090
27442		A	Revision of knee joint	12.25	NA	NA	7.87	8.15	2.10	090
27443		A	Revision of knee joint	11.29	NA	NA	7.53	7.85	1.91	090
27445		A	Revision of knee joint	18.52	NA	NA	10.84	11.25	3.09	090
27446		A	Revision of knee joint	16.26	NA	NA	9.67	10.09	2.81	090
27447		A	Total knee arthroplasty	23.04	NA	NA	13.14	13.54	3.80	090
27448		A	Incision of thigh	11.48	NA	NA	7.48	7.78	1.95	090
27450		A	Incision of thigh	14.47	NA	NA	9.16	9.54	2.43	090
27454		A	Realignment of thigh bone	18.97	NA	NA	10.85	11.29	3.13	090
27455		A	Realignment of knee	13.24	NA	NA	8.60	8.94	2.25	090
27457		A	Realignment of knee	13.92	NA	NA	8.54	8.91	2.35	090
27465		A	Shortening of thigh bone	18.44	NA	NA	10.75	10.64	2.48	090
27466		A	Lengthening of thigh bone	17.13	NA	NA	10.46	10.83	2.78	090
27468		A	Shorten/lengthen thighs	19.82	NA	NA	11.16	11.75	3.31	090
27470		A	Repair of thigh	16.97	NA	NA	10.55	10.89	2.80	090
27472		A	Repair/graft of thigh	18.57	NA	NA	11.09	11.52	3.08	090
27475		A	Surgery to stop leg growth	8.82	NA	NA	6.37	6.60	1.36	090
27477		A	Surgery to stop leg growth	10.03	NA	NA	6.89	7.12	1.74	090
27479		A	Surgery to stop leg growth	13.04	NA	NA	8.35	8.69	2.79	090
27485		A	Surgery to stop leg growth	9.02	NA	NA	6.40	6.67	1.53	090
27486		A	Revise/replace knee joint	20.92	NA	NA	12.14	12.51	3.37	090
27487		A	Revise/replace knee joint	26.91	NA	NA	14.67	15.18	4.40	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27488		A	Removal of knee prosthesis	17.40	NA	NA	10.65	10.94	2.75	090
27495		A	Reinforce thigh	16.40	NA	NA	9.99	10.37	2.72	090
27496		A	Decompression of thigh/knee	6.66	NA	NA	4.95	5.13	0.99	090
27497		A	Decompression of thigh/knee	7.70	NA	NA	4.92	5.06	1.15	090
27498		A	Decompression of thigh/knee	8.54	NA	NA	5.18	5.38	1.24	090
27499		A	Decompression of thigh/knee	9.31	NA	NA	5.80	6.07	1.47	090
27500		A	Treatment of thigh fracture	6.21	5.47	5.65	4.71	4.79	1.02	090
27501		A	Treatment of thigh fracture	6.34	5.12	5.30	5.03	5.13	1.03	090
27502		A	Treatment of thigh fracture	11.24	NA	NA	6.95	7.26	1.79	090
27503		A	Treatment of thigh fracture	11.13	NA	NA	7.45	7.68	1.85	090
27506		A	Treatment of thigh fracture	19.42	NA	NA	11.82	12.09	3.04	090
27507		A	Treatment of thigh fracture	14.39	NA	NA	8.47	8.84	2.43	090
27508		A	Treatment of thigh fracture	6.08	5.72	5.92	5.11	5.22	0.97	090
27509		A	Treatment of thigh fracture	8.02	NA	NA	6.69	7.02	1.34	090
27510		A	Treatment of thigh fracture	9.68	NA	NA	6.47	6.70	1.53	090
27511		A	Treatment of thigh fracture	14.97	NA	NA	8.47	9.18	2.38	090
27513		A	Treatment of thigh fracture	19.11	NA	NA	10.24	11.18	3.13	090
27514		A	Treatment of thigh fracture	14.46	NA	NA	8.25	9.55	3.01	090
27516		A	Treat thigh fx growth plate	5.45	5.65	5.84	5.05	5.18	0.81	090
27517		A	Treat thigh fx growth plate	8.98	NA	NA	6.70	6.90	1.22	090
27519		A	Treat thigh fx growth plate	13.11	NA	NA	7.73	8.71	2.56	090
27520		A	Treat kneecap fracture	2.93	4.08	4.21	3.53	3.51	0.47	090
27524		A	Treat kneecap fracture	10.25	NA	NA	7.14	7.43	1.75	090
27530		A	Treat knee fracture	3.97	4.82	4.96	4.28	4.32	0.65	090
27532		A	Treat knee fracture	7.43	6.50	6.73	5.75	5.94	1.26	090
27535		A	Treat knee fracture	13.27	NA	NA	7.75	8.36	2.01	090
27536		A	Treat knee fracture	17.19	NA	NA	10.59	10.87	2.74	090
27538		A	Treat knee fracture(s)	4.95	5.54	5.70	4.94	5.01	0.84	090
27540		A	Treat knee fracture	11.16	NA	NA	7.68	8.16	2.28	090
27550		A	Treat knee dislocation	5.84	5.33	5.51	4.62	4.71	0.76	090
27552		A	Treat knee dislocation	8.04	NA	NA	6.23	6.42	1.36	090
27556		A	Treat knee dislocation	12.86	NA	NA	7.56	8.60	2.51	090
27557		A	Treat knee dislocation	15.76	NA	NA	8.84	9.94	2.98	090
27558		A	Treat knee dislocation	18.25	NA	NA	9.96	10.76	3.09	090
27560		A	Treat kneecap dislocation	3.88	4.42	4.53	3.90	3.73	0.40	090
27562		A	Treat kneecap dislocation	5.86	NA	NA	4.87	4.85	0.94	090
27566		A	Treat kneecap dislocation	12.59	NA	NA	8.12	8.44	2.13	090
27570		A	Fixation of knee joint	1.76	NA	NA	1.64	1.68	0.30	010
27580		A	Fusion of knee	20.90	NA	NA	12.69	13.25	3.38	090
27590		A	Amputate leg at thigh	13.35	NA	NA	6.18	6.32	1.75	090
27591		A	Amputate leg at thigh	13.82	NA	NA	7.64	7.91	2.03	090
27592		A	Amputate leg at thigh	10.86	NA	NA	5.72	5.85	1.45	090
27594		A	Amputation follow-up surgery	7.17	NA	NA	4.83	4.93	1.02	090
27596		A	Amputation follow-up surgery	11.15	NA	NA	6.14	6.32	1.57	090
27598		A	Amputate lower leg at knee	11.08	NA	NA	6.49	6.64	1.65	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.94	NA	NA	3.95	4.10	0.86	090
27601		A	Decompression of lower leg	5.94	NA	NA	4.41	4.53	0.80	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27602		A	Decompression of lower leg	7.71	NA	NA	4.37	4.57	1.10	090
27603		A	Drain lower leg lesion	5.12	6.99	7.13	3.94	4.00	0.74	090
27604		A	Drain lower leg bursa	4.51	6.23	6.21	3.34	3.50	0.69	090
27605		A	Incision of achilles tendon	2.89	5.09	5.75	1.76	1.91	0.41	010
27606		A	Incision of achilles tendon	4.15	NA	NA	2.67	2.85	0.69	010
27607		A	Treat lower leg bone lesion	8.51	NA	NA	5.89	5.98	1.31	090
27610		A	Explore/treat ankle joint	9.01	NA	NA	6.26	6.46	1.40	090
27612		A	Exploration of ankle joint	8.01	NA	NA	5.35	5.55	1.13	090
27613		A	Biopsy lower leg soft tissue	2.19	3.91	3.75	1.82	1.82	0.20	010
27614		A	Biopsy lower leg soft tissue	5.71	7.54	7.46	3.90	4.04	0.78	090
27615		A	Remove tumor, lower leg	12.93	NA	NA	7.42	7.93	1.84	090
27618		A	Remove lower leg lesion	5.14	6.41	6.33	3.86	3.90	0.72	090
27619		A	Remove lower leg lesion	8.47	9.81	9.76	5.28	5.46	1.25	090
27620		A	Explore/treat ankle joint	6.04	NA	NA	4.63	4.85	0.97	090
27625		A	Remove ankle joint lining	8.37	NA	NA	5.44	5.71	1.28	090
27626		A	Remove ankle joint lining	8.98	NA	NA	5.88	6.16	1.48	090
27630		A	Removal of tendon lesion	4.85	7.77	7.74	3.79	3.94	0.74	090
27635		A	Remove lower leg bone lesion	7.91	NA	NA	5.82	6.06	1.31	090
27637		A	Remove/graft leg bone lesion	10.17	NA	NA	7.28	7.55	1.66	090
27638		A	Remove/graft leg bone lesion	10.87	NA	NA	7.24	7.52	1.85	090
27640		A	Partial removal of tibia	12.10	NA	NA	7.71	8.38	1.89	090
27641		A	Partial removal of fibula	9.73	NA	NA	6.16	6.72	1.46	090
27645		A	Extensive lower leg surgery	14.78	NA	NA	9.26	9.98	2.42	090
27646		A	Extensive lower leg surgery	13.21	NA	NA	7.94	8.74	2.06	090
27647		A	Extensive ankle/heel surgery	12.85	NA	NA	6.26	6.61	1.76	090
27648		A	Injection for ankle x-ray	0.96	2.81	2.99	0.36	0.35	0.08	000
27650		A	Repair achilles tendon	9.00	NA	NA	6.68	6.90	1.59	090
27652		A	Repair/graft achilles tendon	10.64	NA	NA	6.49	6.89	1.72	090
27654		A	Repair of achilles tendon	10.32	NA	NA	6.75	6.86	1.58	090
27656		A	Repair leg fascia defect	4.62	7.91	8.08	3.65	3.69	0.69	090
27658		A	Repair of leg tendon, each	5.03	NA	NA	3.89	4.06	0.79	090
27659		A	Repair of leg tendon, each	6.99	NA	NA	4.67	4.92	1.09	090
27664		A	Repair of leg tendon, each	4.64	NA	NA	3.83	4.02	0.76	090
27665		A	Repair of leg tendon, each	5.46	NA	NA	4.27	4.45	0.89	090
27675		A	Repair lower leg tendons	7.24	NA	NA	4.61	4.90	1.11	090
27676		A	Repair lower leg tendons	8.61	NA	NA	5.88	6.11	1.37	090
27680		A	Release of lower leg tendon	5.79	NA	NA	4.26	4.49	0.93	090
27681		A	Release of lower leg tendons	6.94	NA	NA	5.05	5.28	1.15	090
27685		A	Revision of lower leg tendon	6.57	8.62	8.31	4.58	4.81	0.97	090
27686		A	Revise lower leg tendons	7.64	NA	NA	5.43	5.71	1.24	090
27687		A	Revision of calf tendon	6.30	NA	NA	4.48	4.70	1.00	090
27690		A	Revise lower leg tendon	8.96	NA	NA	6.15	6.22	1.33	090
27691		A	Revise lower leg tendon	10.28	NA	NA	7.36	7.48	1.64	090
27692		A	Revise additional leg tendon	1.87	NA	NA	0.74	0.79	0.32	ZZZ
27695		A	Repair of ankle ligament	6.58	NA	NA	4.88	5.14	1.05	090
27696		A	Repair of ankle ligaments	8.46	NA	NA	5.20	5.52	1.28	090
27698		A	Repair of ankle ligament	9.49	NA	NA	5.92	6.19	1.47	090
27700		A	Revision of ankle joint	9.54	NA	NA	5.22	5.35	1.30	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27702		A	Reconstruct ankle joint	14.28	NA	NA	8.90	9.31	2.38	090
27703		A	Reconstruction, ankle joint	16.79	NA	NA	10.22	10.50	2.77	090
27704		A	Removal of ankle implant	7.69	NA	NA	5.74	5.72	1.27	090
27705		A	Incision of tibia	10.74	NA	NA	7.08	7.37	1.81	090
27707		A	Incision of fibula	4.67	NA	NA	4.51	4.63	0.76	090
27709		A	Incision of tibia & fibula	17.32	NA	NA	10.22	9.72	1.74	090
27712		A	Realignment of lower leg	15.67	NA	NA	10.02	10.22	2.48	090
27715		A	Revision of lower leg	15.36	NA	NA	9.54	9.87	2.50	090
27720		A	Repair of tibia	12.22	NA	NA	8.20	8.52	2.05	090
27722		A	Repair/graft of tibia	12.31	NA	NA	8.09	8.37	2.06	090
27724		A	Repair/graft of tibia	19.18	NA	NA	10.76	11.19	3.17	090
27725		A	Repair of lower leg	17.15	NA	NA	10.99	11.25	2.72	090
27726		A	Repair fibula nonunion	14.20	NA	NA	7.87	7.87	1.43	090
27727		A	Repair of lower leg	14.69	NA	NA	7.47	8.21	2.44	090
27730		A	Repair of tibia epiphysis	7.59	NA	NA	5.80	5.97	1.73	090
27732		A	Repair of fibula epiphysis	5.37	NA	NA	3.82	4.11	0.77	090
27734		A	Repair lower leg epiphyses	8.72	NA	NA	5.05	5.37	1.35	090
27740		A	Repair of leg epiphyses	9.49	NA	NA	5.41	6.07	1.62	090
27742		A	Repair of leg epiphyses	10.49	NA	NA	5.91	5.83	1.80	090
27745		A	Reinforce tibia	10.37	NA	NA	7.14	7.42	1.76	090
27750		A	Treatment of tibia fracture	3.26	4.30	4.43	3.74	3.77	0.55	090
27752		A	Treatment of tibia fracture	6.15	5.98	6.17	5.17	5.31	1.01	090
27756		A	Treatment of tibia fracture	7.33	NA	NA	5.82	5.99	1.17	090
27758		A	Treatment of tibia fracture	12.40	NA	NA	8.28	8.52	2.04	090
27759		A	Treatment of tibia fracture	14.31	NA	NA	9.00	9.35	2.39	090
27760		A	Cltx medial ankle fx	3.09	4.23	4.35	3.65	3.64	0.48	090
27762		A	Cltx med ankle fx w/mnpj	5.33	5.51	5.73	4.70	4.86	0.85	090
27766		A	Optx medial ankle fx	7.73	NA	NA	6.23	6.49	1.44	090
27767		A	Cltx post ankle fx	2.50	3.46	3.46	3.49	3.49	0.30	090
27768		A	Cltx post ankle fx w/mnpj	5.00	NA	NA	4.41	4.41	0.79	090
27769		A	Optx post ankle fx	10.00	NA	NA	6.34	6.34	1.45	090
27780		A	Treatment of fibula fracture	2.72	3.86	3.95	3.32	3.30	0.41	090
27781		A	Treatment of fibula fracture	4.47	4.97	5.11	4.36	4.44	0.73	090
27784		A	Treatment of fibula fracture	9.51	NA	NA	7.00	6.89	1.23	090
27786		A	Treatment of ankle fracture	2.91	4.02	4.14	3.42	3.41	0.46	090
27788		A	Treatment of ankle fracture	4.52	4.96	5.14	4.25	4.36	0.74	090
27792		A	Treatment of ankle fracture	9.55	NA	NA	6.96	6.98	1.32	090
27808		A	Treatment of ankle fracture	2.91	4.36	4.48	3.69	3.70	0.46	090
27810		A	Treatment of ankle fracture	5.20	5.41	5.63	4.59	4.74	0.82	090
27814		A	Treatment of ankle fracture	10.46	NA	NA	7.44	7.74	1.86	090
27816		A	Treatment of ankle fracture	2.96	3.92	4.04	3.28	3.32	0.43	090
27818		A	Treatment of ankle fracture	5.57	5.33	5.61	4.40	4.60	0.82	090
27822		A	Treatment of ankle fracture	11.03	NA	NA	8.40	8.98	1.92	090
27823		A	Treatment of ankle fracture	12.98	NA	NA	9.17	9.77	2.26	090
27824		A	Treat lower leg fracture	3.20	3.72	3.82	3.54	3.55	0.45	090
27825		A	Treat lower leg fracture	6.60	5.88	6.08	4.88	5.02	1.02	090
27826		A	Treat lower leg fracture	10.92	NA	NA	8.39	8.52	1.47	090
27827		A	Treat lower leg fracture	14.56	NA	NA	10.45	11.05	2.44	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27828		A	Treat lower leg fracture	18.20	NA	NA	11.97	12.49	2.82	090
27829		A	Treat lower leg joint	8.64	NA	NA	7.11	7.04	0.95	090
27830		A	Treat lower leg dislocation	3.85	4.26	4.30	3.74	3.77	0.54	090
27831		A	Treat lower leg dislocation	4.62	NA	NA	4.09	4.19	0.73	090
27832		A	Treat lower leg dislocation	10.01	NA	NA	7.06	6.86	1.03	090
27840		A	Treat ankle dislocation	4.65	NA	NA	3.55	3.61	0.46	090
27842		A	Treat ankle dislocation	6.34	NA	NA	4.93	4.99	1.00	090
27846		A	Treat ankle dislocation	10.16	NA	NA	7.00	7.25	1.71	090
27848		A	Treat ankle dislocation	11.56	NA	NA	7.59	8.14	1.95	090
27860		A	Fixation of ankle joint	2.36	NA	NA	1.82	1.86	0.39	010
27870		A	Fusion of ankle joint, open	15.21	NA	NA	9.39	9.69	2.37	090
27871		A	Fusion of tibiofibular joint	9.42	NA	NA	6.67	6.91	1.59	090
27880		A	Amputation of lower leg	15.24	NA	NA	6.90	6.98	1.76	090
27881		A	Amputation of lower leg	13.32	NA	NA	7.59	7.92	1.99	090
27882		A	Amputation of lower leg	9.67	NA	NA	4.98	5.37	1.29	090
27884		A	Amputation follow-up surgery	8.64	NA	NA	5.17	5.33	1.22	090
27886		A	Amputation follow-up surgery	9.88	NA	NA	5.88	6.05	1.40	090
27888		A	Amputation of foot at ankle	10.23	NA	NA	6.28	6.60	1.51	090
27889		A	Amputation of foot at ankle	10.72	NA	NA	5.45	5.72	1.46	090
27892		A	Decompression of leg	7.82	NA	NA	4.96	5.13	1.10	090
27893		A	Decompression of leg	7.78	NA	NA	5.28	5.34	1.10	090
27894		A	Decompression of leg	12.42	NA	NA	7.72	7.75	1.65	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.75	3.87	3.66	1.58	1.68	0.33	010
28002		A	Treatment of foot infection	5.78	6.55	6.17	3.56	3.62	0.61	010
28003		A	Treatment of foot infection	8.95	7.67	7.33	4.57	4.75	1.12	090
28005		A	Treat foot bone lesion	9.30	NA	NA	5.52	5.67	1.16	090
28008		A	Incision of foot fascia	4.50	5.92	5.59	2.91	2.99	0.57	090
28010		A	Incision of toe tendon	2.89	2.78	2.69	2.29	2.32	0.36	090
28011		A	Incision of toe tendons	4.19	3.77	3.66	3.03	3.10	0.59	090
28020		A	Exploration of foot joint	5.06	7.17	6.89	3.55	3.70	0.72	090
28022		A	Exploration of foot joint	4.72	6.70	6.34	3.27	3.42	0.62	090
28024		A	Exploration of toe joint	4.43	6.36	6.09	3.07	3.29	0.58	090
28035		A	Decompression of tibia nerve	5.14	7.22	6.90	3.59	3.72	0.70	090
28043		A	Excision of foot lesion	3.58	4.65	4.45	2.69	2.81	0.46	090
28045		A	Excision of foot lesion	4.77	6.86	6.50	3.22	3.32	0.63	090
28046		A	Resection of tumor, foot	10.55	10.14	9.82	5.74	5.94	1.36	090
28050		A	Biopsy of foot joint lining	4.30	6.74	6.29	3.25	3.34	0.60	090
28052		A	Biopsy of foot joint lining	3.98	6.09	5.80	2.82	2.98	0.53	090
28054		A	Biopsy of toe joint lining	3.49	6.04	5.72	2.74	2.87	0.46	090
28055		A	Neurectomy, foot	6.20	NA	NA	3.47	3.53	0.74	090
28060		A	Partial removal, foot fascia	5.29	6.91	6.57	3.51	3.61	0.70	090
28062		A	Removal of foot fascia	6.58	7.63	7.37	3.78	3.85	0.83	090
28070		A	Removal of foot joint lining	5.15	7.02	6.59	3.42	3.53	0.73	090
28072		A	Removal of foot joint lining	4.63	7.43	6.97	3.61	3.79	0.68	090
28080		A	Removal of foot lesion	4.65	7.42	6.86	4.10	4.00	0.47	090
28086		A	Excise foot tendon sheath	4.83	7.45	7.60	3.67	3.93	0.76	090
28088		A	Excise foot tendon sheath	3.90	6.96	6.67	3.25	3.41	0.61	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28090		A	Removal of foot lesion	4.46	6.57	6.23	3.13	3.22	0.59	090
28092		A	Removal of toe lesions	3.69	6.23	5.99	2.91	3.07	0.49	090
28100		A	Removal of ankle/heel lesion	5.72	8.03	8.03	4.04	4.22	0.82	090
28102		A	Remove/graft foot lesion	7.80	NA	NA	5.67	5.75	1.14	090
28103		A	Remove/graft foot lesion	6.56	NA	NA	4.30	4.39	0.91	090
28104		A	Removal of foot lesion	5.17	6.99	6.63	3.41	3.54	0.70	090
28106		A	Remove/graft foot lesion	7.23	NA	NA	4.28	4.33	0.97	090
28107		A	Remove/graft foot lesion	5.62	7.80	7.50	3.79	3.90	0.74	090
28108		A	Removal of toe lesions	4.21	6.14	5.76	2.92	3.01	0.53	090
28110		A	Part removal of metatarsal	4.13	6.71	6.35	3.01	3.07	0.54	090
28111		A	Part removal of metatarsal	5.06	7.00	6.83	3.21	3.33	0.67	090
28112		A	Part removal of metatarsal	4.54	7.01	6.73	3.22	3.32	0.61	090
28113		A	Part removal of metatarsal	5.88	8.17	7.66	4.56	4.50	0.63	090
28114		A	Removal of metatarsal heads	11.61	13.18	12.82	8.29	8.33	1.42	090
28116		A	Revision of foot	8.94	9.06	8.51	5.18	5.19	1.03	090
28118		A	Removal of heel bone	6.02	7.87	7.48	4.07	4.15	0.84	090
28119		A	Removal of heel spur	5.45	6.98	6.61	3.51	3.57	0.70	090
28120		A	Part removal of ankle/heel	5.64	7.89	7.75	3.94	4.06	0.77	090
28122		A	Partial removal of foot bone	7.56	8.29	7.95	4.75	4.89	0.98	090
28124		A	Partial removal of toe	4.88	6.57	6.19	3.40	3.47	0.60	090
28126		A	Partial removal of toe	3.56	5.79	5.41	2.62	2.72	0.45	090
28130		A	Removal of ankle bone	9.30	NA	NA	5.94	6.15	1.26	090
28140		A	Removal of metatarsal	7.03	7.67	7.57	4.10	4.28	0.92	090
28150		A	Removal of toe	4.14	6.16	5.84	2.92	3.02	0.53	090
28153		A	Partial removal of toe	3.71	6.03	5.61	2.84	2.81	0.47	090
28160		A	Partial removal of toe	3.79	6.16	5.77	2.90	3.01	0.49	090
28171		A	Extensive foot surgery	9.85	NA	NA	5.13	5.22	1.33	090
28173		A	Extensive foot surgery	9.05	8.55	8.33	4.59	4.76	1.12	090
28175		A	Extensive foot surgery	6.17	6.93	6.64	3.57	3.61	0.73	090
28190		A	Removal of foot foreign body	1.98	3.90	3.78	1.32	1.36	0.22	010
28192		A	Removal of foot foreign body	4.69	6.48	6.25	3.12	3.26	0.61	090
28193		A	Removal of foot foreign body	5.79	7.10	6.74	3.56	3.66	0.73	090
28200		A	Repair of foot tendon	4.65	6.67	6.29	3.18	3.28	0.61	090
28202		A	Repair/graft of foot tendon	6.96	7.60	7.52	3.92	4.07	0.91	090
28208		A	Repair of foot tendon	4.42	6.54	6.12	3.16	3.20	0.58	090
28210		A	Repair/graft of foot tendon	6.41	7.39	7.11	3.87	3.92	0.81	090
28220		A	Release of foot tendon	4.58	6.20	5.83	3.01	3.12	0.57	090
28222		A	Release of foot tendons	5.67	6.69	6.34	3.27	3.49	0.69	090
28225		A	Release of foot tendon	3.70	5.72	5.37	2.61	2.69	0.46	090
28226		A	Release of foot tendons	4.58	6.78	6.30	3.26	3.39	0.58	090
28230		A	Incision of foot tendon(s)	4.28	6.06	5.72	2.82	3.04	0.55	090
28232		A	Incision of toe tendon	3.43	5.77	5.47	2.64	2.81	0.44	090
28234		A	Incision of foot tendon	3.43	6.17	5.81	3.04	3.12	0.44	090
28238		A	Revision of foot tendon	7.85	8.22	7.99	4.36	4.51	1.06	090
28240		A	Release of big toe	4.40	6.28	5.88	2.97	3.10	0.58	090
28250		A	Revision of foot fascia	5.97	7.50	7.05	3.88	3.95	0.82	090
28260		A	Release of midfoot joint	8.08	8.19	7.74	4.54	4.67	1.14	090
28261		A	Revision of foot tendon	12.91	10.54	10.08	6.36	6.61	1.57	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28262		A	Revision of foot and ankle	17.01	15.26	14.87	9.78	10.09	2.60	090
28264		A	Release of midfoot joint	10.53	10.66	9.95	6.32	6.57	1.54	090
28270		A	Release of foot contracture	4.82	6.75	6.30	3.41	3.50	0.62	090
28272		A	Release of toe joint, each	3.84	5.63	5.28	2.59	2.66	0.46	090
28280		A	Fusion of toes	5.24	7.13	6.93	3.53	3.77	0.73	090
28285		A	Repair of hammertoe	4.65	6.54	6.13	3.31	3.34	0.59	090
28286		A	Repair of hammertoe	4.61	6.29	5.93	2.98	3.06	0.57	090
28288		A	Partial removal of foot bone	5.81	8.34	7.75	4.61	4.68	0.65	090
28289		A	Repair hallux rigidus	8.11	9.18	8.90	5.28	5.41	1.02	090
28290		A	Correction of bunion	5.72	7.93	7.53	3.91	4.12	0.82	090
28292		A	Correction of bunion	8.72	10.11	9.47	6.08	5.96	0.91	090
28293		A	Correction of bunion	11.10	14.02	13.23	6.79	6.64	1.13	090
28294		A	Correction of bunion	8.63	9.24	8.81	4.75	4.75	1.09	090
28296		A	Correction of bunion	8.16	9.09	8.87	4.95	5.08	1.19	090
28297		A	Correction of bunion	9.31	10.24	9.94	5.33	5.57	1.32	090
28298		A	Correction of bunion	8.01	9.13	8.67	4.60	4.71	1.05	090
28299		A	Correction of bunion	11.39	10.41	10.02	5.76	5.85	1.37	090
28300		A	Incision of heel bone	9.61	NA	NA	6.14	6.38	1.54	090
28302		A	Incision of ankle bone	9.62	NA	NA	6.08	6.29	1.42	090
28304		A	Incision of midfoot bones	9.29	9.55	9.17	5.20	5.35	1.27	090
28305		A	Incise/graft midfoot bones	10.63	NA	NA	6.18	6.33	1.27	090
28306		A	Incision of metatarsal	5.91	8.37	8.00	3.96	4.02	0.84	090
28307		A	Incision of metatarsal	6.39	9.72	10.07	4.67	4.84	0.90	090
28308		A	Incision of metatarsal	5.36	7.77	7.28	3.82	3.79	0.70	090
28309		A	Incision of metatarsals	13.96	NA	NA	7.50	7.63	2.05	090
28310		A	Revision of big toe	5.48	7.34	6.96	3.38	3.43	0.70	090
28312		A	Revision of toe	4.60	7.24	6.80	3.23	3.34	0.63	090
28313		A	Repair deformity of toe	5.06	7.38	6.87	3.75	4.03	0.73	090
28315		A	Removal of sesamoid bone	4.91	6.45	6.07	3.15	3.21	0.63	090
28320		A	Repair of foot bones	9.25	NA	NA	5.60	5.89	1.43	090
28322		A	Repair of metatarsals	8.41	9.59	9.51	5.34	5.60	1.27	090
28340		A	Resect enlarged toe tissue	7.04	7.63	7.35	3.89	3.98	0.84	090
28341		A	Resect enlarged toe	8.60	8.26	7.95	4.29	4.43	1.01	090
28344		A	Repair extra toe(s)	4.31	7.17	6.83	3.42	3.48	0.51	090
28345		A	Repair webbed toe(s)	5.98	7.70	7.34	3.91	4.11	0.80	090
28360		A	Reconstruct cleft foot	14.67	NA	NA	7.90	8.57	2.29	090
28400		A	Treatment of heel fracture	2.22	3.30	3.39	2.87	2.92	0.35	090
28405		A	Treatment of heel fracture	4.63	4.28	4.43	3.57	3.84	0.73	090
28406		A	Treatment of heel fracture	6.44	NA	NA	5.62	5.93	1.11	090
28415		A	Treat heel fracture	15.96	NA	NA	10.33	11.09	2.67	090
28420		A	Treat/graft heel fracture	17.29	NA	NA	10.58	11.19	2.81	090
28430		A	Treatment of ankle fracture	2.14	3.02	3.12	2.50	2.53	0.31	090
28435		A	Treatment of ankle fracture	3.45	3.91	3.91	3.21	3.35	0.55	090
28436		A	Treatment of ankle fracture	4.78	NA	NA	4.94	5.19	0.81	090
28445		A	Treat ankle fracture	15.53	NA	NA	9.53	9.93	2.59	090
28446		A	Osteochondral talus autogrft	17.50	NA	NA	10.65	10.65	2.45	090
28450		A	Treat midfoot fracture, each	1.95	2.84	2.92	2.37	2.40	0.28	090
28455		A	Treat midfoot fracture, each	3.15	3.62	3.58	3.01	3.12	0.44	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28456		A	Treat midfoot fracture	2.75	NA	NA	3.53	3.70	0.44	090
28465		A	Treat midfoot fracture, each	8.64	NA	NA	5.99	6.09	1.10	090
28470		A	Treat metatarsal fracture	1.99	2.76	2.86	2.34	2.37	0.30	090
28475		A	Treat metatarsal fracture	2.97	3.08	3.15	2.49	2.67	0.44	090
28476		A	Treat metatarsal fracture	3.46	NA	NA	4.37	4.53	0.54	090
28485		A	Treat metatarsal fracture	7.28	NA	NA	5.51	5.51	0.83	090
28490		A	Treat big toe fracture	1.12	2.04	2.04	1.63	1.64	0.14	090
28495		A	Treat big toe fracture	1.62	2.42	2.36	1.84	1.90	0.20	090
28496		A	Treat big toe fracture	2.39	7.04	7.36	2.88	2.97	0.36	090
28505		A	Treat big toe fracture	7.28	8.32	8.28	4.82	4.60	0.56	090
28510		A	Treatment of toe fracture	1.12	1.63	1.61	1.56	1.56	0.14	090
28515		A	Treatment of toe fracture	1.50	2.16	2.10	1.77	1.81	0.18	090
28525		A	Treat toe fracture	5.46	7.65	7.63	4.12	3.96	0.49	090
28530		A	Treat sesamoid bone fracture	1.08	1.59	1.55	1.31	1.35	0.14	090
28531		A	Treat sesamoid bone fracture	2.51	5.67	6.09	2.10	2.10	0.34	090
28540		A	Treat foot dislocation	2.10	2.61	2.56	2.19	2.25	0.26	090
28545		A	Treat foot dislocation	2.51	3.46	3.19	2.85	2.73	0.37	090
28546		A	Treat foot dislocation	3.28	7.79	7.59	3.57	3.78	0.52	090
28555		A	Repair foot dislocation	9.49	10.88	10.66	6.48	6.29	1.04	090
28570		A	Treat foot dislocation	1.70	2.28	2.32	1.77	1.91	0.23	090
28575		A	Treat foot dislocation	3.38	4.40	4.24	3.72	3.73	0.56	090
28576		A	Treat foot dislocation	4.48	NA	NA	3.72	3.84	0.69	090
28585		A	Repair foot dislocation	10.92	11.50	10.48	7.06	6.77	1.25	090
28600		A	Treat foot dislocation	1.94	2.95	2.92	2.32	2.42	0.27	090
28605		A	Treat foot dislocation	2.78	3.57	3.47	3.01	3.05	0.40	090
28606		A	Treat foot dislocation	4.97	NA	NA	4.03	4.20	0.82	090
28615		A	Repair foot dislocation	10.46	NA	NA	8.15	8.14	1.30	090
28630		A•	Treat toe dislocation	1.72	1.79	1.74	0.90	0.93	0.20	010
28635		A	Treat toe dislocation	1.93	2.23	2.19	1.33	1.38	0.26	010
28636		A	Treat toe dislocation	2.77	4.06	4.02	1.93	2.11	0.43	010
28645		A	Repair toe dislocation	7.28	8.22	7.42	4.63	4.30	0.57	090
28660		A	Treat toe dislocation	1.25	1.29	1.28	0.78	0.79	0.13	010
28665		A	Treat toe dislocation	1.94	1.80	1.71	1.32	1.35	0.26	010
28666		A	Treat toe dislocation	2.66	NA	NA	1.80	2.00	0.43	010
28675		A	Repair of toe dislocation	5.46	8.22	7.97	4.50	4.23	0.45	090
28705		A	Fusion of foot bones	20.12	NA	NA	10.93	11.34	3.09	090
28715		A	Fusion of foot bones	14.40	NA	NA	8.68	8.97	2.17	090
28725		A	Fusion of foot bones	11.97	NA	NA	6.84	7.21	1.87	090
28730		A	Fusion of foot bones	12.21	NA	NA	7.85	8.02	1.71	090
28735		A	Fusion of foot bones	12.03	NA	NA	7.08	7.28	1.69	090
28737		A	Revision of foot bones	10.83	NA	NA	6.13	6.31	1.47	090
28740		A	Fusion of foot bones	9.09	10.66	10.74	5.99	6.12	1.22	090
28750		A	Fusion of big toe joint	8.37	10.64	10.98	5.93	6.13	1.13	090
28755		A	Fusion of big toe joint	4.79	7.11	6.88	3.34	3.45	0.65	090
28760		A	Fusion of big toe joint	8.94	9.80	9.37	5.33	5.39	1.05	090
28800		A	Amputation of midfoot	8.65	NA	NA	5.01	5.22	1.15	090
28805		A	Amputation thru metatarsal	12.55	NA	NA	5.99	5.92	1.18	090
28810		A	Amputation toe & metatarsal	6.52	NA	NA	4.08	4.18	0.86	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28820		A	Amputation of toe	4.89	7.47	7.51	3.52	3.60	0.61	090
28825		A	Partial amputation of toe	5.85	7.90	7.69	4.09	3.95	0.50	090
28890		A	High energy eswt, plantar f	3.36	4.46	4.79	2.18	2.16	0.41	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	4.31	3.98	1.77	1.76	0.41	000
29010		A	Application of body cast	2.06	3.65	3.57	1.53	1.59	0.45	000
29015		A	Application of body cast	2.41	3.21	3.16	1.40	1.45	0.28	000
29020		A	Application of body cast	2.11	3.22	3.21	1.32	1.34	0.28	000
29025		A	Application of body cast	2.40	3.69	3.56	1.69	1.74	0.44	000
29035		A	Application of body cast	1.77	3.89	3.83	1.54	1.55	0.28	000
29040		A	Application of body cast	2.22	3.35	3.13	1.44	1.46	0.36	000
29044		A	Application of body cast	2.12	3.89	3.92	1.67	1.73	0.35	000
29046		A	Application of body cast	2.41	4.45	4.16	1.95	1.99	0.42	000
29049		A	Application of figure eight	0.89	1.03	1.10	0.55	0.55	0.13	000
29055		A	Application of shoulder cast	1.78	2.98	2.99	1.36	1.39	0.30	000
29058		A	Application of shoulder cast	1.31	1.16	1.26	0.63	0.66	0.17	000
29065		A	Application of long arm cast	0.87	1.27	1.29	0.71	0.72	0.15	000
29075		A	Application of forearm cast	0.77	1.23	1.24	0.67	0.67	0.13	000
29085		A	Apply hand/wrist cast	0.87	1.26	1.27	0.70	0.68	0.14	000
29086		A	Apply finger cast	0.62	1.06	1.04	0.55	0.54	0.07	000
29105		A	Apply long arm splint	0.87	1.08	1.12	0.53	0.53	0.12	000
29125		A	Apply forearm splint	0.59	0.95	0.97	0.42	0.42	0.07	000
29126		A	Apply forearm splint	0.77	0.97	1.03	0.48	0.48	0.07	000
29130		A	Application of finger splint	0.50	0.43	0.44	0.19	0.19	0.06	000
29131		A	Application of finger splint	0.55	0.61	0.64	0.26	0.25	0.03	000
29200		A	Strapping of chest	0.65	0.59	0.62	0.34	0.34	0.04	000
29220		A	Strapping of low back	0.64	0.66	0.67	0.39	0.39	0.04	000
29240		A	Strapping of shoulder	0.71	0.65	0.70	0.38	0.38	0.06	000
29260		A	Strapping of elbow or wrist	0.55	0.64	0.67	0.36	0.35	0.05	000
29280		A	Strapping of hand or finger	0.51	0.64	0.68	0.36	0.35	0.03	000
29305		A	Application of hip cast	2.03	3.34	3.35	1.63	1.67	0.35	000
29325		A	Application of hip casts	2.32	3.70	3.66	1.82	1.86	0.40	000
29345		A	Application of long leg cast	1.40	1.66	1.69	0.96	0.99	0.24	000
29355		A	Application of long leg cast	1.53	1.64	1.66	0.97	1.01	0.26	000
29358		A	Apply long leg cast brace	1.43	2.06	2.06	0.97	1.00	0.25	000
29365		A	Application of long leg cast	1.18	1.58	1.60	0.88	0.90	0.20	000
29405		A	Apply short leg cast	0.86	1.17	1.19	0.65	0.67	0.14	000
29425		A	Apply short leg cast	1.01	1.20	1.21	0.66	0.68	0.15	000
29435		A	Apply short leg cast	1.18	1.51	1.53	0.82	0.85	0.20	000
29440		A	Addition of walker to cast	0.57	0.63	0.65	0.26	0.26	0.08	000
29445		A	Apply rigid leg cast	1.78	1.54	1.61	0.89	0.91	0.27	000
29450		A	Application of leg cast	2.08	1.52	1.51	0.88	0.93	0.27	000
29505		A	Application, long leg splint	0.69	1.05	1.08	0.45	0.45	0.08	000
29515		A	Application lower leg splint	0.73	0.93	0.92	0.45	0.46	0.09	000
29520		A	Strapping of hip	0.54	0.60	0.66	0.34	0.37	0.03	000
29530		A	Strapping of knee	0.57	0.62	0.67	0.35	0.35	0.05	000
29540		A	Strapping of ankle and/or ft	0.51	0.53	0.50	0.30	0.30	0.06	000
29550		A	Strapping of toes	0.47	0.54	0.51	0.29	0.29	0.06	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29580		A	Application of paste boot	0.55	0.70	0.69	0.33	0.34	0.07	000
29590		A	Application of foot splint	0.76	0.58	0.56	0.26	0.27	0.09	000
29700		A	Removal/revision of cast	0.57	0.94	0.93	0.26	0.27	0.08	000
29705		A	Removal/revision of cast	0.76	0.78	0.79	0.38	0.38	0.13	000
29710		A	Removal/revision of cast	1.34	1.34	1.39	0.61	0.63	0.20	000
29715		A	Removal/revision of cast	0.94	1.19	1.18	0.46	0.44	0.09	000
29720		A	Repair of body cast	0.68	1.15	1.16	0.36	0.37	0.12	000
29730		A	Windowing of cast	0.75	0.74	0.76	0.35	0.35	0.12	000
29740		A	Wedging of cast	1.12	1.00	1.04	0.48	0.48	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.10	1.09	0.57	0.57	0.21	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.73	NA	NA	4.98	5.49	0.99	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	NA	5.92	6.36	1.38	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	NA	4.82	5.04	1.02	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	NA	9.70	10.09	2.50	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	NA	9.53	9.92	2.42	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.80	6.06	1.32	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	NA	5.32	5.56	1.22	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	NA	5.80	6.07	1.33	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	NA	5.71	5.97	1.28	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	NA	6.21	6.48	1.41	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	NA	6.70	6.92	1.42	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.78	6.04	1.32	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	NA	6.37	6.67	1.55	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	NA	9.67	10.16	2.67	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	NA	8.46	8.46	2.17	090
29830		A	Elbow arthroscopy	5.80	NA	NA	4.59	4.79	0.99	090
29834		A	Elbow arthroscopy/surgery	6.33	NA	NA	4.99	5.21	1.08	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	NA	5.09	5.30	1.13	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	NA	5.77	6.04	1.22	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	NA	5.25	5.48	1.19	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	NA	5.82	6.11	1.30	090
29840		A	Wrist arthroscopy	5.59	NA	NA	4.71	4.88	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	NA	5.01	5.18	0.92	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	NA	4.98	5.20	1.04	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	NA	5.58	5.82	0.99	090
29846		A	Wrist arthroscopy/surgery	6.80	NA	NA	5.22	5.44	1.07	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	NA	5.38	5.60	1.08	090
29848		A	Wrist endoscopy/surgery	6.24	NA	NA	5.37	5.44	0.86	090
29850		A	Knee arthroscopy/surgery	8.18	NA	NA	5.30	5.24	1.25	090
29851		A	Knee arthroscopy/surgery	13.08	NA	NA	8.51	8.85	2.35	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	NA	7.51	7.84	1.85	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	NA	9.03	9.46	2.40	090
29860		A	Hip arthroscopy, dx	8.85	NA	NA	6.24	6.44	1.36	090
29861		A	Hip arthroscopy/surgery	9.95	NA	NA	6.81	6.96	1.59	090
29862		A	Hip arthroscopy/surgery	10.97	NA	NA	7.82	8.02	1.62	090
29863		A	Hip arthroscopy/surgery	10.97	NA	NA	7.72	7.94	1.42	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	NA	9.65	10.10	2.40	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29867		A	Allgrft implnt, knee w/scope	18.18	NA	NA	11.14	11.69	2.79	090
29868		A	Meniscal trnspl, knee w/scpe	24.89	NA	NA	13.89	14.65	4.36	090
29870		A	Knee arthroscopy, dx	5.11	NA	NA	4.28	4.44	0.85	090
29871		A	Knee arthroscopy/drainage	6.60	NA	NA	5.18	5.36	1.14	090
29873		A	Knee arthroscopy/surgery	6.09	NA	NA	5.69	5.92	1.04	090
29874		A	Knee arthroscopy/surgery	7.10	NA	NA	5.28	5.50	1.11	090
29875		A	Knee arthroscopy/surgery	6.36	NA	NA	4.99	5.22	1.09	090
29876		A	Knee arthroscopy/surgery	8.72	NA	NA	6.36	6.54	1.37	090
29877		A	Knee arthroscopy/surgery	8.15	NA	NA	6.13	6.30	1.28	090
29879		A	Knee arthroscopy/surgery	8.84	NA	NA	6.42	6.61	1.39	090
29880		A	Knee arthroscopy/surgery	9.30	NA	NA	6.62	6.82	1.47	090
29881		A	Knee arthroscopy/surgery	8.56	NA	NA	6.30	6.48	1.34	090
29882		A	Knee arthroscopy/surgery	9.45	NA	NA	6.65	6.81	1.50	090
29883		A	Knee arthroscopy/surgery	11.61	NA	NA	7.86	8.18	1.93	090
29884		A	Knee arthroscopy/surgery	8.13	NA	NA	6.11	6.28	1.27	090
29885		A	Knee arthroscopy/surgery	10.03	NA	NA	7.23	7.43	1.58	090
29886		A	Knee arthroscopy/surgery	8.34	NA	NA	6.22	6.40	1.30	090
29887		A	Knee arthroscopy/surgery	9.98	NA	NA	7.18	7.38	1.57	090
29888		A	Knee arthroscopy/surgery	14.14	NA	NA	8.87	9.23	2.42	090
29889		A	Knee arthroscopy/surgery	17.15	NA	NA	11.16	11.51	2.79	090
29891		A	Ankle arthroscopy/surgery	9.47	NA	NA	6.75	6.96	1.39	090
29892		A	Ankle arthroscopy/surgery	10.07	NA	NA	6.38	6.73	1.41	090
29893		A	Scope, plantar fasciotomy	6.08	8.52	7.98	4.54	4.41	0.63	090
29894		A	Ankle arthroscopy/surgery	7.26	NA	NA	4.83	5.00	1.15	090
29895		A	Ankle arthroscopy/surgery	7.04	NA	NA	4.58	4.82	1.11	090
29897		A	Ankle arthroscopy/surgery	7.23	NA	NA	4.94	5.19	1.17	090
29898		A	Ankle arthroscopy/surgery	8.38	NA	NA	5.28	5.52	1.28	090
29899		A	Ankle arthroscopy/surgery	15.21	NA	NA	9.41	9.72	2.41	090
29900		A	Mcp joint arthroscopy, dx	5.74	NA	NA	4.65	4.97	0.94	090
29901		A	Mcp joint arthroscopy, surg	6.45	NA	NA	4.92	5.27	1.06	090
29902		A	Mcp joint arthroscopy, surg	7.02	NA	NA	5.16	5.52	1.12	090
29904		A	Subtalar arthro w/fb rmvl	8.50	NA	NA	6.08	6.08	1.25	090
29905		A	Subtalar arthro w/exc	9.00	NA	NA	6.71	6.71	1.32	090
29906		A	Subtalar arthro w/deb	9.47	NA	NA	7.08	7.08	1.39	090
29907		A	Subtalar arthro w/fusion	12.00	NA	NA	8.15	8.15	1.90	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.45	4.02	4.04	1.38	1.38	0.12	010
30020		A	Drainage of nose lesion	1.45	4.04	3.86	1.38	1.40	0.12	010
30100		A	Intranasal biopsy	0.94	2.54	2.40	0.76	0.78	0.07	000
30110		A	Removal of nose polyp(s)	1.65	3.86	3.71	1.47	1.50	0.14	010
30115		A	Removal of nose polyp(s)	4.38	NA	NA	5.96	5.93	0.41	090
30117		A	Removal of intranasal lesion	3.20	17.78	16.66	4.89	4.83	0.26	090
30118		A	Removal of intranasal lesion	9.81	NA	NA	8.62	8.78	0.78	090
30120		A	Revision of nose	5.31	7.24	7.07	5.28	5.47	0.52	090
30124		A	Removal of nose lesion	3.14	NA	NA	3.31	3.39	0.25	090
30125		A	Removal of nose lesion	7.21	NA	NA	7.34	7.61	0.63	090
30130		A	Excise inferior turbinate	3.41	NA	NA	5.61	5.62	0.31	090
30140		A	Resect inferior turbinate	3.48	NA	NA	7.03	6.84	0.35	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
30150		A	Partial removal of nose	9.44	NA	NA	8.98	9.51	0.93	090
30160		A	Removal of nose	9.88	NA	NA	8.83	9.20	0.88	090
3016F		I	Pt scrnd unhlthy OH use	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	1.98	1.89	0.67	0.69	0.06	000
30210		A	Nasal sinus therapy	1.10	2.49	2.40	1.28	1.29	0.09	010
30220		A	Insert nasal septal button	1.56	5.74	5.37	1.44	1.47	0.12	010
30300		A	Remove nasal foreign body	1.06	4.22	4.33	1.85	1.87	0.08	010
30310		A	Remove nasal foreign body	1.98	NA	NA	2.89	2.95	0.16	010
30320		A	Remove nasal foreign body	4.56	NA	NA	6.02	6.29	0.39	090
30400		R	Reconstruction of nose	10.58	NA	NA	13.89	14.32	1.04	090
30410		R	Reconstruction of nose	13.72	NA	NA	14.72	15.67	1.42	090
30420		R	Reconstruction of nose	16.62	NA	NA	15.97	16.50	1.46	090
30430		R	Revision of nose	7.96	NA	NA	13.16	13.91	0.77	090
30435		R	Revision of nose	12.45	NA	NA	15.21	16.28	1.22	090
30450		R	Revision of nose	19.38	NA	NA	17.36	18.54	1.97	090
30460		A	Revision of nose	10.24	NA	NA	7.41	8.06	1.03	090
30462		A	Revision of nose	20.12	NA	NA	15.04	16.38	2.54	090
30465		A	Repair nasal stenosis	12.20	NA	NA	11.19	11.41	1.06	090
30520		A	Repair of nasal septum	6.85	NA	NA	8.05	7.72	0.46	090
30540		A	Repair nasal defect	7.81	NA	NA	8.02	8.35	0.67	090
30545		A	Repair nasal defect	11.50	NA	NA	11.17	11.38	1.71	090
30560		A	Release of nasal adhesions	1.28	5.19	5.10	2.02	2.05	0.10	010
30580		A	Repair upper jaw fistula	6.76	8.24	8.14	4.85	5.10	0.89	090
30600		A	Repair mouth/nose fistula	6.07	7.77	7.72	4.33	4.51	0.70	090
30620		A	Intranasal reconstruction	6.04	NA	NA	8.71	8.76	0.57	090
30630		A	Repair nasal septum defect	7.18	NA	NA	7.77	7.83	0.61	090
30801		A	Ablate inf turbinate, superf	1.11	4.27	4.25	2.12	2.08	0.09	010
30802		A	Cauterization, inner nose	2.05	4.91	4.85	2.51	2.48	0.16	010
30901		A	Control of nosebleed	1.21	1.26	1.29	0.32	0.32	0.11	000
30903		A	Control of nosebleed	1.54	3.21	3.09	0.45	0.46	0.13	000
30905		A	Control of nosebleed	1.97	3.87	3.79	0.54	0.60	0.17	000
30906		A	Repeat control of nosebleed	2.45	4.25	4.17	0.82	0.92	0.20	000
30915		A	Ligation, nasal sinus artery	7.36	NA	NA	6.52	6.57	0.58	090
30920		A	Ligation, upper jaw artery	11.03	NA	NA	9.05	9.05	0.80	090
30930		A	Ther fx, nasal inf turbinate	1.28	NA	NA	1.64	1.64	0.12	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.17	3.16	3.09	1.34	1.36	0.09	010
31002		A	Irrigation, sphenoid sinus	1.93	NA	NA	2.80	2.92	0.15	010
31020		A	Exploration, maxillary sinus	2.99	8.50	8.52	5.50	5.44	0.29	090
31030		A	Exploration, maxillary sinus	5.95	10.40	10.70	6.52	6.57	0.60	090
31032		A	Explore sinus, remove polyps	6.61	NA	NA	7.05	7.11	0.59	090
31040		A	Exploration behind upper jaw	9.66	NA	NA	7.84	8.35	0.87	090
31050		A	Exploration, sphenoid sinus	5.31	NA	NA	6.60	6.55	0.49	090
31051		A	Sphenoid sinus surgery	7.16	NA	NA	8.36	8.35	0.62	090
31070		A	Exploration of frontal sinus	4.32	NA	NA	6.17	6.13	0.38	090
31075		A	Exploration of frontal sinus	9.40	NA	NA	9.45	9.54	0.75	090
31080		A	Removal of frontal sinus	12.54	NA	NA	11.11	11.75	1.23	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31081		A	Removal of frontal sinus	13.99	NA	NA	15.36	15.05	2.47	090
31084		A	Removal of frontal sinus	14.75	NA	NA	13.82	13.78	1.19	090
31085		A	Removal of frontal sinus	15.44	NA	NA	14.53	14.42	1.73	090
31086		A	Removal of frontal sinus	14.16	NA	NA	12.71	12.88	1.07	090
31087		A	Removal of frontal sinus	14.39	NA	NA	11.98	12.15	1.44	090
31090		A	Exploration of sinuses	10.88	NA	NA	13.39	13.21	0.94	090
31200		A	Removal of ethmoid sinus	5.03	NA	NA	7.49	7.94	0.29	090
31201		A	Removal of ethmoid sinus	8.49	NA	NA	9.02	9.08	0.82	090
31205		A	Removal of ethmoid sinus	10.47	NA	NA	9.78	10.33	0.67	090
31225		A	Removal of upper jaw	26.44	NA	NA	18.37	18.27	1.59	090
31230		A	Removal of upper jaw	30.56	NA	NA	19.56	19.56	1.78	090
31231		A	Nasal endoscopy, dx	1.10	3.53	3.50	0.78	0.81	0.09	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.22	4.25	1.16	1.24	0.20	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.65	4.73	1.33	1.43	0.26	000
31237		A	Nasal/sinus endoscopy, surg	2.98	4.87	4.96	1.45	1.56	0.28	000
31238		A	Nasal/sinus endoscopy, surg	3.26	4.81	4.93	1.55	1.69	0.27	000
31239		A	Nasal/sinus endoscopy, surg	9.23	NA	NA	6.65	7.00	0.62	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.32	1.43	0.24	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	2.04	2.25	0.45	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	2.86	3.18	0.73	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	1.56	1.70	0.33	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	2.33	2.57	0.55	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	3.52	3.93	0.92	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	1.78	1.95	0.39	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	2.01	2.22	0.46	000
31290		A	Nasal/sinus endoscopy, surg	18.50	NA	NA	9.44	10.12	1.40	010
31291		A	Nasal/sinus endoscopy, surg	19.45	NA	NA	9.91	10.57	1.69	010
31292		A	Nasal/sinus endoscopy, surg	15.79	NA	NA	8.41	8.98	1.21	010
31293		A	Nasal/sinus endoscopy, surg	17.36	NA	NA	9.05	9.65	1.28	010
31294		A	Nasal/sinus endoscopy, surg	20.20	NA	NA	10.03	10.77	1.53	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.71	NA	NA	14.81	14.89	1.17	090
31320		A	Diagnostic incision, larynx	5.62	NA	NA	9.94	10.06	0.46	090
31360		A	Removal of larynx	29.57	NA	NA	20.50	19.60	1.38	090
31365		A	Removal of larynx	38.47	NA	NA	23.68	22.90	1.98	090
31367		A	Partial removal of larynx	30.23	NA	NA	22.93	22.72	1.79	090
31368		A	Partial removal of larynx	33.85	NA	NA	24.99	25.17	2.21	090
31370		A	Partial removal of larynx	27.23	NA	NA	22.57	22.54	1.75	090
31375		A	Partial removal of larynx	25.73	NA	NA	21.62	21.36	1.63	090
31380		A	Partial removal of larynx	25.23	NA	NA	21.21	21.11	1.71	090
31382		A	Partial removal of larynx	28.23	NA	NA	22.93	22.65	1.68	090
31390		A	Removal of larynx & pharynx	42.17	NA	NA	26.71	26.19	2.24	090
31395		A	Reconstruct larynx & pharynx	43.46	NA	NA	29.14	29.00	2.49	090
31400		A	Revision of larynx	11.48	NA	NA	12.60	12.92	0.83	090
31420		A	Removal of epiglottis	11.32	NA	NA	8.86	9.05	0.83	090
31500		A	Insert emergency airway	2.33	NA	NA	0.43	0.46	0.17	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.22	0.24	0.05	000
31505		A	Diagnostic laryngoscopy	0.61	1.40	1.42	0.59	0.60	0.05	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31510		A	Laryngoscopy with biopsy	1.92	3.20	3.24	1.05	1.10	0.16	000
31511		A	Remove foreign body, larynx	2.16	2.94	2.99	1.07	1.07	0.19	000
31512		A	Removal of larynx lesion	2.07	2.95	3.02	1.11	1.18	0.18	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.14	1.22	0.17	000
31515		A	Laryngoscopy for aspiration	1.80	3.23	3.31	0.93	0.96	0.14	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.21	1.30	0.20	000
31525		A	Dx laryngoscopy excl nb	2.63	3.43	3.49	1.28	1.38	0.21	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.30	1.41	0.21	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	1.49	1.59	0.26	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.19	1.26	0.19	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.31	1.41	0.22	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	1.49	1.61	0.29	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	1.66	1.81	0.29	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	1.51	1.63	0.26	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	1.65	1.80	0.29	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	1.85	2.03	0.33	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	2.00	2.20	0.37	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	2.67	2.88	0.37	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	3.81	4.11	0.78	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	2.29	2.51	0.43	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	2.49	2.72	0.49	000
31570		A	Laryngoscope w/vc inj	3.86	4.29	4.65	1.73	1.90	0.31	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	1.90	2.08	0.35	000
31575		A	Diagnostic laryngoscopy	1.10	1.69	1.74	0.78	0.81	0.09	000
31576		A	Laryngoscopy with biopsy	1.97	3.52	3.57	1.09	1.14	0.14	000
31577		A	Remove foreign body, larynx	2.47	3.37	3.47	1.19	1.28	0.21	000
31578		A	Removal of larynx lesion	2.84	3.98	4.07	1.40	1.43	0.23	000
31579		A	Diagnostic laryngoscopy	2.26	2.87	3.10	1.19	1.27	0.18	000
31580		A	Revision of larynx	14.46	NA	NA	14.42	14.83	1.00	090
31582		A	Revision of larynx	22.87	NA	NA	22.78	23.59	1.76	090
31584		A	Treat larynx fracture	20.35	NA	NA	16.05	16.61	1.72	090
31587		A	Revision of larynx	15.12	NA	NA	9.04	9.12	0.97	090
31588		A	Revision of larynx	14.62	NA	NA	12.66	12.93	1.06	090
31590		A	Reinnervate larynx	7.63	NA	NA	13.36	13.93	0.84	090
31595		A	Larynx nerve surgery	8.75	NA	NA	9.67	9.91	0.68	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	2.42	2.62	0.80	000
31601		A	Incision of windpipe	4.44	NA	NA	2.01	2.12	0.40	000
31603		A	Incision of windpipe	4.14	NA	NA	1.29	1.39	0.44	000
31605		A	Incision of windpipe	3.57	NA	NA	0.88	0.96	0.40	000
31610		A	Incision of windpipe	9.29	NA	NA	7.80	7.94	0.79	090
31611		A	Surgery/speech prosthesis	5.92	NA	NA	7.08	7.09	0.46	090
31612		A	Puncture/clear windpipe	0.91	1.06	1.07	0.27	0.29	0.08	000
31613		A	Repair windpipe opening	4.63	NA	NA	6.13	6.11	0.42	090
31614		A	Repair windpipe opening	8.47	NA	NA	9.62	9.42	0.58	090
31615		A	Visualization of windpipe	2.09	2.37	2.43	1.08	1.11	0.16	000
31620		A	Endobronchial us add-on	1.40	5.82	5.79	0.34	0.40	0.11	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.10	5.25	0.92	0.96	0.18	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31623		A	Dx bronchoscope/brush	2.88	5.78	5.96	0.91	0.94	0.13	000
31624		A	Dx bronchoscope/lavage	2.88	5.16	5.33	0.91	0.95	0.13	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.32	5.46	1.03	1.08	0.18	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.73	6.82	1.12	1.17	0.18	000
31629		A	Bronchoscopy/needle bx, each	4.09	11.56	12.26	1.20	1.25	0.16	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.32	1.42	0.32	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.47	1.55	0.34	000
31632		A	Bronchoscopy/lung bx, addÆl	1.03	0.84	0.83	0.25	0.26	0.18	ZZZ
31633		A	Bronchoscopy/needle bx addÆl	1.32	0.97	0.96	0.32	0.34	0.16	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	5.08	5.35	1.16	1.23	0.24	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.39	1.49	0.31	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.43	0.46	0.13	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	1.60	1.70	0.22	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	1.61	1.73	0.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	1.55	1.63	0.35	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.06	1.10	0.20	000
31645		A	Bronchoscopy, clear airways	3.16	4.59	4.74	0.98	1.02	0.16	000
31646		A	Bronchoscopy, reclear airway	2.72	4.32	4.46	0.87	0.90	0.14	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.62	6.05	0.71	0.74	0.15	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.32	0.33	0.07	000
31717		A	Bronchial brush biopsy	2.12	4.70	5.60	0.73	0.74	0.14	000
31720		A	Clearance of airways	1.06	NA	NA	0.28	0.29	0.07	000
31725		A	Clearance of airways	1.96	NA	NA	0.42	0.46	0.14	000
31730		A	Intro, windpipe wire/tube	2.85	24.90	19.26	0.81	0.86	0.21	000
31750		A	Repair of windpipe	15.19	NA	NA	17.51	17.56	1.05	090
31755		A	Repair of windpipe	17.19	NA	NA	24.23	24.36	1.29	090
31760		A	Repair of windpipe	23.36	NA	NA	10.75	10.76	2.95	090
31766		A	Reconstruction of windpipe	31.58	NA	NA	12.07	12.50	4.53	090
31770		A	Repair/graft of bronchus	23.48	NA	NA	9.25	9.52	2.84	090
31775		A	Reconstruct bronchus	24.51	NA	NA	8.77	9.55	3.02	090
31780		A	Reconstruct windpipe	19.70	NA	NA	9.23	9.71	1.65	090
31781		A	Reconstruct windpipe	24.77	NA	NA	10.20	10.71	2.25	090
31785		A	Remove windpipe lesion	18.29	NA	NA	8.02	8.58	1.59	090
31786		A	Remove windpipe lesion	25.34	NA	NA	10.69	11.32	3.30	090
31800		A	Repair of windpipe injury	8.10	NA	NA	8.74	8.89	0.79	090
31805		A	Repair of windpipe injury	13.34	NA	NA	6.72	6.86	1.83	090
31820		A	Closure of windpipe lesion	4.58	5.85	5.82	3.32	3.41	0.38	090
31825		A	Repair of windpipe defect	6.98	7.51	7.57	4.62	4.82	0.53	090
31830		A	Revise windpipe scar	4.54	5.93	5.90	3.61	3.71	0.44	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.20	NA	NA	6.30	6.20	1.26	090
32036		A	Exploration of chest	12.21	NA	NA	6.66	6.62	1.43	090
32095		A	Biopsy through chest wall	10.06	NA	NA	5.34	5.36	1.22	090
32100		A	Exploration/biopsy of chest	16.08	NA	NA	7.39	7.51	2.24	090
32110		A	Explore/repair chest	25.15	NA	NA	10.37	10.49	3.22	090
32120		A	Re-exploration of chest	14.27	NA	NA	7.13	7.13	1.63	090
32124		A	Explore chest free adhesions	15.33	NA	NA	7.32	7.31	1.90	090
32140		A	Removal of lung lesion(s)	16.54	NA	NA	7.71	7.72	1.97	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
32141		A	Remove/treat lung lesions	27.10	NA	NA	11.00	10.16	2.01	090
32150		A	Removal of lung lesion(s)	16.70	NA	NA	7.74	7.73	2.01	090
32151		A	Remove lung foreign body	16.82	NA	NA	8.21	8.18	2.04	090
32160		A	Open chest heart massage	13.02	NA	NA	6.09	5.89	1.31	090
32200		A	Drain, open, lung lesion	18.48	NA	NA	9.13	9.02	2.14	090
32201		A	Drain, percut, lung lesion	3.99	19.76	20.04	1.56	1.50	0.24	000
32215		A	Treat chest lining	12.93	NA	NA	6.62	6.70	1.69	090
32220		A	Release of lung	26.41	NA	NA	12.56	12.69	3.57	090
32225		A	Partial release of lung	16.63	NA	NA	7.81	7.79	2.07	090
32310		A	Removal of chest lining	15.16	NA	NA	7.26	7.31	2.00	090
32320		A	Free/remove chest lining	27.04	NA	NA	12.13	12.17	3.52	090
32400		A	Needle biopsy chest lining	1.76	2.17	2.17	0.62	0.60	0.10	000
32402		A	Open biopsy chest lining	8.89	NA	NA	4.97	5.02	1.07	090
32405		A	Biopsy, lung or mediastinum	1.93	0.76	0.74	0.76	0.73	0.11	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.79	0.76	0.12	000
32421		A	Thoracentesis for aspiration	1.54	2.40	2.57	0.51	0.50	0.08	000
32422		A	Thoracentesis w/tube insert	2.19	2.89	2.98	1.09	1.09	0.12	000
32440		A	Removal of lung	27.17	NA	NA	11.56	11.92	3.69	090
32442		A	Sleeve pneumonectomy	56.37	NA	NA	19.28	18.19	3.85	090
32445		A	Removal of lung	63.60	NA	NA	24.00	21.57	3.72	090
32480		A	Partial removal of lung	25.71	NA	NA	10.83	11.17	3.50	090
32482		A	Bilobectomy	27.28	NA	NA	11.79	12.10	3.67	090
32484		A	Segmentectomy	25.30	NA	NA	10.16	10.49	3.04	090
32486		A	Sleeve lobectomy	42.80	NA	NA	15.74	15.15	3.52	090
32488		A	Completion pneumonectomy	42.83	NA	NA	16.33	15.73	3.81	090
32491		R	Lung volume reduction	25.09	NA	NA	11.57	11.86	2.99	090
32500		A	Partial removal of lung	24.48	NA	NA	10.86	11.26	3.26	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.48	1.50	0.65	ZZZ
32503		A	Resect apical lung tumor	31.61	NA	NA	12.70	13.33	4.38	090
32504		A	Resect apical lung tum/chest	36.41	NA	NA	14.62	15.17	5.09	090
3250F		I	Nonprim loc anat bx site tum	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32540		A	Removal of lung lesion	30.22	NA	NA	12.58	11.87	2.08	090
32550		A	Insert pleural cath	4.17	14.81	16.14	1.63	1.64	0.42	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.05	1.13	0.43	000
32560		A	Treat lung lining chemically	2.19	4.98	5.36	0.63	0.65	0.23	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.21	2.25	0.80	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.35	2.40	0.87	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	3.00	3.01	1.14	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.36	3.39	1.25	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	2.59	2.67	1.00	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	3.15	3.21	1.22	000
32650		A	Thoracoscopy, surgical	10.77	NA	NA	5.47	5.81	1.58	090
32651		A	Thoracoscopy, surgical	18.70	NA	NA	8.05	7.87	1.87	090
32652		A	Thoracoscopy, surgical	29.00	NA	NA	11.80	11.41	2.73	090
32653		A	Thoracoscopy, surgical	18.09	NA	NA	7.80	7.61	1.89	090
32654		A	Thoracoscopy, surgical	20.44	NA	NA	8.47	8.26	1.63	090
32655		A	Thoracoscopy, surgical	16.09	NA	NA	7.25	7.26	1.90	090
32656		A	Thoracoscopy, surgical	13.18	NA	NA	6.22	6.66	1.90	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
32657		A	Thoracoscopy, surgical	12.85	NA	NA	6.28	6.64	2.00	090
32658		A	Thoracoscopy, surgical	11.65	NA	NA	5.87	6.25	1.70	090
32659		A	Thoracoscopy, surgical	11.86	NA	NA	6.03	6.40	1.62	090
32660		A	Thoracoscopy, surgical	17.69	NA	NA	7.75	8.20	2.09	090
32661		A	Thoracoscopy, surgical	13.27	NA	NA	6.31	6.70	1.93	090
32662		A	Thoracoscopy, surgical	14.91	NA	NA	6.94	7.43	2.18	090
32663		A	Thoracoscopy, surgical	24.56	NA	NA	10.02	10.23	2.73	090
32664		A	Thoracoscopy, surgical	14.22	NA	NA	6.55	6.83	2.33	090
32665		A	Thoracoscopy, surgical	21.45	NA	NA	8.99	8.80	2.16	090
32800		A	Repair lung hernia	15.59	NA	NA	7.34	7.38	1.99	090
32810		A	Close chest after drainage	14.83	NA	NA	7.32	7.39	1.94	090
32815		A	Close bronchial fistula	49.79	NA	NA	19.65	17.52	3.28	090
32820		A	Reconstruct injured chest	22.33	NA	NA	10.59	11.01	2.53	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	40.94	NA	NA	21.53	23.12	5.58	090
32852		A	Lung transplant with bypass	44.65	NA	NA	24.03	26.38	6.02	090
32853		A	Lung transplant, double	50.11	NA	NA	24.19	26.15	7.07	090
32854		A	Lung transplant with bypass	53.88	NA	NA	27.66	29.50	7.22	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.69	NA	NA	10.10	10.07	2.94	090
32905		A	Revise & repair chest wall	23.17	NA	NA	9.87	9.96	3.16	090
32906		A	Revise & repair chest wall	29.18	NA	NA	11.83	11.92	3.98	090
32940		A	Revision of lung	21.22	NA	NA	9.00	9.14	2.89	090
32960		A	Therapeutic pneumothorax	1.84	1.69	1.70	0.77	0.72	0.16	000
32997		A	Total lung lavage	7.31	NA	NA	1.83	1.86	0.55	000
32998		A	Perq rf ablate tx, pul tumor	5.68	68.21	68.21	2.35	2.35	0.36	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	1.07	1.00	0.14	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.96	0.92	0.15	000
33015		A	Incision of heart sac	8.44	NA	NA	5.39	5.29	0.65	090
33020		A	Incision of heart sac	14.87	NA	NA	6.77	6.79	1.80	090
33025		A	Incision of heart sac	13.65	NA	NA	6.20	6.25	1.81	090
33030		A	Partial removal of heart sac	22.27	NA	NA	9.61	9.61	2.84	090
33031		A	Partial removal of heart sac	25.30	NA	NA	10.37	10.31	3.14	090
33050		A	Removal of heart sac lesion	16.85	NA	NA	7.80	7.83	2.15	090
33120		A	Removal of heart lesion	27.33	NA	NA	11.36	11.44	3.70	090
33130		A	Removal of heart lesion	24.05	NA	NA	10.28	10.26	3.01	090
33140		A	Heart revascularize (tmr)	28.26	NA	NA	11.35	11.26	2.86	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.84	1.03	0.69	ZZZ
33202		A	Insert epicard eltrd, open	13.15	NA	NA	6.31	6.31	1.71	090
33203		A	Insert epicard eltrd, endo	13.92	NA	NA	6.87	6.87	1.39	090
33206		A	Insertion of heart pacemaker	7.31	NA	NA	5.13	4.97	0.52	090
33207		A	Insertion of heart pacemaker	8.00	NA	NA	5.25	5.12	0.59	090
33208		A	Insertion of heart pacemaker	8.72	NA	NA	5.69	5.47	0.56	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.68	1.58	0.18	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.55	1.49	0.21	000
33212		A	Insertion of pulse generator	5.51	NA	NA	3.72	3.64	0.43	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33213		A	Insertion of pulse generator	6.36	NA	NA	4.23	4.11	0.45	090
33214		A	Upgrade of pacemaker system	7.78	NA	NA	5.28	5.19	0.58	090
33215		A	Reposition pacing-defib lead	4.89	NA	NA	3.47	3.40	0.37	090
33216		A	Insert lead pace-defib, one	5.81	NA	NA	4.54	4.47	0.36	090
33217		A	Insert lead pace-defib, dual	5.78	NA	NA	4.43	4.39	0.39	090
33218		A	Repair lead pace-defib, one	5.97	NA	NA	4.77	4.66	0.37	090
3321F		I	AJCC cncr 0/IA melan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.05	NA	NA	4.80	4.68	0.37	090
33222		A	Revise pocket, pacemaker	5.01	NA	NA	4.28	4.29	0.42	090
33223		A	Revise pocket, pacing-defib	6.49	NA	NA	4.85	4.80	0.45	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	4.96	4.73	0.54	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	4.38	4.11	0.45	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	4.82	4.58	0.59	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.33	NA	NA	3.21	3.23	0.22	090
33234		A	Removal of pacemaker system	7.85	NA	NA	5.47	5.34	0.56	090
33235		A	Removal pacemaker electrode	9.93	NA	NA	7.20	7.12	0.73	090
33236		A	Remove electrode/thoracotomy	12.64	NA	NA	6.71	6.91	1.69	090
33237		A	Remove electrode/thoracotomy	13.75	NA	NA	8.10	8.04	1.59	090
33238		A	Remove electrode/thoracotomy	15.28	NA	NA	7.93	8.01	2.03	090
33240		A	Insert pulse generator	7.61	NA	NA	5.23	5.08	0.41	090
33241		A	Remove pulse generator	3.26	NA	NA	2.95	2.96	0.18	090
33243		A	Remove eltrd/thoracotomy	23.42	NA	NA	11.37	11.42	2.10	090
33244		A	Remove eltrd, transven	13.84	NA	NA	9.45	9.33	0.99	090
33249		A	Eltrd/insert pace-defib	15.02	NA	NA	10.10	9.68	0.77	090
33250		A	Ablate heart dysrhythm focus	25.78	NA	NA	10.81	10.89	3.19	090
33251		A	Ablate heart dysrhythm focus	28.80	NA	NA	11.80	11.79	3.60	090
33254		A	Ablate atria, lmtd	23.58	NA	NA	10.38	10.38	3.35	090
33255		A	Ablate atria w/o bypass, ext	28.91	NA	NA	12.74	12.74	3.94	090
33256		A	Ablate atria w/bypass, exten	34.77	NA	NA	14.73	14.73	4.95	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.05	5.05	0.89	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.52	5.52	1.09	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	7.18	7.18	1.78	ZZZ
33261		A	Ablate heart dysrhythm focus	28.80	NA	NA	11.60	11.67	3.46	090
33265		A	Ablate atria, lmtd, endo	23.58	NA	NA	10.30	10.30	3.35	090
33266		A	Ablate atria, x10sv, endo	32.91	NA	NA	13.44	13.44	4.80	090
33282		A	Implant pat-active ht record	4.70	NA	NA	4.19	4.15	0.23	090
33284		A	Remove pat-active ht record	3.04	NA	NA	3.30	3.36	0.14	090
33300		A	Repair of heart wound	44.89	NA	NA	16.33	14.59	2.66	090
33305		A	Repair of heart wound	76.85	NA	NA	27.40	23.25	3.13	090
33310		A	Exploratory heart surgery	20.22	NA	NA	8.78	9.00	2.59	090
33315		A	Exploratory heart surgery	26.05	NA	NA	11.16	11.11	3.28	090
33320		A	Repair major blood vessel(s)	18.46	NA	NA	8.19	8.21	2.08	090
33321		A	Repair major vessel	20.71	NA	NA	8.69	8.99	2.91	090
33322		A	Repair major blood vessel(s)	24.30	NA	NA	10.55	10.53	2.86	090
33330		A	Insert major vessel graft	25.17	NA	NA	9.91	10.02	2.82	090
33332		A	Insert major vessel graft	24.46	NA	NA	10.54	10.56	3.03	090
33335		A	Insert major vessel graft	33.79	NA	NA	13.35	13.37	4.28	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33400		A	Repair of aortic valve	41.37	NA	NA	16.25	16.14	4.11	090
33401		A	Valvuloplasty, open	24.41	NA	NA	12.90	13.08	3.57	090
33403		A	Valvuloplasty, w/cp bypass	25.39	NA	NA	11.59	12.30	3.55	090
33404		A	Prepare heart-aorta conduit	31.25	NA	NA	12.85	13.31	4.33	090
33405		A	Replacement of aortic valve	41.19	NA	NA	16.19	16.75	5.33	090
33406		A	Replacement of aortic valve	52.55	NA	NA	19.80	19.68	5.45	090
33410		A	Replacement of aortic valve	46.28	NA	NA	17.80	17.54	4.69	090
33411		A	Replacement of aortic valve	61.94	NA	NA	22.76	21.81	5.48	090
33412		A	Replacement of aortic valve	43.77	NA	NA	17.60	18.35	6.39	090
33413		A	Replacement of aortic valve	59.74	NA	NA	22.44	22.08	6.53	090
33414		A	Repair of aortic valve	39.29	NA	NA	15.60	15.27	4.57	090
33415		A	Revision, subvalvular tissue	37.19	NA	NA	13.86	13.43	4.14	090
33416		A	Revise ventricle muscle	36.43	NA	NA	14.34	14.16	4.57	090
33417		A	Repair of aortic valve	29.17	NA	NA	12.54	12.84	4.10	090
33420		A	Revision of mitral valve	25.67	NA	NA	9.31	9.40	1.82	090
33422		A	Revision of mitral valve	29.61	NA	NA	12.32	12.68	3.94	090
33425		A	Repair of mitral valve	49.83	NA	NA	18.83	17.42	4.07	090
33426		A	Repair of mitral valve	43.15	NA	NA	16.92	17.01	5.03	090
33427		A	Repair of mitral valve	44.70	NA	NA	16.85	17.52	6.09	090
33430		A	Replacement of mitral valve	50.75	NA	NA	19.92	19.31	5.10	090
33460		A	Revision of tricuspid valve	44.62	NA	NA	16.62	15.33	3.45	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	NA	21.13	19.12	3.87	090
33464		A	Valvuloplasty, tricuspid	44.49	NA	NA	16.94	16.12	4.15	090
33465		A	Replace tricuspid valve	50.59	NA	NA	18.84	17.41	4.39	090
33468		A	Revision of tricuspid valve	32.82	NA	NA	14.77	14.52	4.07	090
33470		A	Revision of pulmonary valve	21.32	NA	NA	9.20	9.60	1.03	090
33471		A	Valvotomy, pulmonary valve	22.83	NA	NA	10.28	10.17	3.39	090
33472		A	Revision of pulmonary valve	22.90	NA	NA	9.80	10.34	3.55	090
33474		A	Revision of pulmonary valve	39.27	NA	NA	13.91	13.18	3.22	090
33475		A	Replacement, pulmonary valve	42.27	NA	NA	16.11	15.96	4.93	090
33476		A	Revision of heart chamber	26.41	NA	NA	10.54	10.92	2.42	090
33478		A	Revision of heart chamber	27.38	NA	NA	11.51	11.92	3.89	090
33496		A	Repair, prosth valve clot	29.71	NA	NA	12.16	12.34	4.13	090
33500		A	Repair heart vessel fistula	27.82	NA	NA	11.67	11.64	3.87	090
33501		A	Repair heart vessel fistula	19.43	NA	NA	8.51	8.47	1.91	090
33502		A	Coronary artery correction	21.69	NA	NA	9.66	10.03	3.00	090
33503		A	Coronary artery graft	22.29	NA	NA	13.62	12.68	1.78	090
33504		A	Coronary artery graft	25.30	NA	NA	10.63	10.95	3.36	090
33505		A	Repair artery w/tunnel	38.35	NA	NA	13.09	13.07	2.19	090
33506		A	Repair artery, translocation	37.80	NA	NA	13.69	13.94	4.66	090
33507		A	Repair art, intramural	31.35	NA	NA	11.87	12.35	4.06	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.10	0.10	0.04	ZZZ
33510		A	CABG, vein, single	34.87	NA	NA	13.83	14.49	4.41	090
33511		A	CABG, vein, two	38.34	NA	NA	15.20	15.70	4.56	090
33512		A	CABG, vein, three	43.87	NA	NA	17.13	17.29	4.67	090
33513		A	CABG, vein, four	45.26	NA	NA	16.86	17.13	4.88	090
33514		A	CABG, vein, five	47.97	NA	NA	18.49	18.42	4.77	090
33516		A	Cabg, vein, six or more	49.65	NA	NA	19.37	19.27	5.13	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.18	1.10	0.39	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.59	2.34	0.73	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.44	3.17	1.04	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	NA	4.13	3.87	1.37	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	4.63	4.44	1.78	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	5.23	5.06	2.13	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	3.30	2.96	0.88	ZZZ
33533		A	CABG, arterial, single	33.64	NA	NA	13.47	14.26	4.56	090
33534		A	CABG, arterial, two	39.77	NA	NA	15.80	16.31	4.70	090
33535		A	CABG, arterial, three	44.64	NA	NA	17.55	17.74	5.03	090
33536		A	Cabg, arterial, four or more	48.32	NA	NA	18.47	18.47	5.44	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.08	NA	NA	18.04	16.82	4.38	090
33545		A	Repair of heart damage	56.93	NA	NA	20.88	19.61	5.21	090
33548		A	Restore/remodel, ventricle	53.96	NA	NA	21.39	20.91	5.53	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.44	1.44	0.65	ZZZ
33600		A	Closure of valve	30.15	NA	NA	12.46	12.50	4.42	090
33602		A	Closure of valve	29.18	NA	NA	11.42	11.70	3.82	090
33606		A	Anastomosis/artery-aorta	31.37	NA	NA	12.75	13.01	4.41	090
33608		A	Repair anomaly w/conduit	31.72	NA	NA	13.54	13.72	4.74	090
33610		A	Repair by enlargement	31.24	NA	NA	12.93	13.13	4.56	090
33611		A	Repair double ventricle	35.49	NA	NA	13.48	13.68	4.37	090
33612		A	Repair double ventricle	36.49	NA	NA	13.26	13.76	5.30	090
33615		A	Repair, modified fontan	35.76	NA	NA	15.56	14.99	4.32	090
33617		A	Repair single ventricle	38.96	NA	NA	14.33	14.78	5.66	090
33619		A	Repair single ventricle	48.60	NA	NA	16.40	17.54	6.46	090
33641		A	Repair heart septum defect	29.50	NA	NA	11.64	11.15	3.23	090
33645		A	Revision of heart veins	27.98	NA	NA	11.62	11.68	3.79	090
33647		A	Repair heart septum defects	29.37	NA	NA	13.11	13.31	3.32	090
33660		A	Repair of heart defects	31.75	NA	NA	11.80	12.25	4.49	090
33665		A	Repair of heart defects	34.77	NA	NA	13.23	13.41	4.00	090
33670		A	Repair of heart chambers	36.58	NA	NA	13.14	13.18	4.65	090
33675		A	Close mult vsd	35.87	NA	NA	13.60	13.60	4.95	090
33676		A	Close mult vsd w/resection	36.87	NA	NA	14.44	14.44	5.44	090
33677		A	Cl mult vsd w/rem pul band	38.37	NA	NA	14.94	14.94	5.68	090
33681		A	Repair heart septum defect	32.16	NA	NA	13.35	13.71	4.45	090
33684		A	Repair heart septum defect	34.29	NA	NA	13.09	13.26	3.39	090
33688		A	Repair heart septum defect	34.67	NA	NA	12.71	12.18	4.73	090
33690		A	Reinforce pulmonary artery	20.20	NA	NA	8.93	9.26	1.97	090
33692		A	Repair of heart defects	31.38	NA	NA	12.22	12.68	4.58	090
33694		A	Repair of heart defects	35.49	NA	NA	13.95	14.05	5.28	090
33697		A	Repair of heart defects	37.49	NA	NA	17.62	16.97	4.09	090
33702		A	Repair of heart defects	27.11	NA	NA	10.85	11.31	3.68	090
33710		A	Repair of heart defects	30.28	NA	NA	17.07	16.33	4.43	090
33720		A	Repair of heart defect	27.13	NA	NA	11.53	11.74	3.84	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33722		A	Repair of heart defect	29.05	NA	NA	10.37	11.27	1.30	090
33724		A	Repair venous anomaly	27.55	NA	NA	11.83	11.83	4.00	090
33726		A	Repair pul venous stenosis	37.04	NA	NA	14.50	14.50	5.03	090
33730		A	Repair heart-vein defect(s)	36.01	NA	NA	12.48	12.92	5.03	090
33732		A	Repair heart-vein defect	28.80	NA	NA	12.08	12.44	3.68	090
33735		A	Revision of heart chamber	22.04	NA	NA	10.26	9.96	1.92	090
33736		A	Revision of heart chamber	24.16	NA	NA	10.55	10.90	3.09	090
33737		A	Revision of heart chamber	22.34	NA	NA	9.81	10.12	3.25	090
33750		A	Major vessel shunt	22.06	NA	NA	12.65	12.07	1.16	090
33755		A	Major vessel shunt	22.44	NA	NA	10.10	9.80	3.26	090
33762		A	Major vessel shunt	22.44	NA	NA	9.68	9.82	3.14	090
33764		A	Major vessel shunt & graft	22.44	NA	NA	9.08	9.39	3.01	090
33766		A	Major vessel shunt	23.41	NA	NA	11.32	11.43	3.70	090
33767		A	Major vessel shunt	25.14	NA	NA	9.38	9.99	3.82	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	2.68	2.68	1.19	ZZZ
33770		A	Repair great vessels defect	39.02	NA	NA	14.28	14.41	5.74	090
33771		A	Repair great vessels defect	40.58	NA	NA	14.90	14.30	5.68	090
33774		A	Repair great vessels defect	31.54	NA	NA	13.17	13.58	4.81	090
33775		A	Repair great vessels defect	32.83	NA	NA	13.79	14.12	4.99	090
33776		A	Repair great vessels defect	34.53	NA	NA	14.66	14.98	5.09	090
33777		A	Repair great vessels defect	33.95	NA	NA	13.68	14.20	5.49	090
33778		A	Repair great vessels defect	42.62	NA	NA	16.81	16.87	6.20	090
33779		A	Repair great vessels defect	43.15	NA	NA	16.00	15.88	2.92	090
33780		A	Repair great vessels defect	43.85	NA	NA	16.40	17.12	3.68	090
33781		A	Repair great vessels defect	43.16	NA	NA	15.76	15.19	5.97	090
33786		A	Repair arterial trunk	41.74	NA	NA	15.41	15.77	5.71	090
33788		A	Revision of pulmonary artery	27.26	NA	NA	11.29	11.48	4.03	090
33800		A	Aortic suspension	17.23	NA	NA	6.76	7.11	2.46	090
33802		A	Repair vessel defect	18.24	NA	NA	7.83	8.20	2.27	090
33803		A	Repair vessel defect	20.18	NA	NA	7.49	8.08	3.20	090
33813		A	Repair septal defect	21.23	NA	NA	11.29	11.22	3.13	090
33814		A	Repair septal defect	26.41	NA	NA	11.30	11.67	3.85	090
33820		A	Revise major vessel	16.61	NA	NA	7.67	7.86	2.35	090
33822		A	Revise major vessel	17.63	NA	NA	7.97	8.23	2.68	090
33824		A	Revise major vessel	20.10	NA	NA	8.96	9.23	2.89	090
33840		A	Remove aorta constriction	21.21	NA	NA	8.43	8.92	2.16	090
33845		A	Remove aorta constriction	22.77	NA	NA	11.61	11.57	3.22	090
33851		A	Remove aorta constriction	21.85	NA	NA	9.13	9.54	3.18	090
33852		A	Repair septal defect	24.28	NA	NA	10.41	10.67	2.16	090
33853		A	Repair septal defect	32.35	NA	NA	14.87	14.89	4.48	090
33860		A	Ascending aortic graft	59.33	NA	NA	21.84	20.54	5.76	090
33861		A	Ascending aortic graft	43.94	NA	NA	16.81	17.08	6.37	090
33863		A	Ascending aortic graft	58.71	NA	NA	21.10	20.55	6.59	090
33864		A	Ascending aortic graft	60.00	NA	NA	21.50	21.50	6.73	090
33870		A	Transverse aortic arch graft	45.93	NA	NA	17.53	17.78	6.62	090
33875		A	Thoracic aortic graft	35.68	NA	NA	13.84	13.93	4.89	090
33877		A	Thoracoabdominal graft	68.85	NA	NA	22.60	21.08	5.94	090
33880		A	Endovasc taa repr incl subcl	34.48	NA	NA	11.90	12.32	2.75	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33881		A	Endovasc taa repr w/o subcl	29.48	NA	NA	10.28	10.72	2.33	090
33883		A	Insert endovasc prosth, taa	20.99	NA	NA	7.73	8.11	2.11	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.30	2.37	0.86	ZZZ
33886		A	Endovasc prosth, delayed	17.99	NA	NA	6.60	7.02	1.80	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	4.27	4.51	2.18	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	5.06	5.55	2.73	000
33910		A	Remove lung artery emboli	29.59	NA	NA	12.42	12.20	3.70	090
33915		A	Remove lung artery emboli	24.83	NA	NA	9.52	9.57	1.44	090
33916		A	Surgery of great vessel	28.30	NA	NA	14.33	13.61	3.67	090
33917		A	Repair pulmonary artery	25.14	NA	NA	12.64	12.55	3.70	090
33920		A	Repair pulmonary atresia	32.58	NA	NA	12.59	12.93	4.38	090
33922		A	Transect pulmonary artery	24.09	NA	NA	10.32	10.49	3.10	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.65	1.70	0.82	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.25	NA	NA	12.16	12.82	4.61	090
33926		A	Repr pul art, unifocal w/cpb	44.68	NA	NA	12.49	13.82	6.22	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	61.68	NA	NA	23.72	25.04	9.06	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.08	NA	NA	32.74	29.97	6.26	090
33960		A	External circulation assist	19.33	NA	NA	6.04	5.77	2.67	000
33961		A	External circulation assist	10.91	NA	NA	3.42	3.48	0.88	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	2.45	2.31	0.35	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.27	0.26	0.07	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.73	2.62	0.82	000
33971		A	Aortic circulation assist	11.91	NA	NA	6.39	6.31	1.25	090
33973		A	Insert balloon device	9.75	NA	NA	4.02	3.85	1.26	000
33974		A	Remove intra-aortic balloon	14.93	NA	NA	8.26	8.19	1.74	090
33975		A	Implant ventricular device	20.97	NA	NA	7.00	6.84	3.07	XXX
33976		A	Implant ventricular device	22.97	NA	NA	8.18	8.04	3.26	XXX
33977		A	Remove ventricular device	20.07	NA	NA	9.89	10.21	2.81	090
33978		A	Remove ventricular device	22.51	NA	NA	10.28	10.68	3.31	090
33979		A	Insert intracorporeal device	45.93	NA	NA	14.85	14.90	6.97	XXX
33980		A	Remove intracorporeal device	64.86	NA	NA	25.77	25.70	8.59	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.78	NA	NA	6.86	6.84	1.85	090
34051		A	Removal of artery clot	16.91	NA	NA	7.46	7.56	2.21	090
34101		A	Removal of artery clot	10.85	NA	NA	4.44	4.68	1.41	090
34111		A	Removal of arm artery clot	10.85	NA	NA	4.45	4.68	1.40	090
34151		A	Removal of artery clot	26.41	NA	NA	8.93	9.32	3.56	090
34201		A	Removal of artery clot	19.38	NA	NA	6.83	6.49	1.45	090
34203		A	Removal of leg artery clot	17.73	NA	NA	6.66	7.03	2.36	090
34401		A	Removal of vein clot	26.41	NA	NA	10.85	10.83	3.10	090
34421		A	Removal of vein clot	13.29	NA	NA	5.39	5.63	1.55	090
34451		A	Removal of vein clot	28.41	NA	NA	9.72	10.18	3.84	090
34471		A	Removal of vein clot	21.00	NA	NA	7.56	7.01	1.18	090
34490		A	Removal of vein clot	10.83	NA	NA	4.56	4.79	1.41	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
34501		A	Repair valve, femoral vein	16.74	NA	NA	6.97	7.37	2.35	090
34502		A	Reconstruct vena cava	27.86	NA	NA	10.89	11.27	3.63	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.80	NA	NA	7.22	7.79	2.33	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.05	NA	NA	7.04	7.41	2.29	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.77	NA	NA	6.95	7.38	1.74	090
3455F		I	TB scrng done-interpd 6mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3470F		I	RA disease activity, low	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3471F		I	RA disease activity, mod	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3472F		I	RA disease activity, high	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3475F		I	Disease progn RA poor docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3476F		I	Disease progn RA good docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34800		A	Endovas aaa repr w/sm tube	21.46	NA	NA	7.86	8.21	2.46	090
34802		A	Endovas aaa repr w/2-p part	23.71	NA	NA	8.60	8.92	2.33	090
34803		A	Endovas aaa repr w/3-p part	24.74	NA	NA	8.42	8.89	2.01	090
34804		A	Endovas aaa repr w/1-p part	23.71	NA	NA	8.60	8.92	2.30	090
34805		A	Endovas aaa repr w/long tube	22.59	NA	NA	7.62	8.15	2.01	090
34806		A	Aneurysm press sensor add-on	2.06	0.64	0.64	0.64	0.64	0.30	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.13	1.19	0.59	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	1.79	1.91	1.18	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.23	1.32	0.67	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	2.66	2.81	1.50	000
34825		A	Endovasc extend prosth, init	12.72	NA	NA	5.37	5.58	1.28	090
34826		A	Endovasc exten prosth, addÆl	4.12	NA	NA	1.20	1.25	0.44	ZZZ
34830		A	Open aortic tube prosth repr	35.10	NA	NA	11.23	11.87	4.55	090
34831		A	Open aortoiliac prosth repr	37.85	NA	NA	11.87	11.86	4.89	090
34832		A	Open aortofemor prosth repr	37.85	NA	NA	11.94	12.64	4.85	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	3.51	3.75	1.70	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	1.66	1.80	0.76	000
34900		A	Endovasc iliac repr w/graft	16.77	NA	NA	6.47	6.76	2.00	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.70	NA	NA	8.04	8.44	2.81	090
35002		A	Repair artery rupture, neck	22.12	NA	NA	8.24	8.62	3.00	090
35005		A	Repair defect of artery	19.18	NA	NA	7.87	8.13	1.77	090
35011		A	Repair defect of artery	18.50	NA	NA	6.67	7.01	2.55	090
35013		A	Repair artery rupture, arm	23.10	NA	NA	8.20	8.59	3.10	090
35021		A	Repair defect of artery	22.09	NA	NA	8.99	9.12	2.87	090
35022		A	Repair artery rupture, chest	25.62	NA	NA	9.61	9.70	3.17	090
35045		A	Repair defect of arm artery	17.94	NA	NA	6.66	6.89	2.45	090
35081		A	Repair defect of artery	33.37	NA	NA	11.30	11.36	4.01	090
35082		A	Repair artery rupture, aorta	41.93	NA	NA	13.49	13.98	5.44	090
35091		A	Repair defect of artery	35.35	NA	NA	10.60	11.37	5.14	090
35092		A	Repair artery rupture, aorta	50.81	NA	NA	15.43	16.02	6.40	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35102		A	Repair defect of artery	36.37	NA	NA	11.94	12.07	4.48	090
35103		A	Repair artery rupture, groin	43.49	NA	NA	13.59	14.19	5.76	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.17	NA	NA	9.06	9.43	3.47	090
35112		A	Repair artery rupture,spleen	32.44	NA	NA	11.03	11.29	4.08	090
3511F		I	Chlmyd/gonrh tsts docd done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35121		A	Repair defect of artery	31.41	NA	NA	10.15	10.73	4.30	090
35122		A	Repair artery rupture, belly	37.76	NA	NA	12.63	12.95	4.75	090
3512F		I	Syph scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35131		A	Repair defect of artery	26.29	NA	NA	9.15	9.57	3.80	090
35132		A	Repair artery rupture, groin	32.44	NA	NA	10.61	11.08	4.30	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.83	NA	NA	7.25	7.69	2.90	090
35142		A	Repair artery rupture, thigh	25.03	NA	NA	8.73	9.16	3.36	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.61	NA	NA	8.06	8.57	3.24	090
35152		A	Repair artery rupture, knee	27.53	NA	NA	9.43	9.94	3.61	090
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.01	NA	NA	7.23	7.17	1.00	090
35182		A	Repair blood vessel lesion	31.58	NA	NA	12.25	12.41	4.36	090
35184		A	Repair blood vessel lesion	18.72	NA	NA	6.84	7.22	2.53	090
35188		A	Repair blood vessel lesion	15.05	NA	NA	6.35	6.69	2.16	090
35189		A	Repair blood vessel lesion	29.85	NA	NA	10.30	10.73	4.01	090
35190		A	Repair blood vessel lesion	13.33	NA	NA	5.43	5.71	1.80	090
35201		A	Repair blood vessel lesion	16.84	NA	NA	6.64	6.99	2.34	090
35206		A	Repair blood vessel lesion	13.76	NA	NA	5.46	5.74	1.87	090
35207		A	Repair blood vessel lesion	10.85	NA	NA	6.81	6.96	1.48	090
35211		A	Repair blood vessel lesion	24.50	NA	NA	10.07	10.23	3.20	090
35216		A	Repair blood vessel lesion	36.47	NA	NA	14.34	13.03	2.65	090
35221		A	Repair blood vessel lesion	26.54	NA	NA	8.86	9.15	3.37	090
35226		A	Repair blood vessel lesion	15.22	NA	NA	5.96	6.34	2.02	090
35231		A	Repair blood vessel lesion	21.08	NA	NA	8.50	8.83	2.89	090
35236		A	Repair blood vessel lesion	17.94	NA	NA	6.65	6.98	2.43	090
35241		A	Repair blood vessel lesion	25.50	NA	NA	10.46	10.65	3.53	090
35246		A	Repair blood vessel lesion	28.15	NA	NA	11.00	11.13	3.86	090
35251		A	Repair blood vessel lesion	31.83	NA	NA	10.07	10.52	4.13	090
35256		A	Repair blood vessel lesion	18.98	NA	NA	6.75	7.17	2.63	090
35261		A	Repair blood vessel lesion	18.88	NA	NA	7.42	7.59	2.61	090
35266		A	Repair blood vessel lesion	15.75	NA	NA	5.95	6.23	2.10	090
35271		A	Repair blood vessel lesion	24.50	NA	NA	10.07	10.20	3.16	090
35276		A	Repair blood vessel lesion	25.72	NA	NA	10.35	10.59	3.49	090
35281		A	Repair blood vessel lesion	29.93	NA	NA	10.10	10.53	3.97	090
35286		A	Repair blood vessel lesion	17.06	NA	NA	6.60	6.98	2.35	090
35301		A	Rechanneling of artery	19.53	NA	NA	7.03	7.40	2.68	090
35302		A	Rechanneling of artery	21.27	NA	NA	7.28	7.28	2.98	090
35303		A	Rechanneling of artery	23.52	NA	NA	7.91	7.91	3.26	090
35304		A	Rechanneling of artery	24.52	NA	NA	8.15	8.15	3.41	090
35305		A	Rechanneling of artery	23.52	NA	NA	7.87	7.87	3.26	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35306		A	Rechanneling of artery	9.25	NA	NA	2.41	2.41	1.34	ZZZ
35311		A	Rechanneling of artery	28.52	NA	NA	9.86	10.36	3.42	090
35321		A	Rechanneling of artery	16.51	NA	NA	6.07	6.41	2.25	090
35331		A	Rechanneling of artery	27.61	NA	NA	9.75	10.15	3.83	090
35341		A	Rechanneling of artery	26.10	NA	NA	8.78	9.32	3.78	090
35351		A	Rechanneling of artery	24.53	NA	NA	8.10	8.50	3.35	090
35355		A	Rechanneling of artery	19.78	NA	NA	6.72	7.08	2.67	090
35361		A	Rechanneling of artery	30.11	NA	NA	10.11	10.53	4.15	090
35363		A	Rechanneling of artery	32.22	NA	NA	12.00	12.17	4.33	090
35371		A	Rechanneling of artery	15.23	NA	NA	5.56	5.92	2.14	090
35372		A	Rechanneling of artery	18.50	NA	NA	6.42	6.84	2.63	090
35390		A	Reoperation, carotid add-on	3.19	NA	NA	0.88	0.93	0.46	ZZZ
35400		A	Angioscopy	3.00	NA	NA	0.83	0.90	0.43	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.19	3.29	1.25	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.20	2.31	0.94	000
35454		A	Repair arterial blockage	6.03	NA	NA	1.92	2.02	0.87	000
35456		A	Repair arterial blockage	7.34	NA	NA	2.28	2.41	1.04	000
35458		A	Repair arterial blockage	9.48	NA	NA	2.94	3.08	1.26	000
35459		A	Repair arterial blockage	8.62	NA	NA	2.78	2.88	1.21	000
35460		A	Repair venous blockage	6.03	NA	NA	1.86	1.97	0.83	000
35470		A	Repair arterial blockage	8.62	59.34	66.89	3.58	3.53	0.69	000
35471		A	Repair arterial blockage	10.05	63.65	72.99	4.78	4.58	0.67	000
35472		A	Repair arterial blockage	6.90	45.87	50.62	2.79	2.79	0.58	000
35473		A	Repair arterial blockage	6.03	45.13	48.93	2.58	2.55	0.51	000
35474		A	Repair arterial blockage	7.35	58.59	66.04	3.09	3.05	0.57	000
35475		R	Repair arterial blockage	9.48	47.42	49.71	3.60	3.60	0.62	000
35476		A	Repair venous blockage	6.03	36.66	38.77	2.35	2.36	0.34	000
35480		A	Atherectomy, open	11.06	NA	NA	3.26	3.46	1.28	000
35481		A	Atherectomy, open	7.60	NA	NA	2.67	2.73	1.13	000
35482		A	Atherectomy, open	6.64	NA	NA	2.42	2.46	0.89	000
35483		A	Atherectomy, open	8.09	NA	NA	2.77	2.84	1.15	000
35484		A	Atherectomy, open	10.42	NA	NA	3.14	3.30	1.27	000
35485		A	Atherectomy, open	9.48	NA	NA	3.05	3.18	1.35	000
35490		A	Atherectomy, percutaneous	11.06	NA	NA	5.47	5.29	0.71	000
35491		A	Atherectomy, percutaneous	7.60	NA	NA	3.15	3.19	0.74	000
35492		A	Atherectomy, percutaneous	6.64	NA	NA	3.34	3.31	0.43	000
35493		A	Atherectomy, percutaneous	8.09	NA	NA	4.06	4.01	0.56	000
35494		A	Atherectomy, percutaneous	10.42	NA	NA	5.16	5.00	0.59	000
35495		A	Atherectomy, percutaneous	9.48	NA	NA	4.53	4.51	0.69	000
35500		A	Harvest vein for bypass	6.44	NA	NA	1.72	1.80	0.93	ZZZ
35501		A	Artery bypass graft	28.99	NA	NA	11.90	11.06	4.10	090
35506		A	Artery bypass graft	25.23	NA	NA	9.15	9.25	2.87	090
35508		A	Artery bypass graft	25.99	NA	NA	9.84	9.76	2.78	090
35509		A	Artery bypass graft	27.99	NA	NA	11.07	10.52	3.92	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.29	NA	NA	8.30	8.79	2.12	090
35511		A	Artery bypass graft	22.12	NA	NA	8.05	8.40	2.91	090
35512		A	Artery bypass graft	23.79	NA	NA	7.86	8.42	2.12	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35515		A	Artery bypass graft	25.99	NA	NA	8.13	8.44	2.78	090
35516		A	Artery bypass graft	24.11	NA	NA	7.78	7.55	2.34	090
35518		A	Artery bypass graft	22.57	NA	NA	8.24	8.45	3.03	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.00	NA	NA	8.26	8.67	3.13	090
35522		A	Artery bypass graft	23.05	NA	NA	7.91	8.39	2.12	090
35523		A	Artery bypass graft	24.00	NA	NA	9.37	9.37	2.14	090
35525		A	Artery bypass graft	21.59	NA	NA	7.28	7.83	2.12	090
35526		A	Artery bypass graft	31.47	NA	NA	11.28	11.62	3.63	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	38.98	NA	NA	12.54	13.05	5.18	090
35533		A	Artery bypass graft	29.79	NA	NA	10.21	10.61	3.85	090
35535		A	Artery bypass graft	38.00	NA	NA	13.58	13.58	5.23	090
35536		A	Artery bypass graft	33.60	NA	NA	10.52	11.16	4.62	090
35537		A	Artery bypass graft	41.75	NA	NA	13.77	13.77	5.72	090
35538		A	Artery bypass graft	46.82	NA	NA	15.52	15.52	6.39	090
35539		A	Artery bypass graft	43.98	NA	NA	13.75	13.75	6.02	090
35540		A	Artery bypass graft	49.20	NA	NA	15.46	15.46	6.76	090
35548		A	Artery bypass graft	22.57	NA	NA	8.04	8.41	2.98	090
35549		A	Artery bypass graft	24.34	NA	NA	8.90	9.29	3.30	090
35551		A	Artery bypass graft	27.72	NA	NA	10.29	10.61	3.75	090
35556		A	Artery bypass graft	26.62	NA	NA	9.03	9.23	3.10	090
35558		A	Artery bypass graft	23.00	NA	NA	8.25	8.59	3.00	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	33.90	NA	NA	11.24	11.79	4.75	090
35563		A	Artery bypass graft	25.99	NA	NA	8.61	9.11	3.52	090
35565		A	Artery bypass graft	25.00	NA	NA	8.70	9.08	3.30	090
35566		A	Artery bypass graft	32.22	NA	NA	10.47	10.72	3.83	090
35570		A	Artery bypass graft	29.00	NA	NA	10.95	10.95	3.91	090
35571		A	Artery bypass graft	25.39	NA	NA	8.53	9.13	3.43	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.09	2.13	0.99	ZZZ
35583		A	Vein bypass graft	27.62	NA	NA	9.15	9.42	3.17	090
35585		A	Vein bypass graft	32.22	NA	NA	10.49	10.95	4.02	090
35587		A	Vein bypass graft	26.08	NA	NA	8.86	9.53	3.52	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.64	1.64	0.73	ZZZ
35601		A	Artery bypass graft	26.99	NA	NA	10.53	10.07	3.72	090
35606		A	Artery bypass graft	22.36	NA	NA	7.66	8.02	2.70	090
35612		A	Artery bypass graft	16.71	NA	NA	6.82	7.10	2.09	090
35616		A	Artery bypass graft	21.74	NA	NA	7.40	7.59	2.20	090
35621		A	Artery bypass graft	20.95	NA	NA	7.10	7.51	2.92	090
35623		A	Bypass graft, not vein	25.79	NA	NA	8.76	9.22	3.46	090
35626		A	Artery bypass graft	29.06	NA	NA	10.75	11.08	4.08	090
35631		A	Artery bypass graft	35.90	NA	NA	11.14	11.84	4.96	090
35632		A	Artery bypass graft	36.00	NA	NA	12.97	12.97	4.97	090
35633		A	Artery bypass graft	38.98	NA	NA	13.88	13.88	5.39	090
35634		A	Artery bypass graft	35.20	NA	NA	12.73	12.73	4.86	090
35636		A	Artery bypass graft	31.62	NA	NA	10.49	10.97	4.10	090
35637		A	Artery bypass graft	32.92	NA	NA	11.00	11.00	4.44	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35638		A	Artery bypass graft	33.47	NA	NA	11.42	11.42	4.52	090
35642		A	Artery bypass graft	18.85	NA	NA	7.79	8.04	2.28	090
35645		A	Artery bypass graft	18.34	NA	NA	6.44	6.91	2.50	090
35646		A	Artery bypass graft	32.84	NA	NA	10.95	11.51	4.44	090
35647		A	Artery bypass graft	29.62	NA	NA	10.11	10.55	3.99	090
35650		A	Artery bypass graft	20.08	NA	NA	7.06	7.40	2.72	090
35651		A	Artery bypass graft	25.97	NA	NA	9.36	9.72	3.36	090
35654		A	Artery bypass graft	26.17	NA	NA	8.79	9.28	3.53	090
35656		A	Artery bypass graft	20.39	NA	NA	7.16	7.54	2.80	090
35661		A	Artery bypass graft	20.22	NA	NA	7.40	7.80	2.72	090
35663		A	Artery bypass graft	23.80	NA	NA	8.26	8.71	3.11	090
35665		A	Artery bypass graft	22.22	NA	NA	7.72	8.17	3.01	090
35666		A	Artery bypass graft	23.53	NA	NA	8.84	9.31	3.16	090
35671		A	Artery bypass graft	20.64	NA	NA	7.91	8.30	2.78	090
35681		A	Composite bypass graft	1.60	NA	NA	0.44	0.46	0.23	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	1.86	2.00	1.03	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.20	2.36	1.20	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.04	1.12	0.58	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	0.94	0.99	0.47	ZZZ
35691		A	Arterial transposition	18.32	NA	NA	6.63	7.09	2.59	090
35693		A	Arterial transposition	15.64	NA	NA	6.68	6.96	2.22	090
35694		A	Arterial transposition	19.19	NA	NA	6.52	7.06	2.70	090
35695		A	Arterial transposition	19.97	NA	NA	7.02	7.42	2.74	090
35697		A	Reimplant artery each	3.00	NA	NA	0.80	0.86	0.41	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	0.83	0.88	0.44	ZZZ
35701		A	Exploration, carotid artery	9.11	NA	NA	4.53	4.70	1.12	090
3570F		I	Rprt bone scint x-refw/x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35721		A	Exploration, femoral artery	7.66	NA	NA	3.87	4.02	1.03	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.61	NA	NA	4.01	4.18	1.12	090
35761		A	Exploration of artery/vein	5.84	NA	NA	3.55	3.67	0.75	090
35800		A	Explore neck vessels	7.99	NA	NA	4.09	4.24	0.95	090
35820		A	Explore chest vessels	36.81	NA	NA	13.83	12.20	1.95	090
35840		A	Explore abdominal vessels	10.87	NA	NA	4.94	5.04	1.34	090
35860		A	Explore limb vessels	6.72	NA	NA	3.49	3.63	0.78	090
35870		A	Repair vessel graft defect	24.39	NA	NA	8.35	8.73	3.01	090
35875		A	Removal of clot in graft	10.64	NA	NA	4.42	4.62	1.41	090
35876		A	Removal of clot in graft	17.74	NA	NA	6.27	6.59	2.40	090
35879		A	Revise graft w/vein	17.28	NA	NA	6.19	6.58	2.28	090
35881		A	Revise graft w/vein	19.22	NA	NA	6.80	7.29	2.56	090
35883		A	Revise graft w/nonauto graft	23.07	NA	NA	7.69	7.69	3.19	090
35884		A	Revise graft w/vein	24.57	NA	NA	7.84	7.84	3.41	090
35901		A	Excision, graft, neck	8.26	NA	NA	4.33	4.58	1.15	090
35903		A	Excision, graft, extremity	9.44	NA	NA	4.70	5.08	1.30	090
35905		A	Excision, graft, thorax	33.39	NA	NA	10.81	11.43	4.44	090
35907		A	Excision, graft, abdomen	37.14	NA	NA	11.52	12.21	4.92	090
36000		A	Place needle in vein	0.18	0.45	0.48	0.07	0.07	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36002		A	Pseudoaneurysm injection trt	1.96	2.27	2.43	0.91	0.93	0.17	000
36005		A	Injection ext venography	0.95	8.17	8.06	0.39	0.37	0.05	000
36010		A	Place catheter in vein	2.43	10.92	13.05	0.85	0.84	0.20	XXX
36011		A	Place catheter in vein	3.14	19.18	21.40	1.09	1.08	0.27	XXX
36012		A	Place catheter in vein	3.51	19.73	19.58	1.33	1.30	0.23	XXX
36013		A	Place catheter in artery	2.52	17.87	18.79	0.94	0.88	0.25	XXX
36014		A	Place catheter in artery	3.02	18.90	19.26	1.21	1.17	0.19	XXX
36015		A	Place catheter in artery	3.51	19.93	20.92	1.39	1.34	0.21	XXX
36100		A	Establish access to artery	3.02	10.67	11.05	1.20	1.18	0.26	XXX
36120		A	Establish access to artery	2.01	9.31	9.68	0.65	0.65	0.14	XXX
36140		A	Establish access to artery	2.01	10.24	10.90	0.75	0.72	0.16	XXX
36145		A	Artery to vein shunt	2.01	10.19	10.81	0.70	0.69	0.11	XXX
36160		A	Establish access to aorta	2.52	10.98	11.63	1.05	1.00	0.26	XXX
36200		A	Place catheter in aorta	3.02	13.40	14.22	1.07	1.06	0.24	XXX
36215		A	Place catheter in artery	4.67	25.30	25.80	1.96	1.88	0.27	XXX
36216		A	Place catheter in artery	5.27	27.58	28.02	2.21	2.11	0.31	XXX
36217		A	Place catheter in artery	6.29	45.37	48.00	2.60	2.50	0.44	XXX
36218		A	Place catheter in artery	1.01	3.74	4.08	0.41	0.39	0.07	ZZZ
36245		A	Place catheter in artery	4.67	27.79	28.93	2.19	2.06	0.31	XXX
36246		A	Place catheter in artery	5.27	26.84	27.69	2.10	2.04	0.38	XXX
36247		A	Place catheter in artery	6.29	44.08	45.55	2.47	2.40	0.47	XXX
36248		A	Place catheter in artery	1.01	3.12	3.36	0.40	0.39	0.07	ZZZ
36260		A	Insertion of infusion pump	9.82	NA	NA	4.74	4.78	1.29	090
36261		A	Revision of infusion pump	5.55	NA	NA	3.31	3.41	0.70	090
36262		A	Removal of infusion pump	4.05	NA	NA	2.77	2.77	0.54	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.29	0.28	0.07	0.08	0.03	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.30	0.29	0.09	0.09	0.03	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.25	0.26	0.06	0.06	0.01	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.31	0.31	0.05	0.05	0.01	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.24	0.25	0.07	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.23	0.23	0.06	XXX
36430		A	Blood transfusion service	0.00	0.92	0.94	NA	NA	0.06	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.28	0.28	0.10	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	0.83	0.80	0.21	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.91	0.93	0.15	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	1.81	1.92	0.79	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.33	2.43	0.64	0.67	0.12	010
36471		A	Injection therapy of veins	1.60	2.58	2.71	0.82	0.86	0.19	010
36475		A	Endovenous rf, 1st vein	6.72	36.08	40.01	2.08	2.20	0.37	000
36476		A	Endovenous rf, vein add-on	3.38	6.11	6.57	0.92	0.98	0.18	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	26.62	31.74	2.20	2.29	0.37	000
36479		A	Endovenous laser vein addon	3.38	6.77	7.09	0.97	1.01	0.18	ZZZ
36481		A	Insertion of catheter, vein	6.98	3.18	3.83	NA	NA	0.55	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.30	1.32	0.20	000
36510		A	Insertion of catheter, vein	1.09	1.00	1.73	0.30	0.38	0.10	000
36511		A	Apheresis wbc	1.74	NA	NA	0.59	0.62	0.08	000
36512		A	Apheresis rbc	1.74	NA	NA	0.63	0.66	0.08	000
36513		A	Apheresis platelets	1.74	NA	NA	0.66	0.68	0.17	000
36514		A	Apheresis plasma	1.74	10.18	11.91	0.56	0.60	0.08	000
36515		A	Apheresis, adsorp/reinfuse	1.74	43.53	49.35	0.51	0.55	0.08	000
36516		A	Apheresis, selective	1.22	47.29	56.63	0.38	0.41	0.08	000
36522		A	Photopheresis	1.67	34.90	34.35	0.97	0.97	0.13	000
36555		A	Insert non-tunnel cv cath	2.68	4.05	4.49	0.62	0.67	0.11	000
36556		A	Insert non-tunnel cv cath	2.50	2.84	3.55	0.59	0.62	0.19	000
36557		A	Insert tunneled cv cath	5.11	15.26	16.77	2.52	2.56	0.57	010
36558		A	Insert tunneled cv cath	4.81	14.73	16.35	2.48	2.51	0.57	010
36560		A	Insert tunneled cv cath	6.26	21.94	23.93	2.82	2.88	0.57	010
36561		A	Insert tunneled cv cath	6.01	21.87	23.86	2.77	2.82	0.57	010
36563		A	Insert tunneled cv cath	6.21	22.76	23.81	2.72	2.79	0.84	010
36565		A	Insert tunneled cv cath	6.01	17.29	19.19	2.58	2.68	0.57	010
36566		A	Insert tunneled cv cath	6.51	109.47	88.66	2.71	2.82	0.57	010
36568		A	Insert picc cath	1.92	5.79	6.24	0.66	0.64	0.11	000
36569		A	Insert picc cath	1.82	4.48	5.21	0.73	0.69	0.19	000
36570		A	Insert picvad cath	5.33	22.70	25.38	2.81	2.80	0.57	010
36571		A	Insert picvad cath	5.31	24.24	26.56	2.53	2.58	0.57	010
36575		A	Repair tunneled cv cath	0.67	3.25	3.46	0.25	0.25	0.20	000
36576		A	Repair tunneled cv cath	3.21	5.86	6.15	1.62	1.68	0.19	010
36578		A	Replace tunneled cv cath	3.51	9.11	9.64	2.04	2.11	0.19	010
36580		A	Replace cvad cath	1.31	3.95	4.71	0.47	0.46	0.19	000
36581		A	Replace tunneled cv cath	3.45	15.41	16.48	1.83	1.86	0.19	010
36582		A	Replace tunneled cv cath	5.21	21.45	22.64	2.56	2.64	0.19	010
36583		A	Replace tunneled cv cath	5.26	21.38	22.60	2.49	2.60	0.19	010
36584		A	Replace picc cath	1.20	3.97	4.73	0.66	0.63	0.19	000
36585		A	Replace picvad cath	4.81	22.38	23.80	2.50	2.56	0.19	010
36589		A	Removal tunneled cv cath	2.27	1.89	1.99	1.28	1.31	0.24	010
36590		A	Removal tunneled cv cath	3.32	3.64	3.58	1.66	1.68	0.44	010
36591		T	Draw blood off venous device	0.00	0.60	0.60	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.66	0.66	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.81	0.71	NA	NA	0.37	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.81	12.45	1.52	1.51	0.21	000
36596		A	Mech remov tunneled cv cath	0.75	2.56	2.85	0.45	0.46	0.05	000
36597		A	Reposition venous catheter	1.21	2.06	2.15	0.50	0.49	0.07	000
36598		T	Inj w/fluor, eval cv device	0.74	2.17	2.29	0.29	0.88	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.48	0.48	0.08	0.08	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.15	0.17	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	NA	0.56	0.56	0.26	000
36640		A	Insertion catheter, artery	2.10	NA	NA	0.93	0.96	0.21	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.27	0.31	0.14	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.27	0.32	0.11	000
36800		A	Insertion of cannula	2.43	NA	NA	1.55	1.62	0.25	000
36810		A	Insertion of cannula	3.96	NA	NA	1.26	1.37	0.45	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36815		A	Insertion of cannula	2.62	NA	NA	1.12	1.13	0.35	000
36818		A	Av fuse, uppr arm, cephalic	11.81	NA	NA	4.69	5.04	1.90	090
36819		A	Av fuse, uppr arm, basilic	14.39	NA	NA	5.36	5.63	1.96	090
36820		A	Av fusion/forearm vein	14.39	NA	NA	5.46	5.71	1.95	090
36821		A	Av fusion direct any site	12.00	NA	NA	5.05	4.96	1.23	090
36822		A	Insertion of cannula(s)	5.51	NA	NA	3.85	3.99	0.79	090
36823		A	Insertion of cannula(s)	22.82	NA	NA	9.25	9.31	2.89	090
36825		A	Artery-vein autograft	10.00	NA	NA	4.39	4.56	1.35	090
36830		A	Artery-vein nonautograft	12.00	NA	NA	4.32	4.56	1.66	090
36831		A	Open thrombect av fistula	8.01	NA	NA	3.30	3.47	1.09	090
36832		A	Av fistula revision, open	10.50	NA	NA	3.91	4.12	1.44	090
36833		A	Av fistula revision	11.95	NA	NA	4.32	4.55	1.65	090
36834		A	Repair A-V aneurysm	11.11	NA	NA	4.39	4.50	1.37	090
36835		A	Artery to vein shunt	7.43	NA	NA	4.09	4.15	0.98	090
36838		A	Dist revas ligation, hemo	21.59	NA	NA	7.29	7.84	3.02	090
36860		A	External cannula declotting	2.01	3.36	2.97	0.67	0.68	0.11	000
36861		A	Cannula declotting	2.52	NA	NA	1.27	1.33	0.27	000
36870		A	Percut thrombect av fistula	5.17	40.34	43.62	2.86	2.94	0.29	090
37140		A	Revision of circulation	25.12	NA	NA	9.11	9.48	2.02	090
37145		A	Revision of circulation	26.13	NA	NA	10.36	10.51	3.26	090
37160		A	Revision of circulation	23.13	NA	NA	8.53	8.73	2.82	090
37180		A	Revision of circulation	26.13	NA	NA	9.11	9.43	3.35	090
37181		A	Splice spleen/kidney veins	28.26	NA	NA	10.06	10.32	3.41	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	7.03	6.81	1.00	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	NA	3.42	3.32	0.47	000
37184		A	Prim art mech thrombectomy	8.66	49.77	55.39	3.51	3.48	0.55	000
37185		A	Prim art m-thrombect add-on	3.28	16.14	17.87	1.20	1.18	0.21	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	34.48	38.30	2.03	1.94	0.32	ZZZ
37187		A	Venous mech thrombectomy	8.03	47.58	53.36	3.28	3.25	0.51	000
37188		A	Venous m-thrombectomy add-on	5.71	41.21	46.52	2.49	2.46	0.37	000
37195		C	Thrombolytic therapy, stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.84	1.76	0.27	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.45	2.48	0.33	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	3.38	3.30	0.43	000
37203		A	Transcatheter retrieval	5.02	29.61	30.50	2.21	2.17	0.29	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.91	6.68	1.48	000
37205		A	Transcath iv stent, percut	8.27	105.15	79.96	3.35	3.46	0.60	000
37206		A	Transcath iv stent/perc addl	4.12	64.26	48.64	1.62	1.58	0.31	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	2.54	2.70	1.17	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.10	1.17	0.59	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.84	0.81	0.15	000
37210		A	Embolization uterine fibroid	10.60	83.03	83.03	4.37	4.37	0.60	000
37215		R	Transcath stent, cca w/eps	19.58	NA	NA	10.10	9.87	1.09	090
37216		N	Transcath stent, cca w/o eps	18.85	NA	NA	7.86	8.12	1.04	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.79	0.78	0.21	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.50	0.52	0.19	ZZZ
37500		A	Endoscopy ligate perf veins	11.54	NA	NA	5.51	5.86	1.54	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
37565		A	Ligation of neck vein	11.97	NA	NA	5.36	5.44	1.33	090
37600		A	Ligation of neck artery	12.34	NA	NA	5.01	5.43	1.41	090
37605		A	Ligation of neck artery	14.20	NA	NA	5.52	5.88	1.99	090
37606		A	Ligation of neck artery	8.72	NA	NA	4.37	4.43	1.23	090
37607		A	Ligation of a-v fistula	6.19	NA	NA	3.10	3.22	0.85	090
37609		A	Temporal artery procedure	3.02	4.17	4.27	1.86	1.89	0.36	010
37615		A	Ligation of neck artery	7.72	NA	NA	4.20	4.19	0.68	090
37616		A	Ligation of chest artery	18.89	NA	NA	8.33	8.29	2.33	090
37617		A	Ligation of abdomen artery	23.71	NA	NA	8.22	8.48	2.98	090
37618		A	Ligation of extremity artery	5.95	NA	NA	3.43	3.49	0.67	090
37620		A	Revision of major vein	11.49	NA	NA	5.78	5.78	0.91	090
37650		A	Revision of major vein	8.41	NA	NA	4.30	4.41	1.01	090
37660		A	Revision of major vein	22.20	NA	NA	7.81	8.14	2.49	090
37700		A	Revise leg vein	3.76	NA	NA	2.42	2.52	0.53	090
37718		A	Ligate/strip short leg vein	7.05	NA	NA	3.65	3.76	0.14	090
37722		A	Ligate/strip long leg vein	8.08	NA	NA	3.80	3.96	0.86	090
37735		A	Removal of leg veins/lesion	10.81	NA	NA	4.79	4.98	1.48	090
37760		A	Ligation, leg veins, open	10.69	NA	NA	4.69	4.87	1.44	090
37765		A	Phleb veins - extrem - to 20	7.63	NA	NA	3.69	3.93	0.48	090
37766		A	Phleb veins - extrem 20+	9.58	NA	NA	4.26	4.54	0.48	090
37780		A	Revision of leg vein	3.87	NA	NA	2.53	2.62	0.53	090
37785		A	Ligate/divide/excise vein	3.87	4.86	4.96	2.59	2.63	0.54	090
37788		A	Revascularization, penis	23.21	NA	NA	12.81	11.91	2.26	090
37790		A	Penile venous occlusion	8.37	NA	NA	4.55	4.52	0.59	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.47	NA	NA	7.16	6.93	1.92	090
38101		A	Removal of spleen, partial	19.47	NA	NA	7.13	6.99	2.05	090
38102		A	Removal of spleen, total	4.79	NA	NA	1.33	1.41	0.63	ZZZ
38115		A	Repair of ruptured spleen	21.80	NA	NA	7.88	7.59	2.09	090
38120		A	Laparoscopy, splenectomy	16.97	NA	NA	7.14	7.21	2.25	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.01	0.98	0.14	000
38204		B	Bl donor search management	2.00	0.67	0.67	0.67	0.67	0.06	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.57	0.60	0.07	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.57	0.60	0.07	000
38207		I	Cryopreserve stem cells	0.89	0.44	0.44	0.44	0.44	0.01	XXX
38208		I	Thaw preserved stem cells	0.56	0.28	0.28	0.28	0.28	0.02	XXX
38209		I	Wash harvest stem cells	0.24	0.12	0.12	0.12	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	0.78	0.78	0.78	0.78	0.03	XXX
38211		I	Tumor cell deplete of harvst	1.42	0.71	0.71	0.71	0.71	0.02	XXX
38212		I	Rbc depletion of harvest	0.94	0.47	0.47	0.47	0.47	0.02	XXX
38213		I	Platelet deplete of harvest	0.24	0.12	0.12	0.12	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	0.40	0.40	0.40	0.40	0.01	XXX
38215		I	Harvest stem cell concentrte	0.94	0.47	0.47	0.47	0.47	0.02	XXX
38220		A	Bone marrow aspiration	1.08	2.68	2.95	0.49	0.50	0.05	XXX
38221		A	Bone marrow biopsy	1.37	2.80	3.09	0.63	0.63	0.07	XXX
38230		R	Bone marrow collection	4.80	NA	NA	3.12	3.15	0.48	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.01	1.01	0.11	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.03	1.03	0.11	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	0.77	0.77	0.08	000
38300		A	Drainage, lymph node lesion	2.28	4.22	4.25	2.06	2.06	0.25	010
38305		A	Drainage, lymph node lesion	6.55	NA	NA	4.21	4.28	0.88	090
38308		A	Incision of lymph channels	6.73	NA	NA	3.61	3.65	0.85	090
38380		A	Thoracic duct procedure	8.34	NA	NA	5.13	5.28	0.74	090
38381		A	Thoracic duct procedure	13.32	NA	NA	6.30	6.46	1.85	090
38382		A	Thoracic duct procedure	10.51	NA	NA	5.48	5.56	1.37	090
38500		A	Biopsy/removal, lymph nodes	3.76	3.74	3.74	2.07	2.08	0.49	010
38505		A	Needle biopsy, lymph nodes	1.14	2.11	2.10	0.77	0.77	0.09	000
38510		A	Biopsy/removal, lymph nodes	6.69	5.44	5.48	3.21	3.28	0.72	010
38520		A	Biopsy/removal, lymph nodes	6.95	NA	NA	3.88	3.93	0.84	090
38525		A	Biopsy/removal, lymph nodes	6.35	NA	NA	3.53	3.48	0.80	090
38530		A	Biopsy/removal, lymph nodes	8.26	NA	NA	4.29	4.32	1.12	090
38542		A	Explore deep node(s), neck	7.85	NA	NA	4.48	4.49	0.60	090
38550		A	Removal, neck/armpit lesion	6.99	NA	NA	4.32	4.23	0.88	090
38555		A	Removal, neck/armpit lesion	15.42	NA	NA	7.73	7.95	1.76	090
38562		A	Removal, pelvic lymph nodes	10.92	NA	NA	5.96	5.92	1.20	090
38564		A	Removal, abdomen lymph nodes	11.29	NA	NA	5.32	5.32	1.32	090
38570		A	Laparoscopy, lymph node biop	9.28	NA	NA	4.31	4.23	1.13	010
38571		A	Laparoscopy, lymphadenectomy	14.70	NA	NA	7.38	6.97	1.15	010
38572		A	Laparoscopy, lymphadenectomy	16.86	NA	NA	6.28	6.49	1.91	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.68	NA	NA	6.74	6.63	0.72	090
38720		A	Removal of lymph nodes, neck	21.72	NA	NA	10.62	10.33	1.20	090
38724		A	Removal of lymph nodes, neck	23.72	NA	NA	11.42	11.05	1.28	090
38740		A	Remove armpit lymph nodes	10.57	NA	NA	5.16	5.12	1.32	090
38745		A	Remove armpit lymph nodes	13.71	NA	NA	6.23	6.21	1.74	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.55	1.57	0.72	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	1.36	1.44	0.64	ZZZ
38760		A	Remove groin lymph nodes	13.49	NA	NA	6.15	6.16	1.72	090
38765		A	Remove groin lymph nodes	21.78	NA	NA	8.88	8.88	2.48	090
38770		A	Remove pelvis lymph nodes	13.98	NA	NA	7.10	6.78	1.40	090
38780		A	Remove abdomen lymph nodes	17.56	NA	NA	8.58	8.50	1.89	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.76	0.76	0.13	000
38792		A	Identify sentinel node	0.52	NA	NA	0.49	0.48	0.06	000
38794		A	Access thoracic lymph duct	4.51	NA	NA	3.38	3.40	0.32	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.49	NA	NA	4.50	4.55	0.89	090
39010		A	Exploration of chest	13.11	NA	NA	6.32	6.64	1.76	090
39200		A	Removal chest lesion	15.04	NA	NA	6.51	6.78	2.03	090
39220		A	Removal chest lesion	19.47	NA	NA	8.50	8.73	2.46	090
39400		A	Visualization of chest	8.00	NA	NA	4.32	4.46	0.82	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.89	NA	NA	6.05	6.16	1.78	090
39502		A	Repair paraesophageal hernia	17.09	NA	NA	6.83	6.93	2.17	090
39503		A	Repair of diaphragm hernia	108.67	NA	NA	31.73	32.22	10.98	090
39520		A	Repair of diaphragm hernia	16.63	NA	NA	7.08	7.33	2.24	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
39530		A	Repair of diaphragm hernia	16.22	NA	NA	6.57	6.73	2.11	090
39531		A	Repair of diaphragm hernia	17.23	NA	NA	6.49	6.73	2.22	090
39540		A	Repair of diaphragm hernia	14.51	NA	NA	5.88	5.98	1.80	090
39541		A	Repair of diaphragm hernia	15.67	NA	NA	6.37	6.44	1.93	090
39545		A	Revision of diaphragm	14.58	NA	NA	7.16	7.27	1.84	090
39560		A	Resect diaphragm, simple	12.97	NA	NA	5.74	5.89	1.59	090
39561		A	Resect diaphragm, complex	19.75	NA	NA	9.67	9.61	2.45	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40490		A	Biopsy of lip	1.22	2.08	1.97	0.62	0.62	0.05	000
40500		A	Partial excision of lip	4.35	7.78	7.58	4.36	4.36	0.38	090
40510		A	Partial excision of lip	4.74	6.75	6.73	3.72	3.80	0.49	090
40520		A	Partial excision of lip	4.71	6.89	7.07	3.84	3.91	0.52	090
40525		A	Reconstruct lip with flap	7.61	NA	NA	5.55	5.75	0.85	090
40527		A	Reconstruct lip with flap	9.20	NA	NA	6.33	6.60	0.97	090
40530		A	Partial removal of lip	5.45	7.46	7.56	4.27	4.35	0.55	090
40650		A	Repair lip	3.69	5.89	6.13	3.17	3.20	0.38	090
40652		A	Repair lip	4.32	6.98	7.19	3.97	4.05	0.52	090
40654		A	Repair lip	5.37	8.06	8.21	4.76	4.81	0.60	090
40700		A	Repair cleft lip/nasal	13.97	NA	NA	8.54	8.69	0.95	090
40701		A	Repair cleft lip/nasal	17.03	NA	NA	10.58	10.79	1.65	090
40702		A	Repair cleft lip/nasal	14.09	NA	NA	7.24	7.51	1.23	090
40720		A	Repair cleft lip/nasal	14.54	NA	NA	8.69	9.01	1.80	090
40761		A	Repair cleft lip/nasal	15.69	NA	NA	9.63	9.82	1.94	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.19	3.80	3.60	1.88	1.86	0.13	010
40801		A	Drainage of mouth lesion	2.57	4.91	4.70	2.63	2.67	0.31	010
40804		A	Removal, foreign body, mouth	1.26	3.71	3.64	1.83	1.84	0.11	010
40805		A	Removal, foreign body, mouth	2.73	5.02	4.89	2.65	2.70	0.32	010
40806		A	Incision of lip fold	0.31	2.38	2.25	0.51	0.51	0.04	000
40808		A	Biopsy of mouth lesion	0.98	3.56	3.34	1.62	1.59	0.10	010
40810		A	Excision of mouth lesion	1.33	3.65	3.46	1.73	1.71	0.13	010
40812		A	Excise/repair mouth lesion	2.33	4.53	4.34	2.32	2.34	0.28	010
40814		A	Excise/repair mouth lesion	3.45	5.67	5.50	3.73	3.78	0.41	090
40816		A	Excision of mouth lesion	3.70	5.92	5.75	3.83	3.88	0.40	090
40818		A	Excise oral mucosa for graft	2.72	5.85	5.69	3.81	3.86	0.21	090
40819		A	Excise lip or cheek fold	2.45	4.90	4.70	3.11	3.12	0.29	090
40820		A	Treatment of mouth lesion	1.30	5.32	4.99	2.98	2.85	0.11	010
40830		A	Repair mouth laceration	1.78	4.01	3.95	1.99	2.02	0.19	010
40831		A	Repair mouth laceration	2.50	5.19	5.07	2.73	2.82	0.30	010
40840		R	Reconstruction of mouth	9.03	10.21	10.13	5.83	6.13	1.08	090
40842		R	Reconstruction of mouth	9.03	9.71	9.82	5.44	5.79	1.08	090
40843		R	Reconstruction of mouth	12.62	11.95	11.98	6.21	6.63	1.39	090
40844		R	Reconstruction of mouth	16.57	15.97	15.96	9.89	10.33	2.00	090
40845		R	Reconstruction of mouth	19.13	16.07	16.36	10.42	11.15	2.01	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.32	2.52	2.48	1.34	1.36	0.12	010
41005		A	Drainage of mouth lesion	1.28	4.34	4.09	1.81	1.79	0.12	010
41006		A	Drainage of mouth lesion	3.28	5.36	5.23	2.84	2.93	0.35	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
41007		A	Drainage of mouth lesion	3.14	5.49	5.42	2.87	2.91	0.31	090
41008		A	Drainage of mouth lesion	3.40	5.55	5.34	2.93	3.00	0.42	090
41009		A	Drainage of mouth lesion	3.63	5.84	5.64	3.21	3.31	0.47	090
41010		A	Incision of tongue fold	1.08	3.87	3.77	1.57	1.58	0.07	010
41015		A	Drainage of mouth lesion	4.00	6.19	6.00	3.97	4.02	0.46	090
41016		A	Drainage of mouth lesion	4.11	6.27	6.12	4.15	4.18	0.53	090
41017		A	Drainage of mouth lesion	4.11	6.37	6.20	4.18	4.22	0.53	090
41018		A	Drainage of mouth lesion	5.14	6.76	6.62	4.54	4.56	0.68	090
41019		A	Place needles h&n for rt	8.84	NA	NA	3.53	3.53	0.59	000
41100		A	Biopsy of tongue	1.39	2.66	2.61	1.19	1.25	0.15	010
41105		A	Biopsy of tongue	1.44	2.66	2.58	1.22	1.25	0.13	010
41108		A	Biopsy of floor of mouth	1.07	2.49	2.39	1.09	1.10	0.10	010
41110		A	Excision of tongue lesion	1.53	3.61	3.46	1.65	1.65	0.13	010
41112		A	Excision of tongue lesion	2.77	5.22	5.05	3.25	3.25	0.28	090
41113		A	Excision of tongue lesion	3.23	5.49	5.32	3.42	3.44	0.34	090
41114		A	Excision of tongue lesion	8.71	NA	NA	6.49	6.68	0.83	090
41115		A	Excision of tongue fold	1.76	4.27	4.03	1.78	1.81	0.18	010
41116		A	Excision of mouth lesion	2.47	5.50	5.22	2.81	2.81	0.23	090
41120		A	Partial removal of tongue	10.91	NA	NA	14.40	14.66	0.79	090
41130		A	Partial removal of tongue	15.51	NA	NA	15.96	16.06	0.93	090
41135		A	Tongue and neck surgery	29.83	NA	NA	22.25	22.55	1.89	090
41140		A	Removal of tongue	28.81	NA	NA	24.17	24.86	2.27	090
41145		A	Tongue removal, neck surgery	37.59	NA	NA	29.46	29.80	2.55	090
41150		A	Tongue, mouth, jaw surgery	29.52	NA	NA	23.45	23.82	1.95	090
41153		A	Tongue, mouth, neck surgery	33.28	NA	NA	24.40	24.62	2.01	090
41155		A	Tongue, jaw, & neck surgery	43.96	NA	NA	28.46	28.11	2.34	090
41250		A	Repair tongue laceration	1.93	3.70	3.47	1.57	1.47	0.18	010
41251		A	Repair tongue laceration	2.29	3.26	3.27	1.70	1.66	0.22	010
41252		A	Repair tongue laceration	2.99	4.42	4.30	2.06	2.12	0.29	010
4148F		I	Hep A vac injxn admin/recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4149F		I	Hep B vac injxn admin/recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41500		A	Fixation of tongue	3.74	NA	NA	6.99	7.12	0.30	090
41510		A	Tongue to lip surgery	3.45	NA	NA	6.10	6.57	0.20	090
41512		A	Tongue suspension	6.75	NA	NA	8.46	8.46	0.45	090
41520		A	Reconstruction, tongue fold	2.77	5.68	5.43	3.23	3.34	0.27	090
41530		A	Tongue base vol reduction	4.38	73.12	73.12	5.57	5.57	0.31	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.21	4.72	4.20	2.09	1.89	0.12	010
41805		A	Removal foreign body, gum	1.28	4.83	4.30	2.83	2.68	0.13	010
41806		A	Removal foreign body,jawbone	2.73	5.86	5.30	3.40	3.32	0.37	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.35	4.54	4.39	1.78	1.81	0.31	010
41823		R	Excision of gum lesion	3.63	6.66	6.40	3.92	3.95	0.47	090
41825		A	Excision of gum lesion	1.35	3.66	3.52	1.48	1.68	0.15	010
41826		A	Excision of gum lesion	2.35	5.09	4.43	2.61	2.49	0.30	010
41827		A	Excision of gum lesion	3.72	6.68	6.40	3.47	3.52	0.35	090
41828		R	Excision of gum lesion	3.11	4.06	4.00	1.68	2.01	0.44	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
41830		R	Removal of gum tissue	3.38	5.90	5.68	3.12	3.25	0.44	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.90	5.88	5.68	3.29	3.34	0.30	090
41874		R	Repair tooth socket	3.13	5.68	5.48	2.78	2.89	0.45	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4192F		I	Pt not rcvng glucoco thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4193F		I	Pt rcvng<10mg daily predniso	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4194F		I	Pt rcvng>10mg daily predniso	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4195F		I	Pt rcvng anti-rheum thxpy RA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4196F		I	Ptnot rcvng anti-rhm thxpyRA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42000		A	Drainage mouth roof lesion	1.25	2.47	2.50	1.22	1.23	0.12	010
42100		A	Biopsy roof of mouth	1.33	2.26	2.22	1.28	1.30	0.13	010
42104		A	Excision lesion, mouth roof	1.66	3.54	3.30	1.68	1.65	0.16	010
42106		A	Excision lesion, mouth roof	2.12	4.43	4.14	2.10	2.19	0.25	010
42107		A	Excision lesion, mouth roof	4.48	6.58	6.38	3.79	3.84	0.44	090
42120		A	Remove palate/lesion	11.70	NA	NA	12.31	12.20	0.52	090
42140		A	Excision of uvula	1.65	4.51	4.32	2.11	2.11	0.13	090
42145		A	Repair palate, pharynx/uvula	9.63	NA	NA	7.54	7.55	0.65	090
42160		A	Treatment mouth roof lesion	1.82	3.80	3.92	1.74	1.88	0.17	010
42180		A	Repair palate	2.52	3.34	3.28	1.90	1.96	0.21	010
42182		A	Repair palate	3.84	4.06	4.02	2.48	2.63	0.40	010
42200		A	Reconstruct cleft palate	12.41	NA	NA	8.65	9.07	1.27	090
42205		A	Reconstruct cleft palate	13.57	NA	NA	8.84	9.17	1.58	090
42210		A	Reconstruct cleft palate	14.91	NA	NA	10.15	10.50	2.17	090
42215		A	Reconstruct cleft palate	8.88	NA	NA	7.46	7.88	1.31	090
42220		A	Reconstruct cleft palate	7.07	NA	NA	5.91	6.14	0.73	090
42225		A	Reconstruct cleft palate	9.66	NA	NA	12.07	13.35	0.86	090
42226		A	Lengthening of palate	10.24	NA	NA	11.73	12.50	1.01	090
42227		A	Lengthening of palate	9.81	NA	NA	11.18	12.30	0.98	090
42235		A	Repair palate	7.92	NA	NA	9.61	10.19	0.72	090
42260		A	Repair nose to lip fistula	10.10	9.60	9.77	6.02	6.29	1.26	090
42280		A	Preparation, palate mold	1.56	2.22	2.16	0.85	0.93	0.19	010
42281		A	Insertion, palate prosthesis	1.95	2.99	2.91	1.70	1.75	0.17	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.95	3.09	3.03	1.74	1.76	0.16	010
42305		A	Drainage of salivary gland	6.23	NA	NA	4.17	4.31	0.51	090
42310		A	Drainage of salivary gland	1.58	2.30	2.29	1.42	1.45	0.13	010
42320		A	Drainage of salivary gland	2.37	3.71	3.61	1.91	1.96	0.21	010
42330		A	Removal of salivary stone	2.23	3.39	3.34	1.76	1.79	0.19	010
42335		A	Removal of salivary stone	3.35	5.74	5.54	2.90	2.96	0.29	090
42340		A	Removal of salivary stone	4.64	6.62	6.49	3.51	3.63	0.42	090
42400		A	Biopsy of salivary gland	0.78	1.96	1.88	0.66	0.67	0.06	000
42405		A	Biopsy of salivary gland	3.31	3.98	4.00	2.22	2.28	0.28	010
42408		A	Excision of salivary cyst	4.58	6.39	6.29	3.34	3.41	0.45	090
42409		A	Drainage of salivary cyst	2.85	5.23	5.06	2.54	2.60	0.27	090
42410		A	Excise parotid gland/lesion	9.46	NA	NA	5.50	5.70	0.91	090
42415		A	Excise parotid gland/lesion	17.99	NA	NA	9.01	9.50	1.43	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42420		A	Excise parotid gland/lesion	20.87	NA	NA	10.01	10.63	1.65	090
42425		A	Excise parotid gland/lesion	13.31	NA	NA	7.05	7.46	1.05	090
42426		A	Excise parotid gland/lesion	22.54	NA	NA	10.47	11.13	1.81	090
42440		A	Excise submaxillary gland	7.05	NA	NA	4.29	4.42	0.59	090
42450		A	Excise sublingual gland	4.66	6.30	6.22	4.04	4.10	0.42	090
42500		A	Repair salivary duct	4.34	6.12	6.03	3.92	3.99	0.41	090
42505		A	Repair salivary duct	6.23	7.22	7.21	4.74	4.91	0.55	090
42507		A	Parotid duct diversion	6.16	NA	NA	6.42	6.46	0.49	090
42508		A	Parotid duct diversion	9.22	NA	NA	8.53	8.50	1.04	090
42509		A	Parotid duct diversion	11.65	NA	NA	8.30	8.80	0.93	090
42510		A	Parotid duct diversion	8.26	NA	NA	7.04	7.24	0.66	090
42550		A	Injection for salivary x-ray	1.25	2.28	2.52	0.49	0.47	0.07	000
42600		A	Closure of salivary fistula	4.86	6.88	6.82	3.70	3.81	0.43	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.28	1.23	0.67	0.68	0.07	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.47	1.44	0.78	0.80	0.09	000
42665		A	Ligation of salivary duct	2.57	5.07	4.85	2.45	2.49	0.23	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4267F		I	Comprssion thxpy prescribed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.64	2.94	2.88	1.66	1.68	0.13	010
42720		A	Drainage of throat abscess	6.31	4.84	4.85	3.35	3.47	0.44	010
42725		A	Drainage of throat abscess	12.28	NA	NA	7.46	7.67	0.91	090
4275F		I	Potent antivir thxpy Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.41	2.44	2.38	1.31	1.33	0.11	010
42802		A	Biopsy of throat	1.56	4.08	4.26	1.68	1.78	0.12	010
42804		A	Biopsy of upper nose/throat	1.26	3.54	3.60	1.50	1.57	0.10	010
42806		A	Biopsy of upper nose/throat	1.60	3.79	3.87	1.62	1.71	0.13	010
42808		A	Excise pharynx lesion	2.32	3.22	3.19	1.64	1.72	0.19	010
42809		A	Remove pharynx foreign body	1.83	2.23	2.26	1.33	1.33	0.16	010
42810		A	Excision of neck cyst	3.30	6.08	6.00	3.69	3.66	0.29	090
42815		A	Excision of neck cyst	7.23	NA	NA	6.32	6.36	0.61	090
42820		A	Remove tonsils and adenoids	4.17	NA	NA	2.91	3.01	0.31	090
42821		A	Remove tonsils and adenoids	4.31	NA	NA	3.06	3.17	0.35	090
42825		A	Removal of tonsils	3.45	NA	NA	2.94	3.00	0.25	090
42826		A	Removal of tonsils	3.40	NA	NA	2.73	2.81	0.27	090
42830		A	Removal of adenoids	2.60	NA	NA	2.45	2.48	0.20	090
42831		A	Removal of adenoids	2.75	NA	NA	2.69	2.73	0.22	090
42835		A	Removal of adenoids	2.33	NA	NA	2.14	2.23	0.21	090
42836		A	Removal of adenoids	3.21	NA	NA	2.67	2.75	0.26	090
42842		A	Extensive surgery of throat	12.02	NA	NA	12.11	11.86	0.71	090
42844		A	Extensive surgery of throat	17.57	NA	NA	15.72	15.88	1.16	090
42845		A	Extensive surgery of throat	32.35	NA	NA	21.86	22.25	1.99	090
42860		A	Excision of tonsil tags	2.25	NA	NA	2.33	2.35	0.18	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42870		A	Excision of lingual tonsil	5.44	NA	NA	8.68	8.67	0.44	090
42890		A	Partial removal of pharynx	18.92	NA	NA	15.48	15.18	1.05	090
42892		A	Revision of pharyngeal walls	25.77	NA	NA	19.57	19.01	1.28	090
42894		A	Revision of pharyngeal walls	33.61	NA	NA	24.06	23.60	1.87	090
42900		A	Repair throat wound	5.26	NA	NA	3.04	3.20	0.50	010
4290F		I	Pt scrned for inj drug use	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4293F		I	Pt scrnd - hgh-rsk sex behav	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42950		A	Reconstruction of throat	8.16	NA	NA	11.05	11.28	0.72	090
42953		A	Repair throat, esophagus	9.33	NA	NA	13.64	14.60	0.88	090
42955		A	Surgical opening of throat	7.92	NA	NA	10.14	10.30	0.80	090
42960		A	Control throat bleeding	2.35	NA	NA	1.75	1.81	0.19	010
42961		A	Control throat bleeding	5.69	NA	NA	4.54	4.65	0.45	090
42962		A	Control throat bleeding	7.31	NA	NA	5.32	5.48	0.58	090
42970		A	Control nose/throat bleeding	5.76	NA	NA	3.70	3.83	0.39	090
42971		A	Control nose/throat bleeding	6.54	NA	NA	4.59	4.73	0.51	090
42972		A	Control nose/throat bleeding	7.53	NA	NA	4.88	5.10	0.62	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.14	NA	NA	4.42	4.68	0.87	090
43030		A	Throat muscle surgery	7.91	NA	NA	4.69	4.90	0.70	090
43045		A	Incision of esophagus	21.70	NA	NA	10.05	10.24	2.59	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.55	NA	NA	5.50	5.70	0.93	090
43101		A	Excision of esophagus lesion	16.99	NA	NA	7.70	7.76	2.32	090
43107		A	Removal of esophagus	43.97	NA	NA	17.25	17.54	5.24	090
43108		A	Removal of esophagus	82.66	NA	NA	27.13	23.95	4.08	090
43112		A	Removal of esophagus	47.27	NA	NA	17.93	18.33	5.81	090
43113		A	Removal of esophagus	79.85	NA	NA	30.21	26.49	4.43	090
43116		A	Partial removal of esophagus	92.78	NA	NA	33.65	29.47	3.06	090
43117		A	Partial removal of esophagus	43.52	NA	NA	16.27	16.56	5.19	090
43118		A	Partial removal of esophagus	66.86	NA	NA	22.57	20.42	4.11	090
43121		A	Partial removal of esophagus	51.22	NA	NA	19.02	17.72	3.91	090
43122		A	Partial removal of esophagus	43.97	NA	NA	16.38	16.67	5.42	090
43123		A	Partial removal of esophagus	82.91	NA	NA	27.53	24.23	4.16	090
43124		A	Removal of esophagus	68.83	NA	NA	25.78	22.66	3.74	090
43130		A	Removal of esophagus pouch	12.41	NA	NA	6.67	6.91	1.16	090
43135		A	Removal of esophagus pouch	26.09	NA	NA	10.44	9.87	2.34	090
43200		A	Esophagus endoscopy	1.59	3.64	3.77	1.00	1.02	0.13	000
43201		A	Esoph scope w/submucous inj	2.09	5.51	5.30	1.23	1.20	0.15	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.03	5.17	1.01	1.00	0.15	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.06	1.93	0.30	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	2.07	1.94	0.28	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.31	1.29	0.22	000
43216		A	Esophagus endoscopy/lesion	2.40	3.02	2.53	1.28	1.23	0.20	000
43217		A	Esophagus endoscopy	2.90	6.34	6.51	1.41	1.36	0.26	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43219		A	Esophagus endoscopy	2.80	NA	NA	1.59	1.53	0.24	000
43220		A	Esoph endoscopy, dilation	2.10	NA	NA	1.16	1.11	0.17	000
43226		A	Esoph endoscopy, dilation	2.34	NA	NA	1.31	1.24	0.19	000
43227		A	Esoph endoscopy, repair	3.59	NA	NA	1.84	1.74	0.28	000
43228		A	Esoph endoscopy, ablation	3.76	NA	NA	2.02	1.90	0.34	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	1.79	1.67	0.23	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.34	2.21	0.34	000
43234		A	Upper GI endoscopy, exam	2.01	4.84	4.98	1.04	1.00	0.17	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.15	5.16	1.39	1.30	0.19	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.51	6.50	1.69	1.58	0.21	000
43237		A	Endoscopic us exam, esoph	3.98	NA	NA	2.19	2.05	0.43	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.70	2.52	0.43	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.90	5.87	1.60	1.50	0.22	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.50	3.28	0.56	000
43241		A	Upper GI endoscopy with tube	2.59	NA	NA	1.46	1.37	0.21	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	3.81	3.55	0.53	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.43	2.28	0.33	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	NA	2.73	2.54	0.37	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	1.67	1.58	0.26	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.18	2.06	0.34	000
43247		A	Operative upper GI endoscopy	3.38	NA	NA	1.83	1.72	0.27	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	1.82	1.69	0.23	000
43249		A	Esoph endoscopy, dilation	2.90	NA	NA	1.66	1.55	0.22	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	NA	1.64	1.56	0.26	000
43251		A	Operative upper GI endoscopy	3.69	NA	NA	1.98	1.86	0.29	000
43255		A	Operative upper GI endoscopy	4.81	NA	NA	2.60	2.43	0.35	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.30	2.16	0.32	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	2.59	2.50	0.36	000
43258		A	Operative upper GI endoscopy	4.54	NA	NA	2.44	2.28	0.33	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	2.79	2.60	0.35	000
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	3.17	2.95	0.43	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.32	3.09	0.46	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	3.87	3.60	0.54	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	3.84	3.58	0.54	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	4.61	4.29	0.65	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	5.14	4.79	0.73	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	3.79	3.55	0.54	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	4.01	3.74	0.54	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	4.26	3.97	0.60	000
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	3.85	3.59	0.54	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	3.82	3.57	0.54	000
43273		A	Endoscopic pancreatoscopy	2.24	1.08	1.08	1.08	1.08	0.16	ZZZ
43279		A	Lap myotomy, heller	22.00	NA	NA	8.07	8.07	2.62	090
43280		A	Laparoscopy, fundoplasty	18.00	NA	NA	6.94	7.04	2.28	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.21	NA	NA	5.60	5.81	1.12	090
43305		A	Repair esophagus and fistula	17.98	NA	NA	8.68	9.20	1.54	090
43310		A	Repair of esophagus	26.18	NA	NA	10.59	10.73	3.61	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43312		A	Repair esophagus and fistula	29.23	NA	NA	11.34	11.50	4.01	090
43313		A	Esophagoplasty congenital	48.17	NA	NA	16.63	17.22	5.47	090
43314		A	Tracheo-esophagoplasty cong	53.15	NA	NA	22.37	21.62	6.65	090
43320		A	Fuse esophagus & stomach	23.18	NA	NA	9.61	9.53	2.74	090
43324		A	Revise esophagus & stomach	22.86	NA	NA	8.76	8.78	2.76	090
43325		A	Revise esophagus & stomach	22.47	NA	NA	8.71	8.75	2.60	090
43326		A	Revise esophagus & stomach	22.15	NA	NA	9.62	9.56	2.85	090
43330		A	Repair of esophagus	22.06	NA	NA	8.48	8.51	2.63	090
43331		A	Repair of esophagus	22.93	NA	NA	10.29	10.18	2.94	090
43340		A	Fuse esophagus & intestine	22.86	NA	NA	9.07	9.06	2.46	090
43341		A	Fuse esophagus & intestine	24.10	NA	NA	11.21	10.94	2.92	090
43350		A	Surgical opening, esophagus	19.31	NA	NA	8.34	8.39	1.42	090
43351		A	Surgical opening, esophagus	21.87	NA	NA	10.23	10.14	2.47	090
43352		A	Surgical opening, esophagus	17.68	NA	NA	8.49	8.48	2.06	090
43360		A	Gastrointestinal repair	39.90	NA	NA	15.83	15.68	4.97	090
43361		A	Gastrointestinal repair	45.50	NA	NA	17.33	17.26	4.50	090
43400		A	Ligate esophagus veins	25.47	NA	NA	15.23	13.81	1.96	090
43401		A	Esophagus surgery for veins	26.36	NA	NA	10.03	9.92	3.05	090
43405		A	Ligate/staple esophagus	24.55	NA	NA	11.06	10.71	2.84	090
43410		A	Repair esophagus wound	16.28	NA	NA	8.13	8.02	1.72	090
43415		A	Repair esophagus wound	28.70	NA	NA	12.38	12.25	3.53	090
43420		A	Repair esophagus opening	16.65	NA	NA	7.98	7.85	1.43	090
43425		A	Repair esophagus opening	24.91	NA	NA	11.49	11.13	3.03	090
43450		A	Dilate esophagus	1.38	2.60	2.62	0.94	0.88	0.11	000
43453		A	Dilate esophagus	1.51	6.07	6.08	1.02	0.95	0.11	000
43456		A	Dilate esophagus	2.57	12.45	12.81	1.47	1.38	0.20	000
43458		A	Dilate esophagus	3.06	6.74	6.73	1.64	1.55	0.24	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	1.89	1.79	0.31	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.71	NA	NA	5.42	5.32	1.45	090
43501		A	Surgical repair of stomach	22.47	NA	NA	8.44	8.42	2.65	090
43502		A	Surgical repair of stomach	25.56	NA	NA	9.29	9.35	3.10	090
43510		A	Surgical opening of stomach	15.01	NA	NA	7.79	7.51	1.48	090
43520		A	Incision of pyloric muscle	11.21	NA	NA	5.01	5.08	1.36	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.84	0.80	0.14	000
43605		A	Biopsy of stomach	13.64	NA	NA	5.51	5.47	1.58	090
43610		A	Excision of stomach lesion	16.26	NA	NA	6.28	6.26	1.94	090
43611		A	Excision of stomach lesion	20.25	NA	NA	7.87	7.81	2.36	090
43620		A	Removal of stomach	33.91	NA	NA	11.65	11.72	3.96	090
43621		A	Removal of stomach	39.40	NA	NA	13.09	12.84	4.04	090
43622		A	Removal of stomach	39.90	NA	NA	13.07	12.98	4.30	090
43631		A	Removal of stomach, partial	24.38	NA	NA	8.97	9.04	2.99	090
43632		A	Removal of stomach, partial	35.01	NA	NA	11.83	11.19	2.99	090
43633		A	Removal of stomach, partial	33.01	NA	NA	11.29	10.82	3.06	090
43634		A	Removal of stomach, partial	36.51	NA	NA	12.51	11.93	3.33	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.56	0.59	0.27	ZZZ
43640		A	Vagotomy & pylorus repair	19.43	NA	NA	7.61	7.54	2.26	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43641		A	Vagotomy & pylorus repair	19.68	NA	NA	7.57	7.54	2.25	090
43644		A	Lap gastric bypass/roux-en-y	29.24	NA	NA	10.61	10.79	3.16	090
43645		A	Lap gastr bypass incl smll i	31.37	NA	NA	11.09	11.35	3.54	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy, vagus nerve	10.13	NA	NA	4.83	4.82	1.33	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	5.22	5.37	1.55	090
43653		A	Laparoscopy, gastrostomy	8.38	NA	NA	4.56	4.47	1.01	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.29	0.28	0.02	000
43760		A	Change gastrostomy tube	0.90	9.52	7.67	0.35	0.37	0.09	000
43761		A	Reposition gastrostomy tube	2.01	1.11	1.13	0.78	0.75	0.13	000
43770		A	Lap place gastr adj device	17.85	NA	NA	7.70	7.72	2.19	090
43771		A	Lap revise gastr adj device	20.64	NA	NA	8.42	8.48	2.55	090
43772		A	Lap rmvl gastr adj device	15.62	NA	NA	6.38	6.40	1.93	090
43773		A	Lap replace gastr adj device	20.64	NA	NA	8.45	8.50	2.56	090
43774		A	Lap rmvl gastr adj all parts	15.66	NA	NA	6.38	6.44	1.85	090
43800		A	Reconstruction of pylorus	15.35	NA	NA	6.07	6.04	1.82	090
43810		A	Fusion of stomach and bowel	16.80	NA	NA	6.45	6.40	1.94	090
43820		A	Fusion of stomach and bowel	22.40	NA	NA	8.44	7.95	2.04	090
43825		A	Fusion of stomach and bowel	21.63	NA	NA	8.22	8.19	2.54	090
43830		A	Place gastrostomy tube	10.75	NA	NA	5.32	5.21	1.25	090
43831		A	Place gastrostomy tube	8.38	NA	NA	5.14	4.99	1.03	090
43832		A	Place gastrostomy tube	17.26	NA	NA	7.36	7.25	1.98	090
43840		A	Repair of stomach lesion	22.70	NA	NA	8.51	8.09	2.06	090
43842		N	V-band gastroplasty	20.90	NA	NA	9.13	8.81	2.45	090
43843		A	Gastroplasty w/o v-band	21.08	NA	NA	8.05	8.00	2.46	090
43845		A	Gastroplasty duodenal switch	33.12	NA	NA	12.00	11.72	4.06	090
43846		A	Gastric bypass for obesity	27.23	NA	NA	10.30	10.26	3.19	090
43847		A	Gastric bypass incl small i	30.10	NA	NA	10.74	10.80	3.56	090
43848		A	Revision gastroplasty	32.57	NA	NA	11.77	11.81	3.88	090
43850		A	Revise stomach-bowel fusion	27.45	NA	NA	9.61	9.69	3.28	090
43855		A	Revise stomach-bowel fusion	28.56	NA	NA	10.17	10.23	3.47	090
43860		A	Revise stomach-bowel fusion	27.76	NA	NA	9.94	9.97	3.31	090
43865		A	Revise stomach-bowel fusion	28.92	NA	NA	10.17	10.28	3.51	090
43870		A	Repair stomach opening	11.36	NA	NA	5.04	4.92	1.27	090
43880		A	Repair stomach-bowel fistula	27.05	NA	NA	9.73	9.79	3.27	090
43881		C	Impl/redo electrd, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.54	NA	NA	3.48	3.40	0.25	090
43887		A	Remove gastric port, open	4.24	NA	NA	3.11	3.03	0.51	090
43888		A	Change gastric port, open	6.34	NA	NA	3.97	3.93	0.70	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.38	NA	NA	6.88	6.85	2.15	090
44010		A	Incision of small bowel	14.18	NA	NA	5.77	5.70	1.64	090
44015		A	Insert needle cath bowel	2.62	NA	NA	0.74	0.78	0.35	ZZZ
44020		A	Explore small intestine	16.14	NA	NA	6.26	6.19	1.86	090
44021		A	Decompress small bowel	16.23	NA	NA	6.49	6.37	1.87	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44025		A	Incision of large bowel	16.43	NA	NA	6.37	6.30	1.90	090
44050		A	Reduce bowel obstruction	15.44	NA	NA	6.05	6.04	1.86	090
44055		A	Correct malrotation of bowel	25.53	NA	NA	8.93	8.90	2.91	090
44100		A	Biopsy of bowel	2.01	NA	NA	0.96	0.90	0.17	000
44110		A	Excise intestine lesion(s)	13.96	NA	NA	5.67	5.57	1.55	090
44111		A	Excision of bowel lesion(s)	16.44	NA	NA	6.28	6.25	1.87	090
44120		A	Removal of small intestine	20.74	NA	NA	7.48	7.40	2.25	090
44121		A	Removal of small intestine	4.44	NA	NA	1.20	1.28	0.58	ZZZ
44125		A	Removal of small intestine	19.93	NA	NA	7.34	7.34	2.27	090
44126		A	Enterectomy w/o taper, cong	42.02	NA	NA	14.28	14.27	4.69	090
44127		A	Enterectomy w/taper, cong	49.09	NA	NA	16.36	16.24	5.77	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.21	1.29	0.61	ZZZ
44130		A	Bowel to bowel fusion	21.98	NA	NA	8.31	7.80	1.88	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.60	0.64	0.28	ZZZ
44140		A	Partial removal of colon	22.46	NA	NA	8.43	8.50	2.71	090
44141		A	Partial removal of colon	29.75	NA	NA	12.24	11.72	2.53	090
44143		A	Partial removal of colon	27.63	NA	NA	10.70	10.72	3.05	090
44144		A	Partial removal of colon	29.75	NA	NA	11.08	10.74	2.86	090
44145		A	Partial removal of colon	28.45	NA	NA	9.94	10.18	3.29	090
44146		A	Partial removal of colon	35.14	NA	NA	13.87	13.65	3.41	090
44147		A	Partial removal of colon	33.56	NA	NA	11.36	10.71	2.56	090
44150		A	Removal of colon	29.99	NA	NA	13.00	12.78	3.04	090
44151		A	Removal of colon/ileostomy	34.73	NA	NA	14.36	14.15	3.49	090
44155		A	Removal of colon/ileostomy	34.23	NA	NA	13.86	13.75	3.28	090
44156		A	Removal of colon/ileostomy	37.23	NA	NA	15.32	15.28	3.95	090
44157		A	Colectomy w/ileoanal anast	35.49	NA	NA	14.26	14.26	3.93	090
44158		A	Colectomy w/neo-rectum pouch	36.49	NA	NA	14.48	14.48	4.06	090
44160		A	Removal of colon	20.78	NA	NA	7.84	7.83	2.37	090
44180		A	Lap, enterolysis	15.19	NA	NA	6.03	6.09	1.86	090
44186		A	Lap, jejunostomy	10.30	NA	NA	4.72	4.75	1.27	090
44187		A	Lap, ileo/jejuno-stomy	17.27	NA	NA	8.18	8.22	1.96	090
44188		A	Lap, colostomy	19.20	NA	NA	8.95	8.95	2.24	090
44202		A	Lap, enterectomy	23.26	NA	NA	8.66	8.75	2.85	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.18	1.26	0.57	ZZZ
44204		A	Laparo partial colectomy	26.29	NA	NA	9.31	9.49	3.11	090
44205		A	Lap colectomy part w/ileum	22.86	NA	NA	8.17	8.36	2.75	090
44206		A	Lap part colectomy w/stoma	29.63	NA	NA	10.91	11.02	3.46	090
44207		A	L colectomy/coloproctostomy	31.79	NA	NA	10.63	10.87	3.67	090
44208		A	L colectomy/coloproctostomy	33.86	NA	NA	12.41	12.62	3.88	090
44210		A	Laparo total proctocolectomy	29.88	NA	NA	11.62	11.71	3.42	090
44211		A	Lap colectomy w/proctectomy	36.87	NA	NA	13.99	14.20	4.17	090
44212		A	Laparo total proctocolectomy	34.37	NA	NA	13.57	13.63	3.78	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	0.92	1.00	0.44	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44227		A	Lap, close enterostomy	28.49	NA	NA	10.07	10.24	3.38	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.65	NA	NA	5.75	5.70	1.60	090
44310		A	Ileostomy/jejunostomy	17.49	NA	NA	6.68	6.70	1.99	090
44312		A	Revision of ileostomy	9.33	NA	NA	4.78	4.59	0.92	090
44314		A	Revision of ileostomy	16.61	NA	NA	7.05	6.94	1.75	090
44316		A	Devise bowel pouch	23.46	NA	NA	8.82	8.77	2.38	090
44320		A	Colostomy	19.75	NA	NA	7.89	7.85	2.26	090
44322		A	Colostomy with biopsies	13.15	NA	NA	9.16	9.03	1.54	090
44340		A	Revision of colostomy	9.12	NA	NA	5.03	4.85	0.99	090
44345		A	Revision of colostomy	17.06	NA	NA	7.17	7.11	1.97	090
44346		A	Revision of colostomy	19.47	NA	NA	7.79	7.71	2.13	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.54	1.44	0.19	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.68	1.57	0.21	000
44363		A	Small bowel endoscopy	3.49	NA	NA	1.86	1.75	0.27	000
44364		A	Small bowel endoscopy	3.73	NA	NA	2.07	1.93	0.27	000
44365		A	Small bowel endoscopy	3.31	NA	NA	1.85	1.73	0.24	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.44	2.27	0.32	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.49	2.30	0.33	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	2.72	2.54	0.37	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.17	2.06	0.35	000
44373		A	Small bowel endoscopy	3.49	NA	NA	1.86	1.75	0.27	000
44376		A	Small bowel endoscopy	5.25	NA	NA	2.62	2.48	0.42	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	2.90	2.71	0.40	000
44378		A	Small bowel endoscopy	7.12	NA	NA	3.66	3.43	0.52	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	3.92	3.68	0.62	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.76	0.71	0.08	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.89	0.83	0.12	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.69	1.59	0.21	000
44385		A	Endoscopy of bowel pouch	1.82	4.74	4.40	0.89	0.86	0.15	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.49	6.54	1.06	1.01	0.20	000
44388		A	Colonoscopy	2.82	5.98	5.76	1.40	1.34	0.26	000
44389		A	Colonoscopy with biopsy	3.13	6.92	6.86	1.62	1.53	0.27	000
44390		A	Colonoscopy for foreign body	3.82	7.89	7.71	1.87	1.77	0.32	000
44391		A	Colonoscopy for bleeding	4.31	8.56	8.62	2.20	2.08	0.34	000
44392		A	Colonoscopy & polypectomy	3.81	7.09	6.98	1.72	1.67	0.34	000
44393		A	Colonoscopy, lesion removal	4.83	7.93	7.69	2.25	2.16	0.42	000
44394		A	Colonoscopy w/snare	4.42	8.33	8.22	2.17	2.06	0.38	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.47	2.31	0.39	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.19	0.18	0.03	000
44602		A	Suture, small intestine	24.64	NA	NA	7.93	7.56	2.12	090
44603		A	Suture, small intestine	28.03	NA	NA	9.41	8.89	2.42	090
44604		A	Suture, large intestine	18.06	NA	NA	6.35	6.39	2.12	090
44605		A	Repair of bowel lesion	22.00	NA	NA	8.14	8.22	2.52	090
44615		A	Intestinal stricturoplasty	18.08	NA	NA	6.85	6.82	2.07	090
44620		A	Repair bowel opening	14.35	NA	NA	5.71	5.63	1.51	090
44625		A	Repair bowel opening	17.20	NA	NA	6.43	6.41	1.86	090
44626		A	Repair bowel opening	27.82	NA	NA	9.37	9.50	3.27	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44640		A	Repair bowel-skin fistula	24.12	NA	NA	8.44	8.49	2.78	090
44650		A	Repair bowel fistula	25.04	NA	NA	8.80	8.85	2.93	090
44660		A	Repair bowel-bladder fistula	23.83	NA	NA	9.88	9.52	2.14	090
44661		A	Repair bowel-bladder fistula	27.27	NA	NA	9.88	9.82	2.81	090
44680		A	Surgical revision, intestine	17.88	NA	NA	6.81	6.74	2.00	090
44700		A	Suspend bowel w/prosthesis	17.40	NA	NA	6.42	6.50	1.84	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	0.82	0.88	0.37	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	NA	1.67	1.69	0.37	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	1.78	2.08	0.97	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.94	NA	NA	5.63	5.58	1.47	090
44820		A	Excision of mesentery lesion	13.63	NA	NA	5.80	5.73	1.59	090
44850		A	Repair of mesentery	12.03	NA	NA	5.06	5.06	1.39	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	12.44	NA	NA	5.26	5.13	1.33	090
44901		A	Drain app abscess, percut	3.37	19.76	21.85	1.29	1.24	0.22	000
44950		A	Appendectomy	10.52	NA	NA	4.20	4.24	1.31	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.43	0.46	0.20	ZZZ
44960		A	Appendectomy	14.39	NA	NA	5.63	5.57	1.63	090
44970		A	Laparoscopy, appendectomy	9.35	NA	NA	4.32	4.27	1.14	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.20	NA	NA	3.68	3.51	0.52	090
45005		A	Drainage of rectal abscess	2.00	3.89	3.94	1.58	1.58	0.25	010
45020		A	Drainage of rectal abscess	8.43	NA	NA	4.66	4.32	0.55	090
45100		A	Biopsy of rectum	3.96	NA	NA	2.86	2.74	0.44	090
45108		A	Removal of anorectal lesion	5.04	NA	NA	3.16	3.07	0.59	090
45110		A	Removal of rectum	30.57	NA	NA	12.28	12.34	3.36	090
45111		A	Partial removal of rectum	17.89	NA	NA	7.25	7.25	2.07	090
45112		A	Removal of rectum	33.05	NA	NA	10.94	11.17	3.43	090
45113		A	Partial proctectomy	33.09	NA	NA	12.15	12.29	3.49	090
45114		A	Partial removal of rectum	30.63	NA	NA	10.60	10.69	3.36	090
45116		A	Partial removal of rectum	27.56	NA	NA	9.51	9.66	2.88	090
45119		A	Remove rectum w/reservoir	33.35	NA	NA	12.05	12.18	3.36	090
45120		A	Removal of rectum	26.25	NA	NA	9.93	10.00	2.90	090
45121		A	Removal of rectum and colon	28.93	NA	NA	10.51	10.68	3.25	090
45123		A	Partial proctectomy	18.70	NA	NA	7.22	7.14	1.86	090
45126		A	Pelvic exenteration	48.89	NA	NA	18.65	18.83	4.33	090
45130		A	Excision of rectal prolapse	18.37	NA	NA	6.94	6.91	1.80	090
45135		A	Excision of rectal prolapse	22.15	NA	NA	8.79	8.71	2.36	090
45136		A	Excise ileoanal reservior	30.63	NA	NA	12.33	12.40	2.82	090
45150		A	Excision of rectal stricture	5.77	NA	NA	3.67	3.50	0.61	090
45160		A	Excision of rectal lesion	16.17	NA	NA	6.86	6.82	1.68	090
45170		A	Excision of rectal lesion	12.48	NA	NA	5.52	5.47	1.35	090
45190		A	Destruction, rectal tumor	10.29	NA	NA	5.61	5.37	1.13	090
45300		A	Proctosigmoidoscopy dx	0.80	1.93	1.84	0.46	0.42	0.04	000
45303		A	Proctosigmoidoscopy dilate	1.50	19.34	19.22	0.67	0.59	0.05	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.14	3.02	0.61	0.59	0.11	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
45307		A	Proctosigmoidoscopy fb	1.70	3.07	3.06	0.69	0.64	0.11	000
45308		A	Proctosigmoidoscopy removal	1.40	3.29	2.97	0.64	0.59	0.09	000
45309		A	Proctosigmoidoscopy removal	1.50	3.50	3.34	0.71	0.74	0.22	000
45315		A	Proctosigmoidoscopy removal	1.80	3.67	3.47	0.86	0.81	0.15	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.29	3.09	0.78	0.75	0.15	000
45320		A	Proctosigmoidoscopy ablate	1.78	3.47	3.34	0.87	0.83	0.16	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	0.86	0.79	0.13	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.04	0.96	0.16	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.48	2.43	0.63	0.60	0.08	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.19	3.17	0.81	0.75	0.09	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.39	5.30	1.02	0.97	0.16	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.50	5.35	1.01	0.96	0.15	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.56	1.46	0.20	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.13	4.66	0.90	0.85	0.11	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.27	1.20	0.21	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.73	5.61	1.31	1.24	0.19	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.58	5.06	1.69	1.59	0.26	000
45340		A	Sig w/balloon dilation	1.89	10.00	9.06	1.07	1.01	0.15	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.51	1.40	0.19	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.23	2.06	0.30	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.62	1.51	0.23	000
45355		A	Surgical colonoscopy	3.51	NA	NA	1.56	1.52	0.36	000
45378		A	Diagnostic colonoscopy	3.69	6.25	6.24	1.88	1.78	0.30	000
45378	53	A	Diagnostic colonoscopy	0.96	2.48	2.43	0.63	0.60	0.08	000
45379		A	Colonoscopy w/fb removal	4.68	7.98	7.92	2.27	2.16	0.39	000
45380		A	Colonoscopy and biopsy	4.43	7.58	7.50	2.31	2.17	0.35	000
45381		A	Colonoscopy, submucous inj	4.19	7.53	7.45	2.22	2.08	0.30	000
45382		A	Colonoscopy/control bleeding	5.68	10.09	10.08	2.98	2.78	0.41	000
45383		A	Lesion removal colonoscopy	5.86	8.38	8.29	2.72	2.60	0.48	000
45384		A	Lesion remove colonoscopy	4.69	7.04	7.00	2.25	2.15	0.38	000
45385		A	Lesion removal colonoscopy	5.30	8.22	8.13	2.69	2.53	0.42	000
45386		A	Colonoscopy dilate stricture	4.57	11.98	12.11	2.25	2.14	0.39	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	3.04	2.87	0.48	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	2.64	2.48	0.42	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.31	3.11	0.42	000
45395		A	Lap, removal of rectum	32.79	NA	NA	13.53	13.60	3.63	090
45397		A	Lap, remove rectum w/pouch	36.29	NA	NA	14.03	14.12	3.67	090
45400		A	Laparoscopic proc	19.31	NA	NA	7.37	7.50	2.03	090
45402		A	Lap proctopexy w/sig resect	26.38	NA	NA	9.18	9.40	2.82	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.64	NA	NA	4.51	4.27	0.75	090
45505		A	Repair of rectum	8.20	NA	NA	5.15	4.84	0.86	090
45520		A	Treatment of rectal prolapse	0.55	2.81	2.52	0.39	0.38	0.05	000
45540		A	Correct rectal prolapse	18.02	NA	NA	6.69	6.73	1.85	090
45541		A	Correct rectal prolapse	14.72	NA	NA	6.78	6.59	1.55	090
45550		A	Repair rectum/remove sigmoid	24.67	NA	NA	9.32	9.32	2.62	090
45560		A	Repair of rectocele	11.42	NA	NA	5.67	5.52	1.13	090
45562		A	Exploration/repair of rectum	17.82	NA	NA	8.40	8.07	1.84	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
45563		A	Exploration/repair of rectum	26.22	NA	NA	11.08	10.97	3.11	090
45800		A	Repair rect/bladder fistula	20.18	NA	NA	9.54	9.03	1.86	090
45805		A	Repair fistula w/colostomy	23.19	NA	NA	9.94	9.85	2.03	090
45820		A	Repair rectourethral fistula	20.24	NA	NA	9.35	8.94	1.58	090
45825		A	Repair fistula w/colostomy	24.01	NA	NA	11.15	10.84	2.32	090
45900		A	Reduction of rectal prolapse	2.96	NA	NA	1.68	1.64	0.30	010
45905		A	Dilation of anal sphincter	2.32	NA	NA	1.62	1.58	0.27	010
45910		A	Dilation of rectal narrowing	2.82	NA	NA	1.86	1.81	0.30	010
45915		A	Remove rectal obstruction	3.16	4.15	4.20	2.03	2.05	0.30	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	0.76	0.77	0.17	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.94	3.16	2.96	2.30	2.20	0.31	010
46030		A	Removal of rectal marker	1.24	1.87	1.74	0.82	0.79	0.14	010
46040		A	Incision of rectal abscess	5.26	6.49	6.25	4.00	3.91	0.62	090
46045		A	Incision of rectal abscess	5.79	NA	NA	3.98	3.71	0.54	090
46050		A	Incision of anal abscess	1.21	3.12	2.98	0.98	0.94	0.14	010
46060		A	Incision of rectal abscess	6.24	NA	NA	4.47	4.17	0.67	090
46070		A	Incision of anal septum	2.74	NA	NA	2.80	2.57	0.36	090
46080		A	Incision of anal sphincter	2.50	3.05	2.88	1.16	1.15	0.30	010
46083		A	Incise external hemorrhoid	1.42	2.45	2.71	1.02	1.07	0.15	010
46200		A	Removal of anal fissure	3.48	6.20	5.63	3.71	3.51	0.39	090
46210		A	Removal of anal crypt	2.73	5.84	5.67	3.34	3.17	0.31	090
46211		A	Removal of anal crypts	4.31	7.53	7.01	4.50	4.26	0.48	090
46220		A	Removal of anal tag	1.58	2.99	2.82	1.11	1.08	0.17	010
46221		A	Ligation of hemorrhoid(s)	2.31	3.69	3.44	2.00	1.94	0.23	010
46230		A	Removal of anal tags	2.59	3.49	3.39	1.36	1.35	0.30	010
46250		A	Hemorrhoidectomy	4.17	5.95	5.80	2.88	2.82	0.48	090
46255		A	Hemorrhoidectomy	4.88	6.31	6.21	3.11	3.05	0.58	090
46257		A	Remove hemorrhoids & fissure	5.68	NA	NA	3.86	3.62	0.64	090
46258		A	Remove hemorrhoids & fistula	6.28	NA	NA	4.10	3.90	0.68	090
46260		A	Hemorrhoidectomy	6.65	NA	NA	4.12	3.89	0.76	090
46261		A	Remove hemorrhoids & fissure	7.63	NA	NA	4.38	4.19	0.79	090
46262		A	Remove hemorrhoids & fistula	7.80	NA	NA	4.79	4.54	0.83	090
46270		A	Removal of anal fistula	4.81	6.32	6.00	3.92	3.66	0.46	090
46275		A	Removal of anal fistula	5.31	6.58	6.11	3.99	3.75	0.52	090
46280		A	Removal of anal fistula	6.28	NA	NA	4.31	4.05	0.66	090
46285		A	Removal of anal fistula	5.31	6.50	5.83	3.98	3.68	0.44	090
46288		A	Repair anal fistula	7.68	NA	NA	4.79	4.52	0.79	090
46320		A	Removal of hemorrhoid clot	1.62	2.39	2.33	0.90	0.89	0.18	010
46500		A	Injection into hemorrhoid(s)	1.64	3.57	3.21	1.26	1.24	0.16	010
46505		A	Chemodenervation anal musc	3.13	3.29	3.23	2.31	2.23	0.14	010
46600		A	Diagnostic anoscopy	0.55	1.36	1.41	0.39	0.37	0.05	000
46604		A	Anoscopy and dilation	1.03	12.03	11.33	0.52	0.54	0.12	000
46606		A	Anoscopy and biopsy	1.20	3.85	3.84	0.60	0.56	0.09	000
46608		A	Anoscopy, remove for body	1.30	3.66	3.86	0.58	0.60	0.16	000
46610		A	Anoscopy, remove lesion	1.28	3.75	3.83	0.61	0.61	0.15	000
46611		A	Anoscopy	1.30	2.45	2.68	0.58	0.63	0.19	000
46612		A	Anoscopy, remove lesions	1.50	4.33	4.56	0.67	0.75	0.28	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
46614		A	Anoscopy, control bleeding	1.00	1.91	2.02	0.53	0.61	0.20	000
46615		A	Anoscopy	1.50	1.72	1.91	0.65	0.76	0.33	000
46700		A	Repair of anal stricture	9.68	NA	NA	5.27	5.01	0.94	090
46705		A	Repair of anal stricture	7.32	NA	NA	5.06	4.72	0.91	090
46706		A	Repr of anal fistula w/glue	2.41	NA	NA	1.53	1.46	0.28	010
46710		A	Repr per/vag pouch sngl proc	17.01	NA	NA	8.24	8.14	1.38	090
46712		A	Repr per/vag pouch dbl proc	36.32	NA	NA	14.14	14.40	3.67	090
46715		A	Rep perf anoper fistu	7.54	NA	NA	4.58	4.34	0.92	090
46716		A	Rep perf anoper/vestib fistu	17.14	NA	NA	13.84	12.40	1.58	090
46730		A	Construction of absent anus	30.17	NA	NA	15.18	14.42	2.47	090
46735		A	Construction of absent anus	35.66	NA	NA	17.02	16.19	3.21	090
46740		A	Construction of absent anus	33.42	NA	NA	14.96	14.56	2.42	090
46742		A	Repair of imperforated anus	39.66	NA	NA	16.59	16.82	3.20	090
46744		A	Repair of cloacal anomaly	58.46	NA	NA	20.70	20.85	6.40	090
46746		A	Repair of cloacal anomaly	64.93	NA	NA	26.94	26.55	7.70	090
46748		A	Repair of cloacal anomaly	70.91	NA	NA	28.94	27.68	3.37	090
46750		A	Repair of anal sphincter	12.02	NA	NA	5.98	5.76	1.10	090
46751		A	Repair of anal sphincter	9.19	NA	NA	5.62	5.58	0.94	090
46753		A	Reconstruction of anus	8.81	NA	NA	4.77	4.55	0.94	090
46754		A	Removal of suture from anus	2.88	3.72	3.69	2.29	2.14	0.19	010
46760		A	Repair of anal sphincter	17.21	NA	NA	8.18	7.92	1.59	090
46761		A	Repair of anal sphincter	15.16	NA	NA	6.69	6.53	1.43	090
46762		A	Implant artificial sphincter	14.66	NA	NA	7.26	6.84	1.24	090
46900		A	Destruction, anal lesion(s)	1.91	3.66	3.40	1.35	1.33	0.17	010
46910		A	Destruction, anal lesion(s)	1.88	3.89	3.65	1.25	1.20	0.19	010
46916		A	Cryosurgery, anal lesion(s)	1.88	3.80	3.65	1.64	1.58	0.11	010
46917		A	Laser surgery, anal lesions	1.88	8.65	8.79	1.24	1.21	0.21	010
46922		A	Excision of anal lesion(s)	1.88	4.06	3.87	1.22	1.18	0.22	010
46924		A	Destruction, anal lesion(s)	2.78	9.47	9.29	1.57	1.52	0.26	010
46930		A	Destroy internal hemorrhoids	1.56	3.02	3.54	1.79	2.09	0.16	090
46937		A	Cryotherapy of rectal lesion	2.70	3.42	3.27	1.56	1.48	0.14	010
46938		A	Cryotherapy of rectal lesion	4.70	5.99	5.50	3.84	3.65	0.58	090
46940		A	Treatment of anal fissure	2.33	2.82	2.62	1.07	1.08	0.23	010
46942		A	Treatment of anal fissure	2.05	2.78	2.55	0.98	0.99	0.19	010
46945		A	Ligation of hemorrhoids	2.13	4.69	4.34	2.93	2.82	0.19	090
46946		A	Ligation of hemorrhoids	2.60	4.56	4.36	2.63	2.58	0.27	090
46947		A	Hemorrhoidopexy by stapling	5.49	NA	NA	3.16	3.06	0.75	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	7.60	6.48	0.76	0.73	0.12	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.52	0.55	0.25	ZZZ
47010		A	Open drainage, liver lesion	19.27	NA	NA	8.56	8.54	1.81	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.47	1.41	0.22	000
47015		A	Inject/aspirate liver cyst	18.37	NA	NA	8.05	7.93	1.84	090
47100		A	Wedge biopsy of liver	12.78	NA	NA	6.48	6.38	1.53	090
47120		A	Partial removal of liver	38.82	NA	NA	14.67	14.82	4.66	090
47122		A	Extensive removal of liver	59.35	NA	NA	19.80	20.26	7.21	090
47125		A	Partial removal of liver	52.91	NA	NA	17.96	18.39	6.47	090
47130		A	Partial removal of liver	57.06	NA	NA	19.08	19.60	6.96	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.29	NA	NA	29.06	29.74	9.96	090
47136		R	Transplantation of liver	70.39	NA	NA	25.66	26.06	8.44	090
47140		A	Partial removal, donor liver	59.22	NA	NA	22.52	22.51	5.19	090
47141		A	Partial removal, donor liver	71.27	NA	NA	26.46	26.63	5.19	090
47142		A	Partial removal, donor liver	79.21	NA	NA	28.62	28.90	5.19	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	1.63	1.74	0.83	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	1.90	2.03	0.97	XXX
47300		A	Surgery for liver lesion	18.01	NA	NA	7.90	7.75	1.99	090
47350		A	Repair liver wound	22.36	NA	NA	9.21	9.15	2.59	090
47360		A	Repair liver wound	31.18	NA	NA	11.82	11.78	3.38	090
47361		A	Repair liver wound	52.47	NA	NA	17.67	17.92	5.87	090
47362		A	Repair liver wound	23.41	NA	NA	9.59	9.40	2.51	090
47370		A	Laparo ablate liver tumor rf	20.67	NA	NA	7.95	8.01	2.56	090
47371		A	Laparo ablate liver cryosurg	20.67	NA	NA	8.66	8.55	2.61	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.43	NA	NA	9.09	9.18	2.87	090
47381		A	Open ablate liver tumor cryo	24.72	NA	NA	9.57	9.60	2.85	090
47382		A	Percut ablate liver rf	15.19	NA	NA	6.81	6.64	0.96	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.23	NA	NA	13.21	13.29	3.08	090
47420		A	Incision of bile duct	21.92	NA	NA	8.88	8.87	2.63	090
47425		A	Incision of bile duct	22.20	NA	NA	8.93	8.92	2.62	090
47460		A	Incise bile duct sphincter	20.41	NA	NA	9.39	9.16	2.21	090
47480		A	Incision of gallbladder	13.12	NA	NA	6.83	6.61	1.42	090
47490		A	Incision of gallbladder	8.05	NA	NA	5.58	5.59	0.43	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.79	0.75	0.12	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.31	0.29	0.04	000
47510		A	Insert catheter, bile duct	7.94	NA	NA	4.90	4.94	0.46	090
47511		A	Insert bile duct drain	10.74	NA	NA	5.49	5.40	0.62	090
47525		A	Change bile duct catheter	1.54	13.38	13.84	1.29	1.67	0.33	010
47530		A	Revise/reinsert bile tube	5.96	30.57	31.45	3.68	3.70	0.37	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	0.85	0.90	0.40	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.76	2.67	0.42	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.50	2.39	0.37	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.49	3.46	0.96	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	3.06	2.92	0.45	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	3.46	3.30	0.50	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	1.37	1.45	0.65	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	1.66	1.73	0.66	000
47562		A	Laparoscopic cholecystectomy	11.63	NA	NA	5.42	5.32	1.46	090
47563		A	Laparo cholecystectomy/graph	12.03	NA	NA	5.24	5.26	1.58	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	NA	5.63	5.72	1.89	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	5.21	5.26	1.65	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
47600		A	Removal of gallbladder	17.35	NA	NA	7.46	7.14	1.80	090
47605		A	Removal of gallbladder	15.90	NA	NA	6.60	6.58	1.95	090
47610		A	Removal of gallbladder	20.84	NA	NA	7.98	7.98	2.49	090
47612		A	Removal of gallbladder	21.13	NA	NA	8.04	8.01	2.48	090
47620		A	Removal of gallbladder	22.99	NA	NA	8.61	8.61	2.74	090
47630		A	Remove bile duct stone	9.57	NA	NA	5.05	5.02	0.65	090
47700		A	Exploration of bile ducts	16.39	NA	NA	7.67	7.62	2.07	090
47701		A	Bile duct revision	28.62	NA	NA	12.93	12.60	3.68	090
47711		A	Excision of bile duct tumor	25.77	NA	NA	10.05	10.04	3.05	090
47712		A	Excision of bile duct tumor	33.59	NA	NA	12.14	12.24	3.93	090
47715		A	Excision of bile duct cyst	21.42	NA	NA	8.81	8.73	2.49	090
47720		A	Fuse gallbladder & bowel	18.21	NA	NA	7.98	7.87	2.11	090
47721		A	Fuse upper gi structures	21.86	NA	NA	8.96	8.88	2.53	090
47740		A	Fuse gallbladder & bowel	21.10	NA	NA	8.68	8.62	2.42	090
47741		A	Fuse gallbladder & bowel	24.08	NA	NA	9.59	9.53	2.83	090
47760		A	Fuse bile ducts and bowel	38.14	NA	NA	13.67	12.99	3.42	090
47765		A	Fuse liver ducts & bowel	52.01	NA	NA	18.02	16.25	3.30	090
47780		A	Fuse bile ducts and bowel	42.14	NA	NA	14.79	13.92	3.50	090
47785		A	Fuse bile ducts and bowel	56.01	NA	NA	18.80	17.36	4.10	090
47800		A	Reconstruction of bile ducts	26.04	NA	NA	10.11	10.12	3.08	090
47801		A	Placement, bile duct support	17.47	NA	NA	8.99	8.80	1.16	090
47802		A	Fuse liver duct & intestine	24.80	NA	NA	10.06	9.98	2.86	090
47900		A	Suture bile duct injury	22.31	NA	NA	9.01	8.99	2.65	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.82	NA	NA	11.71	11.68	3.48	090
48001		A	Placement of drain, pancreas	39.56	NA	NA	13.51	13.63	4.69	090
48020		A	Removal of pancreatic stone	18.96	NA	NA	8.07	7.89	2.13	090
48100		A	Biopsy of pancreas, open	14.38	NA	NA	6.12	6.00	1.62	090
48102		A	Needle biopsy, pancreas	4.68	9.70	9.28	2.09	2.06	0.28	010
48105		A	Resect/debride pancreas	49.05	NA	NA	16.63	16.65	5.56	090
48120		A	Removal of pancreas lesion	18.33	NA	NA	7.13	7.07	2.10	090
48140		A	Partial removal of pancreas	26.19	NA	NA	9.77	9.73	3.03	090
48145		A	Partial removal of pancreas	27.26	NA	NA	10.06	10.02	3.18	090
48146		A	Pancreatectomy	30.42	NA	NA	12.27	12.22	3.50	090
48148		A	Removal of pancreatic duct	20.26	NA	NA	8.20	8.07	2.30	090
48150		A	Partial removal of pancreas	52.63	NA	NA	18.85	19.06	6.32	090
48152		A	Pancreatectomy	48.47	NA	NA	17.68	17.85	5.80	090
48153		A	Pancreatectomy	52.61	NA	NA	18.74	18.98	6.31	090
48154		A	Pancreatectomy	48.70	NA	NA	17.56	17.77	5.84	090
48155		A	Removal of pancreas	29.27	NA	NA	12.32	12.18	3.27	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection, intraop add-on	1.95	NA	NA	0.74	0.71	0.15	ZZZ
48500		A	Surgery of pancreatic cyst	18.03	NA	NA	8.14	7.96	2.03	090
48510		A	Drain pancreatic pseudocyst	17.06	NA	NA	7.75	7.69	1.83	090
48511		A	Drain pancreatic pseudocyst	3.99	20.21	20.43	1.59	1.53	0.24	000
48520		A	Fuse pancreas cyst and bowel	18.07	NA	NA	7.15	7.05	2.06	090
48540		A	Fuse pancreas cyst and bowel	21.86	NA	NA	8.02	8.06	2.61	090
48545		A	Pancreatorrhaphy	22.10	NA	NA	8.48	8.37	2.38	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
48547		A	Duodenal exclusion	30.25	NA	NA	10.74	10.70	3.42	090
48548		A	Fuse pancreas and bowel	27.96	NA	NA	10.38	10.35	3.28	090
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.23	1.29	0.31	XXX
48554		R	Transpl allograft pancreas	37.03	NA	NA	21.04	20.39	4.19	090
48556		A	Removal, allograft pancreas	19.24	NA	NA	9.78	9.37	2.08	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.44	NA	NA	5.40	5.41	1.52	090
49002		A	Reopening of abdomen	17.55	NA	NA	6.65	6.26	1.37	090
49010		A	Exploration behind abdomen	15.98	NA	NA	6.52	6.38	1.51	090
49020		A	Drain abdominal abscess	26.46	NA	NA	10.31	10.30	2.85	090
49021		A	Drain abdominal abscess	3.37	19.57	19.99	1.34	1.29	0.20	000
49040		A	Drain, open, abdom abscess	16.41	NA	NA	6.76	6.69	1.70	090
49041		A	Drain, percut, abdom abscess	3.99	19.87	19.83	1.59	1.52	0.24	000
49060		A	Drain, open, retrop abscess	18.42	NA	NA	7.56	7.54	1.75	090
49061		A	Drain, percut, retroper absc	3.69	19.70	19.73	1.47	1.41	0.22	000
49062		A	Drain to peritoneal cavity	12.12	NA	NA	5.37	5.40	1.39	090
49080		A	Puncture, peritoneal cavity	1.35	2.72	3.05	0.52	0.51	0.08	000
49081		A	Removal of abdominal fluid	1.26	2.92	2.84	0.50	0.48	0.09	000
49180		A	Biopsy, abdominal mass	1.73	2.52	2.67	0.68	0.66	0.10	000
49203		A	Exc abd tum 5 cm or less	20.00	NA	NA	8.03	8.03	2.27	090
49204		A	Exc abd tum over 5 cm	26.00	NA	NA	9.76	9.76	2.94	090
49205		A	Exc abd tum over 10 cm	30.00	NA	NA	10.92	10.92	3.40	090
49215		A	Excise sacral spine tumor	37.66	NA	NA	13.37	13.57	4.38	090
49220		A	Multiple surgery, abdomen	15.70	NA	NA	6.59	6.61	1.89	090
49250		A	Excision of umbilicus	8.93	NA	NA	4.49	4.44	1.08	090
49255		A	Removal of omentum	12.41	NA	NA	5.79	5.76	1.43	090
49320		A	Diag laparo separate proc	5.09	NA	NA	2.51	2.55	0.65	010
49321		A	Laparoscopy, biopsy	5.39	NA	NA	2.63	2.64	0.70	010
49322		A	Laparoscopy, aspiration	5.96	NA	NA	2.73	2.80	0.71	010
49323		A	Laparo drain lymphocele	10.13	NA	NA	4.82	4.75	1.20	090
49324		A	Lap insertion perm ip cath	6.27	NA	NA	2.85	2.85	0.73	010
49325		A	Lap revision perm ip cath	6.77	NA	NA	2.97	2.97	0.86	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	0.95	0.95	0.44	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.52	2.67	0.69	0.68	0.15	000
49402		A	Remove foreign body, adbomen	14.01	NA	NA	5.78	5.72	1.62	090
49419		A	Insrt abdom cath for chemotx	7.03	NA	NA	3.57	3.58	0.81	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.21	1.18	0.21	000
49421		A	Insert abdom drain, perm	5.87	NA	NA	3.20	3.20	0.74	090
49422		A	Remove perm cannula/catheter	6.26	NA	NA	2.72	2.77	0.83	010
49423		A	Exchange drainage catheter	1.46	13.06	13.35	0.63	0.60	0.09	000
49424		A	Assess cyst, contrast inject	0.76	3.08	3.25	0.33	0.32	0.04	000
49425		A	Insert abdomen-venous drain	12.13	NA	NA	5.53	5.56	1.54	090
49426		A	Revise abdomen-venous shunt	10.33	NA	NA	4.74	4.76	1.28	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.35	0.34	0.07	000
49428		A	Ligation of shunt	6.79	NA	NA	3.22	3.41	0.80	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
49429		A	Removal of shunt	7.41	NA	NA	3.17	3.24	1.02	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.60	0.60	0.28	ZZZ
49436		A	Embedded ip cath exit-site	2.69	NA	NA	1.61	1.61	0.28	010
49440		A	Place gastrostomy tube perc	4.18	24.42	24.42	1.91	1.91	0.49	010
49441		A	Place duod/jej tube perc	4.77	26.44	26.44	2.12	2.12	0.29	010
49442		A	Place cecostomy tube perc	4.00	23.99	23.99	1.69	1.69	0.24	010
49446		A	Change g-tube to g-j perc	3.31	22.87	22.87	1.28	1.28	0.18	000
49450		A	Replace g/c tube perc	1.36	18.27	18.27	0.47	0.47	0.08	000
49451		A	Replace duod/jej tube perc	1.84	16.82	16.82	0.71	0.71	0.11	000
49452		A	Replace g-j tube perc	2.86	20.61	20.61	1.11	1.11	0.18	000
49460		A	Fix g/colon tube w/device	0.96	20.59	20.59	0.35	0.35	0.05	000
49465		A	Fluoro exam of g/colon tube	0.62	3.87	3.87	0.24	0.24	0.03	000
49491		A	Rpr hern preemie reduc	12.42	NA	NA	5.58	5.46	1.40	090
49492		A	Rpr ing hern premie, blocked	15.32	NA	NA	6.55	6.45	1.81	090
49495		A	Rpr ing hernia baby, reduc	6.15	NA	NA	2.91	2.93	0.74	090
49496		A	Rpr ing hernia baby, blocked	9.32	NA	NA	4.56	4.49	1.07	090
49500		A	Rpr ing hernia, init, reduce	5.76	NA	NA	3.35	3.30	0.71	090
49501		A	Rpr ing hernia, init blocked	9.28	NA	NA	4.45	4.39	1.12	090
49505		A	Prp i/hern init reduc >5 yr	7.88	NA	NA	3.97	3.93	1.03	090
49507		A	Prp i/hern init block >5 yr	9.97	NA	NA	4.59	4.56	1.27	090
49520		A	Rerepair ing hernia, reduce	9.91	NA	NA	4.51	4.50	1.28	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	NA	5.16	5.19	1.59	090
49525		A	Repair ing hernia, sliding	8.85	NA	NA	4.23	4.20	1.13	090
49540		A	Repair lumbar hernia	10.66	NA	NA	4.74	4.75	1.37	090
49550		A	Rpr rem hernia, init, reduce	8.91	NA	NA	4.22	4.20	1.14	090
49553		A	Rpr fem hernia, init blocked	9.84	NA	NA	4.53	4.51	1.24	090
49555		A	Rerepair fem hernia, reduce	9.31	NA	NA	4.33	4.33	1.20	090
49557		A	Rerepair fem hernia, blocked	11.54	NA	NA	5.00	5.01	1.47	090
49560		A	Rpr ventral hern init, reduc	11.84	NA	NA	5.04	5.07	1.52	090
49561		A	Rpr ventral hern init, block	15.30	NA	NA	6.02	6.04	1.89	090
49565		A	Rerepair ventrl hern, reduce	12.29	NA	NA	5.28	5.28	1.52	090
49566		A	Rerepair ventrl hern, block	15.45	NA	NA	6.08	6.11	1.91	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	1.33	1.42	0.64	ZZZ
49570		A	Rpr epigastric hern, reduce	5.97	NA	NA	3.43	3.37	0.75	090
49572		A	Rpr epigastric hern, blocked	7.79	NA	NA	3.91	3.81	0.88	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.39	NA	NA	3.02	2.92	0.54	090
49582		A	Rpr umbil hern, block < 5 yr	7.05	NA	NA	3.83	3.74	0.88	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.51	NA	NA	3.58	3.52	0.82	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	NA	3.96	3.91	0.99	090
49590		A	Repair spigelian hernia	8.82	NA	NA	4.20	4.18	1.13	090
49600		A	Repair umbilical lesion	11.47	NA	NA	5.41	5.40	1.32	090
49605		A	Repair umbilical lesion	86.85	NA	NA	29.51	29.33	9.39	090
49606		A	Repair umbilical lesion	18.92	NA	NA	6.99	7.18	2.46	090
49610		A	Repair umbilical lesion	10.83	NA	NA	4.86	4.96	1.07	090
49611		A	Repair umbilical lesion	9.26	NA	NA	4.45	5.10	0.78	090
49650		A	Lap ing hernia repair init	6.30	NA	NA	3.41	3.37	0.93	090
49651		A	Lap ing hernia repair recur	8.29	NA	NA	4.31	4.25	1.14	090
49652		A	Lap vent/abd hernia repair	12.80	NA	NA	5.43	5.43	1.64	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
49653		A	Lap vent/abd hern proc comp	16.10	NA	NA	6.71	6.71	1.99	090
49654		A	Lap inc hernia repair	14.95	NA	NA	6.02	6.02	1.83	090
49655		A	Lap inc hern repair comp	18.00	NA	NA	7.23	7.23	2.22	090
49656		A	Lap inc hernia repair recur	15.00	NA	NA	6.03	6.03	1.86	090
49657		A	Lap inc hern recur comp	22.00	NA	NA	8.32	8.32	2.73	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.26	NA	NA	6.45	6.41	1.62	090
49904		A	Omental flap, extra-abdom	22.16	NA	NA	12.05	12.87	2.70	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	1.81	1.94	0.75	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.13	NA	NA	7.03	6.59	0.93	090
50020		A	Renal abscess, open drain	17.88	NA	NA	9.12	8.80	1.34	090
50021		A	Renal abscess, percut drain	3.37	21.01	21.22	1.34	1.28	0.20	000
50040		A	Drainage of kidney	16.48	NA	NA	9.49	8.83	1.03	090
50045		A	Exploration of kidney	16.67	NA	NA	9.44	8.75	1.24	090
50060		A	Removal of kidney stone	20.80	NA	NA	11.51	10.61	1.36	090
50065		A	Incision of kidney	22.17	NA	NA	12.25	10.73	1.59	090
50070		A	Incision of kidney	21.70	NA	NA	12.05	11.11	1.44	090
50075		A	Removal of kidney stone	26.91	NA	NA	14.51	13.39	1.81	090
50080		A	Removal of kidney stone	15.61	NA	NA	9.07	8.39	1.04	090
50081		A	Removal of kidney stone	23.32	NA	NA	12.93	11.91	1.54	090
50100		A	Revise kidney blood vessels	17.30	NA	NA	7.67	7.72	2.07	090
50120		A	Exploration of kidney	17.06	NA	NA	9.58	8.89	1.21	090
50125		A	Explore and drain kidney	17.67	NA	NA	9.71	9.04	1.43	090
50130		A	Removal of kidney stone	18.67	NA	NA	10.66	9.80	1.22	090
50135		A	Exploration of kidney	20.44	NA	NA	11.23	10.38	1.33	090
50200		A	Biopsy of kidney	2.63	NA	NA	1.27	1.27	0.16	000
50205		A	Biopsy of kidney	12.19	NA	NA	5.71	5.54	1.30	090
5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.53	NA	NA	10.08	9.39	1.35	090
50225		A	Removal kidney open, complex	21.73	NA	NA	11.45	10.65	1.50	090
50230		A	Removal kidney open, radical	23.68	NA	NA	12.42	11.48	1.55	090
50234		A	Removal of kidney & ureter	23.90	NA	NA	12.74	11.79	1.59	090
50236		A	Removal of kidney & ureter	26.74	NA	NA	14.79	13.68	1.77	090
50240		A	Partial removal of kidney	24.01	NA	NA	13.39	12.32	1.55	090
50250		A	Cryoablate renal mass open	22.06	NA	NA	12.49	11.69	1.39	090
50280		A	Removal of kidney lesion	16.94	NA	NA	9.62	8.91	1.19	090
50290		A	Removal of kidney lesion	16.00	NA	NA	8.00	7.63	1.41	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.28	NA	NA	13.02	12.45	2.36	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.18	1.23	0.29	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.05	1.09	0.26	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.23	1.20	0.25	XXX
50340		A	Removal of kidney	13.86	NA	NA	7.71	7.42	1.65	090
50360		A	Transplantation of kidney	40.45	NA	NA	19.24	18.34	3.82	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50365		A	Transplantation of kidney	45.68	NA	NA	21.16	20.46	4.43	090
50370		A	Remove transplanted kidney	18.68	NA	NA	9.43	8.88	1.68	090
50380		A	Reimplantation of kidney	29.66	NA	NA	18.90	17.22	2.51	090
50382		A	Change ureter stent, percut	5.50	26.62	29.07	2.30	2.19	0.34	000
50384		A	Remove ureter stent, percut	5.00	21.14	24.72	2.09	2.00	0.31	000
50385		A	Change stent via transureth	4.44	29.44	29.44	2.15	2.15	0.27	000
50386		A	Remove stent via transureth	3.30	18.64	18.64	1.68	1.68	0.20	000
50387		A	Change ext/int ureter stent	2.00	12.59	14.03	0.82	0.79	0.12	000
50389		A	Remove renal tube w/fluoro	1.10	6.65	8.20	0.44	0.43	0.07	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.79	0.75	0.12	000
50391		A	Instll rx agnt into rnal tub	1.96	1.52	1.54	0.84	0.79	0.14	000
50392		A	Insert kidney drain	3.37	NA	NA	1.65	1.62	0.20	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.97	1.93	0.25	000
50394		A	Injection for kidney x-ray	0.76	1.89	2.09	0.61	0.62	0.05	000
50395		A	Create passage to kidney	3.37	NA	NA	1.70	1.65	0.21	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.19	1.16	0.13	000
50398		A	Change kidney tube	1.46	11.78	12.94	0.62	0.60	0.09	000
50400		A	Revision of kidney/ureter	21.12	NA	NA	11.46	10.59	1.38	090
50405		A	Revision of kidney/ureter	25.68	NA	NA	13.89	12.71	1.79	090
50500		A	Repair of kidney wound	21.07	NA	NA	9.39	9.16	2.02	090
50520		A	Close kidney-skin fistula	18.73	NA	NA	10.22	9.54	1.49	090
50525		A	Repair renal-abdomen fistula	24.21	NA	NA	11.79	11.12	1.84	090
50526		A	Repair renal-abdomen\fistula	26.13	NA	NA	11.10	10.81	1.97	090
50540		A	Revision of horseshoe kidney	20.95	NA	NA	10.67	10.10	1.36	090
50541		A	Laparo ablate renal cyst	16.76	NA	NA	9.20	8.54	1.13	090
50542		A	Laparo ablate renal mass	21.18	NA	NA	11.85	10.95	1.39	090
50543		A	Laparo partial nephrectomy	27.18	NA	NA	14.95	13.79	1.81	090
50544		A	Laparoscopy, pyeloplasty	23.27	NA	NA	12.08	11.22	1.58	090
50545		A	Laparo radical nephrectomy	24.93	NA	NA	13.01	12.08	1.71	090
50546		A	Laparoscopic nephrectomy	21.69	NA	NA	11.98	11.10	1.57	090
50547		A	Laparo removal donor kidney	26.24	NA	NA	12.97	12.53	2.77	090
50548		A	Laparo remove w/ureter	25.26	NA	NA	12.97	12.05	1.73	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.73	4.59	2.83	2.62	0.40	000
50553		A	Kidney endoscopy	5.98	4.74	4.66	2.89	2.71	0.39	000
50555		A	Kidney endoscopy & biopsy	6.52	5.14	5.07	3.19	2.98	0.45	000
50557		A	Kidney endoscopy & treatment	6.61	5.40	5.21	3.27	3.03	0.47	000
50561		A	Kidney endoscopy & treatment	7.58	6.05	5.82	3.69	3.43	0.54	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	5.69	5.36	0.73	090
50570		A	Kidney endoscopy	9.53	NA	NA	4.53	4.21	0.68	000
50572		A	Kidney endoscopy	10.33	NA	NA	4.88	4.55	0.85	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	5.13	4.80	0.77	000
50575		A	Kidney endoscopy	13.96	NA	NA	6.45	6.01	0.99	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	5.16	4.80	0.78	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	5.39	5.05	0.83	000
50590		A	Fragmenting of kidney stone	9.64	17.13	15.98	6.42	5.85	0.65	090
50592		A	Perc rf ablate renal tumor	6.77	72.43	91.82	3.31	3.24	0.43	010
50593		A	Perc cryo ablate renal tum	9.08	118.15	118.15	3.59	3.59	0.58	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50600		A	Exploration of ureter	17.04	NA	NA	9.29	8.65	1.13	090
50605		A	Insert ureteral support	16.66	NA	NA	8.19	7.84	1.45	090
50610		A	Removal of ureter stone	17.12	NA	NA	9.55	8.92	1.43	090
50620		A	Removal of ureter stone	16.30	NA	NA	9.32	8.59	1.07	090
50630		A	Removal of ureter stone	16.08	NA	NA	8.75	8.15	1.09	090
50650		A	Removal of ureter	18.67	NA	NA	10.50	9.70	1.23	090
50660		A	Removal of ureter	20.87	NA	NA	11.29	10.48	1.38	090
50684		A	Injection for ureter x-ray	0.76	3.92	4.19	0.65	0.61	0.05	000
50686		A	Measure ureter pressure	1.51	NA	NA	1.03	0.98	0.11	000
50688		A	Change of ureter tube/stent	1.18	NA	NA	0.99	1.01	0.07	010
50690		A	Injection for ureter x-ray	1.16	1.49	1.58	0.79	0.77	0.07	000
50700		A	Revision of ureter	16.54	NA	NA	9.28	8.76	1.27	090
50715		A	Release of ureter	20.49	NA	NA	8.99	8.94	2.14	090
50722		A	Release of ureter	17.80	NA	NA	7.73	7.77	1.91	090
50725		A	Release/revise ureter	20.05	NA	NA	10.17	9.66	1.52	090
50727		A	Revise ureter	8.17	NA	NA	5.96	5.55	0.61	090
50728		A	Revise ureter	12.00	NA	NA	7.15	6.77	1.00	090
50740		A	Fusion of ureter & kidney	19.92	NA	NA	9.39	8.99	1.97	090
50750		A	Fusion of ureter & kidney	21.07	NA	NA	11.77	10.85	1.38	090
50760		A	Fusion of ureters	19.92	NA	NA	10.31	9.67	1.55	090
50770		A	Splicing of ureters	21.07	NA	NA	10.31	9.74	1.45	090
50780		A	Reimplant ureter in bladder	19.80	NA	NA	10.66	9.91	1.51	090
50782		A	Reimplant ureter in bladder	19.51	NA	NA	9.81	9.57	1.61	090
50783		A	Reimplant ureter in bladder	20.52	NA	NA	9.80	9.42	1.99	090
50785		A	Reimplant ureter in bladder	22.08	NA	NA	11.92	11.04	1.45	090
50800		A	Implant ureter in bowel	16.23	NA	NA	9.66	8.88	1.19	090
50810		A	Fusion of ureter & bowel	22.38	NA	NA	10.41	10.11	2.32	090
50815		A	Urine shunt to intestine	22.06	NA	NA	12.42	11.45	1.54	090
50820		A	Construct bowel bladder	23.89	NA	NA	12.57	11.61	1.90	090
50825		A	Construct bowel bladder	30.48	NA	NA	15.97	14.79	2.08	090
50830		A	Revise urine flow	33.57	NA	NA	16.54	15.48	2.38	090
50840		A	Replace ureter by bowel	22.19	NA	NA	12.62	11.59	1.47	090
50845		A	Appendico-vesicostomy	22.21	NA	NA	13.01	12.01	1.57	090
50860		A	Transplant ureter to skin	16.93	NA	NA	9.66	8.92	1.29	090
50900		A	Repair of ureter	14.89	NA	NA	8.39	7.85	1.14	090
50920		A	Closure ureter/skin fistula	15.66	NA	NA	9.15	8.52	1.01	090
50930		A	Closure ureter/bowel fistula	20.04	NA	NA	9.53	9.16	1.28	090
50940		A	Release of ureter	15.78	NA	NA	9.02	8.38	1.26	090
50945		A	Laparoscopy ureterolithotomy	17.87	NA	NA	9.58	8.96	1.36	090
50947		A	Laparo new ureter/bladder	25.63	NA	NA	13.05	12.24	2.17	090
50948		A	Laparo new ureter/bladder	23.69	NA	NA	12.63	11.67	1.71	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.98	4.81	2.96	2.74	0.41	000
50953		A	Endoscopy of ureter	6.23	5.19	5.00	3.50	3.22	0.43	000
50955		A	Ureter endoscopy & biopsy	6.74	5.42	5.68	3.71	3.46	0.48	000
50957		A	Ureter endoscopy & treatment	6.78	5.52	5.29	3.33	3.10	0.48	000
50961		A	Ureter endoscopy & treatment	6.04	5.03	4.87	3.03	2.82	0.41	000
50970		A	Ureter endoscopy	7.13	NA	NA	3.48	3.23	0.52	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	3.30	3.10	0.49	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	4.37	4.06	0.64	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	4.26	3.97	0.66	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	3.37	3.12	0.48	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.56	NA	NA	5.66	5.22	0.47	090
51030		A	Incise & treat bladder	7.68	NA	NA	5.20	4.90	0.58	090
51040		A	Incise & drain bladder	4.43	NA	NA	3.80	3.55	0.31	090
51045		A	Incise bladder/drain ureter	7.68	NA	NA	5.37	5.02	0.52	090
51050		A	Removal of bladder stone	7.87	NA	NA	5.56	5.09	0.49	090
51060		A	Removal of ureter stone	9.82	NA	NA	6.66	6.13	0.62	090
51065		A	Remove ureter calculus	9.82	NA	NA	6.54	6.01	0.63	090
51080		A	Drainage of bladder abscess	6.61	NA	NA	4.79	4.49	0.43	090
51100		A	Drain bladder by needle	0.78	0.89	0.89	0.28	0.28	0.05	000
51101		A	Drain bladder by trocar/cath	1.02	2.41	2.41	0.38	0.38	0.10	000
51102		A	Drain bl w/cath insertion	2.70	3.72	3.72	1.38	1.38	0.28	000
51500		A	Removal of bladder cyst	10.92	NA	NA	6.16	5.88	1.03	090
51520		A	Removal of bladder lesion	10.08	NA	NA	6.34	5.94	0.69	090
51525		A	Removal of bladder lesion	15.29	NA	NA	8.98	8.28	0.99	090
51530		A	Removal of bladder lesion	13.58	NA	NA	7.81	7.31	1.05	090
51535		A	Repair of ureter lesion	13.77	NA	NA	7.74	7.34	1.23	090
51550		A	Partial removal of bladder	17.10	NA	NA	9.28	8.66	1.31	090
51555		A	Partial removal of bladder	23.03	NA	NA	12.08	11.25	1.70	090
51565		A	Revise bladder & ureter(s)	23.50	NA	NA	12.48	11.62	1.63	090
51570		A	Removal of bladder	27.31	NA	NA	13.89	12.88	1.72	090
51575		A	Removal of bladder & nodes	34.00	NA	NA	17.60	16.24	2.17	090
51580		A	Remove bladder/revise tract	35.14	NA	NA	18.75	17.23	2.25	090
51585		A	Removal of bladder & nodes	39.41	NA	NA	20.62	18.93	2.49	090
51590		A	Remove bladder/revise tract	36.15	NA	NA	18.39	16.98	2.28	090
51595		A	Remove bladder/revise tract	41.12	NA	NA	20.92	19.26	2.60	090
51596		A	Remove bladder/create pouch	44.01	NA	NA	22.75	20.91	2.78	090
51597		A	Removal of pelvic structures	42.61	NA	NA	21.53	19.90	2.82	090
51600		A	Injection for bladder x-ray	0.88	4.22	4.44	0.36	0.34	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.44	0.42	0.04	000
51610		A	Injection for bladder x-ray	1.05	1.91	2.01	0.73	0.70	0.07	000
51700		A	Irrigation of bladder	0.88	1.49	1.52	0.37	0.34	0.06	000
51701		A	Insert bladder catheter	0.50	1.03	1.17	0.26	0.24	0.04	000
51702		A	Insert temp bladder cath	0.50	1.51	1.66	0.35	0.32	0.04	000
51703		A	Insert bladder cath, complex	1.47	2.28	2.40	0.85	0.78	0.10	000
51705		A	Change of bladder tube	1.03	2.02	2.09	0.87	0.81	0.07	010
51710		A	Change of bladder tube	1.50	2.73	2.89	1.22	1.11	0.11	010
51715		A	Endoscopic injection/implant	3.73	4.46	4.33	1.84	1.72	0.29	000
51720		A	Treatment of bladder lesion	1.50	1.65	1.68	0.79	0.77	0.14	000
51725		A	Simple cystometrogram	1.51	4.19	4.54	NA	NA	0.16	000
51725	TC	A	Simple cystometrogram	0.00	3.59	3.97	NA	NA	0.04	000
51725	26	A	Simple cystometrogram	1.51	0.60	0.57	0.60	0.57	0.12	000
51726		A	Complex cystometrogram	1.71	6.98	7.13	NA	NA	0.18	000
51726	TC	A	Complex cystometrogram	0.00	6.29	6.47	NA	NA	0.05	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
51726	26	A	Complex cystometrogram	1.71	0.69	0.66	0.69	0.66	0.13	000
51736		A	Urine flow measurement	0.61	0.95	0.85	NA	NA	0.06	000
51736	TC	A	Urine flow measurement	0.00	0.69	0.61	NA	NA	0.01	000
51736	26	A	Urine flow measurement	0.61	0.26	0.24	0.26	0.24	0.05	000
51741		A	Electro-uroflowmetry, first	1.14	1.29	1.16	NA	NA	0.11	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.81	0.71	NA	NA	0.02	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.48	0.45	0.48	0.45	0.09	000
51772		A	Urethra pressure profile	1.61	5.00	5.15	NA	NA	0.20	000
51772	TC	A	Urethra pressure profile	0.00	4.41	4.57	NA	NA	0.05	000
51772	26	A	Urethra pressure profile	1.61	0.59	0.58	0.59	0.58	0.15	000
51784		A	Anal/urinary muscle study	1.53	4.01	4.01	NA	NA	0.16	000
51784	TC	A	Anal/urinary muscle study	0.00	3.41	3.44	NA	NA	0.04	000
51784	26	A	Anal/urinary muscle study	1.53	0.60	0.57	0.60	0.57	0.12	000
51785		A	Anal/urinary muscle study	1.53	4.51	4.50	NA	NA	0.15	000
51785	TC	A	Anal/urinary muscle study	0.00	3.90	3.92	NA	NA	0.04	000
51785	26	A	Anal/urinary muscle study	1.53	0.61	0.58	0.61	0.58	0.11	000
51792		A	Urinary reflex study	1.10	4.92	5.20	NA	NA	0.20	000
51792	TC	A	Urinary reflex study	0.00	4.50	4.78	NA	NA	0.13	000
51792	26	A	Urinary reflex study	1.10	0.42	0.42	0.42	0.42	0.07	000
51795		A	Urine voiding pressure study	1.53	6.58	6.77	NA	NA	0.22	000
51795	TC	A	Urine voiding pressure study	0.00	5.97	6.19	NA	NA	0.10	000
51795	26	A	Urine voiding pressure study	1.53	0.61	0.58	0.61	0.58	0.12	000
51797		A	Intraabdominal pressure test	0.80	2.41	3.26	NA	NA	0.17	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	2.09	2.89	NA	NA	0.05	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.32	0.37	0.32	0.37	0.12	ZZZ
51798		A	Us urine capacity measure	0.00	0.58	0.52	NA	NA	0.08	XXX
51800		A	Revision of bladder/urethra	18.74	NA	NA	10.54	9.82	1.32	090
51820		A	Revision of urinary tract	19.41	NA	NA	9.75	9.41	1.75	090
51840		A	Attach bladder/urethra	11.28	NA	NA	6.03	5.93	1.06	090
51841		A	Attach bladder/urethra	13.60	NA	NA	6.96	6.83	1.24	090
51845		A	Repair bladder neck	10.07	NA	NA	6.06	5.74	0.79	090
51860		A	Repair of bladder wound	12.49	NA	NA	6.99	6.70	1.16	090
51865		A	Repair of bladder wound	15.69	NA	NA	8.72	8.22	1.23	090
51880		A	Repair of bladder opening	7.81	NA	NA	4.90	4.67	0.72	090
51900		A	Repair bladder/vagina lesion	14.48	NA	NA	8.16	7.65	1.21	090
51920		A	Close bladder-uterus fistula	13.26	NA	NA	7.65	7.16	1.18	090
51925		A	Hysterectomy/bladder repair	17.35	NA	NA	9.01	8.93	2.04	090
51940		A	Correction of bladder defect	30.48	NA	NA	13.75	13.37	2.15	090
51960		A	Revision of bladder & bowel	25.20	NA	NA	13.87	12.84	1.63	090
51980		A	Construct bladder opening	12.44	NA	NA	7.58	7.04	0.86	090
51990		A	Laparo urethral suspension	13.26	NA	NA	6.48	6.41	1.39	090
51992		A	Laparo sling operation	14.77	NA	NA	6.92	6.75	1.41	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	3.67	3.59	1.38	1.23	0.14	000
52001		A	Cystoscopy, removal of clots	5.44	5.19	5.17	2.76	2.54	0.39	000
52005		A	Cystoscopy & ureter catheter	2.37	5.70	5.68	1.44	1.31	0.17	000
52007		A	Cystoscopy and biopsy	3.02	10.64	12.12	1.72	1.58	0.22	000
52010		A	Cystoscopy & duct catheter	3.02	7.35	8.22	1.54	1.44	0.21	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52204		A	Cystoscopy w/biopsy(s)	2.59	8.23	9.82	1.46	1.32	0.17	000
52214		A	Cystoscopy and treatment	3.70	15.55	12.58	1.95	2.36	0.26	000
52224		A	Cystoscopy and treatment	3.14	14.74	20.22	1.71	1.57	0.22	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	2.42	2.24	0.33	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.82	2.60	0.39	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	4.67	4.34	0.69	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	2.44	2.25	0.32	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	2.05	1.90	0.28	000
52265		A	Cystoscopy and treatment	2.94	7.38	8.89	1.53	1.43	0.22	000
52270		A	Cystoscopy & revise urethra	3.36	7.00	8.03	1.85	1.70	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	9.30	10.89	2.43	2.24	0.33	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	2.61	2.41	0.35	000
52277		A	Cystoscopy and treatment	6.16	NA	NA	3.08	2.87	0.44	000
52281		A	Cystoscopy and treatment	2.80	5.28	5.75	1.63	1.49	0.20	000
52282		A	Cystoscopy, implant stent	6.39	NA	NA	3.16	2.93	0.45	000
52283		A	Cystoscopy and treatment	3.73	4.15	4.10	1.99	1.84	0.26	000
52285		A	Cystoscopy and treatment	3.60	4.37	4.29	1.94	1.79	0.26	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	2.42	2.23	0.32	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.70	2.51	0.38	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.89	2.67	0.46	000
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.66	2.46	0.38	000
52310		A	Cystoscopy and treatment	2.81	4.04	4.21	1.52	1.40	0.20	000
52315		A	Cystoscopy and treatment	5.20	6.70	7.21	2.64	2.45	0.37	000
52317		A	Remove bladder stone	6.71	16.97	20.02	3.22	2.99	0.48	000
52318		A	Remove bladder stone	9.18	NA	NA	4.35	4.04	0.65	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	2.36	2.18	0.33	000
52325		A	Cystoscopy, stone removal	6.15	NA	NA	3.00	2.78	0.44	000
52327		A	Cystoscopy, inject material	5.18	2.21	9.64	2.21	2.12	0.37	000
52330		A	Cystoscopy and treatment	5.03	9.32	16.74	2.50	2.32	0.36	000
52332		A	Cystoscopy and treatment	2.83	12.26	10.65	1.64	1.50	0.21	000
52334		A	Create passage to kidney	4.82	NA	NA	2.51	2.32	0.35	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.93	2.75	0.43	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	3.15	2.96	0.46	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	3.46	3.25	0.51	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	3.83	3.58	0.55	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	4.06	3.79	0.58	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	4.51	4.22	0.65	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	3.15	2.90	0.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	3.69	3.40	0.49	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	4.16	3.85	0.57	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	3.89	3.59	0.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	4.54	4.20	0.63	000
52400		A	Cystouretero w/congen repr	8.66	NA	NA	5.00	4.69	0.68	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	2.35	2.19	0.40	000
52450		A	Incision of prostate	7.63	NA	NA	5.68	5.19	0.54	090
52500		A	Revision of bladder neck	7.99	NA	NA	5.85	5.38	0.60	090
52601		A	Prostatectomy (TURP)	15.13	NA	NA	8.91	7.63	0.87	090
52630		A	Remove prostate regrowth	7.65	NA	NA	5.02	4.52	0.51	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52640		A	Relieve bladder contracture	4.73	NA	NA	3.68	3.51	0.47	090
52647		A	Laser surgery of prostate	11.15	41.48	49.72	7.23	6.57	0.73	090
52648		A	Laser surgery of prostate	12.00	42.02	50.13	7.58	6.90	0.79	090
52649		A	Prostate laser enucleation	17.16	NA	NA	9.87	9.87	1.11	090
52700		A	Drainage of prostate abscess	7.39	NA	NA	4.94	4.51	0.48	090
53000		A	Incision of urethra	2.30	NA	NA	1.85	1.78	0.16	010
53010		A	Incision of urethra	4.35	NA	NA	3.96	3.70	0.24	090
53020		A	Incision of urethra	1.77	NA	NA	1.00	0.92	0.13	000
53025		A	Incision of urethra	1.13	NA	NA	0.68	0.64	0.08	000
53040		A	Drainage of urethra abscess	6.49	NA	NA	4.52	4.26	0.45	090
53060		A	Drainage of urethra abscess	2.65	2.00	2.03	1.50	1.47	0.28	010
53080		A	Drainage of urinary leakage	6.82	NA	NA	4.79	5.09	0.52	090
53085		A	Drainage of urinary leakage	11.05	NA	NA	5.07	5.67	0.92	090
53200		A	Biopsy of urethra	2.59	1.76	1.66	1.37	1.27	0.20	000
53210		A	Removal of urethra	13.59	NA	NA	8.07	7.53	0.89	090
53215		A	Removal of urethra	16.72	NA	NA	9.66	8.92	1.10	090
53220		A	Treatment of urethra lesion	7.53	NA	NA	5.19	4.83	0.49	090
53230		A	Removal of urethra lesion	10.31	NA	NA	6.55	6.11	0.73	090
53235		A	Removal of urethra lesion	10.86	NA	NA	7.21	6.65	0.72	090
53240		A	Surgery for urethra pouch	6.98	NA	NA	5.16	4.76	0.52	090
53250		A	Removal of urethra gland	6.42	NA	NA	4.85	4.47	0.49	090
53260		A	Treatment of urethra lesion	3.00	2.47	2.42	1.88	1.77	0.25	010
53265		A	Treatment of urethra lesion	3.14	2.96	2.91	2.04	1.89	0.24	010
53270		A	Removal of urethra gland	3.11	2.43	2.38	1.85	1.77	0.30	010
53275		A	Repair of urethra defect	4.54	NA	NA	2.90	2.74	0.32	010
53400		A	Revise urethra, stage 1	13.98	NA	NA	8.57	7.95	0.98	090
53405		A	Revise urethra, stage 2	15.51	NA	NA	9.37	8.63	1.10	090
53410		A	Reconstruction of urethra	17.53	NA	NA	10.22	9.45	1.16	090
53415		A	Reconstruction of urethra	20.55	NA	NA	11.58	10.54	1.37	090
53420		A	Reconstruct urethra, stage 1	15.04	NA	NA	7.29	7.05	0.96	090
53425		A	Reconstruct urethra, stage 2	16.94	NA	NA	9.73	9.04	1.13	090
53430		A	Reconstruction of urethra	17.30	NA	NA	9.10	8.59	1.15	090
53431		A	Reconstruct urethra/bladder	21.03	NA	NA	11.61	10.74	1.41	090
53440		A	Male sling procedure	15.34	NA	NA	9.70	8.79	0.96	090
53442		A	Remove/revise male sling	13.29	NA	NA	8.80	7.98	0.82	090
53444		A	Insert tandem cuff	14.06	NA	NA	8.48	7.84	0.94	090
53445		A	Insert uro/ves nck sphincter	15.21	NA	NA	9.63	9.01	0.99	090
53446		A	Remove uro sphincter	10.89	NA	NA	7.33	6.82	0.72	090
53447		A	Remove/replace ur sphincter	14.15	NA	NA	8.80	8.22	0.95	090
53448		A	Remov/replc ur sphinctr comp	23.26	NA	NA	13.05	12.08	1.50	090
53449		A	Repair uro sphincter	10.43	NA	NA	6.95	6.41	0.68	090
53450		A	Revision of urethra	6.67	NA	NA	4.95	4.55	0.43	090
53460		A	Revision of urethra	7.65	NA	NA	5.34	4.94	0.50	090
53500		A	Urethrlys, transvag w/ scope	12.87	NA	NA	7.64	7.30	0.90	090
53502		A	Repair of urethra injury	8.16	NA	NA	5.45	5.09	0.62	090
53505		A	Repair of urethra injury	8.16	NA	NA	5.65	5.21	0.54	090
53510		A	Repair of urethra injury	10.83	NA	NA	6.99	6.54	0.74	090
53515		A	Repair of urethra injury	14.09	NA	NA	8.31	7.73	1.05	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
53520		A	Repair of urethra defect	9.35	NA	NA	6.38	5.92	0.61	090
53600		A	Dilate urethra stricture	1.21	1.18	1.17	0.61	0.57	0.09	000
53601		A	Dilate urethra stricture	0.98	1.38	1.35	0.55	0.51	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.55	0.51	0.09	000
53620		A	Dilate urethra stricture	1.62	1.73	1.80	0.88	0.81	0.11	000
53621		A	Dilate urethra stricture	1.35	1.83	1.89	0.71	0.66	0.10	000
53660		A	Dilation of urethra	0.71	1.32	1.32	0.47	0.43	0.05	000
53661		A	Dilation of urethra	0.72	1.30	1.30	0.44	0.40	0.05	000
53665		A	Dilation of urethra	0.76	NA	NA	0.29	0.28	0.06	000
53850		A	Prostatic microwave thermotx	9.98	48.53	60.07	6.18	5.63	0.67	090
53852		A	Prostatic rf thermotx	10.68	45.78	56.68	6.98	6.34	0.70	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.56	2.72	2.78	1.53	1.38	0.11	010
54001		A	Slitting of prepuce	2.21	3.08	3.11	1.72	1.57	0.15	010
54015		A	Drain penis lesion	5.33	NA	NA	3.37	3.17	0.38	010
54050		A	Destruction, penis lesion(s)	1.26	2.13	2.01	1.43	1.33	0.08	010
54055		A	Destruction, penis lesion(s)	1.23	1.99	1.89	1.26	1.15	0.08	010
54056		A	Cryosurgery, penis lesion(s)	1.26	2.33	2.17	1.53	1.43	0.06	010
54057		A	Laser surg, penis lesion(s)	1.26	2.59	2.50	1.37	1.24	0.09	010
54060		A	Excision of penis lesion(s)	1.95	3.11	3.12	1.69	1.53	0.13	010
54065		A	Destruction, penis lesion(s)	2.44	3.27	3.12	2.02	1.83	0.13	010
54100		A	Biopsy of penis	1.90	3.35	3.22	1.42	1.27	0.10	000
54105		A	Biopsy of penis	3.51	4.06	4.12	2.54	2.40	0.25	010
54110		A	Treatment of penis lesion	10.79	NA	NA	6.83	6.33	0.72	090
54111		A	Treat penis lesion, graft	14.29	NA	NA	8.47	7.81	0.96	090
54112		A	Treat penis lesion, graft	16.83	NA	NA	9.86	9.12	1.11	090
54115		A	Treatment of penis lesion	6.82	5.97	5.58	5.16	4.74	0.43	090
54120		A	Partial removal of penis	10.88	NA	NA	7.05	6.47	0.68	090
54125		A	Removal of penis	14.43	NA	NA	8.54	7.88	0.95	090
54130		A	Remove penis & nodes	21.66	NA	NA	12.28	11.28	1.52	090
54135		A	Remove penis & nodes	27.99	NA	NA	15.04	13.85	1.88	090
54150		A	Circumcision w/regionl block	1.90	2.34	2.73	0.76	0.75	0.16	000
54160		A	Circumcision, neonate	2.50	3.86	3.94	1.59	1.47	0.19	010
54161		A	Circum 28 days or older	3.29	NA	NA	2.30	2.12	0.23	010
54162		A	Lysis penil circumic lesion	3.27	4.04	4.20	2.34	2.12	0.21	010
54163		A	Repair of circumcision	3.27	NA	NA	2.95	2.72	0.21	010
54164		A	Frenulotomy of penis	2.77	NA	NA	2.73	2.51	0.18	010
54200		A	Treatment of penis lesion	1.08	2.02	1.97	1.32	1.24	0.08	010
54205		A	Treatment of penis lesion	8.84	NA	NA	6.31	5.92	0.56	090
54220		A	Treatment of penis lesion	2.42	3.33	3.47	1.40	1.29	0.17	000
54230		A	Prepare penis study	1.34	1.44	1.36	0.95	0.87	0.09	000
54231		A	Dynamic cavernosometry	2.04	2.01	1.85	1.30	1.20	0.16	000
54235		A	Penile injection	1.19	1.42	1.31	0.93	0.84	0.08	000
54240		A	Penis study	1.31	1.59	1.45	NA	NA	0.17	000
54240	TC	A	Penis study	0.00	1.04	0.93	NA	NA	0.06	000
54240	26	A	Penis study	1.31	0.55	0.52	0.55	0.52	0.11	000
54250		A	Penis study	2.22	1.33	1.23	NA	NA	0.18	000
54250	TC	A	Penis study	0.00	0.37	0.33	NA	NA	0.02	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
54250	26	A	Penis study	2.22	0.96	0.90	0.96	0.90	0.16	000
54300		A	Revision of penis	11.07	NA	NA	7.15	6.77	0.76	090
54304		A	Revision of penis	13.15	NA	NA	8.21	7.75	0.88	090
54308		A	Reconstruction of urethra	12.49	NA	NA	7.87	7.41	0.84	090
54312		A	Reconstruction of urethra	14.36	NA	NA	8.93	8.46	1.24	090
54316		A	Reconstruction of urethra	17.90	NA	NA	10.52	9.89	1.21	090
54318		A	Reconstruction of urethra	12.28	NA	NA	7.94	7.42	1.39	090
54322		A	Reconstruction of urethra	13.85	NA	NA	8.38	7.91	0.92	090
54324		A	Reconstruction of urethra	17.40	NA	NA	10.18	9.64	1.14	090
54326		A	Reconstruction of urethra	16.87	NA	NA	8.71	8.50	1.11	090
54328		A	Revise penis/urethra	16.74	NA	NA	9.69	9.10	0.98	090
54332		A	Revise penis/urethra	18.22	NA	NA	10.66	9.94	1.21	090
54336		A	Revise penis/urethra	21.44	NA	NA	9.79	9.93	2.21	090
54340		A	Secondary urethral surgery	9.58	NA	NA	6.22	5.93	0.63	090
54344		A	Secondary urethral surgery	16.91	NA	NA	10.08	9.51	1.54	090
54348		A	Secondary urethral surgery	18.17	NA	NA	10.71	10.14	1.23	090
54352		A	Reconstruct urethra/penis	25.95	NA	NA	14.39	13.61	2.25	090
54360		A	Penis plastic surgery	12.65	NA	NA	7.85	7.41	0.84	090
54380		A	Repair penis	14.03	NA	NA	8.71	8.20	0.93	090
54385		A	Repair penis	16.38	NA	NA	11.45	10.68	0.86	090
54390		A	Repair penis and bladder	22.59	NA	NA	10.00	9.87	1.54	090
54400		A	Insert semi-rigid prosthesis	9.09	NA	NA	5.99	5.59	0.64	090
54401		A	Insert self-contd prosthesis	10.26	NA	NA	8.41	7.75	0.73	090
54405		A	Insert multi-comp penis pros	14.39	NA	NA	8.57	7.93	0.95	090
54406		A	Remove muti-comp penis pros	12.76	NA	NA	7.99	7.36	0.86	090
54408		A	Repair multi-comp penis pros	13.73	NA	NA	8.67	7.95	0.90	090
54410		A	Remove/replace penis prosth	15.00	NA	NA	9.40	8.72	1.10	090
54411		A	Remov/replc penis pros, comp	18.14	NA	NA	10.99	10.03	1.13	090
54415		A	Remove self-contd penis pros	8.75	NA	NA	6.23	5.74	0.58	090
54416		A	Remv/repl penis contain pros	11.87	NA	NA	8.26	7.55	0.77	090
54417		A	Remv/replc penis pros, compl	15.94	NA	NA	9.61	8.77	1.00	090
54420		A	Revision of penis	12.26	NA	NA	7.81	7.26	0.81	090
54430		A	Revision of penis	10.93	NA	NA	7.30	6.77	0.72	090
54435		A	Revision of penis	6.71	NA	NA	5.15	4.78	0.43	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.88	0.90	0.52	0.50	0.08	000
54500		A	Biopsy of testis	1.31	NA	NA	0.84	0.77	0.10	000
54505		A	Biopsy of testis	3.47	NA	NA	2.53	2.38	0.27	010
54512		A	Excise lesion testis	9.23	NA	NA	5.88	5.45	0.67	090
54520		A	Removal of testis	5.25	NA	NA	3.84	3.59	0.50	090
54522		A	Orchiectomy, partial	10.15	NA	NA	5.93	5.67	0.89	090
54530		A	Removal of testis	8.35	NA	NA	5.93	5.52	0.66	090
54535		A	Extensive testis surgery	13.06	NA	NA	7.55	7.06	0.95	090
54550		A	Exploration for testis	8.31	NA	NA	5.50	5.09	0.59	090
54560		A	Exploration for testis	11.97	NA	NA	6.56	6.22	0.90	090
54600		A	Reduce testis torsion	7.54	NA	NA	5.31	4.88	0.51	090
54620		A	Suspension of testis	5.16	NA	NA	3.39	3.16	0.37	010
54640		A	Suspension of testis	7.57	NA	NA	5.59	5.13	0.62	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
54650		A	Orchiopexy (Fowler-Stephens)	12.24	NA	NA	7.58	7.05	1.16	090
54660		A	Revision of testis	5.64	NA	NA	4.43	4.08	0.44	090
54670		A	Repair testis injury	6.57	NA	NA	4.83	4.52	0.47	090
54680		A	Relocation of testis(es)	13.91	NA	NA	7.88	7.46	1.16	090
54690		A	Laparoscopy, orchiectomy	11.60	NA	NA	5.79	5.59	1.02	090
54692		A	Laparoscopy, orchiopexy	13.64	NA	NA	8.00	7.37	1.30	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.44	NA	NA	2.44	2.32	0.28	010
54800		A	Biopsy of epididymis	2.33	NA	NA	1.38	1.27	0.23	000
54830		A	Remove epididymis lesion	5.91	NA	NA	4.59	4.20	0.41	090
54840		A	Remove epididymis lesion	5.22	NA	NA	3.94	3.65	0.37	090
54860		A	Removal of epididymis	6.85	NA	NA	5.05	4.62	0.45	090
54861		A	Removal of epididymis	9.57	NA	NA	6.44	5.92	0.63	090
54865		A	Explore epididymis	5.67	NA	NA	4.47	4.09	0.40	090
54900		A	Fusion of spermatic ducts	14.05	NA	NA	6.91	6.64	0.93	090
54901		A	Fusion of spermatic ducts	18.92	NA	NA	11.12	10.24	1.83	090
55000		A	Drainage of hydrocele	1.43	1.87	1.92	0.95	0.88	0.11	000
55040		A	Removal of hydrocele	5.39	NA	NA	4.10	3.80	0.43	090
55041		A	Removal of hydroceles	8.41	NA	NA	5.92	5.44	0.60	090
55060		A	Repair of hydrocele	6.05	NA	NA	4.62	4.24	0.46	090
55100		A	Drainage of scrotum abscess	2.40	3.48	3.54	2.13	1.99	0.17	010
55110		A	Explore scrotum	6.23	NA	NA	4.62	4.26	0.43	090
55120		A	Removal of scrotum lesion	5.62	NA	NA	4.35	4.01	0.39	090
55150		A	Removal of scrotum	8.01	NA	NA	5.73	5.27	0.56	090
55175		A	Revision of scrotum	5.77	NA	NA	4.49	4.13	0.37	090
55180		A	Revision of scrotum	11.63	NA	NA	7.59	7.05	0.90	090
55200		A	Incision of sperm duct	4.50	7.97	9.08	3.26	3.05	0.33	090
55250		A	Removal of sperm duct(s)	3.32	7.75	8.70	3.11	2.89	0.25	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.49	1.45	0.25	000
55400		A	Repair of sperm duct	8.53	NA	NA	5.69	5.29	0.64	090
55450		A	Ligation of sperm duct	4.38	5.88	6.18	2.84	2.61	0.29	010
55500		A	Removal of hydrocele	6.12	NA	NA	4.32	4.02	0.55	090
55520		A	Removal of sperm cord lesion	6.56	NA	NA	3.89	3.74	0.75	090
55530		A	Revise spermatic cord veins	5.69	NA	NA	4.26	3.95	0.45	090
55535		A	Revise spermatic cord veins	7.09	NA	NA	5.01	4.61	0.47	090
55540		A	Revise hernia & sperm veins	8.20	NA	NA	4.40	4.26	0.94	090
55550		A	Laparo ligate spermatic vein	7.10	NA	NA	4.77	4.41	0.57	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.91	NA	NA	5.10	4.67	0.62	090
55605		A	Incise sperm duct pouch	8.63	NA	NA	5.35	5.10	0.64	090
55650		A	Remove sperm duct pouch	12.52	NA	NA	7.57	7.01	0.92	090
55680		A	Remove sperm pouch lesion	5.59	NA	NA	3.86	3.64	0.47	090
55700		A	Biopsy of prostate	2.58	3.74	3.86	1.41	1.22	0.11	000
55705		A	Biopsy of prostate	4.58	NA	NA	3.00	2.83	0.32	010
55706		A	Prostate saturation sampling	6.15	NA	NA	4.39	4.39	0.39	010
55720		A	Drainage of prostate abscess	7.67	NA	NA	5.05	4.75	0.95	090
55725		A	Drainage of prostate abscess	9.90	NA	NA	6.76	6.20	0.70	090
55801		A	Removal of prostate	19.62	NA	NA	11.10	10.25	1.34	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
55810		A	Extensive prostate surgery	24.14	NA	NA	12.99	12.00	1.60	090
55812		A	Extensive prostate surgery	29.69	NA	NA	15.86	14.67	2.05	090
55815		A	Extensive prostate surgery	32.75	NA	NA	17.27	15.96	2.17	090
55821		A	Removal of prostate	15.63	NA	NA	9.18	8.45	1.01	090
55831		A	Removal of prostate	17.06	NA	NA	9.80	9.03	1.10	090
55840		A	Extensive prostate surgery	24.45	NA	NA	13.47	12.45	1.61	090
55842		A	Extensive prostate surgery	26.31	NA	NA	14.33	13.23	1.73	090
55845		A	Extensive prostate surgery	30.52	NA	NA	15.88	14.67	2.03	090
55860		A	Surgical exposure, prostate	15.71	NA	NA	9.09	8.44	1.02	090
55862		A	Extensive prostate surgery	19.89	NA	NA	11.34	10.49	1.49	090
55865		A	Extensive prostate surgery	24.39	NA	NA	13.59	12.53	1.63	090
55866		A	Laparo radical prostatectomy	32.25	NA	NA	17.07	15.76	2.17	090
55870		A	Electroejaculation	2.58	2.52	2.28	1.52	1.41	0.16	000
55873		A	Cryoablate prostate	20.25	NA	NA	11.92	11.20	1.38	090
55875		A	Transperi needle place, pros	13.31	NA	NA	8.23	7.65	0.89	090
55876		A	Place rt device/marker, pros	1.73	2.09	2.09	1.10	1.10	0.28	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	3.42	3.42	0.58	000
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.46	1.18	1.22	1.16	1.16	0.17	010
56420		A	Drainage of gland abscess	1.41	1.51	1.71	0.79	0.85	0.16	010
56440		A	Surgery for vulva lesion	2.86	NA	NA	1.59	1.63	0.34	010
56441		A	Lysis of labial lesion(s)	1.99	1.73	1.75	1.58	1.54	0.20	010
56442		A	Hymenotomy	0.68	NA	NA	0.53	0.53	0.08	000
56501		A	Destroy, vulva lesions, sim	1.55	1.64	1.68	1.23	1.24	0.18	010
56515		A	Destroy vulva lesion/s compl	3.03	2.42	2.46	1.79	1.80	0.33	010
56605		A	Biopsy of vulva/perineum	1.10	0.93	0.97	0.36	0.39	0.13	000
56606		A	Biopsy of vulva/perineum	0.55	0.37	0.40	0.16	0.18	0.07	ZZZ
56620		A	Partial removal of vulva	7.35	NA	NA	4.71	4.74	0.90	090
56625		A	Complete removal of vulva	9.55	NA	NA	4.92	5.03	1.02	090
56630		A	Extensive vulva surgery	14.67	NA	NA	6.55	6.64	1.49	090
56631		A	Extensive vulva surgery	18.81	NA	NA	8.05	8.26	1.96	090
56632		A	Extensive vulva surgery	21.61	NA	NA	9.68	9.66	2.39	090
56633		A	Extensive vulva surgery	19.47	NA	NA	8.18	8.30	1.98	090
56634		A	Extensive vulva surgery	20.48	NA	NA	8.57	8.81	2.17	090
56637		A	Extensive vulva surgery	24.57	NA	NA	9.63	10.01	2.61	090
56640		A	Extensive vulva surgery	24.65	NA	NA	9.28	9.64	2.89	090
56700		A	Partial removal of hymen	2.79	NA	NA	1.78	1.79	0.30	010
56740		A	Remove vagina gland lesion	4.83	NA	NA	2.38	2.43	0.56	010
56800		A	Repair of vagina	3.90	NA	NA	2.05	2.09	0.44	010
56805		A	Repair clitoris	19.75	NA	NA	8.02	8.39	2.15	090
56810		A	Repair of perineum	4.26	NA	NA	2.11	2.16	0.49	010
56820		A	Exam of vulva w/scope	1.50	1.21	1.24	0.56	0.58	0.18	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.55	1.61	0.72	0.77	0.25	000
57000		A	Exploration of vagina	2.99	NA	NA	1.72	1.72	0.31	010
57010		A	Drainage of pelvic abscess	6.74	NA	NA	3.85	3.84	0.71	090
57020		A	Drainage of pelvic fluid	1.50	0.78	0.82	0.47	0.50	0.18	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
57022		A	I & d vaginal hematoma, pp	2.70	NA	NA	1.39	1.41	0.26	010
57023		A	I & d vag hematoma, non-ob	5.13	NA	NA	2.49	2.51	0.58	010
57061		A	Destroy vag lesions, simple	1.27	1.51	1.55	1.12	1.12	0.15	010
57065		A	Destroy vag lesions, complex	2.63	2.04	2.11	1.52	1.56	0.31	010
57100		A	Biopsy of vagina	1.20	0.96	0.99	0.39	0.41	0.14	000
57105		A	Biopsy of vagina	1.71	1.60	1.65	1.34	1.37	0.20	010
57106		A	Remove vagina wall, partial	7.35	NA	NA	4.40	4.35	0.73	090
57107		A	Remove vagina tissue, part	24.43	NA	NA	9.55	9.80	2.72	090
57109		A	Vaginectomy partial w/nodes	28.25	NA	NA	10.62	10.80	3.22	090
57110		A	Remove vagina wall, complete	15.38	NA	NA	6.45	6.67	1.74	090
57111		A	Remove vagina tissue, compl	28.25	NA	NA	10.78	11.27	3.18	090
57112		A	Vaginectomy w/nodes, compl	30.37	NA	NA	11.64	11.78	3.08	090
57120		A	Closure of vagina	8.18	NA	NA	4.32	4.40	0.89	090
57130		A	Remove vagina lesion	2.44	1.99	2.03	1.51	1.52	0.29	010
57135		A	Remove vagina lesion	2.68	2.05	2.11	1.56	1.59	0.31	010
57150		A	Treat vagina infection	0.55	0.59	0.72	0.16	0.18	0.07	000
57155		A	Insert uteri tandems/ovoids	6.79	NA	NA	3.58	3.84	0.43	090
57160		A	Insert pessary/other device	0.89	1.05	1.04	0.27	0.29	0.10	000
57170		A	Fitting of diaphragm/cap	0.91	0.58	0.81	0.27	0.28	0.11	000
57180		A	Treat vaginal bleeding	1.60	1.86	1.94	0.95	1.03	0.19	010
57200		A	Repair of vagina	4.34	NA	NA	3.00	2.98	0.46	090
57210		A	Repair vagina/perineum	5.63	NA	NA	3.39	3.41	0.62	090
57220		A	Revision of urethra	4.77	NA	NA	3.10	3.11	0.51	090
57230		A	Repair of urethral lesion	6.22	NA	NA	3.78	3.70	0.54	090
57240		A	Repair bladder & vagina	11.42	NA	NA	5.71	5.25	0.62	090
57250		A	Repair rectum & vagina	11.42	NA	NA	5.26	4.85	0.65	090
57260		A	Repair of vagina	14.36	NA	NA	6.12	5.81	0.97	090
57265		A	Extensive repair of vagina	15.86	NA	NA	6.66	6.52	1.32	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	1.62	1.71	0.64	ZZZ
57268		A	Repair of bowel bulge	7.47	NA	NA	4.45	4.39	0.79	090
57270		A	Repair of bowel pouch	13.57	NA	NA	5.95	6.04	1.42	090
57280		A	Suspension of vagina	16.62	NA	NA	7.21	7.26	1.68	090
57282		A	Colpopexy, extraperitoneal	7.84	NA	NA	4.65	4.62	1.02	090
57283		A	Colpopexy, intraperitoneal	11.58	NA	NA	5.30	5.47	1.02	090
57284		A	Repair paravag defect, open	14.25	NA	NA	6.24	6.48	1.41	090
57285		A	Repair paravag defect, vag	11.52	NA	NA	5.36	5.36	0.63	090
57287		A	Revise/remove sling repair	10.97	NA	NA	7.03	6.66	0.90	090
57288		A	Repair bladder defect	12.00	NA	NA	6.56	6.41	1.12	090
57289		A	Repair bladder & vagina	12.69	NA	NA	6.81	6.63	1.21	090
57291		A	Construction of vagina	8.54	NA	NA	4.77	4.82	0.93	090
57292		A	Construct vagina with graft	13.91	NA	NA	6.25	6.43	1.58	090
57295		A	Revise vag graft via vagina	7.74	NA	NA	4.34	4.38	0.91	090
57296		A	Revise vag graft, open abd	16.46	NA	NA	6.88	6.88	1.68	090
57300		A	Repair rectum-vagina fistula	8.58	NA	NA	4.57	4.51	0.87	090
57305		A	Repair rectum-vagina fistula	15.24	NA	NA	6.47	6.43	1.73	090
57307		A	Fistula repair & colostomy	17.02	NA	NA	7.21	7.17	2.02	090
57308		A	Fistula repair, transperine	10.48	NA	NA	5.05	5.07	1.14	090
57310		A	Repair urethrovaginal lesion	7.55	NA	NA	5.18	4.86	0.54	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
57311		A	Repair urethrovaginal lesion	8.81	NA	NA	5.72	5.33	0.65	090
57320		A	Repair bladder-vagina lesion	8.78	NA	NA	5.57	5.28	0.69	090
57330		A	Repair bladder-vagina lesion	13.11	NA	NA	7.13	6.79	1.06	090
57335		A	Repair vagina	19.87	NA	NA	8.81	8.88	1.92	090
57400		A	Dilation of vagina	2.27	NA	NA	1.05	1.07	0.26	000
57410		A	Pelvic examination	1.75	NA	NA	0.89	0.89	0.18	000
57415		A	Remove vaginal foreign body	2.44	NA	NA	1.55	1.52	0.24	010
57420		A	Exam of vagina w/scope	1.60	1.25	1.28	0.59	0.61	0.19	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.61	1.67	0.76	0.81	0.27	000
57423		A	Repair paravag defect, lap	16.00	NA	NA	6.81	6.81	1.65	090
57425		A	Laparoscopy, surg, colpopexy	16.93	NA	NA	7.25	7.11	1.76	090
57452		A	Exam of cervix w/scope	1.50	1.19	1.21	0.76	0.76	0.18	000
57454		A	Bx/curett of cervix w/scope	2.33	1.42	1.48	0.99	1.03	0.28	000
57455		A	Biopsy of cervix w/scope	1.99	1.51	1.57	0.70	0.74	0.24	000
57456		A	Endocerv curettage w/scope	1.85	1.47	1.52	0.66	0.70	0.22	000
57460		A	Bx of cervix w/scope, leep	2.83	4.26	4.67	1.14	1.20	0.34	000
57461		A	Conz of cervix w/scope, leep	3.43	4.56	4.96	1.12	1.21	0.41	000
57500		A	Biopsy of cervix	1.20	2.00	2.14	0.66	0.65	0.12	000
57505		A	Endocervical curettage	1.16	1.32	1.36	1.07	1.08	0.14	010
57510		A	Cauterization of cervix	1.90	1.32	1.38	0.92	0.95	0.23	010
57511		A	Cryocautery of cervix	1.92	1.61	1.67	1.29	1.31	0.23	010
57513		A	Laser surgery of cervix	1.92	1.59	1.62	1.30	1.33	0.23	010
57520		A	Conization of cervix	4.06	3.40	3.54	2.55	2.64	0.49	090
57522		A	Conization of cervix	3.62	2.79	2.89	2.29	2.34	0.41	090
57530		A	Removal of cervix	5.19	NA	NA	3.21	3.26	0.58	090
57531		A	Removal of cervix, radical	29.77	NA	NA	11.24	11.75	3.35	090
57540		A	Removal of residual cervix	13.19	NA	NA	5.72	5.86	1.49	090
57545		A	Remove cervix/repair pelvis	14.00	NA	NA	5.93	6.13	1.52	090
57550		A	Removal of residual cervix	6.24	NA	NA	3.73	3.76	0.67	090
57555		A	Remove cervix/repair vagina	9.84	NA	NA	4.76	4.85	1.09	090
57556		A	Remove cervix, repair bowel	9.26	NA	NA	4.83	4.85	0.92	090
57558		A	D&c of cervical stump	1.69	1.37	1.40	1.08	1.09	0.20	010
57700		A	Revision of cervix	4.22	NA	NA	3.45	3.37	0.41	090
57720		A	Revision of cervix	4.53	NA	NA	2.97	3.01	0.49	090
57800		A	Dilation of cervical canal	0.77	0.72	0.73	0.42	0.43	0.09	000
58100		A	Biopsy of uterus lining	1.53	1.15	1.20	0.60	0.63	0.18	000
58110		A	Bx done w/colposcopy add-on	0.77	0.40	0.44	0.23	0.25	0.09	ZZZ
58120		A	Dilation and curettage	3.54	2.73	2.63	1.71	1.75	0.39	010
58140		A	Myomectomy abdom method	15.69	NA	NA	6.40	6.59	1.82	090
58145		A	Myomectomy vag method	8.81	NA	NA	4.36	4.48	0.97	090
58146		A	Myomectomy abdom complex	20.24	NA	NA	7.82	8.13	2.33	090
58150		A	Total hysterectomy	17.21	NA	NA	6.83	7.01	1.85	090
58152		A	Total hysterectomy	21.73	NA	NA	8.36	8.75	2.48	090
58180		A	Partial hysterectomy	16.50	NA	NA	6.63	6.85	1.64	090
58200		A	Extensive hysterectomy	23.00	NA	NA	8.57	8.95	2.55	090
58210		A	Extensive hysterectomy	30.76	NA	NA	11.32	11.81	3.38	090
58240		A	Removal of pelvis contents	49.02	NA	NA	18.89	18.61	4.23	090
58260		A	Vaginal hysterectomy	14.02	NA	NA	6.02	6.20	1.57	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58262		A	Vag hyst including t/o	15.81	NA	NA	6.52	6.75	1.80	090
58263		A	Vag hyst w/t/o & vag repair	17.10	NA	NA	6.95	7.20	1.95	090
58267		A	Vag hyst w/urinary repair	18.23	NA	NA	7.31	7.59	2.07	090
58270		A	Vag hyst w/enterocele repair	15.20	NA	NA	6.19	6.42	1.74	090
58275		A	Hysterectomy/revise vagina	16.90	NA	NA	6.95	7.17	1.92	090
58280		A	Hysterectomy/revise vagina	18.20	NA	NA	7.28	7.54	2.07	090
58285		A	Extensive hysterectomy	23.30	NA	NA	8.53	8.91	2.71	090
58290		A	Vag hyst complex	20.17	NA	NA	7.71	8.08	2.30	090
58291		A	Vag hyst incl t/o, complex	21.96	NA	NA	8.30	8.72	2.53	090
58292		A	Vag hyst t/o & repair, compl	23.25	NA	NA	8.61	9.07	2.68	090
58293		A	Vag hyst w/uro repair, compl	24.23	NA	NA	8.85	9.32	2.79	090
58294		A	Vag hyst w/enterocele, compl	21.45	NA	NA	8.00	8.41	2.40	090
58300		N	Insert intrauterine device	1.01	0.78	0.94	0.34	0.35	0.12	XXX
58301		A	Remove intrauterine device	1.27	1.05	1.12	0.37	0.40	0.15	000
58321		A	Artificial insemination	0.92	1.02	1.05	0.29	0.31	0.10	000
58322		A	Artificial insemination	1.10	1.03	1.08	0.32	0.35	0.13	000
58323		A	Sperm washing	0.23	0.16	0.25	0.07	0.08	0.03	000
58340		A	Catheter for hysterography	0.88	2.13	2.39	0.58	0.60	0.09	000
58345		A	Reopen fallopian tube	4.67	NA	NA	2.16	2.24	0.41	010
58346		A	Insert heyman uteri capsule	7.48	NA	NA	3.85	3.88	0.56	090
58350		A	Reopen fallopian tube	1.03	1.35	1.38	0.89	0.90	0.12	010
58353		A	Endometr ablate, thermal	3.57	22.36	25.75	1.76	1.84	0.43	010
58356		A	Endometrial cryoablation	6.36	42.50	47.35	1.97	2.16	0.82	010
58400		A	Suspension of uterus	7.06	NA	NA	3.97	3.97	0.75	090
58410		A	Suspension of uterus	13.70	NA	NA	5.79	5.96	1.45	090
58520		A	Repair of ruptured uterus	13.38	NA	NA	5.68	5.78	1.47	090
58540		A	Revision of uterus	15.61	NA	NA	6.43	6.58	1.79	090
58541		A	Lsh, uterus 250 g or less	14.57	NA	NA	6.37	6.37	1.68	090
58542		A	Lsh w/t/o ut 250 g or less	16.43	NA	NA	6.94	6.94	1.69	090
58543		A	Lsh uterus above 250 g	16.74	NA	NA	7.01	7.01	1.73	090
58544		A	Lsh w/t/o uterus above 250 g	18.24	NA	NA	7.41	7.41	1.89	090
58545		A	Laparoscopic myomectomy	15.45	NA	NA	6.10	6.39	1.78	090
58546		A	Laparo-myomectomy, complex	19.84	NA	NA	7.41	7.80	2.31	090
58548		A	Lap radical hyst	31.45	NA	NA	11.70	11.70	3.52	090
58550		A	Laparo-asst vag hysterectomy	14.97	NA	NA	6.38	6.62	1.73	090
58552		A	Laparo-vag hyst incl t/o	16.78	NA	NA	6.85	7.16	1.73	090
58553		A	Laparo-vag hyst, complex	19.96	NA	NA	7.44	7.83	2.31	090
58554		A	Laparo-vag hyst w/t/o, compl	22.98	NA	NA	8.65	9.11	2.28	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.77	2.63	1.29	1.35	0.40	000
58558		A	Hysteroscopy, biopsy	4.74	3.66	3.29	1.74	1.85	0.57	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	2.16	2.31	0.74	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	2.40	2.58	0.84	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	3.29	3.54	1.21	000
58562		A	Hysteroscopy, remove fb	5.20	3.57	3.27	1.84	1.98	0.63	000
58563		A	Hysteroscopy, ablation	6.16	36.52	41.54	2.16	2.31	0.74	000
58565		A	Hysteroscopy, sterilization	7.06	41.19	43.39	3.48	3.59	1.19	090
58570		A	Tlh, uterus 250 g or less	15.75	NA	NA	6.72	6.72	1.82	090
58571		A	Tlh w/t/o 250 g or less	17.56	NA	NA	7.25	7.25	1.81	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58572		A	Tlh, uterus over 250 g	19.96	NA	NA	7.94	7.94	2.31	090
58573		A	Tlh w/t/o uterus over 250 g	22.98	NA	NA	8.82	8.82	2.28	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.86	NA	NA	2.93	3.04	0.66	090
58605		A	Division of fallopian tube	5.25	NA	NA	2.75	2.85	0.59	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.43	0.46	0.18	ZZZ
58615		A	Occlude fallopian tube(s)	3.91	NA	NA	2.03	2.20	0.47	010
58660		A	Laparoscopy, lysis	11.54	NA	NA	4.68	4.84	1.40	090
58661		A	Laparoscopy, remove adnexa	11.30	NA	NA	4.19	4.44	1.34	010
58662		A	Laparoscopy, excise lesions	12.08	NA	NA	4.95	5.17	1.43	090
58670		A	Laparoscopy, tubal cautery	5.86	NA	NA	3.03	3.10	0.67	090
58671		A	Laparoscopy, tubal block	5.86	NA	NA	3.02	3.09	0.68	090
58672		A	Laparoscopy, fimbrioplasty	12.88	NA	NA	4.87	5.21	1.60	090
58673		A	Laparoscopy, salpingostomy	13.99	NA	NA	5.41	5.71	1.70	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.84	NA	NA	5.67	5.76	1.51	090
58720		A	Removal of ovary/tube(s)	12.08	NA	NA	5.28	5.42	1.39	090
58740		A	Adhesiolysis tube, ovary	14.79	NA	NA	6.31	6.53	1.72	090
58750		A	Repair oviduct	15.56	NA	NA	6.32	6.59	1.85	090
58752		A	Revise ovarian tube(s)	15.56	NA	NA	6.72	6.79	1.81	090
58760		A	Fimbrioplasty	13.85	NA	NA	5.91	6.12	1.80	090
58770		A	Create new tubal opening	14.69	NA	NA	5.48	5.85	1.74	090
58800		A	Drainage of ovarian cyst(s)	4.54	3.31	3.40	2.80	2.83	0.43	090
58805		A	Drainage of ovarian cyst(s)	6.34	NA	NA	3.62	3.60	0.69	090
58820		A	Drain ovary abscess, open	4.62	NA	NA	2.99	3.07	0.52	090
58822		A	Drain ovary abscess, percut	11.71	NA	NA	5.76	5.64	1.16	090
58823		A	Drain pelvic abscess, percut	3.37	19.82	20.24	1.29	1.25	0.24	000
58825		A	Transposition, ovary(s)	11.70	NA	NA	5.16	5.33	1.32	090
58900		A	Biopsy of ovary(s)	6.51	NA	NA	3.65	3.64	0.69	090
58920		A	Partial removal of ovary(s)	11.87	NA	NA	5.08	5.21	1.43	090
58925		A	Removal of ovarian cyst(s)	12.33	NA	NA	5.46	5.53	1.41	090
58940		A	Removal of ovary(s)	8.12	NA	NA	4.16	4.15	0.91	090
58943		A	Removal of ovary(s)	19.42	NA	NA	7.53	7.82	2.23	090
58950		A	Resect ovarian malignancy	18.24	NA	NA	7.56	7.79	2.05	090
58951		A	Resect ovarian malignancy	24.15	NA	NA	9.04	9.42	2.64	090
58952		A	Resect ovarian malignancy	27.15	NA	NA	10.29	10.68	3.03	090
58953		A	Tah, rad dissect for debulk	33.97	NA	NA	12.31	12.90	3.84	090
58954		A	Tah rad debulk/lymph remove	36.97	NA	NA	13.26	13.90	4.18	090
58956		A	Bso, omentectomy w/tah	22.65	NA	NA	8.98	9.34	4.01	090
58957		A	Resect recurrent gyn mal	26.06	NA	NA	10.02	10.02	2.95	090
58958		A	Resect recur gyn mal w/lym	29.06	NA	NA	11.03	11.03	3.29	090
58960		A	Exploration of abdomen	15.68	NA	NA	6.59	6.80	1.80	090
58970		A	Retrieval of oocyte	3.52	1.88	2.00	1.33	1.37	0.43	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.45	2.51	1.63	1.68	0.47	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	1.74	1.83	0.57	0.59	0.31	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.29	1.32	0.71	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.20	1.29	0.82	000
59015		A	Chorion biopsy	2.20	1.45	1.48	0.84	0.89	0.52	000
59020		A	Fetal contract stress test	0.66	1.05	0.99	NA	NA	0.26	000
59020	TC	A	Fetal contract stress test	0.00	0.86	0.78	NA	NA	0.10	000
59020	26	A	Fetal contract stress test	0.66	0.19	0.21	0.19	0.21	0.16	000
59025		A	Fetal non-stress test	0.53	0.63	0.58	NA	NA	0.15	000
59025	TC	A	Fetal non-stress test	0.00	0.47	0.41	NA	NA	0.02	000
59025	26	A	Fetal non-stress test	0.53	0.16	0.17	0.16	0.17	0.13	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.59	0.63	0.47	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.26	0.28	0.21	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.21	0.23	0.17	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.67	4.80	2.03	2.11	0.28	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	3.36	3.31	0.16	000
59074		A	Fetal fluid drainage w/us	5.24	4.14	4.26	1.94	2.04	0.28	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	2.99	3.03	0.16	000
59100		A	Remove uterus lesion	13.26	NA	NA	5.67	5.88	2.95	090
59120		A	Treat ectopic pregnancy	12.56	NA	NA	5.61	5.79	2.73	090
59121		A	Treat ectopic pregnancy	12.64	NA	NA	5.55	5.76	2.79	090
59130		A	Treat ectopic pregnancy	14.98	NA	NA	6.92	6.40	3.39	090
59135		A	Treat ectopic pregnancy	14.82	NA	NA	6.80	6.92	3.31	090
59136		A	Treat ectopic pregnancy	14.15	NA	NA	5.94	6.12	3.14	090
59140		A	Treat ectopic pregnancy	5.86	NA	NA	3.69	3.32	1.29	090
59150		A	Treat ectopic pregnancy	12.19	NA	NA	5.39	5.56	2.79	090
59151		A	Treat ectopic pregnancy	12.01	NA	NA	5.06	5.32	2.74	090
59160		A	D & c after delivery	2.73	2.02	2.34	1.22	1.46	0.64	010
59200		A	Insert cervical dilator	0.79	0.94	1.00	0.23	0.25	0.19	000
59300		A	Episiotomy or vaginal repair	2.41	2.15	2.16	1.00	0.99	0.57	000
59320		A	Revision of cervix	2.48	NA	NA	1.04	1.09	0.59	000
59325		A	Revision of cervix	4.06	NA	NA	1.49	1.60	0.88	000
59350		A	Repair of uterus	4.94	NA	NA	1.31	1.46	1.17	000
59400		A	Obstetrical care	26.80	NA	NA	14.46	14.71	5.50	MMM
59409		A	Obstetrical care	13.48	NA	NA	3.94	4.29	3.22	MMM
59410		A	Obstetrical care	15.29	NA	NA	5.20	5.49	3.52	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.67	0.70	0.40	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.46	0.51	0.38	MMM
59425		A	Antepartum care only	6.22	4.30	4.29	1.80	1.82	1.14	MMM
59426		A	Antepartum care only	11.04	7.88	7.81	3.20	3.21	1.98	MMM
59430		A	Care after delivery	2.13	1.11	1.14	0.74	0.79	0.50	MMM
59510		A	Cesarean delivery	30.34	NA	NA	16.39	16.65	6.25	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	4.72	5.10	3.80	MMM
59515		A	Cesarean delivery	18.26	NA	NA	6.49	6.84	4.13	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	2.52	2.72	1.95	ZZZ
59610		A	Vbac delivery	28.21	NA	NA	15.26	15.45	5.87	MMM
59612		A	Vbac delivery only	15.04	NA	NA	4.47	4.88	3.59	MMM
59614		A	Vbac care after delivery	16.59	NA	NA	5.43	5.82	3.89	MMM
59618		A	Attempted vbac delivery	31.78	NA	NA	16.98	17.33	6.61	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	5.21	5.61	4.17	MMM

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
59622		A	Attempted vbac after care	19.70	NA	NA	7.10	7.50	4.50	MMM
59812		A	Treatment of miscarriage	4.39	3.14	3.00	2.41	2.45	0.95	090
59820		A	Care of miscarriage	4.68	4.09	4.19	3.50	3.52	0.95	090
59821		A	Treatment of miscarriage	4.97	3.88	3.99	3.24	3.28	1.06	090
59830		A	Treat uterus infection	6.51	NA	NA	3.53	3.65	1.44	090
59840		R	Abortion	3.01	2.05	2.08	1.83	1.90	0.71	010
59841		R	Abortion	5.57	3.19	3.27	2.63	2.72	1.24	010
59850		R	Abortion	5.90	NA	NA	3.18	3.20	1.28	090
59851		R	Abortion	5.92	NA	NA	3.35	3.45	1.28	090
59852		R	Abortion	8.23	NA	NA	4.87	4.92	1.81	090
59855		R	Abortion	6.38	NA	NA	3.17	3.27	1.45	090
59856		R	Abortion	7.74	NA	NA	3.44	3.60	1.79	090
59857		R	Abortion	9.30	NA	NA	4.21	4.35	2.02	090
59866		R	Abortion (mpr)	3.99	NA	NA	1.52	1.62	0.87	000
59870		A	Evacuate mole of uterus	6.40	NA	NA	4.66	4.63	1.42	090
59871		A	Remove cerclage suture	2.13	NA	NA	0.95	1.00	0.50	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.78	2.19	2.13	1.80	1.78	0.15	010
60100		A	Biopsy of thyroid	1.56	1.36	1.37	0.57	0.56	0.10	000
60200		A	Remove thyroid lesion	9.91	NA	NA	5.66	5.75	1.01	090
60210		A	Partial thyroid excision	11.15	NA	NA	5.42	5.49	1.23	090
60212		A	Partial thyroid excision	16.32	NA	NA	7.35	7.45	1.95	090
60220		A	Partial removal of thyroid	12.29	NA	NA	5.89	5.97	1.32	090
60225		A	Partial removal of thyroid	14.67	NA	NA	7.16	7.24	1.64	090
60240		A	Removal of thyroid	16.18	NA	NA	6.69	6.93	1.86	090
60252		A	Removal of thyroid	21.88	NA	NA	9.24	9.47	2.30	090
60254		A	Extensive thyroid surgery	28.29	NA	NA	11.71	12.35	2.61	090
60260		A	Repeat thyroid surgery	18.18	NA	NA	7.75	7.99	1.94	090
60270		A	Removal of thyroid	23.07	NA	NA	9.79	9.98	2.33	090
60271		A	Removal of thyroid	17.54	NA	NA	7.55	7.83	1.75	090
60280		A	Remove thyroid duct lesion	6.05	NA	NA	4.55	4.59	0.54	090
60281		A	Remove thyroid duct lesion	8.71	NA	NA	5.35	5.48	0.73	090
60300		A	Aspir/inj thyroid cyst	0.97	1.93	1.80	0.33	0.33	0.07	000
60500		A	Explore parathyroid glands	16.69	NA	NA	7.14	7.22	2.01	090
60502		A	Re-explore parathyroids	21.01	NA	NA	8.84	8.99	2.54	090
60505		A	Explore parathyroid glands	22.91	NA	NA	9.85	10.14	2.65	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	1.30	1.38	0.53	ZZZ
60520		A	Removal of thymus gland	17.07	NA	NA	7.19	7.48	2.20	090
60521		A	Removal of thymus gland	19.11	NA	NA	8.64	8.89	2.82	090
60522		A	Removal of thymus gland	23.37	NA	NA	10.19	10.48	3.27	090
60540		A	Explore adrenal gland	17.91	NA	NA	8.61	8.37	1.75	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.19	1.13	0.13	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.16	1.14	0.16	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	1.59	1.53	0.34	000
61026		A	Injection into brain canal	1.69	NA	NA	1.33	1.35	0.33	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.17	1.20	0.11	000
61055		A	Injection into brain canal	2.10	NA	NA	1.36	1.37	0.17	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.10	1.08	0.17	000
61105		A	Twist drill hole	5.40	NA	NA	4.60	4.45	1.32	090
61107		A	Drill skull for implantation	4.99	NA	NA	1.94	2.09	1.29	000
61108		A	Drill skull for drainage	11.51	NA	NA	8.30	8.03	2.64	090
61120		A	Burr hole for puncture	9.52	NA	NA	6.71	6.54	2.10	090
61140		A	Pierce skull for biopsy	17.10	NA	NA	10.58	10.43	4.12	090
61150		A	Pierce skull for drainage	18.80	NA	NA	10.79	10.71	4.32	090
61151		A	Pierce skull for drainage	13.41	NA	NA	8.09	8.04	3.01	090
61154		A	Pierce skull & remove clot	16.92	NA	NA	10.96	10.61	4.21	090
61156		A	Pierce skull for drainage	17.37	NA	NA	10.08	10.04	4.23	090
61210		A	Pierce skull, implant device	5.83	NA	NA	2.27	2.44	1.50	000
61215		A	Insert brain-fluid device	5.77	NA	NA	5.40	5.06	1.26	090
61250		A	Pierce skull & explore	11.41	NA	NA	7.25	7.17	2.77	090
61253		A	Pierce skull & explore	13.41	NA	NA	7.18	7.33	2.62	090
61304		A	Open skull for exploration	23.31	NA	NA	12.79	12.83	5.63	090
61305		A	Open skull for exploration	28.51	NA	NA	15.56	15.53	6.09	090
61312		A	Open skull for drainage	30.07	NA	NA	15.72	15.58	6.36	090
61313		A	Open skull for drainage	27.94	NA	NA	15.64	15.46	6.45	090
61314		A	Open skull for drainage	25.77	NA	NA	14.53	14.19	6.28	090
61315		A	Open skull for drainage	29.52	NA	NA	15.89	15.96	7.16	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.55	0.56	0.35	ZZZ
61320		A	Open skull for drainage	27.32	NA	NA	14.70	14.74	6.62	090
61321		A	Open skull for drainage	30.40	NA	NA	15.60	15.77	7.14	090
61322		A	Decompressive craniotomy	34.08	NA	NA	17.89	17.37	7.63	090
61323		A	Decompressive lobectomy	34.93	NA	NA	17.55	17.23	8.03	090
61330		A	Decompress eye socket	25.17	NA	NA	12.35	12.72	2.32	090
61332		A	Explore/biopsy eye socket	28.50	NA	NA	13.38	13.97	4.83	090
61333		A	Explore orbit/remove lesion	29.17	NA	NA	13.94	14.38	3.92	090
61334		A	Explore orbit/remove object	19.50	NA	NA	8.82	9.29	1.75	090
61340		A	Subtemporal decompression	20.01	NA	NA	11.42	11.38	4.84	090
61343		A	Incise skull (press relief)	31.73	NA	NA	16.54	16.65	7.64	090
61345		A	Relieve cranial pressure	29.10	NA	NA	15.76	15.70	7.04	090
61440		A	Incise skull for surgery	28.53	NA	NA	15.64	15.32	6.90	090
61450		A	Incise skull for surgery	27.59	NA	NA	14.45	14.44	5.79	090
61458		A	Incise skull for brain wound	28.71	NA	NA	15.51	15.54	7.03	090
61460		A	Incise skull for surgery	30.11	NA	NA	15.09	15.46	6.04	090
61470		A	Incise skull for surgery	27.52	NA	NA	14.78	14.58	5.90	090
61480		A	Incise skull for surgery	27.95	NA	NA	11.24	12.27	6.73	090
61490		A	Incise skull for surgery	27.12	NA	NA	14.63	14.58	6.92	090
61500		A	Removal of skull lesion	19.05	NA	NA	10.98	10.96	4.11	090
61501		A	Remove infected skull bone	16.22	NA	NA	9.85	9.71	3.22	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61510		A	Removal of brain lesion	30.63	NA	NA	17.39	17.26	7.35	090
61512		A	Remove brain lining lesion	36.99	NA	NA	19.07	19.26	9.08	090
61514		A	Removal of brain abscess	27.10	NA	NA	14.86	14.79	6.54	090
61516		A	Removal of brain lesion	26.45	NA	NA	14.46	14.44	6.35	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.54	0.57	0.35	ZZZ
61518		A	Removal of brain lesion	39.69	NA	NA	20.79	20.92	9.65	090
61519		A	Remove brain lining lesion	43.28	NA	NA	21.47	21.82	10.63	090
61520		A	Removal of brain lesion	56.89	NA	NA	27.01	27.91	11.21	090
61521		A	Removal of brain lesion	46.84	NA	NA	22.70	23.13	11.39	090
61522		A	Removal of brain abscess	31.41	NA	NA	16.78	16.73	7.62	090
61524		A	Removal of brain lesion	29.76	NA	NA	15.68	15.71	7.16	090
61526		A	Removal of brain lesion	53.90	NA	NA	23.64	25.16	7.07	090
61530		A	Removal of brain lesion	45.43	NA	NA	20.42	21.63	6.15	090
61531		A	Implant brain electrodes	16.28	NA	NA	10.70	10.33	3.79	090
61533		A	Implant brain electrodes	21.36	NA	NA	12.12	12.00	5.12	090
61534		A	Removal of brain lesion	22.88	NA	NA	13.40	13.11	5.44	090
61535		A	Remove brain electrodes	13.05	NA	NA	9.04	8.66	3.02	090
61536		A	Removal of brain lesion	37.59	NA	NA	19.23	19.41	9.21	090
61537		A	Removal of brain tissue	36.35	NA	NA	17.91	17.16	6.94	090
61538		A	Removal of brain tissue	39.35	NA	NA	19.31	18.35	6.94	090
61539		A	Removal of brain tissue	34.15	NA	NA	17.30	17.46	8.32	090
61540		A	Removal of brain tissue	31.30	NA	NA	16.57	16.78	8.32	090
61541		A	Incision of brain tissue	30.81	NA	NA	16.25	16.27	6.60	090
61542		A	Removal of brain tissue	33.03	NA	NA	17.29	17.47	8.03	090
61543		A	Removal of brain tissue	31.18	NA	NA	15.75	15.95	7.56	090
61544		A	Remove & treat brain lesion	27.26	NA	NA	11.07	11.79	5.97	090
61545		A	Excision of brain tumor	46.23	NA	NA	23.24	23.54	10.63	090
61546		A	Removal of pituitary gland	33.31	NA	NA	17.16	17.28	7.67	090
61548		A	Removal of pituitary gland	23.27	NA	NA	12.02	12.24	3.43	090
61550		A	Release of skull seams	15.44	NA	NA	9.26	8.69	0.98	090
61552		A	Release of skull seams	20.27	NA	NA	12.37	11.58	1.06	090
61556		A	Incise skull/sutures	24.00	NA	NA	13.02	12.63	4.65	090
61557		A	Incise skull/sutures	23.16	NA	NA	13.91	13.87	5.80	090
61558		A	Excision of skull/sutures	26.35	NA	NA	15.04	14.86	1.36	090
61559		A	Excision of skull/sutures	33.82	NA	NA	18.84	19.01	8.51	090
61563		A	Excision of skull tumor	28.35	NA	NA	15.18	15.23	5.17	090
61564		A	Excision of skull tumor	34.59	NA	NA	18.43	18.44	8.78	090
61566		A	Removal of brain tissue	32.32	NA	NA	17.22	17.40	6.94	090
61567		A	Incision of brain tissue	36.84	NA	NA	19.63	19.94	6.54	090
61570		A	Remove foreign body, brain	26.38	NA	NA	14.19	14.16	5.88	090
61571		A	Incise skull for brain wound	28.29	NA	NA	15.55	15.48	6.79	090
61575		A	Skull base/brainstem surgery	36.43	NA	NA	16.78	17.54	5.34	090
61576		A	Skull base/brainstem surgery	55.11	NA	NA	32.59	33.21	5.58	090
61580		A	Craniofacial approach, skull	34.34	NA	NA	23.30	23.93	3.37	090
61581		A	Craniofacial approach, skull	38.88	NA	NA	27.36	26.44	3.92	090
61582		A	Craniofacial approach, skull	34.93	NA	NA	30.77	29.97	7.21	090
61583		A	Craniofacial approach, skull	38.41	NA	NA	26.10	25.91	9.21	090
61584		A	Orbitocranial approach/skull	37.61	NA	NA	25.82	25.56	8.18	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61585		A	Orbitocranial approach/skull	42.46	NA	NA	25.18	25.57	7.03	090
61586		A	Resect nasopharynx, skull	27.28	NA	NA	22.05	22.23	4.37	090
61590		A	Infratemporal approach/skull	46.87	NA	NA	25.83	26.59	5.31	090
61591		A	Infratemporal approach/skull	46.87	NA	NA	25.93	26.90	5.66	090
61592		A	Orbitocranial approach/skull	42.98	NA	NA	27.79	27.54	10.07	090
61595		A	Transtemporal approach/skull	33.57	NA	NA	21.88	22.05	3.98	090
61596		A	Transcochlear approach/skull	39.31	NA	NA	21.74	22.47	3.40	090
61597		A	Transcondylar approach/skull	40.73	NA	NA	23.45	23.39	8.84	090
61598		A	Transpetrosal approach/skull	36.41	NA	NA	21.40	21.91	5.70	090
61600		A	Resect/excise cranial lesion	29.84	NA	NA	20.15	20.11	3.79	090
61601		A	Resect/excise cranial lesion	31.04	NA	NA	22.24	21.85	6.63	090
61605		A	Resect/excise cranial lesion	32.40	NA	NA	20.14	20.64	2.86	090
61606		A	Resect/excise cranial lesion	41.94	NA	NA	25.63	25.57	8.97	090
61607		A	Resect/excise cranial lesion	40.82	NA	NA	22.31	22.73	6.90	090
61608		A	Resect/excise cranial lesion	45.45	NA	NA	26.57	26.64	10.75	090
61609		A	Transect artery, sinus	9.88	NA	NA	3.31	3.70	2.56	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	11.73	12.11	7.68	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	2.93	3.16	1.89	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	10.11	10.94	4.31	ZZZ
61613		A	Remove aneurysm, sinus	44.94	NA	NA	26.46	26.48	8.45	090
61615		A	Resect/excise lesion, skull	35.63	NA	NA	21.93	22.18	4.73	090
61616		A	Resect/excise lesion, skull	46.60	NA	NA	27.57	27.91	8.26	090
61618		A	Repair dura	18.58	NA	NA	10.56	10.55	3.72	090
61619		A	Repair dura	22.01	NA	NA	11.61	11.80	3.95	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	3.97	4.00	1.05	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	7.98	7.73	1.96	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	6.59	6.33	1.24	000
61630		R	Intracranial angioplasty	22.07	NA	NA	8.88	9.81	2.02	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	9.62	10.63	2.21	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	4.13	4.13	0.71	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.45	1.45	0.25	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	2.90	2.90	0.50	ZZZ
61680		A	Intracranial vessel surgery	32.40	NA	NA	17.38	17.43	7.95	090
61682		A	Intracranial vessel surgery	63.31	NA	NA	28.72	29.66	15.90	090
61684		A	Intracranial vessel surgery	41.49	NA	NA	20.06	20.59	10.31	090
61686		A	Intracranial vessel surgery	67.32	NA	NA	31.56	32.43	16.71	090
61690		A	Intracranial vessel surgery	31.18	NA	NA	16.58	16.65	6.94	090
61692		A	Intracranial vessel surgery	54.43	NA	NA	25.67	26.18	13.43	090
61697		A	Brain aneurysm repr, complx	63.22	NA	NA	29.90	29.50	12.85	090
61698		A	Brain aneurysm repr, complx	69.45	NA	NA	32.59	31.19	12.54	090
61700		A	Brain aneurysm repr, simple	50.44	NA	NA	24.72	25.55	13.02	090
61702		A	Inner skull vessel surgery	59.86	NA	NA	28.31	27.81	10.79	090
61703		A	Clamp neck artery	18.70	NA	NA	11.29	11.11	4.06	090
61705		A	Revise circulation to head	37.97	NA	NA	18.14	18.46	8.87	090
61708		A	Revise circulation to head	37.07	NA	NA	15.18	15.21	2.51	090
61710		A	Revise circulation to head	31.19	NA	NA	15.22	14.86	4.52	090
61711		A	Fusion of skull arteries	38.10	NA	NA	18.87	19.15	9.42	090
61720		A	Incise skull/brain surgery	17.52	NA	NA	8.63	8.99	2.79	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61735		A	Incise skull/brain surgery	22.22	NA	NA	10.31	10.80	2.73	090
61750		A	Incise skull/brain biopsy	19.73	NA	NA	11.26	11.12	4.72	090
61751		A	Brain biopsy w/ct/mr guide	18.64	NA	NA	11.63	11.46	4.56	090
61760		A	Implant brain electrodes	22.24	NA	NA	12.45	11.55	5.42	090
61770		A	Incise skull for treatment	23.09	NA	NA	11.18	11.47	3.55	090
61790		A	Treat trigeminal nerve	11.50	NA	NA	7.63	7.21	2.82	090
61791		A	Treat trigeminal tract	15.31	NA	NA	9.10	9.08	3.40	090
61795		A	Brain surgery using computer	4.03	NA	NA	1.52	1.65	0.79	ZZZ
61796		A	Srs, cranial lesion simple	10.79	NA	NA	6.85	6.85	2.64	090
61797		A	Srs, cran les simple, addl	3.48	1.34	1.34	1.34	1.34	0.72	ZZZ
61798		A	Srs, cranial lesion complex	10.79	NA	NA	6.85	6.85	2.64	090
61799		A	Srs, cran les complex, addl	4.81	1.85	1.85	1.85	1.85	1.00	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.11	1.11	0.57	ZZZ
61850		A	Implant neuroelectrodes	13.26	NA	NA	8.43	8.26	3.22	090
61860		A	Implant neuroelectrodes	22.16	NA	NA	12.26	12.24	4.95	090
61863		A	Implant neuroelectrode	20.56	NA	NA	12.58	12.41	5.43	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	1.77	1.90	5.43	ZZZ
61867		A	Implant neuroelectrode	32.88	NA	NA	17.17	17.43	5.43	090
61868		A	Implant neuroelectrde, addÆl	7.91	NA	NA	3.10	3.34	5.43	ZZZ
61870		A	Implant neuroelectrodes	16.24	NA	NA	9.87	9.85	3.87	090
61875		A	Implant neuroelectrodes	16.36	NA	NA	9.92	9.60	2.95	090
61880		A	Revise/remove neuroelectrode	6.87	NA	NA	5.44	5.24	1.66	090
61885		A	Insrt/redo neurostim 1 array	7.37	NA	NA	7.38	6.87	1.59	090
61886		A	Implant neurostim arrays	9.73	NA	NA	8.86	8.25	1.97	090
61888		A	Revise/remove neuroreceiver	5.20	NA	NA	3.52	3.57	1.33	010
62000		A	Treat skull fracture	13.83	NA	NA	7.16	6.76	1.06	090
62005		A	Treat skull fracture	17.53	NA	NA	10.25	9.91	3.87	090
62010		A	Treatment of head injury	21.30	NA	NA	11.98	11.94	5.14	090
62100		A	Repair brain fluid leakage	23.40	NA	NA	12.25	12.41	4.84	090
62115		A	Reduction of skull defect	22.71	NA	NA	7.16	8.30	5.51	090
62116		A	Reduction of skull defect	24.90	NA	NA	14.21	14.03	6.11	090
62117		A	Reduction of skull defect	28.26	NA	NA	15.02	15.14	4.53	090
62120		A	Repair skull cavity lesion	24.39	NA	NA	17.53	17.81	3.00	090
62121		A	Incise skull repair	22.93	NA	NA	14.30	14.62	4.17	090
62140		A	Repair of skull defect	14.45	NA	NA	8.69	8.62	3.47	090
62141		A	Repair of skull defect	15.97	NA	NA	9.49	9.40	3.76	090
62142		A	Remove skull plate/flap	11.73	NA	NA	7.91	7.70	2.73	090
62143		A	Replace skull plate/flap	14.05	NA	NA	8.75	8.59	3.37	090
62145		A	Repair of skull & brain	19.99	NA	NA	11.15	11.11	4.50	090
62146		A	Repair of skull with graft	17.18	NA	NA	9.65	9.67	3.62	090
62147		A	Repair of skull with graft	20.57	NA	NA	11.26	11.30	4.32	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	0.78	0.80	0.48	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.18	1.27	0.77	ZZZ
62161		A	Dissect brain w/scope	21.10	NA	NA	12.09	12.12	5.19	090
62162		A	Remove colloid cyst w/scope	26.67	NA	NA	15.00	15.00	5.91	090
62163		A	Neuroendoscopy w/fb removal	16.40	NA	NA	10.62	10.47	4.01	090
62164		A	Remove brain tumor w/scope	29.27	NA	NA	16.00	15.77	5.38	090
62165		A	Remove pituit tumor w/scope	23.10	NA	NA	12.34	12.63	3.01	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
62180		A	Establish brain cavity shunt	22.45	NA	NA	12.74	12.66	4.98	090
62190		A	Establish brain cavity shunt	12.07	NA	NA	8.20	7.94	2.80	090
62192		A	Establish brain cavity shunt	13.25	NA	NA	8.16	8.05	3.02	090
62194		A	Replace/irrigate catheter	5.68	NA	NA	3.47	3.22	0.92	010
62200		A	Establish brain cavity shunt	19.19	NA	NA	10.95	10.95	4.65	090
62201		A	Brain cavity shunt w/scope	15.89	NA	NA	10.41	10.20	3.68	090
62220		A	Establish brain cavity shunt	14.00	NA	NA	8.32	8.26	3.35	090
62223		A	Establish brain cavity shunt	13.90	NA	NA	9.43	9.16	3.14	090
62225		A	Replace/irrigate catheter	6.11	NA	NA	5.25	4.97	1.39	090
62230		A	Replace/revise brain shunt	11.35	NA	NA	7.27	7.09	2.71	090
62252		A	Csf shunt reprogram	0.74	1.70	1.65	NA	NA	0.21	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.41	1.34	NA	NA	0.02	XXX
62252	26	A	Csf shunt reprogram	0.74	0.29	0.31	0.29	0.31	0.19	XXX
62256		A	Remove brain cavity shunt	7.30	NA	NA	5.91	5.62	1.72	090
62258		A	Replace brain cavity shunt	15.54	NA	NA	9.32	9.19	3.74	090
62263		A	Epidural lysis mult sessions	6.41	8.72	9.74	2.88	2.96	0.41	010
62264		A	Epidural lysis on single day	4.42	4.67	5.45	1.25	1.29	0.27	010
62267		A	Interdiscal perq aspir, dx	3.00	3.38	3.38	1.15	1.15	0.23	000
62268		A	Drain spinal cord cyst	4.73	5.33	6.90	1.86	1.94	0.43	000
62269		A	Needle biopsy, spinal cord	5.01	5.31	7.67	1.77	1.82	0.37	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.37	2.53	0.60	0.59	0.08	000
62272		A	Drain cerebro spinal fluid	1.35	3.04	3.19	0.64	0.66	0.18	000
62273		A	Inject epidural patch	2.15	1.70	1.96	0.61	0.63	0.13	000
62280		A	Treat spinal cord lesion	2.63	4.26	4.94	1.13	1.10	0.30	010
62281		A	Treat spinal cord lesion	2.66	3.98	4.41	1.04	1.00	0.19	010
62282		A	Treat spinal canal lesion	2.33	3.89	5.02	1.09	1.05	0.17	010
62284		A	Injection for myelogram	1.54	3.77	4.07	0.75	0.74	0.13	000
62287		A	Percutaneous diskectomy	8.88	NA	NA	4.40	4.70	0.58	090
62290		A	Inject for spine disk x-ray	3.00	4.48	5.15	1.20	1.25	0.23	000
62291		A	Inject for spine disk x-ray	2.91	4.26	4.69	1.14	1.17	0.26	000
62292		A	Injection into disk lesion	9.14	NA	NA	2.33	2.87	0.82	090
62294		A	Injection into spinal artery	12.77	NA	NA	6.90	6.59	1.24	090
62310		A	Inject spine c/t	1.91	3.04	3.49	0.60	0.61	0.12	000
62311		A	Inject spine l/s (cd)	1.54	2.67	3.24	0.55	0.56	0.09	000
62318		A	Inject spine w/cath, c/t	2.04	3.07	3.74	0.44	0.49	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	2.81	3.36	0.46	0.50	0.11	000
62350		A	Implant spinal canal cath	6.00	NA	NA	2.80	3.09	1.02	010
62351		A	Implant spinal canal cath	11.54	NA	NA	7.68	7.56	2.25	090
62355		A	Remove spinal canal catheter	4.30	NA	NA	2.35	2.56	0.71	010
62360		A	Insert spine infusion device	4.28	NA	NA	2.50	2.55	0.34	010
62361		A	Implant spine infusion pump	5.60	NA	NA	3.48	3.60	0.80	010
62362		A	Implant spine infusion pump	6.05	NA	NA	3.11	3.43	1.18	010
62365		A	Remove spine infusion device	4.60	NA	NA	2.72	2.94	0.86	010
62367		A	Analyze spine infusion pump	0.48	0.44	0.48	0.13	0.12	0.03	XXX
62368		A	Analyze spine infusion pump	0.75	0.58	0.61	0.19	0.18	0.06	XXX
63001		A	Removal of spinal lamina	17.51	NA	NA	10.03	9.92	3.77	090
63003		A	Removal of spinal lamina	17.64	NA	NA	10.02	10.00	3.73	090
63005		A	Removal of spinal lamina	16.28	NA	NA	10.11	10.10	3.35	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63011		A	Removal of spinal lamina	15.78	NA	NA	9.22	9.00	3.38	090
63012		A	Removal of spinal lamina	16.72	NA	NA	10.01	10.06	3.49	090
63015		A	Removal of spinal lamina	20.70	NA	NA	12.15	12.10	4.76	090
63016		A	Removal of spinal lamina	21.90	NA	NA	12.07	12.03	4.59	090
63017		A	Removal of spinal lamina	17.18	NA	NA	10.60	10.57	3.64	090
63020		A	Neck spine disk surgery	16.05	NA	NA	10.10	10.02	3.72	090
63030		A	Low back disk surgery	13.03	NA	NA	8.75	8.69	3.01	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.27	1.36	0.79	ZZZ
63040		A	Laminotomy, single cervical	20.18	NA	NA	11.29	11.37	4.68	090
63042		A	Laminotomy, single lumbar	18.61	NA	NA	10.88	11.02	4.26	090
63043		C	Laminotomy, addÆl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, addÆl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.82	NA	NA	10.56	10.53	3.99	090
63046		A	Removal of spinal lamina	17.12	NA	NA	10.11	10.15	3.56	090
63047		A	Removal of spinal lamina	15.22	NA	NA	9.58	9.68	3.24	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.40	1.47	0.72	ZZZ
63050		A	Cervical laminoplasty	21.88	NA	NA	12.38	12.27	4.67	090
63051		A	C-laminoplasty w/graft/plate	25.38	NA	NA	13.58	13.59	4.67	090
63055		A	Decompress spinal cord	23.42	NA	NA	12.85	12.95	5.29	090
63056		A	Decompress spinal cord	21.73	NA	NA	11.69	11.94	4.76	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	2.10	2.24	1.22	ZZZ
63064		A	Decompress spinal cord	26.09	NA	NA	13.45	13.73	5.71	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.31	1.40	0.69	ZZZ
63075		A	Neck spine disk surgery	19.47	NA	NA	11.28	11.51	4.63	090
63076		A	Neck spine disk surgery	4.04	NA	NA	1.62	1.73	0.96	ZZZ
63077		A	Spine disk surgery, thorax	22.75	NA	NA	11.62	11.94	3.99	090
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.29	1.38	0.66	ZZZ
63081		A	Removal of vertebral body	25.97	NA	NA	13.95	14.07	5.56	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	1.75	1.88	1.02	ZZZ
63085		A	Removal of vertebral body	29.34	NA	NA	14.04	14.43	4.49	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.24	1.33	0.59	ZZZ
63087		A	Removal of vertebral body	37.38	NA	NA	17.69	18.18	6.22	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	1.75	1.86	0.82	ZZZ
63090		A	Removal of vertebral body	30.78	NA	NA	14.98	15.28	4.22	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.21	1.27	0.48	ZZZ
63101		A	Removal of vertebral body	33.92	NA	NA	17.85	18.25	5.71	090
63102		A	Removal of vertebral body	33.92	NA	NA	17.53	18.01	5.71	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	1.96	2.10	0.69	ZZZ
63170		A	Incise spinal cord tract(s)	22.08	NA	NA	12.24	12.17	4.87	090
63172		A	Drainage of spinal cyst	19.66	NA	NA	11.23	11.11	4.49	090
63173		A	Drainage of spinal cyst	24.18	NA	NA	13.88	13.64	5.70	090
63180		A	Revise spinal cord ligaments	20.40	NA	NA	10.81	10.88	3.96	090
63182		A	Revise spinal cord ligaments	22.69	NA	NA	9.75	10.07	5.32	090
63185		A	Incise spinal column/nerves	16.36	NA	NA	9.79	9.39	2.80	090
63190		A	Incise spinal column/nerves	18.76	NA	NA	11.01	10.82	3.25	090
63191		A	Incise spinal column/nerves	18.79	NA	NA	6.09	7.20	6.36	090
63194		A	Incise spinal column & cord	21.97	NA	NA	11.96	11.93	3.27	090
63195		A	Incise spinal column & cord	21.54	NA	NA	11.92	11.72	4.88	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63196		A	Incise spinal column & cord	25.14	NA	NA	14.13	13.97	5.78	090
63197		A	Incise spinal column & cord	23.95	NA	NA	13.79	13.42	5.38	090
63198		A	Incise spinal column & cord	29.75	NA	NA	12.24	11.31	6.45	090
63199		A	Incise spinal column & cord	31.32	NA	NA	16.13	15.89	1.40	090
63200		A	Release of spinal cord	21.31	NA	NA	12.21	12.01	4.97	090
63250		A	Revise spinal cord vessels	43.73	NA	NA	21.66	21.27	9.04	090
63251		A	Revise spinal cord vessels	44.49	NA	NA	22.10	22.27	10.44	090
63252		A	Revise spinal cord vessels	44.48	NA	NA	22.09	22.18	10.67	090
63265		A	Excise intraspinal lesion	23.69	NA	NA	13.36	13.24	5.45	090
63266		A	Excise intraspinal lesion	24.55	NA	NA	13.49	13.44	5.56	090
63267		A	Excise intraspinal lesion	19.32	NA	NA	11.42	11.36	4.38	090
63268		A	Excise intraspinal lesion	19.89	NA	NA	11.67	11.37	3.70	090
63270		A	Excise intraspinal lesion	29.67	NA	NA	15.70	15.68	6.84	090
63271		A	Excise intraspinal lesion	29.79	NA	NA	15.85	15.81	6.92	090
63272		A	Excise intraspinal lesion	27.37	NA	NA	14.74	14.76	6.20	090
63273		A	Excise intraspinal lesion	26.34	NA	NA	13.18	13.50	5.76	090
63275		A	Biopsy/excise spinal tumor	25.73	NA	NA	13.97	13.95	5.82	090
63276		A	Biopsy/excise spinal tumor	25.56	NA	NA	13.98	13.94	5.85	090
63277		A	Biopsy/excise spinal tumor	22.26	NA	NA	12.44	12.49	5.03	090
63278		A	Biopsy/excise spinal tumor	21.99	NA	NA	12.20	12.27	4.56	090
63280		A	Biopsy/excise spinal tumor	30.14	NA	NA	16.52	16.51	7.29	090
63281		A	Biopsy/excise spinal tumor	29.84	NA	NA	16.28	16.29	7.19	090
63282		A	Biopsy/excise spinal tumor	28.00	NA	NA	15.57	15.54	6.78	090
63283		A	Biopsy/excise spinal tumor	26.61	NA	NA	14.72	14.74	6.28	090
63285		A	Biopsy/excise spinal tumor	37.90	NA	NA	18.84	19.16	9.21	090
63286		A	Biopsy/excise spinal tumor	37.47	NA	NA	19.12	19.36	9.24	090
63287		A	Biopsy/excise spinal tumor	39.93	NA	NA	20.12	20.24	9.42	090
63290		A	Biopsy/excise spinal tumor	40.67	NA	NA	20.45	20.53	9.05	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.03	2.06	1.03	ZZZ
63300		A	Removal of vertebral body	26.67	NA	NA	14.19	14.25	5.99	090
63301		A	Removal of vertebral body	31.42	NA	NA	15.20	15.32	5.41	090
63302		A	Removal of vertebral body	31.00	NA	NA	15.13	15.34	5.55	090
63303		A	Removal of vertebral body	33.42	NA	NA	15.31	15.75	4.69	090
63304		A	Removal of vertebral body	33.70	NA	NA	17.60	17.56	6.43	090
63305		A	Removal of vertebral body	36.09	NA	NA	16.27	16.75	5.73	090
63306		A	Removal of vertebral body	35.40	NA	NA	18.75	18.55	8.35	090
63307		A	Removal of vertebral body	34.81	NA	NA	17.48	17.35	4.47	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.08	2.22	1.29	ZZZ
63600		A	Remove spinal cord lesion	15.02	NA	NA	4.55	4.77	1.52	090
63610		A	Stimulation of spinal cord	8.72	12.91	24.68	1.68	1.83	0.86	000
63615		A	Remove lesion of spinal cord	17.22	NA	NA	8.77	8.91	2.85	090
63620		A	Srs, spinal lesion	10.79	NA	NA	6.85	6.85	2.64	090
63621		A	Srs, spinal lesion, addl	4.00	1.54	1.54	1.54	1.54	0.83	ZZZ
63650		A	Implant neuroelectrodes	7.15	NA	NA	2.71	2.83	0.53	090
63655		A	Implant neuroelectrodes	11.43	NA	NA	7.79	7.58	2.44	090
63660		A	Revise/remove neuroelectrode	6.87	NA	NA	3.48	3.52	0.78	090
63685		A	Insrt/redo spine n generator	6.00	NA	NA	2.90	3.22	1.05	090
63688		A	Revise/remove neuroreceiver	5.25	NA	NA	2.88	3.05	0.89	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63700		A	Repair of spinal herniation	17.32	NA	NA	10.25	10.29	3.53	090
63702		A	Repair of spinal herniation	19.26	NA	NA	11.87	11.69	4.13	090
63704		A	Repair of spinal herniation	22.23	NA	NA	11.99	12.25	4.58	090
63706		A	Repair of spinal herniation	25.15	NA	NA	14.66	14.42	6.25	090
63707		A	Repair spinal fluid leakage	12.52	NA	NA	8.00	7.94	2.52	090
63709		A	Repair spinal fluid leakage	15.52	NA	NA	9.25	9.31	3.10	090
63710		A	Graft repair of spine defect	15.27	NA	NA	9.39	9.33	3.41	090
63740		A	Install spinal shunt	12.50	NA	NA	8.66	8.35	2.94	090
63741		A	Install spinal shunt	9.02	NA	NA	4.64	4.68	1.66	090
63744		A	Revision of spinal shunt	8.86	NA	NA	5.48	5.43	1.90	090
63746		A	Removal of spinal shunt	7.25	NA	NA	5.83	5.32	1.53	090
64400		A	N block inj, trigeminal	1.11	1.41	1.54	0.45	0.45	0.07	000
64402		A	N block inj, facial	1.25	1.39	1.45	0.49	0.52	0.09	000
64405		A	N block inj, occipital	1.32	1.15	1.23	0.51	0.50	0.08	000
64408		A	N block inj, vagus	1.41	1.51	1.53	0.77	0.79	0.10	000
64410		A	N block inj, phrenic	1.43	1.84	2.01	0.55	0.52	0.09	000
64412		A	N block inj, spinal accessor	1.18	2.11	2.25	0.60	0.56	0.08	000
64413		A	N block inj, cervical plexus	1.40	1.31	1.44	0.50	0.50	0.08	000
64415		A	N block inj, brachial plexus	1.48	1.40	1.75	0.31	0.35	0.09	000
64416		A	N block cont infuse, b plex	1.81	NA	NA	0.22	0.36	0.31	000
64417		A	N block inj, axillary	1.44	1.40	1.81	0.31	0.36	0.11	000
64418		A	N block inj, suprascapular	1.32	1.81	2.02	0.51	0.50	0.07	000
64420		A	N block inj, intercost, sng	1.18	2.43	2.80	0.46	0.45	0.08	000
64421		A	N block inj, intercost, mlt	1.68	3.56	4.20	0.56	0.55	0.11	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.31	1.40	0.56	0.55	0.13	000
64430		A	N block inj, pudendal	1.46	2.39	2.43	0.81	0.74	0.10	000
64435		A	N block inj, paracervical	1.45	1.97	2.11	0.58	0.61	0.16	000
64445		A	N block inj, sciatic, sng	1.48	1.60	1.87	0.51	0.51	0.10	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	NA	0.23	0.43	0.20	000
64447		A	N block inj fem, single	1.50	NA	NA	0.18	0.24	0.09	000
64448		A	N block inj fem, cont inf	1.63	NA	NA	0.19	0.35	0.18	000
64449		A	N block inj, lumbar plexus	1.81	NA	NA	0.26	0.44	0.15	000
64450		A	N block, other peripheral	1.27	1.25	1.25	0.49	0.49	0.13	000
64455		A	N block inj, plantar digit	0.75	0.52	0.52	0.24	0.24	0.09	000
64470		A	Inj paravertebral c/t	1.85	3.81	4.68	0.73	0.73	0.11	000
64472		A	Inj paravertebral c/t add-on	1.29	1.23	1.51	0.35	0.35	0.08	ZZZ
64475		A	Inj paravertebral l/s	1.41	3.61	4.44	0.60	0.61	0.10	000
64476		A	Inj paravertebral l/s add-on	0.98	1.11	1.37	0.24	0.24	0.07	ZZZ
64479		A	Inj foramen epidural c/t	2.20	3.77	4.71	0.85	0.86	0.12	000
64480		A	Inj foramen epidural add-on	1.54	1.58	1.90	0.42	0.44	0.10	ZZZ
64483		A	Inj foramen epidural l/s	1.90	3.80	4.83	0.78	0.79	0.11	000
64484		A	Inj foramen epidural add-on	1.33	1.65	2.06	0.35	0.36	0.08	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.11	1.14	0.74	0.72	0.10	000
64508		A	N block, carotid sinus s/p	1.12	2.11	2.42	0.57	0.61	0.07	000
64510		A	N block, stellate ganglion	1.22	1.91	2.30	0.45	0.46	0.07	000
64517		A	N block inj, hypogas plxs	2.20	1.77	2.01	0.72	0.76	0.11	000
64520		A	N block, lumbar/thoracic	1.35	2.64	3.27	0.55	0.55	0.08	000
64530		A	N block inj, celiac pelus	1.58	2.74	3.18	0.66	0.66	0.10	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64550		A	Apply neurostimulator	0.18	0.19	0.21	0.05	0.05	0.01	000
64553		A	Implant neuroelectrodes	2.33	2.60	2.66	1.46	1.56	0.18	010
64555		A	Implant neuroelectrodes	2.29	2.97	3.01	1.64	1.53	0.19	010
64560		A	Implant neuroelectrodes	2.38	2.91	2.85	1.62	1.54	0.22	010
64561		A	Implant neuroelectrodes	7.07	19.29	22.04	3.92	3.64	0.51	010
64565		A	Implant neuroelectrodes	1.78	2.12	2.42	1.11	1.15	0.13	010
64573		A	Implant neuroelectrodes	8.15	NA	NA	5.31	5.31	1.60	090
64575		A	Implant neuroelectrodes	4.37	NA	NA	2.28	2.38	0.61	090
64577		A	Implant neuroelectrodes	4.64	NA	NA	3.61	3.54	1.04	090
64580		A	Implant neuroelectrodes	4.14	NA	NA	2.84	3.03	0.36	090
64581		A	Implant neuroelectrodes	14.15	NA	NA	6.98	6.59	1.05	090
64585		A	Revise/remove neuroelectrode	2.08	4.62	6.30	1.79	1.88	0.20	010
64590		A	Insrt/redo pn/gastr stimul	2.42	4.86	5.44	1.94	2.03	0.19	010
64595		A	Revise/rmv pn/gastr stimul	1.75	5.02	6.38	1.67	1.74	0.19	010
64600		A	Injection treatment of nerve	3.46	5.44	6.44	1.72	1.71	0.34	010
64605		A	Injection treatment of nerve	5.62	7.59	8.10	2.52	2.44	0.79	010
64610		A	Injection treatment of nerve	7.17	9.16	9.10	3.89	3.85	1.58	010
64612		A	Destroy nerve, face muscle	1.98	1.61	1.83	1.37	1.36	0.11	010
64613		A	Destroy nerve, neck muscle	1.98	1.37	1.77	1.15	1.17	0.11	010
64614		A	Destroy nerve, extrem musc	2.20	1.61	2.02	1.32	1.32	0.10	010
64620		A	Injection treatment of nerve	2.86	3.40	3.82	1.18	1.22	0.20	010
64622		A	Destr paravertebrl nerve l/s	3.02	4.09	5.02	1.31	1.33	0.18	010
64623		A	Destr paravertebral n add-on	0.99	1.67	2.00	0.24	0.23	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.82	4.78	5.54	1.94	1.95	0.20	010
64627		A	Destr paravertebral n add-on	1.16	2.39	2.93	0.27	0.27	0.07	ZZZ
64630		A	Injection treatment of nerve	3.02	2.72	2.73	1.84	1.74	0.22	010
64632		A	N block inj, common digit	1.20	0.95	0.95	0.63	0.63	0.05	010
64640		A	Injection treatment of nerve	2.78	2.37	2.83	1.41	1.52	0.29	010
64650		A	Chemodenerv eccrine glands	0.70	0.98	0.95	0.26	0.27	0.06	000
64653		A	Chemodenerv eccrine glands	0.88	1.06	1.03	0.32	0.33	0.08	000
64680		A	Injection treatment of nerve	2.64	4.36	4.96	1.29	1.33	0.18	010
64681		A	Injection treatment of nerve	3.78	4.88	6.00	1.35	1.53	0.28	010
64702		A	Revise finger/toe nerve	6.10	NA	NA	5.25	4.91	0.61	090
64704		A	Revise hand/foot nerve	4.61	NA	NA	3.40	3.38	0.61	090
64708		A	Revise arm/leg nerve	6.22	NA	NA	5.04	5.00	0.96	090
64712		A	Revision of sciatic nerve	7.98	NA	NA	5.02	5.01	0.95	090
64713		A	Revision of arm nerve(s)	11.29	NA	NA	6.74	6.54	1.83	090
64714		A	Revise low back nerve(s)	10.44	NA	NA	5.30	5.03	1.19	090
64716		A	Revision of cranial nerve	6.86	NA	NA	5.58	5.69	0.63	090
64718		A	Revise ulnar nerve at elbow	7.06	NA	NA	6.28	6.23	1.05	090
64719		A	Revise ulnar nerve at wrist	4.89	NA	NA	4.21	4.30	0.77	090
64721		A	Carpal tunnel surgery	4.84	4.76	4.92	4.70	4.88	0.73	090
64722		A	Relieve pressure on nerve(s)	4.74	NA	NA	3.30	3.24	0.48	090
64726		A	Release foot/toe nerve	4.21	NA	NA	2.72	2.74	0.54	090
64727		A	Internal nerve revision	3.10	NA	NA	1.28	1.34	0.48	ZZZ
64732		A	Incision of brow nerve	4.81	NA	NA	4.20	4.03	0.98	090
64734		A	Incision of cheek nerve	5.45	NA	NA	4.25	4.21	0.89	090
64736		A	Incision of chin nerve	5.13	NA	NA	4.26	4.21	0.52	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64738		A	Incision of jaw nerve	6.26	NA	NA	4.40	4.46	1.08	090
64740		A	Incision of tongue nerve	6.12	NA	NA	4.74	4.84	0.69	090
64742		A	Incision of facial nerve	6.75	NA	NA	4.34	4.44	0.73	090
64744		A	Incise nerve, back of head	5.64	NA	NA	3.86	3.84	1.16	090
64746		A	Incise diaphragm nerve	6.46	NA	NA	3.89	4.05	0.82	090
64752		A	Incision of vagus nerve	7.59	NA	NA	4.29	4.30	0.93	090
64755		A	Incision of stomach nerves	14.97	NA	NA	6.15	6.03	1.84	090
64760		A	Incision of vagus nerve	7.49	NA	NA	3.87	3.78	0.81	090
64761		A	Incision of pelvis nerve	6.94	NA	NA	4.00	3.89	0.53	090
64763		A	Incise hip/thigh nerve	7.46	NA	NA	5.55	5.47	0.94	090
64766		A	Incise hip/thigh nerve	9.34	NA	NA	5.65	5.56	1.06	090
64771		A	Sever cranial nerve	8.02	NA	NA	5.89	5.82	1.23	090
64772		A	Incision of spinal nerve	7.74	NA	NA	5.58	5.42	1.40	090
64774		A	Remove skin nerve lesion	5.70	NA	NA	4.02	3.98	0.74	090
64776		A	Remove digit nerve lesion	5.52	NA	NA	3.76	3.75	0.76	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	1.24	1.31	0.46	ZZZ
64782		A	Remove limb nerve lesion	6.76	NA	NA	4.30	4.18	0.86	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	1.51	1.60	0.51	ZZZ
64784		A	Remove nerve lesion	10.49	NA	NA	6.46	6.51	1.38	090
64786		A	Remove sciatic nerve lesion	16.12	NA	NA	8.73	9.03	2.61	090
64787		A	Implant nerve end	4.29	NA	NA	1.70	1.81	0.58	ZZZ
64788		A	Remove skin nerve lesion	5.14	NA	NA	4.08	3.93	0.73	090
64790		A	Removal of nerve lesion	11.97	NA	NA	7.07	7.12	2.11	090
64792		A	Removal of nerve lesion	15.71	NA	NA	9.31	9.21	2.49	090
64795		A	Biopsy of nerve	3.01	NA	NA	1.47	1.50	0.52	000
64802		A	Remove sympathetic nerves	10.24	NA	NA	3.55	3.96	1.29	090
64804		A	Remove sympathetic nerves	15.78	NA	NA	5.23	5.73	2.15	090
64809		A	Remove sympathetic nerves	14.61	NA	NA	5.97	5.94	1.50	090
64818		A	Remove sympathetic nerves	11.24	NA	NA	4.35	4.60	1.33	090
64820		A	Remove sympathetic nerves	10.64	NA	NA	7.13	7.14	1.49	090
64821		A	Remove sympathetic nerves	9.19	NA	NA	6.78	6.93	1.24	090
64822		A	Remove sympathetic nerves	9.19	NA	NA	6.47	6.68	1.30	090
64823		A	Remove sympathetic nerves	10.80	NA	NA	6.81	7.16	1.57	090
64831		A	Repair of digit nerve	9.00	NA	NA	6.77	6.86	1.41	090
64832		A	Repair nerve add-on	5.65	NA	NA	2.43	2.57	0.85	ZZZ
64834		A	Repair of hand or foot nerve	10.71	NA	NA	6.72	6.83	1.54	090
64835		A	Repair of hand or foot nerve	11.60	NA	NA	7.25	7.37	1.74	090
64836		A	Repair of hand or foot nerve	11.60	NA	NA	7.29	7.40	1.68	090
64837		A	Repair nerve add-on	6.25	NA	NA	2.73	2.86	0.97	ZZZ
64840		A	Repair of leg nerve	13.87	NA	NA	8.02	8.10	1.37	090
64856		A	Repair/transpose nerve	14.94	NA	NA	8.84	8.95	2.13	090
64857		A	Repair arm/leg nerve	15.69	NA	NA	9.15	9.29	2.22	090
64858		A	Repair sciatic nerve	17.69	NA	NA	10.51	10.60	3.34	090
64859		A	Nerve surgery	4.25	NA	NA	1.82	1.92	0.67	ZZZ
64861		A	Repair of arm nerves	20.74	NA	NA	10.63	10.94	4.09	090
64862		A	Repair of low back nerves	20.94	NA	NA	9.15	9.87	4.32	090
64864		A	Repair of facial nerve	13.31	NA	NA	7.42	7.78	1.26	090
64865		A	Repair of facial nerve	15.96	NA	NA	11.56	12.08	1.50	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64866		A	Fusion of facial/other nerve	16.70	NA	NA	11.73	12.12	2.05	090
64868		A	Fusion of facial/other nerve	14.80	NA	NA	10.36	10.65	1.43	090
64870		A	Fusion of facial/other nerve	16.95	NA	NA	7.62	7.92	1.30	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	0.86	0.92	0.29	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	1.22	1.30	0.42	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.13	1.29	0.47	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	NA	9.39	9.97	1.63	090
64886		A	Nerve graft, head or neck	20.72	NA	NA	11.13	11.77	2.09	090
64890		A	Nerve graft, hand or foot	16.11	NA	NA	9.47	9.62	2.30	090
64891		A	Nerve graft, hand or foot	17.22	NA	NA	10.54	9.82	1.63	090
64892		A	Nerve graft, arm or leg	15.61	NA	NA	9.37	9.26	2.48	090
64893		A	Nerve graft, arm or leg	16.74	NA	NA	9.25	9.43	2.62	090
64895		A	Nerve graft, hand or foot	20.26	NA	NA	11.08	10.75	2.58	090
64896		A	Nerve graft, hand or foot	21.81	NA	NA	12.57	12.20	3.17	090
64897		A	Nerve graft, arm or leg	19.25	NA	NA	10.73	10.74	2.55	090
64898		A	Nerve graft, arm or leg	20.82	NA	NA	11.88	11.89	2.78	090
64901		A	Nerve graft add-on	10.20	NA	NA	4.10	4.40	1.37	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	4.64	4.98	1.55	ZZZ
64905		A	Nerve pedicle transfer	14.98	NA	NA	9.20	9.04	2.01	090
64907		A	Nerve pedicle transfer	19.90	NA	NA	10.86	11.31	3.17	090
64910		A	Nerve repair w/allograft	11.21	NA	NA	8.04	8.04	1.74	090
64911		A	Neurorraphy w/vein autograft	14.21	NA	NA	9.13	9.13	1.91	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.13	NA	NA	6.87	7.26	0.32	090
65093		A	Revise eye with implant	6.93	NA	NA	6.96	7.42	0.34	090
65101		A	Removal of eye	8.10	NA	NA	8.13	8.50	0.35	090
65103		A	Remove eye/insert implant	8.64	NA	NA	8.32	8.69	0.37	090
65105		A	Remove eye/attach implant	9.70	NA	NA	9.03	9.41	0.42	090
65110		A	Removal of eye	15.42	NA	NA	11.79	12.29	0.81	090
65112		A	Remove eye/revise socket	18.18	NA	NA	13.54	14.22	1.30	090
65114		A	Remove eye/revise socket	19.32	NA	NA	13.95	14.58	1.02	090
65125		A	Revise ocular implant	3.18	6.64	7.20	3.22	3.32	0.19	090
65130		A	Insert ocular implant	8.22	NA	NA	7.85	8.20	0.35	090
65135		A	Insert ocular implant	8.40	NA	NA	7.96	8.32	0.36	090
65140		A	Attach ocular implant	9.23	NA	NA	8.66	8.98	0.40	090
65150		A	Revise ocular implant	6.32	NA	NA	6.48	6.87	0.31	090
65155		A	Reinsert ocular implant	9.87	NA	NA	8.87	9.29	0.50	090
65175		A	Removal of ocular implant	7.22	NA	NA	7.25	7.58	0.31	090
65205		A	Remove foreign body from eye	0.71	0.58	0.59	0.33	0.32	0.03	000
65210		A	Remove foreign body from eye	0.84	0.73	0.75	0.41	0.40	0.04	000
65220		A	Remove foreign body from eye	0.71	0.60	0.61	0.29	0.29	0.05	000
65222		A	Remove foreign body from eye	0.93	0.80	0.82	0.44	0.43	0.04	000
65235		A	Remove foreign body from eye	8.78	NA	NA	7.00	6.96	0.37	090
65260		A	Remove foreign body from eye	12.29	NA	NA	9.09	9.25	0.57	090
65265		A	Remove foreign body from eye	14.06	NA	NA	10.03	10.20	0.62	090
65270		A	Repair of eye wound	1.92	3.81	4.18	1.25	1.28	0.09	010
65272		A	Repair of eye wound	4.49	6.40	6.74	3.31	3.31	0.19	090
65273		A	Repair of eye wound	5.03	NA	NA	3.51	3.53	0.22	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
65275		A	Repair of eye wound	6.14	6.43	6.41	4.06	4.04	0.26	090
65280		A	Repair of eye wound	8.87	NA	NA	6.10	6.15	0.38	090
65285		A	Repair of eye wound	14.43	NA	NA	8.85	8.96	0.64	090
65286		A	Repair of eye wound	6.45	8.84	9.44	4.58	4.60	0.27	090
65290		A	Repair of eye socket wound	6.35	NA	NA	4.62	4.66	0.31	090
65400		A	Removal of eye lesion	7.27	7.62	7.81	6.05	6.08	0.30	090
65410		A	Biopsy of cornea	1.47	1.70	1.81	0.91	0.92	0.07	000
65420		A	Removal of eye lesion	4.24	6.91	7.42	4.07	4.17	0.21	090
65426		A	Removal of eye lesion	5.93	8.29	8.78	4.73	4.79	0.25	090
65430		A	Corneal smear	1.47	1.13	1.17	0.90	0.92	0.07	000
65435		A	Curette/treat cornea	0.92	0.88	0.91	0.67	0.68	0.04	000
65436		A	Curette/treat cornea	4.72	3.89	3.95	3.57	3.60	0.21	090
65450		A	Treatment of corneal lesion	3.35	3.75	3.84	3.68	3.75	0.16	090
65600		A	Revision of cornea	4.07	4.53	4.66	3.51	3.48	0.17	090
65710		A	Corneal transplant	14.09	NA	NA	10.55	10.74	0.61	090
65730		A	Corneal transplant	15.99	NA	NA	11.44	11.61	0.70	090
65750		A	Corneal transplant	16.60	NA	NA	11.12	11.36	0.74	090
65755		A	Corneal transplant	16.49	NA	NA	11.08	11.31	0.73	090
65756		A	Corneal trnspl, endothelial	16.60	NA	NA	10.14	10.14	0.74	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.41	NA	NA	12.26	12.53	0.87	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	4.96	4.96	5.12	4.05	4.08	0.21	090
65775		A	Correction of astigmatism	6.73	NA	NA	5.50	5.63	0.28	090
65780		A	Ocular reconst, transplant	10.43	NA	NA	9.19	9.49	0.44	090
65781		A	Ocular reconst, transplant	17.84	NA	NA	12.12	12.54	0.44	090
65782		A	Ocular reconst, transplant	15.16	NA	NA	10.65	11.01	0.44	090
65800		A	Drainage of eye	1.91	1.45	1.54	1.08	1.11	0.09	000
65805		A	Drainage of eye	1.91	1.75	1.86	1.08	1.11	0.09	000
65810		A	Drainage of eye	5.67	NA	NA	4.84	4.81	0.24	090
65815		A	Drainage of eye	5.85	8.03	8.54	4.74	4.77	0.25	090
65820		A	Relieve inner eye pressure	8.72	NA	NA	7.82	8.15	0.40	090
65850		A	Incision of eye	11.24	NA	NA	7.67	7.88	0.52	090
65855		A	Laser surgery of eye	3.90	3.59	3.78	2.74	2.84	0.19	010
65860		A	Incise inner eye adhesions	3.56	3.35	3.53	2.19	2.27	0.18	090
65865		A	Incise inner eye adhesions	5.66	NA	NA	4.84	5.05	0.28	090
65870		A	Incise inner eye adhesions	7.21	NA	NA	5.90	6.04	0.31	090
65875		A	Incise inner eye adhesions	7.61	NA	NA	6.35	6.47	0.32	090
65880		A	Incise inner eye adhesions	8.16	NA	NA	6.53	6.67	0.35	090
65900		A	Remove eye lesion	12.26	NA	NA	9.19	9.48	0.54	090
65920		A	Remove implant of eye	9.74	NA	NA	7.75	7.87	0.41	090
65930		A	Remove blood clot from eye	8.24	NA	NA	6.02	6.23	0.37	090
66020		A	Injection treatment of eye	1.61	2.45	2.62	1.32	1.35	0.08	010
66030		A	Injection treatment of eye	1.27	2.31	2.48	1.18	1.21	0.06	010
66130		A	Remove eye lesion	7.74	7.71	8.21	5.11	5.25	0.38	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
66150		A	Glaucoma surgery	10.18	NA	NA	9.09	9.19	0.46	090
66155		A	Glaucoma surgery	10.17	NA	NA	9.08	9.17	0.41	090
66160		A	Glaucoma surgery	12.04	NA	NA	9.82	9.94	0.50	090
66165		A	Glaucoma surgery	9.89	NA	NA	8.97	9.06	0.40	090
66170		A	Glaucoma surgery	14.57	NA	NA	11.95	12.05	0.60	090
66172		A	Incision of eye	18.26	NA	NA	15.15	15.20	0.74	090
66180		A	Implant eye shunt	16.02	NA	NA	10.19	10.36	0.71	090
66185		A	Revise eye shunt	9.35	NA	NA	7.32	7.35	0.40	090
66220		A	Repair eye lesion	8.98	NA	NA	7.39	7.33	0.40	090
66225		A	Repair/graft eye lesion	12.38	NA	NA	8.49	8.57	0.55	090
66250		A	Follow-up surgery of eye	6.92	9.37	9.98	5.45	5.47	0.30	090
66500		A	Incision of iris	3.75	NA	NA	4.03	4.19	0.18	090
66505		A	Incision of iris	4.13	NA	NA	4.40	4.56	0.20	090
66600		A	Remove iris and lesion	9.89	NA	NA	8.55	8.49	0.43	090
66605		A	Removal of iris	13.99	NA	NA	9.62	9.74	0.77	090
66625		A	Removal of iris	5.19	NA	NA	4.35	4.45	0.26	090
66630		A	Removal of iris	7.10	NA	NA	5.55	5.60	0.31	090
66635		A	Removal of iris	7.19	NA	NA	5.58	5.64	0.31	090
66680		A	Repair iris & ciliary body	6.24	NA	NA	5.23	5.25	0.27	090
66682		A	Repair iris & ciliary body	7.15	NA	NA	6.89	6.84	0.31	090
66700		A	Destruction, ciliary body	5.06	4.92	5.02	3.75	3.80	0.24	090
66710		A	Ciliary transsleral therapy	5.06	4.73	4.85	3.75	3.78	0.23	090
66711		A	Ciliary endoscopic ablation	7.70	NA	NA	6.52	6.52	0.30	090
66720		A	Destruction, ciliary body	4.86	5.42	5.53	4.39	4.49	0.26	090
66740		A	Destruction, ciliary body	5.06	4.66	4.78	3.75	3.82	0.23	090
66761		A	Revision of iris	4.87	5.14	5.26	4.32	4.33	0.20	090
66762		A	Revision of iris	5.25	5.23	5.35	4.22	4.24	0.23	090
66770		A	Removal of inner eye lesion	5.98	5.68	5.79	4.75	4.78	0.26	090
66820		A	Incision, secondary cataract	3.93	NA	NA	4.71	5.00	0.19	090
66821		A	After cataract laser surgery	3.32	3.90	3.96	3.50	3.54	0.11	090
66825		A	Reposition intraocular lens	8.82	NA	NA	8.00	8.29	0.40	090
66830		A	Removal of lens lesion	9.27	NA	NA	6.65	6.74	0.36	090
66840		A	Removal of lens material	8.98	NA	NA	6.49	6.60	0.39	090
66850		A	Removal of lens material	10.32	NA	NA	7.38	7.46	0.45	090
66852		A	Removal of lens material	11.18	NA	NA	7.72	7.84	0.49	090
66920		A	Extraction of lens	9.93	NA	NA	6.93	7.04	0.44	090
66930		A	Extraction of lens	11.38	NA	NA	7.81	7.91	0.49	090
66940		A	Extraction of lens	10.14	NA	NA	7.30	7.39	0.43	090
66982		A	Cataract surgery, complex	14.83	NA	NA	9.03	9.26	0.63	090
66983		A	Cataract surg w/iol, 1 stage	10.20	NA	NA	6.76	6.61	0.14	090
66984		A	Cataract surg w/iol, 1 stage	10.36	NA	NA	6.79	6.96	0.39	090
66985		A	Insert lens prosthesis	9.73	NA	NA	7.40	7.43	0.36	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	8.43	8.63	0.60	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	0.59	0.62	0.07	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.77	NA	NA	4.74	4.78	0.28	090
67010		A	Partial removal of eye fluid	6.94	NA	NA	5.20	5.26	0.34	090
67015		A	Release of eye fluid	7.00	NA	NA	5.89	6.04	0.34	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67025		A	Replace eye fluid	7.91	8.06	8.37	6.14	6.17	0.34	090
67027		A	Implant eye drug system	11.43	NA	NA	7.71	7.80	0.54	090
67028		A	Injection eye drug	2.52	2.22	2.35	1.32	1.36	0.12	000
67030		A	Incise inner eye strands	5.91	NA	NA	5.75	5.79	0.24	090
67031		A	Laser surgery, eye strands	4.34	4.21	4.31	3.55	3.58	0.18	090
67036		A	Removal of inner eye fluid	13.09	NA	NA	8.46	8.65	0.58	090
67039		A	Laser treatment of retina	16.39	NA	NA	11.21	11.48	0.71	090
67040		A	Laser treatment of retina	19.23	NA	NA	12.59	12.90	0.85	090
67041		A	Vit for macular pucker	19.00	NA	NA	10.99	10.99	0.86	090
67042		A	Vit for macular hole	22.13	NA	NA	12.21	12.21	1.00	090
67043		A	Vit for membrane dissect	22.94	NA	NA	13.10	13.10	1.04	090
67101		A	Repair detached retina	8.60	8.70	8.83	6.42	6.46	0.37	090
67105		A	Repair detached retina	8.35	7.63	7.76	6.03	6.08	0.37	090
67107		A	Repair detached retina	16.35	NA	NA	10.85	10.99	0.73	090
67108		A	Repair detached retina	22.49	NA	NA	13.65	13.87	1.02	090
67110		A	Repair detached retina	10.02	9.20	9.48	7.27	7.31	0.44	090
67112		A	Rerepair detached retina	18.45	NA	NA	11.43	11.56	0.83	090
67113		A	Repair retinal detach, cplx	25.00	NA	NA	14.47	14.47	1.13	090
67115		A	Release encircling material	5.93	NA	NA	5.11	5.11	0.25	090
67120		A	Remove eye implant material	6.92	7.52	7.80	5.48	5.51	0.29	090
67121		A	Remove eye implant material	12.00	NA	NA	8.32	8.39	0.53	090
67141		A	Treatment of retina	6.00	5.57	5.65	4.82	4.84	0.26	090
67145		A	Treatment of retina	6.17	5.51	5.57	4.89	4.91	0.27	090
67208		A	Treatment of retinal lesion	7.50	5.87	5.94	5.43	5.46	0.33	090
67210		A	Treatment of retinal lesion	9.35	6.20	6.31	5.73	5.78	0.44	090
67218		A	Treatment of retinal lesion	20.22	NA	NA	11.28	11.52	0.92	090
67220		A	Treatment of choroid lesion	14.19	9.65	9.87	8.61	8.73	0.65	090
67221		R	Ocular photodynamic ther	3.45	3.01	3.35	1.49	1.58	0.20	000
67225		A	Eye photodynamic ther add-on	0.47	0.22	0.23	0.18	0.19	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.38	6.20	6.31	5.37	5.42	0.33	090
67228		A	Treatment of retinal lesion	13.67	13.93	13.35	10.59	10.10	0.63	090
67229		A	Tr retinal les preterm inf	16.00	NA	NA	10.00	10.00	0.71	090
67250		A	Reinforce eye wall	9.46	NA	NA	7.93	8.26	0.47	090
67255		A	Reinforce/graft eye wall	9.97	NA	NA	8.70	9.02	0.44	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.59	NA	NA	5.73	5.82	0.37	090
67312		A	Revise two eye muscles	9.48	NA	NA	6.48	6.56	0.43	090
67314		A	Revise eye muscle	8.59	NA	NA	6.41	6.46	0.39	090
67316		A	Revise two eye muscles	10.73	NA	NA	7.17	7.27	0.49	090
67318		A	Revise eye muscle(s)	8.92	NA	NA	6.77	6.83	0.41	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	2.11	2.08	0.22	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	1.99	1.95	0.21	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	2.17	2.14	0.23	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	1.98	1.94	0.20	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	0.97	1.01	0.13	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	2.35	2.32	0.25	ZZZ
67343		A	Release eye tissue	8.29	NA	NA	6.27	6.34	0.37	090
67345		A	Destroy nerve of eye muscle	2.98	2.24	2.33	1.78	1.84	0.17	010

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67346		A	Biopsy, eye muscle	2.87	NA	NA	1.72	1.76	0.15	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	10.97	NA	NA	9.69	10.11	0.56	090
67405		A	Explore/drain eye socket	9.00	NA	NA	8.67	8.97	0.44	090
67412		A	Explore/treat eye socket	10.17	NA	NA	8.82	9.37	0.48	090
67413		A	Explore/treat eye socket	10.09	NA	NA	8.98	9.45	0.50	090
67414		A	Explr/decompress eye socket	17.78	NA	NA	12.21	12.19	0.65	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	0.67	0.69	0.09	000
67420		A	Explore/treat eye socket	21.62	NA	NA	14.85	15.52	1.15	090
67430		A	Explore/treat eye socket	14.99	NA	NA	12.69	13.27	0.86	090
67440		A	Explore/drain eye socket	14.56	NA	NA	12.23	12.77	0.70	090
67445		A	Explr/decompress eye socket	18.96	NA	NA	12.75	13.07	0.90	090
67450		A	Explore/biopsy eye socket	15.11	NA	NA	12.76	13.28	0.68	090
67500		A	Inject/treat eye socket	1.44	0.61	0.63	0.48	0.43	0.05	000
67505		A	Inject/treat eye socket	1.27	0.77	0.75	0.61	0.54	0.05	000
67515		A	Inject/treat eye socket	1.40	0.82	0.76	0.66	0.59	0.03	000
67550		A	Insert eye socket implant	11.52	NA	NA	10.02	10.36	0.72	090
67560		A	Revise eye socket implant	11.93	NA	NA	10.08	10.43	0.60	090
67570		A	Decompress optic nerve	14.21	NA	NA	11.54	12.08	0.68	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.37	4.29	4.74	1.21	1.22	0.07	010
67710		A	Incision of eyelid	1.04	3.68	4.12	1.10	1.13	0.05	010
67715		A	Incision of eyelid fold	1.24	3.78	4.19	1.18	1.21	0.06	010
67800		A	Remove eyelid lesion	1.39	1.43	1.48	0.94	0.97	0.07	010
67801		A	Remove eyelid lesions	1.89	1.73	1.79	1.14	1.17	0.09	010
67805		A	Remove eyelid lesions	2.24	2.24	2.32	1.48	1.52	0.11	010
67808		A	Remove eyelid lesion(s)	4.47	NA	NA	3.70	3.73	0.19	090
67810		A	Biopsy of eyelid	1.48	3.91	3.77	0.73	0.72	0.06	000
67820		A	Revise eyelashes	0.71	0.45	0.49	0.52	0.53	0.04	000
67825		A	Revise eyelashes	1.40	1.43	1.51	1.30	1.33	0.07	010
67830		A	Revise eyelashes	1.72	3.99	4.39	1.37	1.40	0.08	010
67835		A	Revise eyelashes	5.61	NA	NA	4.22	4.33	0.28	090
67840		A	Remove eyelid lesion	2.06	3.93	4.32	1.51	1.55	0.10	010
67850		A	Treat eyelid lesion	1.71	3.43	3.43	1.56	1.54	0.07	010
67875		A	Closure of eyelid by suture	1.35	2.40	2.63	0.87	0.89	0.07	000
67880		A	Revision of eyelid	4.47	5.53	5.81	3.69	3.73	0.19	090
67882		A	Revision of eyelid	5.87	6.50	6.80	4.63	4.69	0.25	090
67900		A	Repair brow defect	6.69	7.49	7.90	4.79	4.91	0.38	090
67901		A	Repair eyelid defect	7.47	9.10	8.20	5.48	5.47	0.54	090
67902		A	Repair eyelid defect	9.68	NA	NA	6.67	6.38	0.60	090
67903		A	Repair eyelid defect	6.42	6.73	7.46	4.49	4.76	0.47	090
67904		A	Repair eyelid defect	7.83	8.34	8.68	5.59	5.52	0.41	090
67906		A	Repair eyelid defect	6.84	NA	NA	4.66	4.76	0.46	090
67908		A	Repair eyelid defect	5.19	5.67	5.93	4.27	4.55	0.28	090
67909		A	Revise eyelid defect	5.46	6.30	6.75	4.32	4.49	0.31	090
67911		A	Revise eyelid defect	7.38	NA	NA	5.26	5.15	0.31	090
67912		A	Correction eyelid w/implant	6.23	13.10	14.60	4.87	5.05	0.28	090
67914		A	Repair eyelid defect	3.70	4.82	5.21	2.78	2.86	0.19	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67915		A	Repair eyelid defect	3.21	4.36	4.78	2.51	2.59	0.16	090
67916		A	Repair eyelid defect	5.37	6.47	6.88	4.29	4.42	0.28	090
67917		A	Repair eyelid defect	6.08	6.85	7.27	4.57	4.71	0.36	090
67921		A	Repair eyelid defect	3.42	4.68	5.07	2.65	2.72	0.17	090
67922		A	Repair eyelid defect	3.09	4.21	4.65	2.41	2.50	0.15	090
67923		A	Repair eyelid defect	5.94	6.57	6.97	4.49	4.62	0.30	090
67924		A	Repair eyelid defect	5.84	7.04	7.53	4.24	4.36	0.30	090
67930		A	Repair eyelid wound	3.62	4.46	4.78	1.91	1.98	0.19	010
67935		A	Repair eyelid wound	6.27	6.89	7.31	3.77	3.94	0.39	090
67938		A	Remove eyelid foreign body	1.35	3.83	4.23	1.25	1.26	0.06	010
67950		A	Revision of eyelid	5.88	6.77	7.25	4.53	4.71	0.36	090
67961		A	Revision of eyelid	5.75	6.92	7.38	4.46	4.61	0.33	090
67966		A	Revision of eyelid	8.83	8.26	8.50	5.99	5.90	0.37	090
67971		A	Reconstruction of eyelid	9.87	NA	NA	6.47	6.69	0.53	090
67973		A	Reconstruction of eyelid	12.96	NA	NA	8.14	8.45	0.75	090
67974		A	Reconstruction of eyelid	12.93	NA	NA	8.08	8.39	0.75	090
67975		A	Reconstruction of eyelid	9.21	NA	NA	6.23	6.43	0.50	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.39	1.27	1.31	1.09	1.12	0.06	010
68040		A	Treatment of eyelid lesions	0.85	0.62	0.65	0.38	0.39	0.04	000
68100		A	Biopsy of eyelid lining	1.35	2.37	2.60	0.90	0.91	0.07	000
68110		A	Remove eyelid lining lesion	1.79	3.08	3.35	1.52	1.56	0.09	010
68115		A	Remove eyelid lining lesion	2.38	4.34	4.76	1.75	1.79	0.12	010
68130		A	Remove eyelid lining lesion	4.99	6.75	7.26	4.17	4.29	0.24	090
68135		A	Remove eyelid lining lesion	1.86	1.63	1.68	1.52	1.56	0.09	010
68200		A	Treat eyelid by injection	0.49	0.46	0.48	0.30	0.31	0.02	000
68320		A	Revise/graft eyelid lining	6.44	9.29	9.81	5.49	5.51	0.27	090
68325		A	Revise/graft eyelid lining	8.43	NA	NA	6.28	6.36	0.44	090
68326		A	Revise/graft eyelid lining	8.22	NA	NA	6.15	6.23	0.35	090
68328		A	Revise/graft eyelid lining	9.25	NA	NA	6.60	6.79	0.54	090
68330		A	Revise eyelid lining	5.63	7.51	8.01	4.60	4.64	0.24	090
68335		A	Revise/graft eyelid lining	8.26	NA	NA	6.16	6.23	0.36	090
68340		A	Separate eyelid adhesions	4.84	6.96	7.45	4.00	4.03	0.21	090
68360		A	Revise eyelid lining	5.04	6.54	6.93	4.10	4.13	0.22	090
68362		A	Revise eyelid lining	8.41	NA	NA	6.22	6.28	0.36	090
68371		A	Harvest eye tissue, alograft	4.97	NA	NA	4.19	4.34	0.44	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.71	4.33	4.74	1.24	1.39	0.08	010
68420		A	Incise/drain tear sac	2.32	4.61	5.02	1.49	1.65	0.11	010
68440		A	Incise tear duct opening	0.96	1.27	1.47	1.20	1.22	0.05	010
68500		A	Removal of tear gland	12.49	NA	NA	9.24	9.39	0.55	090
68505		A	Partial removal, tear gland	12.41	NA	NA	9.23	9.61	0.55	090
68510		A	Biopsy of tear gland	4.60	5.30	5.82	2.17	2.16	0.23	000
68520		A	Removal of tear sac	8.58	NA	NA	6.74	6.93	0.37	090
68525		A	Biopsy of tear sac	4.42	NA	NA	1.71	1.79	0.22	000
68530		A	Clearance of tear duct	3.67	5.66	6.30	2.19	2.31	0.18	010
68540		A	Remove tear gland lesion	11.93	NA	NA	8.84	9.00	0.52	090
68550		A	Remove tear gland lesion	14.86	NA	NA	10.53	10.76	0.80	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
68700		A	Repair tear ducts	7.67	NA	NA	5.79	5.85	0.32	090
68705		A	Revise tear duct opening	2.08	3.07	3.35	1.64	1.68	0.10	010
68720		A	Create tear sac drain	9.78	NA	NA	7.17	7.36	0.44	090
68745		A	Create tear duct drain	9.70	NA	NA	7.31	7.46	0.52	090
68750		A	Create tear duct drain	9.87	NA	NA	7.67	7.84	0.43	090
68760		A	Close tear duct opening	1.75	2.62	2.85	1.50	1.54	0.09	010
68761		A	Close tear duct opening	1.38	1.86	1.97	1.28	1.30	0.06	010
68770		A	Close tear system fistula	8.09	NA	NA	5.93	5.25	0.35	090
68801		A	Dilate tear duct opening	0.96	1.78	1.82	1.42	1.44	0.05	010
68810		A	Probe nasolacrimal duct	2.09	3.16	3.29	2.04	2.20	0.10	010
68811		A	Probe nasolacrimal duct	2.39	NA	NA	2.19	2.25	0.13	010
68815		A	Probe nasolacrimal duct	3.24	6.44	6.91	2.52	2.60	0.17	010
68816		A	Probe nl duct w/balloon	3.00	12.66	12.66	2.60	2.60	0.16	010
68840		A	Explore/irrigate tear ducts	1.27	1.53	1.55	1.31	1.26	0.06	010
68850		A	Injection for tear sac x-ray	0.80	0.74	0.78	0.63	0.64	0.04	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.47	2.85	2.87	1.34	1.35	0.12	010
69005		A	Drain external ear lesion	2.13	3.00	2.99	1.65	1.70	0.17	010
69020		A	Drain outer ear canal lesion	1.50	4.07	4.06	1.92	1.96	0.12	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.83	1.80	0.42	0.41	0.03	000
69105		A	Biopsy of external ear canal	0.85	2.61	2.55	0.72	0.73	0.07	000
69110		A	Remove external ear, partial	3.47	7.79	7.55	4.49	4.49	0.30	090
69120		A	Removal of external ear	4.08	NA	NA	5.38	5.59	0.38	090
69140		A	Remove ear canal lesion(s)	8.03	NA	NA	13.18	13.23	0.65	090
69145		A	Remove ear canal lesion(s)	2.65	6.92	6.65	3.37	3.36	0.21	090
69150		A	Extensive ear canal surgery	13.49	NA	NA	11.69	12.15	1.22	090
69155		A	Extensive ear/neck surgery	23.06	NA	NA	17.56	18.10	1.93	090
69200		A	Clear outer ear canal	0.77	2.12	2.19	0.62	0.60	0.06	000
69205		A	Clear outer ear canal	1.20	NA	NA	1.24	1.27	0.10	010
69210		A	Remove impacted ear wax	0.61	0.58	0.59	0.18	0.19	0.05	000
69220		A	Clean out mastoid cavity	0.83	2.52	2.49	0.69	0.70	0.07	000
69222		A	Clean out mastoid cavity	1.42	3.91	3.90	1.89	1.94	0.12	010
69300		R	Revise external ear	6.69	10.48	8.93	5.19	4.96	0.72	YYY
69310		A	Rebuild outer ear canal	10.85	NA	NA	15.41	15.66	0.85	090
69320		A	Rebuild outer ear canal	17.03	NA	NA	20.17	20.64	1.37	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.76	2.62	0.69	0.69	0.07	000
69401		A	Inflate middle ear canal	0.63	1.42	1.38	0.56	0.59	0.05	000
69405		A	Catheterize middle ear canal	2.65	3.65	3.62	2.01	2.09	0.21	010
69420		A	Incision of eardrum	1.35	3.28	3.25	1.56	1.57	0.11	010
69421		A	Incision of eardrum	1.75	NA	NA	1.86	1.94	0.15	010
69424		A	Remove ventilating tube	0.85	2.30	2.28	0.68	0.68	0.07	000
69433		A	Create eardrum opening	1.54	3.28	3.24	1.60	1.61	0.13	010
69436		A	Create eardrum opening	1.98	NA	NA	1.91	2.01	0.19	010
69440		A	Exploration of middle ear	7.62	NA	NA	9.11	9.04	0.61	090
69450		A	Eardrum revision	5.61	NA	NA	7.62	7.49	0.45	090
69501		A	Mastoidectomy	9.12	NA	NA	8.58	8.71	0.73	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69502		A	Mastoidectomy	12.44	NA	NA	11.12	11.26	1.00	090
69505		A	Remove mastoid structures	13.05	NA	NA	16.08	16.39	1.05	090
69511		A	Extensive mastoid surgery	13.58	NA	NA	16.36	16.68	1.09	090
69530		A	Extensive mastoid surgery	20.24	NA	NA	19.99	20.45	1.54	090
69535		A	Remove part of temporal bone	37.27	NA	NA	27.32	28.55	2.93	090
69540		A	Remove ear lesion	1.22	3.83	3.81	1.85	1.88	0.10	010
69550		A	Remove ear lesion	11.04	NA	NA	14.22	14.42	0.89	090
69552		A	Remove ear lesion	19.69	NA	NA	18.34	18.97	1.59	090
69554		A	Remove ear lesion	35.71	NA	NA	23.56	25.32	2.92	090
69601		A	Mastoid surgery revision	13.31	NA	NA	12.08	12.25	1.07	090
69602		A	Mastoid surgery revision	13.64	NA	NA	12.82	12.96	1.10	090
69603		A	Mastoid surgery revision	14.08	NA	NA	16.54	17.03	1.14	090
69604		A	Mastoid surgery revision	14.08	NA	NA	13.21	13.36	1.14	090
69605		A	Mastoid surgery revision	18.55	NA	NA	19.39	19.83	1.50	090
69610		A	Repair of eardrum	4.44	4.93	5.10	2.67	2.83	0.36	010
69620		A	Repair of eardrum	5.94	10.80	10.91	5.87	5.99	0.48	090
69631		A	Repair eardrum structures	9.93	NA	NA	11.55	11.49	0.80	090
69632		A	Rebuild eardrum structures	12.82	NA	NA	13.40	13.45	1.03	090
69633		A	Rebuild eardrum structures	12.17	NA	NA	13.15	13.15	0.98	090
69635		A	Repair eardrum structures	13.39	NA	NA	16.31	16.46	1.08	090
69636		A	Rebuild eardrum structures	15.29	NA	NA	18.21	18.53	1.23	090
69637		A	Rebuild eardrum structures	15.18	NA	NA	18.19	18.49	1.22	090
69641		A	Revise middle ear & mastoid	12.77	NA	NA	12.56	12.65	1.03	090
69642		A	Revise middle ear & mastoid	16.91	NA	NA	15.66	15.85	1.36	090
69643		A	Revise middle ear & mastoid	15.45	NA	NA	14.31	14.47	1.24	090
69644		A	Revise middle ear & mastoid	17.09	NA	NA	18.84	19.27	1.37	090
69645		A	Revise middle ear & mastoid	16.57	NA	NA	18.68	19.06	1.33	090
69646		A	Revise middle ear & mastoid	18.23	NA	NA	19.16	19.61	1.46	090
69650		A	Release middle ear bone	9.71	NA	NA	9.53	9.65	0.78	090
69660		A	Revise middle ear bone	11.94	NA	NA	10.64	10.80	0.96	090
69661		A	Revise middle ear bone	15.80	NA	NA	13.63	13.93	1.27	090
69662		A	Revise middle ear bone	15.49	NA	NA	12.69	12.98	1.25	090
69666		A	Repair middle ear structures	9.80	NA	NA	9.78	9.85	0.79	090
69667		A	Repair middle ear structures	9.81	NA	NA	9.85	9.91	0.79	090
69670		A	Remove mastoid air cells	11.62	NA	NA	11.22	11.37	0.93	090
69676		A	Remove middle ear nerve	9.58	NA	NA	10.64	10.70	0.81	090
69700		A	Close mastoid fistula	8.28	NA	NA	8.40	8.63	0.67	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.50	NA	NA	10.59	10.66	0.83	090
69714		A	Implant temple bone w/stimul	14.31	NA	NA	11.85	12.09	1.13	090
69715		A	Temple bne implnt w/stimulat	18.80	NA	NA	13.60	13.99	1.48	090
69717		A	Temple bone implant revision	15.29	NA	NA	12.22	12.81	0.90	090
69718		A	Revise temple bone implant	19.05	NA	NA	13.69	14.13	3.22	090
69720		A	Release facial nerve	14.57	NA	NA	13.95	14.13	1.16	090
69725		A	Release facial nerve	27.44	NA	NA	18.47	18.93	2.45	090
69740		A	Repair facial nerve	16.18	NA	NA	12.35	12.64	1.27	090
69745		A	Repair facial nerve	16.91	NA	NA	13.42	13.84	1.14	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69801		A	Incise inner ear	8.61	NA	NA	9.64	9.62	0.69	090
69802		A	Incise inner ear	13.39	NA	NA	11.99	12.11	1.06	090
69805		A	Explore inner ear	14.55	NA	NA	11.04	11.27	1.12	090
69806		A	Explore inner ear	12.52	NA	NA	10.53	10.68	1.00	090
69820		A	Establish inner ear window	10.40	NA	NA	10.45	10.66	0.90	090
69840		A	Revise inner ear window	10.32	NA	NA	11.47	11.92	0.79	090
69905		A	Remove inner ear	11.15	NA	NA	11.29	11.33	0.90	090
69910		A	Remove inner ear & mastoid	13.80	NA	NA	11.04	11.29	1.07	090
69915		A	Incise inner ear nerve	22.65	NA	NA	14.84	15.29	1.70	090
69930		A	Implant cochlear device	17.60	NA	NA	12.24	12.90	1.36	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.44	NA	NA	16.71	17.30	2.29	090
69955		A	Release facial nerve	29.22	NA	NA	19.11	19.73	2.49	090
69960		A	Release inner ear canal	29.22	NA	NA	17.76	18.38	2.18	090
69970		A	Remove inner ear lesion	32.21	NA	NA	20.12	20.96	2.42	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.35	1.46	0.89	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.80	3.28	NA	NA	0.27	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.35	2.85	NA	NA	0.22	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.45	0.43	0.45	0.43	0.05	XXX
70015		A	Contrast x-ray of brain	1.19	2.86	2.59	NA	NA	0.16	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.40	2.14	NA	NA	0.08	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.46	0.45	0.46	0.45	0.08	XXX
70030		A	X-ray eye for foreign body	0.17	0.61	0.57	NA	NA	0.03	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.54	0.51	NA	NA	0.02	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.07	0.06	0.07	0.06	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.63	0.62	NA	NA	0.03	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.57	0.56	NA	NA	0.02	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.80	0.78	NA	NA	0.05	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.71	0.69	NA	NA	0.04	XXX
70110	26	A	X-ray exam of jaw	0.25	0.09	0.09	0.09	0.09	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.68	0.68	NA	NA	0.05	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	0.62	NA	NA	0.04	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.15	1.09	NA	NA	0.07	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.03	0.97	NA	NA	0.05	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.12	0.12	0.12	0.12	0.02	XXX
70134		A	X-ray exam of middle ear	0.34	0.90	0.88	NA	NA	0.07	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.77	0.76	NA	NA	0.05	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.13	0.12	0.13	0.12	0.02	XXX
70140		A	X-ray exam of facial bones	0.19	0.54	0.58	NA	NA	0.05	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.48	0.52	NA	NA	0.04	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.06	0.06	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.84	0.85	NA	NA	0.06	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.75	0.76	NA	NA	0.05	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.09	0.09	0.09	0.09	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.70	0.67	NA	NA	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70160	TC	A	X-ray exam of nasal bones	0.00	0.64	0.61	NA	NA	0.02	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.12	0.11	0.12	0.11	0.01	XXX
70190		A	X-ray exam of eye sockets	0.21	0.72	0.71	NA	NA	0.05	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.64	0.64	NA	NA	0.04	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.08	0.07	0.08	0.07	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.87	0.87	NA	NA	0.06	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.77	0.77	NA	NA	0.05	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.10	0.10	0.10	0.10	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.57	0.60	NA	NA	0.05	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.52	0.54	NA	NA	0.04	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.72	0.76	NA	NA	0.06	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.64	0.68	NA	NA	0.05	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.08	0.08	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.60	0.58	NA	NA	0.03	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.53	0.51	NA	NA	0.02	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.07	0.07	0.07	0.07	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.69	0.70	NA	NA	0.05	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	0.62	NA	NA	0.04	XXX
70250	26	A	X-ray exam of skull	0.24	0.07	0.08	0.07	0.08	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.87	0.90	NA	NA	0.08	XXX
70260	TC	A	X-ray exam of skull	0.00	0.76	0.79	NA	NA	0.06	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.11	0.11	0.02	XXX
70300		A	X-ray exam of teeth	0.10	0.23	0.26	NA	NA	0.03	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.20	0.22	NA	NA	0.02	XXX
70300	26	A	X-ray exam of teeth	0.10	0.03	0.04	0.03	0.04	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.80	0.73	NA	NA	0.03	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.75	0.67	NA	NA	0.02	XXX
70310	26	A	X-ray exam of teeth	0.16	0.05	0.06	0.05	0.06	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.06	1.02	NA	NA	0.06	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.98	0.94	NA	NA	0.05	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.08	0.08	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.61	0.60	NA	NA	0.03	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.55	0.54	NA	NA	0.02	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	1.01	0.99	NA	NA	0.06	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.92	0.90	NA	NA	0.05	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.09	0.09	0.09	0.09	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.43	1.65	NA	NA	0.14	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.25	1.47	NA	NA	0.12	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.18	0.18	0.18	0.18	0.02	XXX
70336		A	Magnetic image, jaw joint	1.48	12.06	12.00	NA	NA	0.66	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.51	11.46	NA	NA	0.59	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.55	0.54	0.55	0.54	0.07	XXX
70350		A	X-ray head for orthodontia	0.17	0.33	0.36	NA	NA	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70350	TC	A	X-ray head for orthodontia	0.00	0.27	0.30	NA	NA	0.02	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.30	0.38	NA	NA	0.05	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.23	0.31	NA	NA	0.04	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.07	0.07	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.56	0.54	NA	NA	0.03	XXX
70360	TC	A	X-ray exam of neck	0.00	0.50	0.48	NA	NA	0.02	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.69	1.63	NA	NA	0.08	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.58	1.52	NA	NA	0.07	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.11	0.11	0.01	XXX
70371		A	Speech evaluation, complex	0.84	1.46	1.69	NA	NA	0.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.19	1.42	NA	NA	0.12	XXX
70371	26	A	Speech evaluation, complex	0.84	0.27	0.27	0.27	0.27	0.04	XXX
70373		A	Contrast x-ray of larynx	0.44	1.54	1.64	NA	NA	0.13	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.42	1.52	NA	NA	0.11	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.12	0.12	0.12	0.12	0.02	XXX
70380		A	X-ray exam of salivary gland	0.17	0.81	0.79	NA	NA	0.05	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.75	0.73	NA	NA	0.04	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.32	2.22	NA	NA	0.13	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.17	2.08	NA	NA	0.11	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.15	0.14	0.15	0.14	0.02	XXX
70450		A	Ct head/brain w/o dye	0.85	4.87	4.92	NA	NA	0.29	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.54	4.60	NA	NA	0.25	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.33	0.32	0.33	0.32	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	6.44	6.35	NA	NA	0.35	XXX
70460	TC	A	Ct head/brain w/dye	0.00	6.00	5.93	NA	NA	0.30	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.44	0.42	0.44	0.42	0.05	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	7.85	7.78	NA	NA	0.43	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.36	7.31	NA	NA	0.37	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.49	0.47	0.49	0.47	0.06	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	8.40	7.60	NA	NA	0.31	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	7.91	7.13	NA	NA	0.25	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.49	0.47	0.49	0.47	0.06	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	9.87	8.95	NA	NA	0.36	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	9.34	8.44	NA	NA	0.30	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.53	0.51	0.53	0.51	0.06	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	11.29	10.37	NA	NA	0.43	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	10.74	9.84	NA	NA	0.37	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.55	0.53	0.55	0.53	0.06	XXX
70486		A	Ct maxillofacial w/o dye	1.14	6.73	6.34	NA	NA	0.30	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	6.30	5.92	NA	NA	0.25	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.43	0.42	0.43	0.42	0.05	XXX
70487		A	Ct maxillofacial w/dye	1.30	8.27	7.75	NA	NA	0.36	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	7.76	7.26	NA	NA	0.30	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.51	0.49	0.51	0.49	0.06	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	10.26	9.60	NA	NA	0.43	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	9.72	9.08	NA	NA	0.37	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.54	0.52	0.54	0.52	0.06	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	6.43	6.12	NA	NA	0.31	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	5.94	5.64	NA	NA	0.25	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.49	0.48	0.49	0.48	0.06	XXX
70491		A	Ct soft tissue neck w/dye	1.38	7.96	7.51	NA	NA	0.36	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	7.42	7.00	NA	NA	0.30	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.54	0.51	0.54	0.51	0.06	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	9.93	9.35	NA	NA	0.43	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	9.38	8.82	NA	NA	0.37	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.55	0.53	0.55	0.53	0.06	XXX
70496		A	Ct angiography, head	1.75	16.89	15.49	NA	NA	0.66	XXX
70496	TC	A	Ct angiography, head	0.00	16.20	14.83	NA	NA	0.58	XXX
70496	26	A	Ct angiography, head	1.75	0.69	0.66	0.69	0.66	0.08	XXX
70498		A	Ct angiography, neck	1.75	16.99	15.57	NA	NA	0.66	XXX
70498	TC	A	Ct angiography, neck	0.00	16.28	14.90	NA	NA	0.58	XXX
70498	26	A	Ct angiography, neck	1.75	0.71	0.67	0.71	0.67	0.08	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	13.99	13.44	NA	NA	0.45	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	13.49	12.95	NA	NA	0.39	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.50	0.49	0.50	0.49	0.06	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	15.00	14.78	NA	NA	0.54	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	14.39	14.19	NA	NA	0.47	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.61	0.59	0.61	0.59	0.07	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	18.51	20.32	NA	NA	0.94	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	17.70	19.54	NA	NA	0.84	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.81	0.78	0.81	0.78	0.10	XXX
70544		A	Mr angiography head w/o dye	1.20	15.64	14.65	NA	NA	0.64	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	15.18	14.21	NA	NA	0.59	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.46	0.44	0.46	0.44	0.05	XXX
70545		A	Mr angiography head w/dye	1.20	15.54	14.58	NA	NA	0.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	15.08	14.14	NA	NA	0.59	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.46	0.44	0.46	0.44	0.05	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	23.69	23.57	NA	NA	0.67	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	23.01	22.91	NA	NA	0.59	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.68	0.66	0.68	0.66	0.08	XXX
70547		A	Mr angiography neck w/o dye	1.20	15.57	14.61	NA	NA	0.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	15.12	14.17	NA	NA	0.59	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.45	0.44	0.45	0.44	0.05	XXX
70548		A	Mr angiography neck w/dye	1.20	16.43	15.25	NA	NA	0.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	15.97	14.81	NA	NA	0.59	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.46	0.44	0.46	0.44	0.05	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	23.72	23.59	NA	NA	0.67	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	23.03	22.93	NA	NA	0.59	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.69	0.66	0.69	0.66	0.08	XXX
70551		A	Mri brain w/o dye	1.48	14.28	13.66	NA	NA	0.66	XXX
70551	TC	A	Mri brain w/o dye	0.00	13.72	13.12	NA	NA	0.59	XXX
70551	26	A	Mri brain w/o dye	1.48	0.56	0.54	0.56	0.54	0.07	XXX
70552		A	Mri brain w/dye	1.78	15.43	15.11	NA	NA	0.78	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70552	TC	A	Mri brain w/dye	0.00	14.75	14.45	NA	NA	0.70	XXX
70552	26	A	Mri brain w/dye	1.78	0.68	0.66	0.68	0.66	0.08	XXX
70553		A	Mri brain w/o & w/dye	2.36	17.87	19.87	NA	NA	1.41	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	16.98	19.00	NA	NA	1.31	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.89	0.87	0.89	0.87	0.10	XXX
70554		A	Fmri brain by tech	2.11	14.14	14.14	NA	NA	0.92	XXX
70554	TC	A	Fmri brain by tech	0.00	13.34	13.34	NA	NA	0.82	XXX
70554	26	A	Fmri brain by tech	2.11	0.80	0.80	0.80	0.80	0.10	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.98	0.98	0.98	0.98	0.11	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.12	1.13	1.12	1.13	0.08	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.17	1.19	1.17	1.19	0.10	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.25	1.25	1.25	1.25	0.12	XXX
71010		A	Chest x-ray	0.18	0.44	0.45	NA	NA	0.03	XXX
71010	TC	A	Chest x-ray	0.00	0.37	0.39	NA	NA	0.02	XXX
71010	26	A	Chest x-ray	0.18	0.07	0.06	0.07	0.06	0.01	XXX
71015		A	Chest x-ray	0.21	0.56	0.57	NA	NA	0.03	XXX
71015	TC	A	Chest x-ray	0.00	0.49	0.50	NA	NA	0.02	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.07	0.07	0.01	XXX
71020		A	Chest x-ray	0.22	0.57	0.61	NA	NA	0.05	XXX
71020	TC	A	Chest x-ray	0.00	0.49	0.53	NA	NA	0.04	XXX
71020	26	A	Chest x-ray	0.22	0.08	0.08	0.08	0.08	0.01	XXX
71021		A	Chest x-ray	0.27	0.70	0.73	NA	NA	0.06	XXX
71021	TC	A	Chest x-ray	0.00	0.61	0.64	NA	NA	0.05	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71022		A	Chest x-ray	0.31	0.91	0.90	NA	NA	0.06	XXX
71022	TC	A	Chest x-ray	0.00	0.80	0.79	NA	NA	0.05	XXX
71022	26	A	Chest x-ray	0.31	0.11	0.11	0.11	0.11	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.55	1.39	NA	NA	0.06	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.39	1.24	NA	NA	0.05	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.16	0.15	0.16	0.15	0.01	XXX
71030		A	Chest x-ray	0.31	0.91	0.91	NA	NA	0.06	XXX
71030	TC	A	Chest x-ray	0.00	0.80	0.80	NA	NA	0.05	XXX
71030	26	A	Chest x-ray	0.31	0.11	0.11	0.11	0.11	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	2.07	1.96	NA	NA	0.10	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.85	1.75	NA	NA	0.08	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.22	0.21	0.22	0.21	0.02	XXX
71035		A	Chest x-ray	0.18	0.78	0.73	NA	NA	0.03	XXX
71035	TC	A	Chest x-ray	0.00	0.71	0.66	NA	NA	0.02	XXX
71035	26	A	Chest x-ray	0.18	0.07	0.07	0.07	0.07	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.03	1.94	NA	NA	0.11	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71040	TC	A	Contrast x-ray of bronchi	0.00	1.81	1.73	NA	NA	0.08	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.22	0.21	0.22	0.21	0.03	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.07	2.93	NA	NA	0.16	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.80	2.66	NA	NA	0.13	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.27	0.27	0.27	0.27	0.03	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.28	0.26	0.28	0.26	0.02	XXX
71100		A	X-ray exam of ribs	0.22	0.62	0.63	NA	NA	0.05	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.54	0.55	NA	NA	0.04	XXX
71100	26	A	X-ray exam of ribs	0.22	0.08	0.08	0.08	0.08	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.76	0.76	NA	NA	0.05	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.66	0.67	NA	NA	0.04	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.10	0.09	0.10	0.09	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.77	0.79	NA	NA	0.06	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.68	0.70	NA	NA	0.05	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	1.06	1.04	NA	NA	0.07	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.95	0.93	NA	NA	0.06	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.11	0.11	0.11	0.11	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.62	0.65	NA	NA	0.05	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.55	0.58	NA	NA	0.04	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.07	0.07	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.75	0.76	NA	NA	0.05	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.67	0.68	NA	NA	0.04	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.08	0.08	0.08	0.08	0.01	XXX
71250		A	Ct thorax w/o dye	1.16	6.40	6.38	NA	NA	0.36	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.95	5.95	NA	NA	0.31	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.45	0.43	0.45	0.43	0.05	XXX
71260		A	Ct thorax w/dye	1.24	7.92	7.82	NA	NA	0.42	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.44	7.36	NA	NA	0.37	XXX
71260	26	A	Ct thorax w/dye	1.24	0.48	0.46	0.48	0.46	0.05	XXX
71270		A	Ct thorax w/o & w/dye	1.38	9.95	9.81	NA	NA	0.52	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	9.42	9.30	NA	NA	0.46	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.53	0.51	0.53	0.51	0.06	XXX
71275		A	Ct angiography, chest	1.92	11.61	11.99	NA	NA	0.48	XXX
71275	TC	A	Ct angiography, chest	0.00	10.86	11.27	NA	NA	0.39	XXX
71275	26	A	Ct angiography, chest	1.92	0.75	0.72	0.75	0.72	0.09	XXX
71550		A	Mri chest w/o dye	1.46	16.14	15.05	NA	NA	0.51	XXX
71550	TC	A	Mri chest w/o dye	0.00	15.59	14.52	NA	NA	0.45	XXX
71550	26	A	Mri chest w/o dye	1.46	0.55	0.53	0.55	0.53	0.06	XXX
71551		A	Mri chest w/dye	1.73	17.65	16.77	NA	NA	0.60	XXX
71551	TC	A	Mri chest w/dye	0.00	17.01	16.15	NA	NA	0.52	XXX
71551	26	A	Mri chest w/dye	1.73	0.64	0.62	0.64	0.62	0.08	XXX
71552		A	Mri chest w/o & w/dye	2.26	22.24	23.15	NA	NA	0.78	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	21.36	22.30	NA	NA	0.68	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.88	0.85	0.88	0.85	0.10	XXX
71555		R	Mri angio chest w or w/o dye	1.81	15.10	14.30	NA	NA	0.67	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71555	TC	R	Mri angio chest w or w/o dye	0.00	14.38	13.61	NA	NA	0.59	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.72	0.69	0.72	0.69	0.08	XXX
72010		A	X-ray exam of spine	0.45	1.42	1.36	NA	NA	0.08	XXX
72010	TC	A	X-ray exam of spine	0.00	1.28	1.22	NA	NA	0.06	XXX
72010	26	A	X-ray exam of spine	0.45	0.14	0.14	0.14	0.14	0.02	XXX
72020		A	X-ray exam of spine	0.15	0.47	0.47	NA	NA	0.03	XXX
72020	TC	A	X-ray exam of spine	0.00	0.41	0.41	NA	NA	0.02	XXX
72020	26	A	X-ray exam of spine	0.15	0.06	0.06	0.06	0.06	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.76	0.74	NA	NA	0.05	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.68	0.66	NA	NA	0.04	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72050		A	X-ray exam of neck spine	0.31	1.07	1.05	NA	NA	0.07	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.95	0.94	NA	NA	0.06	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.12	0.11	0.12	0.11	0.01	XXX
72052		A	X-ray exam of neck spine	0.36	1.38	1.35	NA	NA	0.08	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.25	1.22	NA	NA	0.06	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.13	0.13	0.13	0.13	0.02	XXX
72069		A	X-ray exam of trunk spine	0.22	0.75	0.70	NA	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.66	0.62	NA	NA	0.02	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.09	0.08	0.09	0.08	0.01	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.64	0.66	NA	NA	0.05	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.56	0.58	NA	NA	0.04	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.77	0.78	NA	NA	0.06	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.69	0.70	NA	NA	0.05	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.94	0.95	NA	NA	0.07	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.86	0.87	NA	NA	0.06	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.68	0.70	NA	NA	0.05	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.60	0.62	NA	NA	0.04	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72090		A	X-ray exam of trunk spine	0.28	0.99	0.94	NA	NA	0.05	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.88	0.83	NA	NA	0.04	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.11	0.11	0.11	0.11	0.01	XXX
72100		A	X-ray exam of lower spine	0.22	0.80	0.79	NA	NA	0.05	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.72	0.71	NA	NA	0.04	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72110		A	X-ray exam of lower spine	0.31	1.14	1.10	NA	NA	0.07	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.02	0.99	NA	NA	0.06	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.12	0.11	0.12	0.11	0.01	XXX
72114		A	X-ray exam of lower spine	0.36	1.55	1.49	NA	NA	0.08	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.41	1.36	NA	NA	0.06	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.14	0.13	0.14	0.13	0.02	XXX
72120		A	X-ray exam of lower spine	0.22	1.07	1.04	NA	NA	0.07	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.98	0.96	NA	NA	0.06	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.09	0.08	0.09	0.08	0.01	XXX
72125		A	Ct neck spine w/o dye	1.16	6.41	6.40	NA	NA	0.36	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72125	TC	A	Ct neck spine w/o dye	0.00	5.96	5.97	NA	NA	0.31	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.45	0.43	0.45	0.43	0.05	XXX
72126		A	Ct neck spine w/dye	1.22	7.92	7.82	NA	NA	0.42	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.45	7.37	NA	NA	0.37	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.47	0.45	0.47	0.45	0.05	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	9.88	9.74	NA	NA	0.52	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	9.40	9.28	NA	NA	0.46	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.48	0.46	0.48	0.46	0.06	XXX
72128		A	Ct chest spine w/o dye	1.16	6.40	6.38	NA	NA	0.36	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.95	5.95	NA	NA	0.31	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.45	0.43	0.45	0.43	0.05	XXX
72129		A	Ct chest spine w/dye	1.22	7.91	7.83	NA	NA	0.42	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.44	7.37	NA	NA	0.37	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.47	0.46	0.47	0.46	0.05	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	9.90	9.77	NA	NA	0.52	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	9.42	9.30	NA	NA	0.46	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.48	0.47	0.48	0.47	0.06	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.37	6.37	NA	NA	0.36	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.93	5.94	NA	NA	0.31	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.44	0.43	0.44	0.43	0.05	XXX
72132		A	Ct lumbar spine w/dye	1.22	7.90	7.82	NA	NA	0.42	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.43	7.36	NA	NA	0.37	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.47	0.46	0.47	0.46	0.05	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	9.89	9.76	NA	NA	0.52	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	9.41	9.29	NA	NA	0.46	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.48	0.47	0.48	0.47	0.06	XXX
72141		A	Mri neck spine w/o dye	1.60	12.32	12.20	NA	NA	0.66	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.72	11.62	NA	NA	0.59	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.60	0.58	0.60	0.58	0.07	XXX
72142		A	Mri neck spine w/dye	1.92	15.44	15.13	NA	NA	0.79	XXX
72142	TC	A	Mri neck spine w/dye	0.00	14.72	14.43	NA	NA	0.70	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.72	0.70	0.72	0.70	0.09	XXX
72146		A	Mri chest spine w/o dye	1.60	12.33	12.53	NA	NA	0.71	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	11.73	11.94	NA	NA	0.64	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.60	0.59	0.60	0.59	0.07	XXX
72147		A	Mri chest spine w/dye	1.92	13.42	13.62	NA	NA	0.79	XXX
72147	TC	A	Mri chest spine w/dye	0.00	12.69	12.91	NA	NA	0.70	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.73	0.71	0.73	0.71	0.09	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.27	12.47	NA	NA	0.71	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	11.72	11.93	NA	NA	0.64	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.55	0.54	0.55	0.54	0.07	XXX
72149		A	Mri lumbar spine w/dye	1.78	15.37	15.08	NA	NA	0.78	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	14.70	14.42	NA	NA	0.70	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.67	0.66	0.67	0.66	0.08	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	17.57	19.66	NA	NA	1.42	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	16.60	18.72	NA	NA	1.31	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.97	0.94	0.97	0.94	0.11	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	16.03	18.50	NA	NA	1.42	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72157	TC	A	Mri chest spine w/o & w/dye	0.00	15.05	17.55	NA	NA	1.31	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.98	0.95	0.98	0.95	0.11	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	17.48	19.57	NA	NA	1.41	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	16.59	18.71	NA	NA	1.31	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.89	0.86	0.89	0.86	0.10	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	16.24	15.46	NA	NA	0.74	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	15.64	14.83	NA	NA	0.64	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.60	0.63	0.60	0.63	0.10	XXX
72170		A	X-ray exam of pelvis	0.17	0.50	0.51	NA	NA	0.03	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.43	0.45	NA	NA	0.02	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.07	0.06	0.07	0.06	0.01	XXX
72190		A	X-ray exam of pelvis	0.21	0.84	0.82	NA	NA	0.05	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.76	0.74	NA	NA	0.04	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.08	0.08	0.08	0.08	0.01	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	11.21	11.59	NA	NA	0.47	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	10.50	10.91	NA	NA	0.39	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.71	0.68	0.71	0.68	0.08	XXX
72192		A	Ct pelvis w/o dye	1.09	5.98	6.07	NA	NA	0.36	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.56	5.66	NA	NA	0.31	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.42	0.41	0.42	0.41	0.05	XXX
72193		A	Ct pelvis w/dye	1.16	7.48	7.43	NA	NA	0.41	XXX
72193	TC	A	Ct pelvis w/dye	0.00	7.03	7.00	NA	NA	0.36	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.45	0.43	0.45	0.43	0.05	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	10.04	9.77	NA	NA	0.48	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	9.57	9.32	NA	NA	0.43	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.47	0.45	0.47	0.45	0.05	XXX
72195		A	Mri pelvis w/o dye	1.46	14.24	13.63	NA	NA	0.51	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	13.69	13.10	NA	NA	0.45	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.55	0.53	0.55	0.53	0.06	XXX
72196		A	Mri pelvis w/dye	1.73	15.25	14.97	NA	NA	0.60	XXX
72196	TC	A	Mri pelvis w/dye	0.00	14.59	14.33	NA	NA	0.52	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.66	0.64	0.66	0.64	0.08	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	18.71	20.49	NA	NA	1.02	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	17.85	19.66	NA	NA	0.92	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.86	0.83	0.86	0.83	0.10	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	14.97	14.21	NA	NA	0.67	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	14.27	13.54	NA	NA	0.59	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.70	0.67	0.70	0.67	0.08	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.59	0.59	NA	NA	0.03	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.53	0.53	NA	NA	0.02	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.06	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.73	0.72	NA	NA	0.05	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.66	0.65	NA	NA	0.04	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.07	0.07	0.07	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.57	0.59	NA	NA	0.05	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.51	0.53	NA	NA	0.04	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.06	0.06	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.57	3.19	NA	NA	0.29	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72240	TC	A	Contrast x-ray of neck spine	0.00	2.22	2.86	NA	NA	0.25	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.35	0.33	0.35	0.33	0.04	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.25	2.84	NA	NA	0.26	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.94	2.54	NA	NA	0.22	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.31	0.30	0.31	0.30	0.04	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.53	2.99	NA	NA	0.26	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.22	2.69	NA	NA	0.22	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.31	0.30	0.31	0.30	0.04	XXX
72270		A	Contrast x-ray, spine	1.33	4.00	4.64	NA	NA	0.39	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.48	4.15	NA	NA	0.33	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.52	0.49	0.52	0.49	0.06	XXX
72275		A	Epidurography	0.76	1.74	1.88	NA	NA	0.26	XXX
72275	TC	A	Epidurography	0.00	1.52	1.67	NA	NA	0.22	XXX
72275	26	A	Epidurography	0.76	0.22	0.21	0.22	0.21	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	1.49	3.30	NA	NA	0.50	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.15	2.96	NA	NA	0.43	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.34	0.34	0.34	0.34	0.07	XXX
72291		C	Perq vertebroplasty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq vertebroplasty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq vertebroplasty, fluor	1.31	0.52	0.51	0.52	0.51	0.10	XXX
72292		C	Perq vertebroplasty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq vertebroplasty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq vertebroplasty, ct	1.38	0.56	0.54	0.56	0.54	0.07	XXX
72295		A	X-ray of lower spine disk	0.83	1.46	3.13	NA	NA	0.46	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.20	2.87	NA	NA	0.40	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.26	0.26	0.26	0.26	0.06	XXX
73000		A	X-ray exam of collar bone	0.16	0.55	0.56	NA	NA	0.03	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.49	0.50	NA	NA	0.02	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.58	0.57	NA	NA	0.03	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.51	0.51	NA	NA	0.02	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.07	0.06	0.07	0.06	0.01	XXX
73020		A	X-ray exam of shoulder	0.15	0.44	0.46	NA	NA	0.03	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.38	0.41	NA	NA	0.02	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.57	0.59	NA	NA	0.05	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.50	0.52	NA	NA	0.04	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.07	0.07	0.07	0.07	0.01	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.23	2.25	NA	NA	0.14	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.02	2.05	NA	NA	0.12	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.21	0.20	0.21	0.20	0.02	XXX
73050		A	X-ray exam of shoulders	0.20	0.73	0.73	NA	NA	0.05	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.65	0.65	NA	NA	0.04	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.08	0.08	0.08	0.01	XXX
73060		A	X-ray exam of humerus	0.17	0.56	0.58	NA	NA	0.05	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.50	0.52	NA	NA	0.04	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73070		A	X-ray exam of elbow	0.15	0.55	0.55	NA	NA	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73070	TC	A	X-ray exam of elbow	0.00	0.49	0.50	NA	NA	0.02	XXX
73070	26	A	X-ray exam of elbow	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.75	0.72	NA	NA	0.05	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.69	0.66	NA	NA	0.04	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	1.86	1.97	NA	NA	0.14	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.66	1.78	NA	NA	0.12	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.20	0.19	0.20	0.19	0.02	XXX
73090		A	X-ray exam of forearm	0.16	0.55	0.55	NA	NA	0.03	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.49	0.50	NA	NA	0.02	XXX
73090	26	A	X-ray exam of forearm	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73092		A	X-ray exam of arm, infant	0.16	0.58	0.57	NA	NA	0.03	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.53	0.52	NA	NA	0.02	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.59	0.58	NA	NA	0.03	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.53	0.52	NA	NA	0.02	XXX
73100	26	A	X-ray exam of wrist	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73110		A	X-ray exam of wrist	0.17	0.76	0.72	NA	NA	0.03	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.70	0.66	NA	NA	0.02	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.25	2.14	NA	NA	0.12	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.05	1.94	NA	NA	0.10	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.20	0.20	0.20	0.20	0.02	XXX
73120		A	X-ray exam of hand	0.16	0.55	0.54	NA	NA	0.03	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	0.49	NA	NA	0.02	XXX
73120	26	A	X-ray exam of hand	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.65	0.64	NA	NA	0.03	XXX
73130	TC	A	X-ray exam of hand	0.00	0.59	0.58	NA	NA	0.02	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73140		A	X-ray exam of finger(s)	0.13	0.67	0.62	NA	NA	0.03	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.62	0.57	NA	NA	0.02	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.05	0.05	0.05	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	6.33	6.09	NA	NA	0.30	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	5.91	5.69	NA	NA	0.25	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.42	0.40	0.42	0.40	0.05	XXX
73201		A	Ct upper extremity w/dye	1.16	7.84	7.46	NA	NA	0.36	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	7.39	7.03	NA	NA	0.31	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.45	0.43	0.45	0.43	0.05	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	10.48	9.83	NA	NA	0.44	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	10.01	9.38	NA	NA	0.39	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.47	0.45	0.47	0.45	0.05	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	10.80	11.01	NA	NA	0.47	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.06	10.31	NA	NA	0.39	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.74	0.70	0.74	0.70	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	14.47	13.79	NA	NA	0.45	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	13.98	13.31	NA	NA	0.39	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.49	0.48	0.49	0.48	0.06	XXX
73219		A	Mri upper extremity w/dye	1.62	15.25	14.97	NA	NA	0.54	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73219	TC	A	Mri upper extremity w/dye	0.00	14.64	14.38	NA	NA	0.47	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.61	0.59	0.61	0.59	0.07	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	18.78	20.53	NA	NA	0.94	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	17.97	19.74	NA	NA	0.84	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.81	0.79	0.81	0.79	0.10	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	13.37	12.96	NA	NA	0.45	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	12.86	12.47	NA	NA	0.39	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.51	0.49	0.51	0.49	0.06	XXX
73222		A	Mri joint upr extrem w/dye	1.62	14.14	14.13	NA	NA	0.54	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.53	13.54	NA	NA	0.47	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.61	0.59	0.61	0.59	0.07	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	17.42	19.51	NA	NA	0.94	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	16.61	18.73	NA	NA	0.84	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.81	0.78	0.81	0.78	0.10	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	16.22	15.12	NA	NA	0.69	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	15.64	14.52	NA	NA	0.59	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.58	0.60	0.58	0.60	0.10	XXX
73500		A	X-ray exam of hip	0.17	0.49	0.49	NA	NA	0.03	XXX
73500	TC	A	X-ray exam of hip	0.00	0.42	0.43	NA	NA	0.02	XXX
73500	26	A	X-ray exam of hip	0.17	0.07	0.06	0.07	0.06	0.01	XXX
73510		A	X-ray exam of hip	0.21	0.77	0.74	NA	NA	0.05	XXX
73510	TC	A	X-ray exam of hip	0.00	0.69	0.66	NA	NA	0.04	XXX
73510	26	A	X-ray exam of hip	0.21	0.08	0.08	0.08	0.08	0.01	XXX
73520		A	X-ray exam of hips	0.26	0.77	0.77	NA	NA	0.05	XXX
73520	TC	A	X-ray exam of hips	0.00	0.68	0.68	NA	NA	0.04	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.09	0.09	0.01	XXX
73525		A	Contrast x-ray of hip	0.54	1.84	1.96	NA	NA	0.15	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.64	1.76	NA	NA	0.12	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.20	0.20	0.20	0.20	0.03	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.11	0.11	0.11	0.11	0.01	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.80	0.75	NA	NA	0.05	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.72	0.68	NA	NA	0.04	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.08	0.07	0.08	0.07	0.01	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.16	1.44	NA	NA	0.15	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.00	1.28	NA	NA	0.12	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.16	0.16	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.54	0.56	NA	NA	0.05	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.48	0.50	NA	NA	0.04	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.57	0.57	NA	NA	0.03	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.51	0.51	NA	NA	0.02	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73562		A	X-ray exam of knee, 3	0.18	0.72	0.70	NA	NA	0.05	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.65	0.63	NA	NA	0.04	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.07	0.07	0.07	0.01	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.85	0.81	NA	NA	0.05	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.76	0.73	NA	NA	0.04	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.09	0.08	0.09	0.08	0.01	XXX
73565		A	X-ray exam of knees	0.17	0.64	0.62	NA	NA	0.03	XXX
73565	TC	A	X-ray exam of knees	0.00	0.57	0.55	NA	NA	0.02	XXX
73565	26	A	X-ray exam of knees	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.51	2.59	NA	NA	0.17	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.30	2.39	NA	NA	0.14	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.21	0.20	0.21	0.20	0.03	XXX
73590		A	X-ray exam of lower leg	0.17	0.53	0.54	NA	NA	0.03	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.47	0.48	NA	NA	0.02	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73592		A	X-ray exam of leg, infant	0.16	0.58	0.57	NA	NA	0.03	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.53	0.52	NA	NA	0.02	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.55	0.54	NA	NA	0.03	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	0.49	NA	NA	0.02	XXX
73600	26	A	X-ray exam of ankle	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.66	0.64	NA	NA	0.03	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.60	0.58	NA	NA	0.02	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	1.94	2.03	NA	NA	0.15	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.75	1.84	NA	NA	0.12	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.19	0.19	0.19	0.19	0.03	XXX
73620		A	X-ray exam of foot	0.16	0.52	0.52	NA	NA	0.03	XXX
73620	TC	A	X-ray exam of foot	0.00	0.47	0.47	NA	NA	0.02	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.64	0.63	NA	NA	0.03	XXX
73630	TC	A	X-ray exam of foot	0.00	0.58	0.57	NA	NA	0.02	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.54	0.53	NA	NA	0.03	XXX
73650	TC	A	X-ray exam of heel	0.00	0.48	0.48	NA	NA	0.02	XXX
73650	26	A	X-ray exam of heel	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.62	0.58	NA	NA	0.03	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.58	0.54	NA	NA	0.02	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.04	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	6.35	6.10	NA	NA	0.30	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	5.93	5.70	NA	NA	0.25	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.42	0.40	0.42	0.40	0.05	XXX
73701		A	Ct lower extremity w/dye	1.16	7.90	7.52	NA	NA	0.36	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	7.45	7.08	NA	NA	0.31	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.45	0.44	0.45	0.44	0.05	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	10.50	9.86	NA	NA	0.44	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	10.03	9.40	NA	NA	0.39	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.47	0.46	0.47	0.46	0.05	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	12.18	12.06	NA	NA	0.47	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	11.40	11.32	NA	NA	0.39	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.78	0.74	0.78	0.74	0.08	XXX
73718		A	Mri lower extremity w/o dye	1.35	14.10	13.52	NA	NA	0.45	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73718	TC	A	Mri lower extremity w/o dye	0.00	13.60	13.03	NA	NA	0.39	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.50	0.49	0.50	0.49	0.06	XXX
73719		A	Mri lower extremity w/dye	1.62	15.02	14.79	NA	NA	0.54	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	14.41	14.20	NA	NA	0.47	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.61	0.59	0.61	0.59	0.07	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	18.77	20.52	NA	NA	0.94	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	17.95	19.73	NA	NA	0.84	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.82	0.79	0.82	0.79	0.10	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	13.69	13.21	NA	NA	0.45	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	13.18	12.72	NA	NA	0.39	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.51	0.49	0.51	0.49	0.06	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	14.31	14.26	NA	NA	0.54	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.69	13.66	NA	NA	0.47	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.62	0.60	0.62	0.60	0.07	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	17.35	19.46	NA	NA	0.94	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	16.54	18.67	NA	NA	0.84	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.81	0.79	0.81	0.79	0.10	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	14.98	14.21	NA	NA	0.67	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	14.27	13.53	NA	NA	0.59	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.71	0.68	0.71	0.68	0.08	XXX
74000		A	X-ray exam of abdomen	0.18	0.47	0.49	NA	NA	0.03	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.40	0.43	NA	NA	0.02	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.07	0.06	0.07	0.06	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.78	0.75	NA	NA	0.05	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.70	0.67	NA	NA	0.04	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.08	0.08	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.80	0.78	NA	NA	0.05	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.70	0.68	NA	NA	0.04	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.10	0.10	0.10	0.10	0.01	XXX
74022		A	X-ray exam series, abdomen	0.32	0.98	0.95	NA	NA	0.06	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.86	0.83	NA	NA	0.05	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.12	0.12	0.12	0.12	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	6.02	6.04	NA	NA	0.35	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.56	5.60	NA	NA	0.30	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.46	0.44	0.46	0.44	0.05	XXX
74160		A	Ct abdomen w/dye	1.27	8.73	8.39	NA	NA	0.42	XXX
74160	TC	A	Ct abdomen w/dye	0.00	8.24	7.91	NA	NA	0.36	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.49	0.48	0.49	0.48	0.06	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	12.06	11.30	NA	NA	0.49	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	11.52	10.78	NA	NA	0.43	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.54	0.52	0.54	0.52	0.06	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.15	12.30	NA	NA	0.47	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	11.40	11.58	NA	NA	0.39	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.75	0.72	0.75	0.72	0.08	XXX
74181		A	Mri abdomen w/o dye	1.46	12.31	12.18	NA	NA	0.51	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.75	11.64	NA	NA	0.45	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.56	0.54	0.56	0.54	0.06	XXX
74182		A	Mri abdomen w/dye	1.73	17.19	16.43	NA	NA	0.60	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74182	TC	A	Mri abdomen w/dye	0.00	16.53	15.79	NA	NA	0.52	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.66	0.64	0.66	0.64	0.08	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	18.74	20.51	NA	NA	1.02	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	17.88	19.68	NA	NA	0.92	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.86	0.83	0.86	0.83	0.10	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	14.91	14.17	NA	NA	0.67	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	14.22	13.50	NA	NA	0.59	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.69	0.67	0.69	0.67	0.08	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.19	0.18	0.19	0.18	0.02	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.76	1.66	NA	NA	0.08	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.62	1.52	NA	NA	0.06	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.14	0.14	0.14	0.14	0.02	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.99	1.84	NA	NA	0.08	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.82	1.67	NA	NA	0.06	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.17	0.17	0.17	0.17	0.02	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.94	1.83	NA	NA	0.09	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.73	1.63	NA	NA	0.07	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.21	0.20	0.21	0.20	0.02	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.51	0.48	0.51	0.48	0.05	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.30	2.15	NA	NA	0.11	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	2.03	1.89	NA	NA	0.08	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.27	0.26	0.27	0.26	0.03	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.55	2.34	NA	NA	0.11	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.29	2.09	NA	NA	0.08	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.26	0.25	0.26	0.25	0.03	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.93	3.63	NA	NA	0.17	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.58	3.29	NA	NA	0.13	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.35	0.34	0.35	0.34	0.04	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	2.78	2.56	NA	NA	0.13	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.51	2.30	NA	NA	0.10	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.27	0.26	0.27	0.26	0.03	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.20	2.88	NA	NA	0.14	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	2.93	2.62	NA	NA	0.11	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.27	0.26	0.27	0.26	0.03	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.31	3.96	NA	NA	0.18	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	3.96	3.62	NA	NA	0.14	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.35	0.34	0.35	0.34	0.04	XXX
74250		A	X-ray exam of small bowel	0.47	2.46	2.21	NA	NA	0.09	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.28	2.04	NA	NA	0.07	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.18	0.17	0.18	0.17	0.02	XXX
74251		A	X-ray exam of small bowel	0.69	9.90	7.82	NA	NA	0.10	XXX
74251	TC	A	X-ray exam of small bowel	0.00	9.63	7.56	NA	NA	0.07	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.27	0.26	0.27	0.26	0.03	XXX
74260		A	X-ray exam of small bowel	0.50	8.21	6.58	NA	NA	0.10	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74260	TC	A	X-ray exam of small bowel	0.00	8.02	6.40	NA	NA	0.08	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.19	0.18	0.19	0.18	0.02	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.56	3.15	NA	NA	0.14	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	3.29	2.89	NA	NA	0.11	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.27	0.26	0.27	0.26	0.03	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.92	4.34	NA	NA	0.17	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.54	3.97	NA	NA	0.13	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.38	0.37	0.38	0.37	0.04	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.53	3.45	NA	NA	0.23	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.76	2.71	NA	NA	0.14	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.77	0.74	0.77	0.74	0.09	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.57	1.39	NA	NA	0.06	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.45	1.27	NA	NA	0.05	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.12	0.12	0.12	0.12	0.01	XXX
74291		A	Contrast x-rays, gallbladder	0.20	1.57	1.29	NA	NA	0.03	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.49	1.22	NA	NA	0.02	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.08	0.07	0.08	0.07	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.14	0.13	0.14	0.13	0.02	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.08	0.08	0.08	0.08	0.01	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.17	0.16	0.17	0.16	0.02	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.13	2.44	NA	NA	0.19	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.91	2.23	NA	NA	0.17	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.22	0.21	0.22	0.21	0.02	XXX
74327		A	X-ray bile stone removal	0.70	2.98	2.74	NA	NA	0.14	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.70	2.47	NA	NA	0.11	XXX
74327	26	A	X-ray bile stone removal	0.70	0.28	0.27	0.28	0.27	0.03	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.28	0.27	0.28	0.27	0.03	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.28	0.27	0.28	0.27	0.03	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.36	0.34	0.36	0.34	0.04	XXX
74340		C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.21	0.20	0.21	0.20	0.02	XXX
74355		C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.31	0.29	0.31	0.29	0.03	XXX
74360		C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74360	TC	C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.24	0.23	0.24	0.23	0.02	XXX
74363		C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.36	0.34	0.36	0.34	0.04	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.57	2.39	NA	NA	0.13	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.38	2.21	NA	NA	0.11	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.19	0.18	0.19	0.18	0.02	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.68	2.55	NA	NA	0.13	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.49	2.36	NA	NA	0.11	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.19	0.19	0.19	0.19	0.02	XXX
74415		A	Contrst x-ray, urinary tract	0.49	3.24	3.00	NA	NA	0.14	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	3.05	2.82	NA	NA	0.12	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.19	0.18	0.19	0.18	0.02	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.15	0.14	0.15	0.14	0.02	XXX
74425		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.14	0.14	0.14	0.14	0.02	XXX
74430		A	Contrast x-ray, bladder	0.32	1.94	1.75	NA	NA	0.08	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.81	1.63	NA	NA	0.06	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.13	0.12	0.13	0.12	0.02	XXX
74440		A	X-ray, male genital tract	0.38	2.05	1.85	NA	NA	0.08	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.90	1.71	NA	NA	0.06	XXX
74440	26	A	X-ray, male genital tract	0.38	0.15	0.14	0.15	0.14	0.02	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.48	0.45	0.48	0.45	0.07	XXX
74450		C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.13	0.13	0.13	0.13	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	2.16	2.05	NA	NA	0.12	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	2.02	1.92	NA	NA	0.10	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.14	0.13	0.14	0.13	0.02	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.22	0.21	0.22	0.21	0.02	XXX
74475		A	X-ray control, cath insert	0.54	2.12	2.66	NA	NA	0.24	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.90	2.45	NA	NA	0.22	XXX
74475	26	A	X-ray control, cath insert	0.54	0.22	0.21	0.22	0.21	0.02	XXX
74480		A	X-ray control, cath insert	0.54	2.13	2.67	NA	NA	0.24	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.91	2.46	NA	NA	0.22	XXX
74480	26	A	X-ray control, cath insert	0.54	0.22	0.21	0.22	0.21	0.02	XXX
74485		A	X-ray guide, GU dilation	0.54	2.27	2.54	NA	NA	0.20	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	2.05	2.33	NA	NA	0.17	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.22	0.21	0.22	0.21	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.66	0.79	NA	NA	0.08	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74710	TC	A	X-ray measurement of pelvis	0.00	0.53	0.66	NA	NA	0.06	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.13	0.13	0.13	0.13	0.02	XXX
74740		A	X-ray, female genital tract	0.38	1.74	1.67	NA	NA	0.09	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.60	1.53	NA	NA	0.07	XXX
74740	26	A	X-ray, female genital tract	0.38	0.14	0.14	0.14	0.14	0.02	XXX
74742		C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.23	0.22	0.23	0.22	0.03	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.24	0.23	0.24	0.23	0.03	XXX
75557		A	Cardiac mri for morph	2.35	11.04	11.04	NA	NA	0.97	XXX
75557	TC	A	Cardiac mri for morph	0.00	10.04	10.04	NA	NA	0.87	XXX
75557	26	A	Cardiac mri for morph	2.35	1.00	1.00	1.00	1.00	0.10	XXX
75558		N	Cardiac mri flow/velocity	2.60	13.80	13.80	NA	NA	1.07	XXX
75558	TC	N	Cardiac mri flow/velocity	0.00	12.93	12.93	NA	NA	0.96	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.87	0.87	0.87	0.87	0.11	XXX
75559		A	Cardiac mri w/stress img	2.95	16.82	16.82	NA	NA	0.97	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	15.47	15.47	NA	NA	0.87	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.35	1.35	1.35	1.35	0.10	XXX
75560		N	Cardiac mri flow/vel/stress	3.00	18.71	18.71	NA	NA	1.00	XXX
75560	TC	N	Cardiac mri flow/vel/stress	0.00	17.71	17.71	NA	NA	0.89	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	1.00	1.00	1.00	1.00	0.11	XXX
75561		A	Cardiac mri for morph w/dye	2.60	15.63	15.63	NA	NA	1.07	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	14.53	14.53	NA	NA	0.96	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	1.10	1.10	1.10	1.10	0.11	XXX
75562		N	Card mri flow/vel w/dye	2.86	18.62	18.62	NA	NA	1.03	XXX
75562	TC	N	Card mri flow/vel w/dye	0.00	17.66	17.66	NA	NA	0.92	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	0.96	0.96	0.96	0.96	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	19.59	19.59	NA	NA	1.08	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	18.15	18.15	NA	NA	0.97	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.44	1.44	1.44	1.44	0.11	XXX
75564		N	Ht mri w/flo/vel/strs & dye	3.35	21.91	21.91	NA	NA	1.21	XXX
75564	TC	N	Ht mri w/flo/vel/strs & dye	0.00	20.79	20.79	NA	NA	1.08	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	1.12	1.12	1.12	1.12	0.13	XXX
75600		A	Contrast x-ray exam of aorta	0.49	6.09	7.79	NA	NA	0.67	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	5.85	7.56	NA	NA	0.65	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.24	0.23	0.24	0.23	0.02	XXX
75605		A	Contrast x-ray exam of aorta	1.14	3.42	5.84	NA	NA	0.70	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.92	5.36	NA	NA	0.65	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.50	0.48	0.50	0.48	0.05	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.29	5.73	NA	NA	0.71	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.84	5.30	NA	NA	0.65	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.45	0.43	0.45	0.43	0.06	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.66	6.20	NA	NA	0.80	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	2.92	5.49	NA	NA	0.69	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.74	0.71	0.74	0.71	0.11	XXX
75635		A	Ct angio abdominal arteries	2.40	12.75	13.78	NA	NA	0.50	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75635	TC	A	Ct angio abdominal arteries	0.00	11.75	12.83	NA	NA	0.39	XXX
75635	26	A	Ct angio abdominal arteries	2.40	1.00	0.95	1.00	0.95	0.11	XXX
75650		A	Artery x-rays, head & neck	1.49	3.49	5.91	NA	NA	0.72	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	2.88	5.33	NA	NA	0.65	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.61	0.58	0.61	0.58	0.07	XXX
75658		A	Artery x-rays, arm	1.31	3.63	6.00	NA	NA	0.72	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.17	5.54	NA	NA	0.65	XXX
75658	26	A	Artery x-rays, arm	1.31	0.46	0.46	0.46	0.46	0.07	XXX
75660		A	Artery x-rays, head & neck	1.31	3.82	6.15	NA	NA	0.71	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.29	5.64	NA	NA	0.65	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.53	0.51	0.53	0.51	0.06	XXX
75662		A	Artery x-rays, head & neck	1.66	4.89	6.98	NA	NA	0.71	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	4.16	6.29	NA	NA	0.65	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.73	0.69	0.73	0.69	0.06	XXX
75665		A	Artery x-rays, head & neck	1.31	4.08	6.34	NA	NA	0.74	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.56	5.84	NA	NA	0.65	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.52	0.50	0.52	0.50	0.09	XXX
75671		A	Artery x-rays, head & neck	1.66	5.05	7.09	NA	NA	0.72	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	4.37	6.44	NA	NA	0.65	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.68	0.65	0.68	0.65	0.07	XXX
75676		A	Artery x-rays, neck	1.31	3.83	6.15	NA	NA	0.72	XXX
75676	TC	A	Artery x-rays, neck	0.00	3.31	5.65	NA	NA	0.65	XXX
75676	26	A	Artery x-rays, neck	1.31	0.52	0.50	0.52	0.50	0.07	XXX
75680		A	Artery x-rays, neck	1.66	4.55	6.72	NA	NA	0.72	XXX
75680	TC	A	Artery x-rays, neck	0.00	3.85	6.06	NA	NA	0.65	XXX
75680	26	A	Artery x-rays, neck	1.66	0.70	0.66	0.70	0.66	0.07	XXX
75685		A	Artery x-rays, spine	1.31	3.86	6.17	NA	NA	0.71	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.32	5.66	NA	NA	0.65	XXX
75685	26	A	Artery x-rays, spine	1.31	0.54	0.51	0.54	0.51	0.06	XXX
75705		A	Artery x-rays, spine	2.18	4.15	6.46	NA	NA	0.78	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.27	5.62	NA	NA	0.65	XXX
75705	26	A	Artery x-rays, spine	2.18	0.88	0.84	0.88	0.84	0.13	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.84	6.15	NA	NA	0.72	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.40	5.72	NA	NA	0.65	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.44	0.43	0.44	0.43	0.07	XXX
75716		A	Artery x-rays, arms/legs	1.31	4.82	6.88	NA	NA	0.72	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	4.29	6.38	NA	NA	0.65	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.53	0.50	0.53	0.50	0.07	XXX
75722		A	Artery x-rays, kidney	1.14	3.74	6.07	NA	NA	0.70	XXX
75722	TC	A	Artery x-rays, kidney	0.00	3.24	5.60	NA	NA	0.65	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.50	0.47	0.50	0.47	0.05	XXX
75724		A	Artery x-rays, kidneys	1.49	4.90	6.99	NA	NA	0.70	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	4.15	6.28	NA	NA	0.65	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.75	0.71	0.75	0.71	0.05	XXX
75726		A	Artery x-rays, abdomen	1.14	3.75	6.08	NA	NA	0.70	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	3.29	5.64	NA	NA	0.65	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.46	0.44	0.46	0.44	0.05	XXX
75731		A	Artery x-rays, adrenal gland	1.14	4.10	6.34	NA	NA	0.71	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75731	TC	A	Artery x-rays, adrenal gland	0.00	3.53	5.82	NA	NA	0.65	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.57	0.52	0.57	0.52	0.06	XXX
75733		A	Artery x-rays, adrenals	1.31	5.26	7.23	NA	NA	0.71	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	4.57	6.60	NA	NA	0.65	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.69	0.63	0.69	0.63	0.06	XXX
75736		A	Artery x-rays, pelvis	1.14	3.83	6.14	NA	NA	0.71	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	3.36	5.69	NA	NA	0.65	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.47	0.45	0.47	0.45	0.06	XXX
75741		A	Artery x-rays, lung	1.31	3.17	5.66	NA	NA	0.71	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.64	5.15	NA	NA	0.65	XXX
75741	26	A	Artery x-rays, lung	1.31	0.53	0.51	0.53	0.51	0.06	XXX
75743		A	Artery x-rays, lungs	1.66	3.62	6.01	NA	NA	0.72	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.92	5.35	NA	NA	0.65	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.70	0.66	0.70	0.66	0.07	XXX
75746		A	Artery x-rays, lung	1.14	3.53	5.91	NA	NA	0.70	XXX
75746	TC	A	Artery x-rays, lung	0.00	3.08	5.48	NA	NA	0.65	XXX
75746	26	A	Artery x-rays, lung	1.14	0.45	0.43	0.45	0.43	0.05	XXX
75756		A	Artery x-rays, chest	1.14	4.13	6.38	NA	NA	0.69	XXX
75756	TC	A	Artery x-rays, chest	0.00	3.55	5.83	NA	NA	0.65	XXX
75756	26	A	Artery x-rays, chest	1.14	0.58	0.55	0.58	0.55	0.04	XXX
75774		A	Artery x-ray, each vessel	0.36	2.44	5.03	NA	NA	0.67	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.30	4.89	NA	NA	0.65	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.14	0.14	0.14	0.14	0.02	ZZZ
75790		A	Visualize A-V shunt	1.84	3.12	2.83	NA	NA	0.17	XXX
75790	TC	A	Visualize A-V shunt	0.00	2.48	2.20	NA	NA	0.08	XXX
75790	26	A	Visualize A-V shunt	1.84	0.64	0.63	0.64	0.63	0.09	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.25	0.25	0.25	0.25	0.08	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.48	0.45	0.48	0.45	0.05	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.32	0.31	0.32	0.31	0.05	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.48	0.45	0.48	0.45	0.05	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.15	1.85	NA	NA	0.07	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	1.98	1.68	NA	NA	0.05	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.17	0.17	0.17	0.17	0.02	XXX
75810		C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.47	0.45	0.47	0.45	0.05	XXX
75820		A	Vein x-ray, arm/leg	0.70	2.92	2.49	NA	NA	0.09	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.62	2.21	NA	NA	0.06	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.30	0.28	0.30	0.28	0.03	XXX
75822		A	Vein x-ray, arms/legs	1.06	3.15	2.83	NA	NA	0.13	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75822	TC	A	Vein x-ray, arms/legs	0.00	2.75	2.44	NA	NA	0.08	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.40	0.39	0.40	0.39	0.05	XXX
75825		A	Vein x-ray, trunk	1.14	2.93	5.46	NA	NA	0.72	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.51	5.05	NA	NA	0.65	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.42	0.41	0.42	0.41	0.07	XXX
75827		A	Vein x-ray, chest	1.14	2.93	5.46	NA	NA	0.70	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.53	5.07	NA	NA	0.65	XXX
75827	26	A	Vein x-ray, chest	1.14	0.40	0.39	0.40	0.39	0.05	XXX
75831		A	Vein x-ray, kidney	1.14	3.05	5.55	NA	NA	0.71	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.62	5.13	NA	NA	0.65	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.43	0.42	0.43	0.42	0.06	XXX
75833		A	Vein x-ray, kidneys	1.49	3.62	6.01	NA	NA	0.74	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	3.09	5.49	NA	NA	0.65	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.53	0.52	0.53	0.52	0.09	XXX
75840		A	Vein x-ray, adrenal gland	1.14	2.96	5.48	NA	NA	0.72	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.57	5.09	NA	NA	0.65	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.39	0.39	0.39	0.39	0.07	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.70	6.07	NA	NA	0.72	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	3.12	5.51	NA	NA	0.65	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.58	0.56	0.58	0.56	0.07	XXX
75860		A	Vein x-ray, neck	1.14	3.25	5.71	NA	NA	0.69	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.76	5.24	NA	NA	0.65	XXX
75860	26	A	Vein x-ray, neck	1.14	0.49	0.47	0.49	0.47	0.04	XXX
75870		A	Vein x-ray, skull	1.14	3.17	5.64	NA	NA	0.70	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.74	5.22	NA	NA	0.65	XXX
75870	26	A	Vein x-ray, skull	1.14	0.43	0.42	0.43	0.42	0.05	XXX
75872		A	Vein x-ray, skull	1.14	3.97	6.24	NA	NA	0.79	XXX
75872	TC	A	Vein x-ray, skull	0.00	3.49	5.79	NA	NA	0.65	XXX
75872	26	A	Vein x-ray, skull	1.14	0.48	0.45	0.48	0.45	0.14	XXX
75880		A	Vein x-ray, eye socket	0.70	2.96	2.52	NA	NA	0.09	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	2.72	2.28	NA	NA	0.06	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.24	0.24	0.24	0.24	0.03	XXX
75885		A	Vein x-ray, liver	1.44	3.22	5.71	NA	NA	0.71	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.64	5.15	NA	NA	0.65	XXX
75885	26	A	Vein x-ray, liver	1.44	0.58	0.56	0.58	0.56	0.06	XXX
75887		A	Vein x-ray, liver	1.44	3.32	5.77	NA	NA	0.71	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.73	5.21	NA	NA	0.65	XXX
75887	26	A	Vein x-ray, liver	1.44	0.59	0.56	0.59	0.56	0.06	XXX
75889		A	Vein x-ray, liver	1.14	3.09	5.58	NA	NA	0.70	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.63	5.14	NA	NA	0.65	XXX
75889	26	A	Vein x-ray, liver	1.14	0.46	0.44	0.46	0.44	0.05	XXX
75891		A	Vein x-ray, liver	1.14	3.09	5.58	NA	NA	0.70	XXX
75891	TC	A	Vein x-ray, liver	0.00	2.63	5.14	NA	NA	0.65	XXX
75891	26	A	Vein x-ray, liver	1.14	0.46	0.44	0.46	0.44	0.05	XXX
75893		A	Venous sampling by catheter	0.54	2.82	5.33	NA	NA	0.67	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.61	5.13	NA	NA	0.65	XXX
75893	26	A	Venous sampling by catheter	0.54	0.21	0.20	0.21	0.20	0.02	XXX
75894		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75894	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.51	0.49	0.51	0.49	0.08	XXX
75896		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.54	0.52	0.54	0.52	0.05	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.68	0.65	0.68	0.65	0.07	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.18	0.18	0.18	0.18	0.03	XXX
75901		A	Remove cva device obstruct	0.49	4.14	3.48	NA	NA	0.85	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.95	3.30	NA	NA	0.83	XXX
75901	26	A	Remove cva device obstruct	0.49	0.19	0.18	0.19	0.18	0.02	XXX
75902		A	Remove cva lumen obstruct	0.39	1.63	1.58	NA	NA	0.85	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.48	1.44	NA	NA	0.83	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.15	0.14	0.15	0.14	0.02	XXX
75940		C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.20	0.19	0.20	0.19	0.04	XXX
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.15	0.15	0.15	0.15	0.04	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.13	0.13	0.13	0.13	0.05	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.39	1.42	1.39	1.42	0.43	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.42	0.43	0.42	0.43	0.13	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.68	0.71	0.68	0.71	0.15	XXX
75956		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.09	2.25	2.09	2.25	0.69	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.78	1.92	1.78	1.92	0.59	XXX
75958		C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.13	1.23	1.13	1.23	0.39	XXX
75959		C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	1.00	1.10	1.00	1.10	0.34	XXX
75960		A	Transcath iv stent rs&i	0.82	2.63	5.79	NA	NA	0.82	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75960	TC	A	Transcath iv stent rs&i	0.00	2.30	5.47	NA	NA	0.77	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.33	0.32	0.33	0.32	0.05	XXX
75961		A	Retrieval, broken catheter	4.24	4.77	6.57	NA	NA	0.73	XXX
75961	TC	A	Retrieval, broken catheter	0.00	3.11	4.98	NA	NA	0.55	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.66	1.59	1.66	1.59	0.18	XXX
75962		A	Repair arterial blockage	0.54	3.38	6.54	NA	NA	0.86	XXX
75962	TC	A	Repair arterial blockage	0.00	3.18	6.34	NA	NA	0.83	XXX
75962	26	A	Repair arterial blockage	0.54	0.20	0.20	0.20	0.20	0.03	XXX
75964		A	Repair artery blockage, each	0.36	2.28	3.85	NA	NA	0.46	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	2.15	3.72	NA	NA	0.43	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.13	0.13	0.03	ZZZ
75966		A	Repair arterial blockage	1.31	4.01	7.08	NA	NA	0.89	XXX
75966	TC	A	Repair arterial blockage	0.00	3.43	6.53	NA	NA	0.83	XXX
75966	26	A	Repair arterial blockage	1.31	0.58	0.55	0.58	0.55	0.06	XXX
75968		A	Repair artery blockage, each	0.36	2.31	3.87	NA	NA	0.45	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	2.15	3.72	NA	NA	0.43	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.16	0.15	0.16	0.15	0.02	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.34	0.32	0.34	0.32	0.04	XXX
75978		A	Repair venous blockage	0.54	3.22	6.42	NA	NA	0.85	XXX
75978	TC	A	Repair venous blockage	0.00	3.03	6.23	NA	NA	0.83	XXX
75978	26	A	Repair venous blockage	0.54	0.19	0.19	0.19	0.19	0.02	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.58	0.55	0.58	0.55	0.06	XXX
75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.58	0.55	0.58	0.55	0.06	XXX
75984		A	Xray control catheter change	0.72	2.32	2.30	NA	NA	0.14	XXX
75984	TC	A	Xray control catheter change	0.00	2.03	2.02	NA	NA	0.11	XXX
75984	26	A	Xray control catheter change	0.72	0.29	0.28	0.29	0.28	0.03	XXX
75989		A	Abscess drainage under x-ray	1.19	2.27	2.59	NA	NA	0.22	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.80	2.14	NA	NA	0.17	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.47	0.45	0.47	0.45	0.05	XXX
75992		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.23	0.22	0.23	0.22	0.03	XXX
75993		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.14	0.14	0.14	0.14	0.02	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.33	0.36	0.33	0.36	0.07	XXX
75995		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.49	0.48	0.49	0.48	0.05	XXX
75996		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75996	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.13	0.13	0.13	0.13	0.02	ZZZ
76000		A	Fluoroscope examination	0.17	2.72	2.39	NA	NA	0.08	XXX
76000	TC	A	Fluoroscope examination	0.00	2.66	2.33	NA	NA	0.07	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.06	0.06	0.06	0.01	XXX
76001		C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.26	0.25	0.26	0.25	0.05	XXX
76010		A	X-ray, nose to rectum	0.18	0.54	0.56	NA	NA	0.03	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.47	0.49	NA	NA	0.02	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.07	0.07	0.07	0.07	0.01	XXX
76080		A	X-ray exam of fistula	0.54	1.10	1.14	NA	NA	0.08	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.89	0.93	NA	NA	0.06	XXX
76080	26	A	X-ray exam of fistula	0.54	0.21	0.21	0.21	0.21	0.02	XXX
76098		A	X-ray exam, breast specimen	0.16	0.32	0.36	NA	NA	0.03	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.26	0.30	NA	NA	0.02	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.06	0.06	0.06	0.06	0.01	XXX
76100		A	X-ray exam of body section	0.58	3.53	3.01	NA	NA	0.10	XXX
76100	TC	A	X-ray exam of body section	0.00	3.31	2.80	NA	NA	0.07	XXX
76100	26	A	X-ray exam of body section	0.58	0.22	0.21	0.22	0.21	0.03	XXX
76101		A	Complex body section x-ray	0.58	5.32	4.41	NA	NA	0.11	XXX
76101	TC	A	Complex body section x-ray	0.00	5.12	4.21	NA	NA	0.08	XXX
76101	26	A	Complex body section x-ray	0.58	0.20	0.20	0.20	0.20	0.03	XXX
76102		A	Complex body section x-rays	0.58	7.50	6.12	NA	NA	0.14	XXX
76102	TC	A	Complex body section x-rays	0.00	7.31	5.93	NA	NA	0.11	XXX
76102	26	A	Complex body section x-rays	0.58	0.19	0.19	0.19	0.19	0.03	XXX
76120		A	Cine/video x-rays	0.38	1.75	1.62	NA	NA	0.08	XXX
76120	TC	A	Cine/video x-rays	0.00	1.63	1.49	NA	NA	0.06	XXX
76120	26	A	Cine/video x-rays	0.38	0.12	0.13	0.12	0.13	0.02	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.13	0.12	0.13	0.12	0.01	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.51	0.49	NA	NA	0.02	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.39	1.92	NA	NA	0.10	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.31	1.84	NA	NA	0.08	XXX
76376	26	A	3d render w/o postprocess	0.20	0.08	0.08	0.08	0.08	0.02	XXX
76377		A	3d rendering w/postprocess	0.79	1.40	1.98	NA	NA	0.39	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.10	1.69	NA	NA	0.31	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.30	0.29	0.30	0.29	0.08	XXX
76380		A	CAT scan follow-up study	0.98	4.68	4.48	NA	NA	0.22	XXX
76380	TC	A	CAT scan follow-up study	0.00	4.31	4.12	NA	NA	0.18	XXX
76380	26	A	CAT scan follow-up study	0.98	0.37	0.36	0.37	0.36	0.04	XXX
76390		N	Mr spectroscopy	1.40	10.47	10.74	NA	NA	0.66	XXX
76390	TC	N	Mr spectroscopy	0.00	10.00	10.27	NA	NA	0.59	XXX
76390	26	N	Mr spectroscopy	1.40	0.47	0.47	0.47	0.47	0.07	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.69	2.43	NA	NA	0.14	XXX
76506	TC	A	Echo exam of head	0.00	2.46	2.20	NA	NA	0.08	XXX
76506	26	A	Echo exam of head	0.63	0.23	0.23	0.23	0.23	0.06	XXX
76510		A	Ophth us, b & quant a	1.55	2.28	2.43	NA	NA	0.10	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.67	1.80	NA	NA	0.07	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.61	0.63	0.61	0.63	0.03	XXX
76511		A	Ophth us, quant a only	0.94	1.36	1.63	NA	NA	0.10	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.00	1.26	NA	NA	0.07	XXX
76511	26	A	Ophth us, quant a only	0.94	0.36	0.37	0.36	0.37	0.03	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.17	1.45	NA	NA	0.12	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.81	1.07	NA	NA	0.10	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.36	0.38	0.36	0.38	0.02	XXX
76513		A	Echo exam of eye, water bath	0.66	1.45	1.54	NA	NA	0.12	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.22	1.30	NA	NA	0.10	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.23	0.24	0.23	0.24	0.02	XXX
76514		A	Echo exam of eye, thickness	0.17	0.16	0.16	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.10	0.09	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.06	0.07	0.06	0.07	0.01	XXX
76516		A	Echo exam of eye	0.54	1.16	1.23	NA	NA	0.08	XXX
76516	TC	A	Echo exam of eye	0.00	0.96	1.02	NA	NA	0.07	XXX
76516	26	A	Echo exam of eye	0.54	0.20	0.21	0.20	0.21	0.01	XXX
76519		A	Echo exam of eye	0.54	1.29	1.36	NA	NA	0.08	XXX
76519	TC	A	Echo exam of eye	0.00	1.08	1.14	NA	NA	0.07	XXX
76519	26	A	Echo exam of eye	0.54	0.21	0.22	0.21	0.22	0.01	XXX
76529		A	Echo exam of eye	0.57	1.16	1.21	NA	NA	0.10	XXX
76529	TC	A	Echo exam of eye	0.00	0.94	0.99	NA	NA	0.08	XXX
76529	26	A	Echo exam of eye	0.57	0.22	0.22	0.22	0.22	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.65	2.38	NA	NA	0.10	XXX
76536	TC	A	Us exam of head and neck	0.00	2.45	2.19	NA	NA	0.08	XXX
76536	26	A	Us exam of head and neck	0.56	0.20	0.19	0.20	0.19	0.02	XXX
76604		A	Us exam, chest	0.55	1.83	1.74	NA	NA	0.09	XXX
76604	TC	A	Us exam, chest	0.00	1.62	1.54	NA	NA	0.07	XXX
76604	26	A	Us exam, chest	0.55	0.21	0.20	0.21	0.20	0.02	XXX
76645		A	Us exam, breast(s)	0.54	2.10	1.89	NA	NA	0.08	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.90	1.69	NA	NA	0.06	XXX
76645	26	A	Us exam, breast(s)	0.54	0.20	0.20	0.20	0.20	0.02	XXX
76700		A	Us exam, abdom, complete	0.81	3.00	2.81	NA	NA	0.15	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76700	TC	A	Us exam, abdom, complete	0.00	2.70	2.52	NA	NA	0.11	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.30	0.29	0.30	0.29	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.34	2.16	NA	NA	0.11	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.11	1.94	NA	NA	0.08	XXX
76705	26	A	Echo exam of abdomen	0.59	0.23	0.22	0.23	0.22	0.03	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.90	2.73	NA	NA	0.14	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.62	2.46	NA	NA	0.11	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.28	0.27	0.28	0.27	0.03	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.39	2.39	NA	NA	0.11	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	2.16	2.16	NA	NA	0.08	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.23	0.23	0.23	0.22	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.39	3.11	NA	NA	0.14	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.10	2.83	NA	NA	0.11	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.29	0.28	0.29	0.28	0.03	XXX
76800		A	Us exam, spinal canal	1.13	2.25	2.13	NA	NA	0.13	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.93	1.81	NA	NA	0.08	XXX
76800	26	A	Us exam, spinal canal	1.13	0.32	0.32	0.32	0.32	0.05	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.46	2.47	NA	NA	0.16	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.11	2.12	NA	NA	0.12	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.35	0.35	0.35	0.35	0.04	XXX
76802		A	Ob us < 14 wks, addÆl fetus	0.83	0.98	1.07	NA	NA	0.16	ZZZ
76802	TC	A	Ob us < 14 wks, addÆl fetus	0.00	0.70	0.79	NA	NA	0.12	ZZZ
76802	26	A	Ob us < 14 wks, addÆl fetus	0.83	0.28	0.28	0.28	0.28	0.04	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	3.01	2.88	NA	NA	0.16	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.68	2.54	NA	NA	0.12	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.33	0.34	0.33	0.34	0.04	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.64	1.58	NA	NA	0.26	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.31	1.25	NA	NA	0.22	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.33	0.33	0.33	0.33	0.04	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	3.03	3.33	NA	NA	0.52	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.45	2.72	NA	NA	0.43	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.58	0.61	0.58	0.61	0.09	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.90	3.36	NA	NA	0.49	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.36	2.79	NA	NA	0.41	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.54	0.57	0.54	0.57	0.08	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.17	2.17	NA	NA	0.19	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.81	1.81	NA	NA	0.14	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.36	0.36	0.36	0.36	0.05	XXX
76814		A	Ob us nuchal meas, add-on	0.99	1.14	1.14	NA	NA	0.19	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.84	0.84	NA	NA	0.14	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.30	0.30	0.30	0.30	0.05	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.79	1.75	NA	NA	0.11	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.57	1.53	NA	NA	0.08	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.22	0.22	0.03	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.34	2.12	NA	NA	0.10	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	2.08	1.84	NA	NA	0.06	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.26	0.28	0.26	0.28	0.04	XXX
76817		A	Transvaginal us, obstetric	0.75	2.00	1.95	NA	NA	0.09	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76817	TC	A	Transvaginal us, obstetric	0.00	1.75	1.70	NA	NA	0.06	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.25	0.25	0.25	0.25	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.18	2.14	NA	NA	0.15	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.86	1.80	NA	NA	0.10	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.32	0.34	0.32	0.34	0.05	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.61	1.69	NA	NA	0.13	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.36	1.43	NA	NA	0.10	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.25	0.26	0.25	0.26	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.56	0.87	NA	NA	0.15	XXX
76820	TC	A	Umbilical artery echo	0.00	0.41	0.71	NA	NA	0.12	XXX
76820	26	A	Umbilical artery echo	0.50	0.15	0.16	0.15	0.16	0.03	XXX
76821		A	Middle cerebral artery echo	0.70	1.83	1.85	NA	NA	0.15	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.62	1.62	NA	NA	0.12	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.21	0.23	0.21	0.23	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.31	3.89	NA	NA	0.18	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.78	3.34	NA	NA	0.11	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.53	0.55	0.53	0.55	0.07	XXX
76826		A	Echo exam of fetal heart	0.83	2.67	2.25	NA	NA	0.08	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.42	1.99	NA	NA	0.05	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.25	0.26	0.25	0.26	0.03	XXX
76827		A	Echo exam of fetal heart	0.58	1.05	1.28	NA	NA	0.14	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.87	1.09	NA	NA	0.12	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.18	0.19	0.18	0.19	0.02	XXX
76828		A	Echo exam of fetal heart	0.56	0.62	0.81	NA	NA	0.11	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.46	0.63	NA	NA	0.08	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.16	0.18	0.16	0.18	0.03	XXX
76830		A	Transvaginal us, non-ob	0.69	2.73	2.49	NA	NA	0.13	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.49	2.25	NA	NA	0.10	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.24	0.24	0.24	0.24	0.03	XXX
76831		A	Echo exam, uterus	0.72	2.68	2.46	NA	NA	0.13	XXX
76831	TC	A	Echo exam, uterus	0.00	2.46	2.23	NA	NA	0.10	XXX
76831	26	A	Echo exam, uterus	0.72	0.22	0.23	0.22	0.23	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.77	2.51	NA	NA	0.13	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.51	2.26	NA	NA	0.10	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.26	0.25	0.26	0.25	0.03	XXX
76857		A	Us exam, pelvic, limited	0.38	2.46	2.31	NA	NA	0.08	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	2.30	2.16	NA	NA	0.06	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.16	0.15	0.16	0.15	0.02	XXX
76870		A	Us exam, scrotum	0.64	2.80	2.53	NA	NA	0.13	XXX
76870	TC	A	Us exam, scrotum	0.00	2.55	2.29	NA	NA	0.10	XXX
76870	26	A	Us exam, scrotum	0.64	0.25	0.24	0.25	0.24	0.03	XXX
76872		A	Us, transrectal	0.69	3.36	3.10	NA	NA	0.14	XXX
76872	TC	A	Us, transrectal	0.00	3.07	2.82	NA	NA	0.10	XXX
76872	26	A	Us, transrectal	0.69	0.29	0.28	0.29	0.28	0.04	XXX
76873		A	Echograp trans r, pros study	1.55	3.35	3.16	NA	NA	0.25	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.76	2.60	NA	NA	0.16	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.59	0.56	0.59	0.56	0.09	XXX
76880		A	Us exam, extremity	0.59	3.13	2.75	NA	NA	0.11	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76880	TC	A	Us exam, extremity	0.00	2.94	2.56	NA	NA	0.08	XXX
76880	26	A	Us exam, extremity	0.59	0.19	0.19	0.19	0.19	0.03	XXX
76885		A	Us exam infant hips, dynamic	0.74	3.25	2.88	NA	NA	0.13	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	2.97	2.61	NA	NA	0.10	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.28	0.27	0.28	0.27	0.03	XXX
76886		A	Us exam infant hips, static	0.62	2.18	2.04	NA	NA	0.11	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.97	1.83	NA	NA	0.08	XXX
76886	26	A	Us exam infant hips, static	0.62	0.21	0.21	0.21	0.21	0.03	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.97	1.93	NA	NA	0.12	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.63	1.61	NA	NA	0.10	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.34	0.32	0.34	0.32	0.02	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.35	0.32	0.35	0.32	0.02	XXX
76936		A	Echo guide for artery repair	1.99	6.02	6.26	NA	NA	0.47	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.26	5.53	NA	NA	0.34	XXX
76936	26	A	Echo guide for artery repair	1.99	0.76	0.73	0.76	0.73	0.13	XXX
76937		A	Us guide, vascular access	0.30	0.62	0.59	NA	NA	0.13	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.51	0.48	NA	NA	0.10	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.11	0.11	0.11	0.11	0.03	ZZZ
76940		C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.70	0.69	0.70	0.69	0.31	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.43	0.44	0.43	0.44	0.07	XXX
76942		A	Echo guide for biopsy	0.67	4.70	4.30	NA	NA	0.13	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.45	4.05	NA	NA	0.10	XXX
76942	26	A	Echo guide for biopsy	0.67	0.25	0.25	0.25	0.25	0.03	XXX
76945		C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.22	0.22	0.22	0.22	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.44	0.75	NA	NA	0.12	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.33	0.63	NA	NA	0.10	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.11	0.12	0.11	0.12	0.02	XXX
76948		A	Echo guide, ova aspiration	0.38	0.45	0.75	NA	NA	0.12	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.34	0.63	NA	NA	0.10	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.11	0.12	0.11	0.12	0.02	XXX
76950		A	Echo guidance radiotherapy	0.58	1.20	1.28	NA	NA	0.10	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.00	1.08	NA	NA	0.07	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.20	0.20	0.20	0.20	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.22	2.42	NA	NA	0.37	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.68	1.91	NA	NA	0.29	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.54	0.51	0.54	0.51	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	2.02	1.81	NA	NA	0.08	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.90	1.69	NA	NA	0.06	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.12	0.12	0.12	0.12	0.02	XXX
76975		C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76975	TC	C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.32	0.31	0.32	0.31	0.04	XXX
76977		A	Us bone density measure	0.05	0.10	0.29	NA	NA	0.06	XXX
76977	TC	A	Us bone density measure	0.00	0.09	0.27	NA	NA	0.05	XXX
76977	26	A	Us bone density measure	0.05	0.01	0.02	0.01	0.02	0.01	XXX
76998		C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.38	0.39	0.38	0.39	0.13	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	2.70	2.39	NA	NA	0.11	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.56	2.25	NA	NA	0.10	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.14	0.14	0.14	0.14	0.01	ZZZ
77002		A	Needle localization by xray	0.54	1.27	1.33	NA	NA	0.09	XXX
77002	TC	A	Needle localization by xray	0.00	1.09	1.15	NA	NA	0.07	XXX
77002	26	A	Needle localization by xray	0.54	0.18	0.18	0.18	0.18	0.02	XXX
77003		A	Fluoroguide for spine inject	0.60	0.76	0.94	NA	NA	0.10	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.61	0.79	NA	NA	0.07	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.15	0.15	0.15	0.15	0.03	XXX
77011		A	Ct scan for localization	1.21	19.78	17.03	NA	NA	0.47	XXX
77011	TC	A	Ct scan for localization	0.00	19.34	16.60	NA	NA	0.42	XXX
77011	26	A	Ct scan for localization	1.21	0.44	0.43	0.44	0.43	0.05	XXX
77012		A	Ct scan for needle biopsy	1.16	2.34	3.93	NA	NA	0.47	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.89	3.49	NA	NA	0.42	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.45	0.44	0.45	0.44	0.05	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.59	1.52	1.59	1.52	0.18	XXX
77014		A	Ct scan for therapy guide	0.85	4.35	4.08	NA	NA	0.20	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.05	3.79	NA	NA	0.16	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.30	0.29	0.30	0.29	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.77	10.28	NA	NA	0.64	XXX
77021	TC	A	Mr guidance for needle place	0.00	9.20	9.72	NA	NA	0.55	XXX
77021	26	A	Mr guidance for needle place	1.50	0.57	0.56	0.57	0.56	0.09	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.52	1.49	1.52	1.49	0.24	XXX
77031		A	Stereotact guide for brst bx	1.59	1.89	3.35	NA	NA	0.46	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.31	2.78	NA	NA	0.37	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.58	0.57	0.58	0.57	0.09	XXX
77032		A	Guidance for needle, breast	0.56	0.85	1.01	NA	NA	0.09	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.63	0.80	NA	NA	0.07	XXX
77032	26	A	Guidance for needle, breast	0.56	0.22	0.21	0.22	0.21	0.02	XXX
77051		A	Computer dx mammogram add-on	0.06	0.20	0.26	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.18	0.24	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.19	0.26	NA	NA	0.02	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77052	TC	A	Comp screen mammogram add-on	0.00	0.17	0.24	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.23	1.61	NA	NA	0.16	XXX
77053	TC	A	X-ray of mammary duct	0.00	1.09	1.48	NA	NA	0.14	XXX
77053	26	A	X-ray of mammary duct	0.36	0.14	0.13	0.14	0.13	0.02	XXX
77054		A	X-ray of mammary ducts	0.45	1.66	2.21	NA	NA	0.21	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.49	2.04	NA	NA	0.19	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.17	0.17	0.17	0.17	0.02	XXX
77055		A	Mammogram, one breast	0.70	1.64	1.56	NA	NA	0.09	XXX
77055	TC	A	Mammogram, one breast	0.00	1.37	1.30	NA	NA	0.06	XXX
77055	26	A	Mammogram, one breast	0.70	0.27	0.26	0.27	0.26	0.03	XXX
77056		A	Mammogram, both breasts	0.87	2.14	2.00	NA	NA	0.11	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.81	1.68	NA	NA	0.07	XXX
77056	26	A	Mammogram, both breasts	0.87	0.33	0.32	0.33	0.32	0.04	XXX
77057		A	Mammogram, screening	0.70	1.45	1.46	NA	NA	0.10	XXX
77057	TC	A	Mammogram, screening	0.00	1.18	1.20	NA	NA	0.07	XXX
77057	26	A	Mammogram, screening	0.70	0.27	0.26	0.27	0.26	0.03	XXX
77058		A	Mri, one breast	1.63	21.45	20.67	NA	NA	0.99	XXX
77058	TC	A	Mri, one breast	0.00	20.83	20.07	NA	NA	0.92	XXX
77058	26	A	Mri, one breast	1.63	0.62	0.60	0.62	0.60	0.07	XXX
77059		A	Mri, both breasts	1.63	21.31	22.15	NA	NA	1.31	XXX
77059	TC	A	Mri, both breasts	0.00	20.69	21.55	NA	NA	1.24	XXX
77059	26	A	Mri, both breasts	1.63	0.62	0.60	0.62	0.60	0.07	XXX
77071		A	X-ray stress view	0.41	0.76	0.62	0.76	0.62	0.06	XXX
77072		A	X-rays for bone age	0.19	0.43	0.43	NA	NA	0.03	XXX
77072	TC	A	X-rays for bone age	0.00	0.36	0.36	NA	NA	0.02	XXX
77072	26	A	X-rays for bone age	0.19	0.07	0.07	0.07	0.07	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.66	0.71	NA	NA	0.06	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.55	0.61	NA	NA	0.05	XXX
77073	26	A	X-rays, bone length studies	0.27	0.11	0.10	0.11	0.10	0.01	XXX
77074		A	X-rays, bone survey, limited	0.45	1.43	1.37	NA	NA	0.08	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.26	1.20	NA	NA	0.06	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.17	0.17	0.17	0.17	0.02	XXX
77075		A	X-rays, bone survey complete	0.54	2.28	2.11	NA	NA	0.10	XXX
77075	TC	A	X-rays, bone survey complete	0.00	2.07	1.91	NA	NA	0.08	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.21	0.20	0.21	0.20	0.02	XXX
77076		A	X-rays, bone survey, infant	0.70	2.05	1.78	NA	NA	0.08	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.84	1.56	NA	NA	0.05	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.21	0.22	0.21	0.22	0.03	XXX
77077		A	Joint survey, single view	0.31	0.65	0.79	NA	NA	0.08	XXX
77077	TC	A	Joint survey, single view	0.00	0.53	0.68	NA	NA	0.06	XXX
77077	26	A	Joint survey, single view	0.31	0.12	0.11	0.12	0.11	0.02	XXX
77078		A	Ct bone density, axial	0.25	4.70	4.30	NA	NA	0.17	XXX
77078	TC	A	Ct bone density, axial	0.00	4.61	4.21	NA	NA	0.16	XXX
77078	26	A	Ct bone density, axial	0.25	0.09	0.09	0.09	0.09	0.01	XXX
77079		A	Ct bone density, peripheral	0.22	0.74	1.31	NA	NA	0.06	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.68	1.25	NA	NA	0.05	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.06	0.06	0.06	0.06	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77080		A	Dxa bone density, axial	0.20	1.09	1.61	NA	NA	0.18	XXX
77080	TC	A	Dxa bone density, axial	0.00	1.02	1.54	NA	NA	0.17	XXX
77080	26	A	Dxa bone density, axial	0.20	0.07	0.07	0.07	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	0.56	NA	NA	0.06	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.40	0.49	NA	NA	0.05	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.07	0.07	0.07	0.07	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.51	0.58	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.46	0.53	NA	NA	0.05	XXX
77082	26	A	Dxa bone density, vert fx	0.17	0.05	0.05	0.05	0.05	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.36	0.48	NA	NA	0.06	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.31	0.42	NA	NA	0.05	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.05	0.06	0.05	0.06	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	14.44	13.79	NA	NA	0.66	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	13.82	13.19	NA	NA	0.59	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.62	0.60	0.62	0.60	0.07	XXX
77261		A	Radiation therapy planning	1.39	0.51	0.51	0.51	0.51	0.07	XXX
77262		A	Radiation therapy planning	2.11	0.73	0.74	0.73	0.74	0.11	XXX
77263		A	Radiation therapy planning	3.14	1.08	1.09	1.08	1.09	0.16	XXX
77280		A	Set radiation therapy field	0.70	4.34	4.19	NA	NA	0.22	XXX
77280	TC	A	Set radiation therapy field	0.00	4.10	3.95	NA	NA	0.18	XXX
77280	26	A	Set radiation therapy field	0.70	0.24	0.24	0.24	0.24	0.04	XXX
77285		A	Set radiation therapy field	1.05	7.87	7.40	NA	NA	0.35	XXX
77285	TC	A	Set radiation therapy field	0.00	7.51	7.04	NA	NA	0.30	XXX
77285	26	A	Set radiation therapy field	1.05	0.36	0.36	0.36	0.36	0.05	XXX
77290		A	Set radiation therapy field	1.56	13.15	11.64	NA	NA	0.43	XXX
77290	TC	A	Set radiation therapy field	0.00	12.61	11.11	NA	NA	0.35	XXX
77290	26	A	Set radiation therapy field	1.56	0.54	0.53	0.54	0.53	0.08	XXX
77295		A	Set radiation therapy field	4.56	7.36	12.90	NA	NA	1.71	XXX
77295	TC	A	Set radiation therapy field	0.00	5.78	11.35	NA	NA	1.48	XXX
77295	26	A	Set radiation therapy field	4.56	1.58	1.55	1.58	1.55	0.23	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.16	1.26	NA	NA	0.10	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.95	1.05	NA	NA	0.07	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.21	0.21	0.21	0.21	0.03	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	56.26	49.93	NA	NA	1.88	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	53.49	47.21	NA	NA	1.48	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.77	2.72	2.77	2.72	0.40	XXX
77305		A	Teletx isodose plan simple	0.70	0.89	1.20	NA	NA	0.15	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.65	0.96	NA	NA	0.11	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.24	0.24	0.24	0.24	0.04	XXX
77310		A	Teletx isodose plan intermed	1.05	1.24	1.61	NA	NA	0.18	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.88	1.25	NA	NA	0.13	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.36	0.36	0.36	0.36	0.05	XXX
77315		A	Teletx isodose plan complex	1.56	2.07	2.35	NA	NA	0.22	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.53	1.82	NA	NA	0.14	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.54	0.53	0.54	0.53	0.08	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77321		A	Special teletx port plan	0.95	1.50	2.21	NA	NA	0.26	XXX
77321	TC	A	Special teletx port plan	0.00	1.17	1.89	NA	NA	0.21	XXX
77321	26	A	Special teletx port plan	0.95	0.33	0.32	0.33	0.32	0.05	XXX
77326		A	Brachytx isodose calc simp	0.93	2.91	2.85	NA	NA	0.18	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.59	2.54	NA	NA	0.13	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.32	0.31	0.32	0.31	0.05	XXX
77327		A	Brachytx isodose calc interm	1.39	4.02	4.00	NA	NA	0.25	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.54	3.53	NA	NA	0.18	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.48	0.47	0.48	0.47	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.15	5.28	NA	NA	0.36	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.43	4.57	NA	NA	0.25	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.72	0.71	0.72	0.71	0.11	XXX
77331		A	Special radiation dosimetry	0.87	0.80	0.80	NA	NA	0.06	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	0.50	NA	NA	0.02	XXX
77331	26	A	Special radiation dosimetry	0.87	0.30	0.30	0.30	0.30	0.04	XXX
77332		A	Radiation treatment aid(s)	0.54	1.53	1.52	NA	NA	0.10	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.34	1.34	NA	NA	0.07	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.19	0.18	0.19	0.18	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.52	0.94	NA	NA	0.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.23	0.65	NA	NA	0.11	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.29	0.29	0.29	0.29	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	2.68	2.93	NA	NA	0.23	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.25	2.51	NA	NA	0.17	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.43	0.42	0.43	0.42	0.06	XXX
77336		A	Radiation physics consult	0.00	1.10	1.58	NA	NA	0.16	XXX
77370		A	Radiation physics consult	0.00	2.95	3.09	NA	NA	0.18	XXX
77371		C	Srs, multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77372		A	Srs, linear based	0.00	22.30	22.30	NA	NA	0.13	XXX
77373		A	Sbrt delivery	0.00	41.38	41.38	NA	NA	0.13	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.45	0.79	NA	NA	0.11	XXX
77402		A	Radiation treatment delivery	0.00	4.27	3.65	NA	NA	0.11	XXX
77403		A	Radiation treatment delivery	0.00	3.66	3.20	NA	NA	0.11	XXX
77404		A	Radiation treatment delivery	0.00	4.11	3.53	NA	NA	0.11	XXX
77406		A	Radiation treatment delivery	0.00	4.14	3.56	NA	NA	0.11	XXX
77407		A	Radiation treatment delivery	0.00	6.96	5.76	NA	NA	0.12	XXX
77408		A	Radiation treatment delivery	0.00	5.03	4.31	NA	NA	0.12	XXX
77409		A	Radiation treatment delivery	0.00	5.63	4.76	NA	NA	0.12	XXX
77411		A	Radiation treatment delivery	0.00	5.60	4.73	NA	NA	0.12	XXX
77412		A	Radiation treatment delivery	0.00	6.63	5.57	NA	NA	0.13	XXX
77413		A	Radiation treatment delivery	0.00	6.69	5.61	NA	NA	0.13	XXX
77414		A	Radiation treatment delivery	0.00	7.53	6.24	NA	NA	0.13	XXX
77416		A	Radiation treatment delivery	0.00	7.56	6.27	NA	NA	0.13	XXX
77417		A	Radiology port film(s)	0.00	0.35	0.41	NA	NA	0.04	XXX
77418		A	Radiation tx delivery, imrt	0.00	12.88	14.20	NA	NA	0.13	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.33	2.63	NA	NA	0.12	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.20	2.50	NA	NA	0.10	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.13	0.13	0.13	0.13	0.02	XXX
77422		A	Neutron beam tx, simple	0.00	6.40	5.24	NA	NA	0.13	XXX
77423		A	Neutron beam tx, complex	0.00	7.27	6.03	NA	NA	0.13	XXX
77427		A	Radiation tx management, x5	3.70	1.45	1.35	1.45	1.35	0.17	XXX
77431		A	Radiation therapy management	1.81	0.80	0.77	0.80	0.77	0.09	XXX
77432		A	Stereotactic radiation trmt	7.92	2.73	2.78	2.73	2.78	0.41	XXX
77435		A	Sbrt management	13.00	4.76	4.76	NA	NA	0.67	XXX
77470		A	Special radiation treatment	2.09	1.92	4.41	NA	NA	0.70	XXX
77470	TC	A	Special radiation treatment	0.00	1.20	3.70	NA	NA	0.59	XXX
77470	26	A	Special radiation treatment	2.09	0.72	0.71	0.72	0.71	0.11	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	10.01	8.42	NA	NA	0.24	XXX
77600	TC	R	Hyperthermia treatment	0.00	9.48	7.89	NA	NA	0.16	XXX
77600	26	R	Hyperthermia treatment	1.56	0.53	0.53	0.53	0.53	0.08	XXX
77605		R	Hyperthermia treatment	2.09	19.45	15.80	NA	NA	0.38	XXX
77605	TC	R	Hyperthermia treatment	0.00	18.87	15.20	NA	NA	0.22	XXX
77605	26	R	Hyperthermia treatment	2.09	0.58	0.60	0.58	0.60	0.16	XXX
77610		R	Hyperthermia treatment	1.56	19.10	15.24	NA	NA	0.24	XXX
77610	TC	R	Hyperthermia treatment	0.00	18.64	14.77	NA	NA	0.16	XXX
77610	26	R	Hyperthermia treatment	1.56	0.46	0.47	0.46	0.47	0.08	XXX
77615		R	Hyperthermia treatment	2.09	27.28	21.68	NA	NA	0.33	XXX
77615	TC	R	Hyperthermia treatment	0.00	26.57	20.98	NA	NA	0.22	XXX
77615	26	R	Hyperthermia treatment	2.09	0.71	0.70	0.71	0.70	0.11	XXX
77620		R	Hyperthermia treatment	1.56	10.55	8.82	NA	NA	0.36	XXX
77620	TC	R	Hyperthermia treatment	0.00	10.11	8.36	NA	NA	0.16	XXX
77620	26	R	Hyperthermia treatment	1.56	0.44	0.46	0.44	0.46	0.20	XXX
77750		A	Infuse radioactive materials	4.94	4.55	4.14	NA	NA	0.32	090
77750	TC	A	Infuse radioactive materials	0.00	2.84	2.46	NA	NA	0.07	090
77750	26	A	Infuse radioactive materials	4.94	1.71	1.68	1.71	1.68	0.25	090
77761		A	Apply intrcav radiat simple	3.82	6.24	5.59	NA	NA	0.33	090
77761	TC	A	Apply intrcav radiat simple	0.00	4.93	4.33	NA	NA	0.14	090
77761	26	A	Apply intrcav radiat simple	3.82	1.31	1.26	1.31	1.26	0.19	090
77762		A	Apply intrcav radiat interm	5.73	7.60	7.08	NA	NA	0.48	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.62	5.13	NA	NA	0.19	090
77762	26	A	Apply intrcav radiat interm	5.73	1.98	1.95	1.98	1.95	0.29	090
77763		A	Apply intrcav radiat compl	8.60	10.29	9.54	NA	NA	0.66	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.30	6.61	NA	NA	0.23	090
77763	26	A	Apply intrcav radiat compl	8.60	2.99	2.93	2.99	2.93	0.43	090
77776		A	Apply interstit radiat simpl	4.67	7.27	6.25	NA	NA	0.57	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.51	4.69	NA	NA	0.13	090
77776	26	A	Apply interstit radiat simpl	4.67	1.76	1.56	1.76	1.56	0.44	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77777		A	Apply interstit radiat inter	7.49	8.20	7.82	NA	NA	0.61	090
77777	TC	A	Apply interstit radiat inter	0.00	5.44	5.15	NA	NA	0.22	090
77777	26	A	Apply interstit radiat inter	7.49	2.76	2.67	2.76	2.67	0.39	090
77778		A	Apply interstit radiat compl	11.23	11.32	10.70	NA	NA	0.84	090
77778	TC	A	Apply interstit radiat compl	0.00	7.41	6.86	NA	NA	0.27	090
77778	26	A	Apply interstit radiat compl	11.23	3.91	3.84	3.91	3.84	0.57	090
77785		A	Hdr brachytx, 1 channel	1.42	3.54	3.54	NA	NA	0.20	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	3.05	3.05	NA	NA	0.13	XXX
77785	26	A	Hdr brachytx, 1 channel	1.42	0.49	0.49	0.49	0.49	0.07	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	8.61	11.76	NA	NA	0.46	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	7.49	10.72	NA	NA	0.29	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.12	1.04	1.12	1.04	0.17	XXX
77787		A	Hdr brachytx over 12 chan	4.89	15.80	17.41	NA	NA	0.69	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	14.12	15.70	NA	NA	0.44	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	1.68	1.71	1.68	1.71	0.25	XXX
77789		A	Apply surface radiation	1.14	1.95	1.67	NA	NA	0.08	000
77789	TC	A	Apply surface radiation	0.00	1.55	1.28	NA	NA	0.02	000
77789	26	A	Apply surface radiation	1.14	0.40	0.39	0.40	0.39	0.06	000
77790		A	Radiation handling	1.05	1.45	1.30	NA	NA	0.07	XXX
77790	TC	A	Radiation handling	0.00	1.09	0.94	NA	NA	0.02	XXX
77790	26	A	Radiation handling	1.05	0.36	0.36	0.36	0.36	0.05	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.84	1.64	NA	NA	0.07	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.77	1.57	NA	NA	0.06	XXX
78000	26	A	Thyroid, single uptake	0.19	0.07	0.07	0.07	0.07	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	2.29	2.07	NA	NA	0.08	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	2.19	1.97	NA	NA	0.07	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.10	0.10	0.10	0.10	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.92	1.70	NA	NA	0.07	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.79	1.58	NA	NA	0.06	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.13	0.12	0.13	0.12	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.18	5.28	NA	NA	0.15	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	5.99	5.10	NA	NA	0.13	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78007		A	Thyroid image, mult uptakes	0.50	3.03	2.97	NA	NA	0.16	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.84	2.78	NA	NA	0.14	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.19	0.19	0.19	0.19	0.02	XXX
78010		A	Thyroid imaging	0.39	4.16	3.61	NA	NA	0.13	XXX
78010	TC	A	Thyroid imaging	0.00	4.01	3.47	NA	NA	0.11	XXX
78010	26	A	Thyroid imaging	0.39	0.15	0.14	0.15	0.14	0.02	XXX
78011		A	Thyroid imaging with flow	0.45	4.60	4.10	NA	NA	0.15	XXX
78011	TC	A	Thyroid imaging with flow	0.00	4.42	3.93	NA	NA	0.13	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.18	0.17	0.18	0.17	0.02	XXX
78015		A	Thyroid met imaging	0.67	5.37	4.74	NA	NA	0.17	XXX
78015	TC	A	Thyroid met imaging	0.00	5.11	4.49	NA	NA	0.14	XXX
78015	26	A	Thyroid met imaging	0.67	0.26	0.25	0.26	0.25	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78016		A	Thyroid met imaging/studies	0.82	8.63	7.43	NA	NA	0.21	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	8.31	7.12	NA	NA	0.18	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.32	0.31	0.32	0.31	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	7.92	7.38	NA	NA	0.33	XXX
78018	TC	A	Thyroid met imaging, body	0.00	7.59	7.06	NA	NA	0.29	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.33	0.32	0.33	0.32	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.83	1.76	NA	NA	0.16	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.60	1.53	NA	NA	0.14	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.23	0.23	0.23	0.23	0.02	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.48	3.76	NA	NA	0.15	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	3.16	3.45	NA	NA	0.11	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.32	0.31	0.32	0.31	0.04	XXX
78075		A	Adrenal nuclear imaging	0.74	11.49	10.05	NA	NA	0.32	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	11.20	9.77	NA	NA	0.29	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.29	0.28	0.29	0.28	0.03	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	4.18	3.70	NA	NA	0.14	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.97	3.49	NA	NA	0.12	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.21	0.21	0.21	0.21	0.02	XXX
78103		A	Bone marrow imaging, mult	0.75	5.45	4.95	NA	NA	0.20	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	5.16	4.67	NA	NA	0.17	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.29	0.28	0.29	0.28	0.03	XXX
78104		A	Bone marrow imaging, body	0.80	6.16	5.72	NA	NA	0.25	XXX
78104	TC	A	Bone marrow imaging, body	0.00	5.84	5.41	NA	NA	0.22	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.32	0.31	0.32	0.31	0.03	XXX
78110		A	Plasma volume, single	0.19	2.11	1.84	NA	NA	0.07	XXX
78110	TC	A	Plasma volume, single	0.00	2.04	1.77	NA	NA	0.06	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.07	0.07	0.01	XXX
78111		A	Plasma volume, multiple	0.22	2.21	2.33	NA	NA	0.15	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.12	2.24	NA	NA	0.14	XXX
78111	26	A	Plasma volume, multiple	0.22	0.09	0.09	0.09	0.09	0.01	XXX
78120		A	Red cell mass, single	0.23	2.11	2.05	NA	NA	0.12	XXX
78120	TC	A	Red cell mass, single	0.00	2.02	1.96	NA	NA	0.11	XXX
78120	26	A	Red cell mass, single	0.23	0.09	0.09	0.09	0.09	0.01	XXX
78121		A	Red cell mass, multiple	0.32	2.23	2.44	NA	NA	0.15	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.11	2.32	NA	NA	0.14	XXX
78121	26	A	Red cell mass, multiple	0.32	0.12	0.12	0.12	0.12	0.01	XXX
78122		A	Blood volume	0.45	2.30	2.92	NA	NA	0.26	XXX
78122	TC	A	Blood volume	0.00	2.12	2.75	NA	NA	0.24	XXX
78122	26	A	Blood volume	0.45	0.18	0.17	0.18	0.17	0.02	XXX
78130		A	Red cell survival study	0.61	3.52	3.42	NA	NA	0.17	XXX
78130	TC	A	Red cell survival study	0.00	3.29	3.19	NA	NA	0.14	XXX
78130	26	A	Red cell survival study	0.61	0.23	0.23	0.23	0.23	0.03	XXX
78135		A	Red cell survival kinetics	0.64	8.71	7.82	NA	NA	0.28	XXX
78135	TC	A	Red cell survival kinetics	0.00	8.46	7.58	NA	NA	0.25	XXX
78135	26	A	Red cell survival kinetics	0.64	0.25	0.24	0.25	0.24	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78140		A	Red cell sequestration	0.61	2.93	3.24	NA	NA	0.24	XXX
78140	TC	A	Red cell sequestration	0.00	2.69	3.01	NA	NA	0.21	XXX
78140	26	A	Red cell sequestration	0.61	0.24	0.23	0.24	0.23	0.03	XXX
78185		A	Spleen imaging	0.40	5.20	4.54	NA	NA	0.15	XXX
78185	TC	A	Spleen imaging	0.00	5.05	4.39	NA	NA	0.13	XXX
78185	26	A	Spleen imaging	0.40	0.15	0.15	0.15	0.15	0.02	XXX
78190		A	Platelet survival, kinetics	1.09	9.34	8.55	NA	NA	0.38	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.97	8.18	NA	NA	0.30	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.37	0.37	0.37	0.37	0.08	XXX
78191		A	Platelet survival	0.61	3.48	4.50	NA	NA	0.40	XXX
78191	TC	A	Platelet survival	0.00	3.25	4.28	NA	NA	0.37	XXX
78191	26	A	Platelet survival	0.61	0.23	0.22	0.23	0.22	0.03	XXX
78195		A	Lymph system imaging	1.20	8.65	7.62	NA	NA	0.28	XXX
78195	TC	A	Lymph system imaging	0.00	8.19	7.17	NA	NA	0.22	XXX
78195	26	A	Lymph system imaging	1.20	0.46	0.45	0.46	0.45	0.06	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.63	4.11	NA	NA	0.15	XXX
78201	TC	A	Liver imaging	0.00	4.48	3.96	NA	NA	0.13	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.15	0.15	0.02	XXX
78202		A	Liver imaging with flow	0.51	5.29	4.75	NA	NA	0.16	XXX
78202	TC	A	Liver imaging with flow	0.00	5.11	4.57	NA	NA	0.14	XXX
78202	26	A	Liver imaging with flow	0.51	0.18	0.18	0.18	0.18	0.02	XXX
78205		A	Liver imaging (3D)	0.71	5.24	5.48	NA	NA	0.34	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.96	5.21	NA	NA	0.31	XXX
78205	26	A	Liver imaging (3D)	0.71	0.28	0.27	0.28	0.27	0.03	XXX
78206		A	Liver image (3d) with flow	0.96	8.52	7.97	NA	NA	0.15	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.15	7.61	NA	NA	0.11	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.37	0.36	0.37	0.36	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.78	4.37	NA	NA	0.16	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.59	4.19	NA	NA	0.14	XXX
78215	26	A	Liver and spleen imaging	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78216		A	Liver & spleen image/flow	0.57	2.84	3.05	NA	NA	0.20	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.62	2.84	NA	NA	0.18	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.22	0.21	0.22	0.21	0.02	XXX
78220		A	Liver function study	0.49	3.07	3.28	NA	NA	0.21	XXX
78220	TC	A	Liver function study	0.00	2.88	3.10	NA	NA	0.19	XXX
78220	26	A	Liver function study	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78223		A	Hepatobiliary imaging	0.84	8.43	7.32	NA	NA	0.23	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.10	7.01	NA	NA	0.19	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.33	0.31	0.33	0.31	0.04	XXX
78230		A	Salivary gland imaging	0.45	4.12	3.68	NA	NA	0.15	XXX
78230	TC	A	Salivary gland imaging	0.00	3.95	3.52	NA	NA	0.13	XXX
78230	26	A	Salivary gland imaging	0.45	0.17	0.16	0.17	0.16	0.02	XXX
78231		A	Serial salivary imaging	0.52	2.82	2.96	NA	NA	0.19	XXX
78231	TC	A	Serial salivary imaging	0.00	2.63	2.77	NA	NA	0.17	XXX
78231	26	A	Serial salivary imaging	0.52	0.19	0.19	0.19	0.19	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78232		A	Salivary gland function exam	0.47	2.85	3.07	NA	NA	0.20	XXX
78232	TC	A	Salivary gland function exam	0.00	2.67	2.89	NA	NA	0.18	XXX
78232	26	A	Salivary gland function exam	0.47	0.18	0.18	0.18	0.18	0.02	XXX
78258		A	Esophageal motility study	0.74	5.66	5.04	NA	NA	0.17	XXX
78258	TC	A	Esophageal motility study	0.00	5.36	4.75	NA	NA	0.14	XXX
78258	26	A	Esophageal motility study	0.74	0.30	0.29	0.30	0.29	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	6.08	5.65	NA	NA	0.25	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.81	5.39	NA	NA	0.22	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.27	0.26	0.27	0.26	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.91	5.57	NA	NA	0.25	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.67	5.33	NA	NA	0.22	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.24	0.24	0.24	0.24	0.03	XXX
78264		A	Gastric emptying study	0.78	7.10	6.44	NA	NA	0.25	XXX
78264	TC	A	Gastric emptying study	0.00	6.80	6.15	NA	NA	0.22	XXX
78264	26	A	Gastric emptying study	0.78	0.30	0.29	0.30	0.29	0.03	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.94	1.87	NA	NA	0.11	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.87	1.80	NA	NA	0.10	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.07	0.07	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.94	1.89	NA	NA	0.11	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.88	1.83	NA	NA	0.10	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.06	0.06	0.06	0.06	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	1.97	2.09	NA	NA	0.14	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.89	2.01	NA	NA	0.13	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.08	0.08	0.08	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	8.55	7.72	NA	NA	0.29	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	8.16	7.35	NA	NA	0.25	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.39	0.37	0.39	0.37	0.04	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.15	0.14	0.15	0.14	0.02	XXX
78290		A	MeckelÆs divert exam	0.68	8.42	7.16	NA	NA	0.19	XXX
78290	TC	A	MeckelÆs divert exam	0.00	8.16	6.90	NA	NA	0.16	XXX
78290	26	A	MeckelÆs divert exam	0.68	0.26	0.26	0.26	0.26	0.03	XXX
78291		A	Leveen/shunt patency exam	0.88	6.16	5.47	NA	NA	0.20	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.82	5.14	NA	NA	0.16	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.34	0.33	0.34	0.33	0.04	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	4.19	3.82	NA	NA	0.17	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.95	3.59	NA	NA	0.14	XXX
78300	26	A	Bone imaging, limited area	0.62	0.24	0.23	0.24	0.23	0.03	XXX
78305		A	Bone imaging, multiple areas	0.83	5.44	5.07	NA	NA	0.23	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	5.13	4.77	NA	NA	0.19	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.31	0.30	0.31	0.30	0.04	XXX
78306		A	Bone imaging, whole body	0.86	6.02	5.67	NA	NA	0.26	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78306	TC	A	Bone imaging, whole body	0.00	5.69	5.35	NA	NA	0.22	XXX
78306	26	A	Bone imaging, whole body	0.86	0.33	0.32	0.33	0.32	0.04	XXX
78315		A	Bone imaging, 3 phase	1.02	8.54	7.70	NA	NA	0.29	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	8.14	7.32	NA	NA	0.25	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.40	0.38	0.40	0.38	0.04	XXX
78320		A	Bone imaging (3D)	1.04	5.36	5.60	NA	NA	0.35	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.96	5.21	NA	NA	0.31	XXX
78320	26	A	Bone imaging (3D)	1.04	0.40	0.39	0.40	0.39	0.04	XXX
78350		N	Bone mineral, single photon	0.22	0.59	0.65	NA	NA	0.06	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.52	0.58	NA	NA	0.05	XXX
78350	26	N	Bone mineral, single photon	0.22	0.07	0.07	0.07	0.07	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	NA	NA	0.10	0.11	0.01	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.12	0.13	0.12	0.13	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	5.00	4.40	NA	NA	0.16	XXX
78428	TC	A	Cardiac shunt imaging	0.00	4.65	4.06	NA	NA	0.13	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.35	0.34	0.35	0.34	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.46	3.86	NA	NA	0.13	XXX
78445	TC	A	Vascular flow imaging	0.00	4.27	3.68	NA	NA	0.11	XXX
78445	26	A	Vascular flow imaging	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78456		A	Acute venous thrombus image	1.00	9.42	8.16	NA	NA	0.33	XXX
78456	TC	A	Acute venous thrombus image	0.00	8.91	7.70	NA	NA	0.29	XXX
78456	26	A	Acute venous thrombus image	1.00	0.51	0.46	0.51	0.46	0.04	XXX
78457		A	Venous thrombosis imaging	0.77	4.63	4.21	NA	NA	0.17	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.34	3.93	NA	NA	0.14	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.29	0.28	0.29	0.28	0.03	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.61	4.55	NA	NA	0.25	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.26	4.21	NA	NA	0.21	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.35	0.34	0.35	0.34	0.04	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.68	0.65	0.68	0.65	0.05	XXX
78460		A	Heart muscle blood, single	0.86	4.61	4.13	NA	NA	0.17	XXX
78460	TC	A	Heart muscle blood, single	0.00	4.26	3.80	NA	NA	0.13	XXX
78460	26	A	Heart muscle blood, single	0.86	0.35	0.33	0.35	0.33	0.04	XXX
78461		A	Heart muscle blood, multiple	1.23	4.02	4.31	NA	NA	0.30	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	3.52	3.83	NA	NA	0.25	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.50	0.48	0.50	0.48	0.05	XXX
78464		A	Heart image (3d), single	1.09	5.64	6.11	NA	NA	0.41	XXX
78464	TC	A	Heart image (3d), single	0.00	5.12	5.62	NA	NA	0.37	XXX
78464	26	A	Heart image (3d), single	1.09	0.52	0.49	0.52	0.49	0.04	XXX
78465		A	Heart image (3d), multiple	1.46	10.96	11.32	NA	NA	0.67	XXX
78465	TC	A	Heart image (3d), multiple	0.00	10.23	10.64	NA	NA	0.62	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.73	0.68	0.73	0.68	0.05	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78466		A	Heart infarct image	0.69	4.44	4.06	NA	NA	0.17	XXX
78466	TC	A	Heart infarct image	0.00	4.14	3.77	NA	NA	0.14	XXX
78466	26	A	Heart infarct image	0.69	0.30	0.29	0.30	0.29	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	5.59	5.19	NA	NA	0.22	XXX
78468	TC	A	Heart infarct image (ef)	0.00	5.19	4.82	NA	NA	0.19	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.40	0.37	0.40	0.37	0.03	XXX
78469		A	Heart infarct image (3D)	0.92	5.94	5.85	NA	NA	0.31	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.51	5.45	NA	NA	0.28	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.43	0.40	0.43	0.40	0.03	XXX
78472		A	Gated heart, planar, single	0.98	5.89	5.89	NA	NA	0.34	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.45	5.48	NA	NA	0.30	XXX
78472	26	A	Gated heart, planar, single	0.98	0.44	0.41	0.44	0.41	0.04	XXX
78473		A	Gated heart, multiple	1.47	7.59	7.91	NA	NA	0.48	XXX
78473	TC	A	Gated heart, multiple	0.00	6.90	7.26	NA	NA	0.42	XXX
78473	26	A	Gated heart, multiple	1.47	0.69	0.65	0.69	0.65	0.06	XXX
78478		A	Heart wall motion add-on	0.50	0.78	1.03	NA	NA	0.12	XXX
78478	TC	A	Heart wall motion add-on	0.00	0.53	0.79	NA	NA	0.10	XXX
78478	26	A	Heart wall motion add-on	0.50	0.25	0.24	0.25	0.24	0.02	XXX
78480		A	Heart function add-on	0.30	0.68	0.96	NA	NA	0.12	XXX
78480	TC	A	Heart function add-on	0.00	0.53	0.79	NA	NA	0.10	XXX
78480	26	A	Heart function add-on	0.30	0.15	0.17	0.15	0.17	0.02	XXX
78481		A	Heart first pass, single	0.98	4.84	5.04	NA	NA	0.31	XXX
78481	TC	A	Heart first pass, single	0.00	4.33	4.57	NA	NA	0.28	XXX
78481	26	A	Heart first pass, single	0.98	0.51	0.47	0.51	0.47	0.03	XXX
78483		A	Heart first pass, multiple	1.47	6.54	7.02	NA	NA	0.46	XXX
78483	TC	A	Heart first pass, multiple	0.00	5.75	6.29	NA	NA	0.41	XXX
78483	26	A	Heart first pass, multiple	1.47	0.79	0.73	0.79	0.73	0.05	XXX
78491		C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.70	0.67	0.70	0.67	0.06	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.92	0.87	0.92	0.87	0.07	XXX
78494		A	Heart image, spect	1.19	5.92	6.32	NA	NA	0.35	XXX
78494	TC	A	Heart image, spect	0.00	5.38	5.81	NA	NA	0.30	XXX
78494	26	A	Heart image, spect	1.19	0.54	0.51	0.54	0.51	0.05	XXX
78496		A	Heart first pass add-on	0.50	0.86	2.47	NA	NA	0.32	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.62	2.24	NA	NA	0.30	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.24	0.23	0.24	0.23	0.02	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	5.08	4.74	NA	NA	0.21	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.79	4.46	NA	NA	0.18	XXX
78580	26	A	Lung perfusion imaging	0.74	0.29	0.28	0.29	0.28	0.03	XXX
78584		A	Lung V/Q image single breath	0.99	3.01	3.14	NA	NA	0.21	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.62	2.77	NA	NA	0.17	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.39	0.37	0.39	0.37	0.04	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78585		A	Lung V/Q imaging	1.09	8.58	7.95	NA	NA	0.35	XXX
78585	TC	A	Lung V/Q imaging	0.00	8.16	7.54	NA	NA	0.30	XXX
78585	26	A	Lung V/Q imaging	1.09	0.42	0.41	0.42	0.41	0.05	XXX
78586		A	Aerosol lung image, single	0.40	4.12	3.78	NA	NA	0.16	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.97	3.63	NA	NA	0.14	XXX
78586	26	A	Aerosol lung image, single	0.40	0.15	0.15	0.15	0.15	0.02	XXX
78587		A	Aerosol lung image, multiple	0.49	5.38	4.80	NA	NA	0.16	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	5.19	4.61	NA	NA	0.14	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.19	0.19	0.19	0.19	0.02	XXX
78588		A	Perfusion lung image	1.09	8.60	7.36	NA	NA	0.23	XXX
78588	TC	A	Perfusion lung image	0.00	8.18	6.95	NA	NA	0.18	XXX
78588	26	A	Perfusion lung image	1.09	0.42	0.41	0.42	0.41	0.05	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	4.11	3.84	NA	NA	0.16	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	3.95	3.69	NA	NA	0.14	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.16	0.15	0.16	0.15	0.02	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.79	4.50	NA	NA	0.20	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	4.60	4.32	NA	NA	0.18	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78594		A	Vent image, mult proj, gas	0.53	5.29	5.28	NA	NA	0.27	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	5.09	5.08	NA	NA	0.25	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.20	0.20	0.20	0.20	0.02	XXX
78596		A	Lung differential function	1.27	8.68	8.41	NA	NA	0.42	XXX
78596	TC	A	Lung differential function	0.00	8.24	7.97	NA	NA	0.37	XXX
78596	26	A	Lung differential function	1.27	0.44	0.44	0.44	0.44	0.05	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	4.46	4.12	NA	NA	0.16	XXX
78600	TC	A	Brain image < 4 views	0.00	4.29	3.95	NA	NA	0.14	XXX
78600	26	A	Brain image < 4 views	0.44	0.17	0.17	0.17	0.17	0.02	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.35	4.91	NA	NA	0.20	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.15	4.72	NA	NA	0.18	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.20	0.19	0.20	0.19	0.02	XXX
78605		A	Brain image 4+ views	0.53	4.84	4.53	NA	NA	0.20	XXX
78605	TC	A	Brain image 4+ views	0.00	4.62	4.32	NA	NA	0.18	XXX
78605	26	A	Brain image 4+ views	0.53	0.22	0.21	0.22	0.21	0.02	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.39	7.34	NA	NA	0.24	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.15	7.10	NA	NA	0.21	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.24	0.24	0.24	0.24	0.03	XXX
78607		A	Brain imaging (3D)	1.23	8.66	8.26	NA	NA	0.40	XXX
78607	TC	A	Brain imaging (3D)	0.00	8.19	7.80	NA	NA	0.35	XXX
78607	26	A	Brain imaging (3D)	1.23	0.47	0.46	0.47	0.46	0.05	XXX
78608		C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.58	0.56	0.58	0.56	0.06	XXX
78609		N	Brain imaging (PET)	1.50	0.00	0.49	NA	NA	0.06	XXX
78609	TC	N	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (PET)	1.50	0.00	0.49	0.00	0.49	0.06	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78610		A	Brain flow imaging only	0.30	4.43	4.34	NA	NA	0.11	XXX
78610	TC	A	Brain flow imaging only	0.00	4.31	4.21	NA	NA	0.10	XXX
78610	26	A	Brain flow imaging only	0.30	0.12	0.13	0.12	0.13	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	8.56	7.76	NA	NA	0.30	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.30	7.50	NA	NA	0.27	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.26	0.26	0.26	0.26	0.03	XXX
78635		A	CSF ventriculography	0.61	8.59	7.15	NA	NA	0.16	XXX
78635	TC	A	CSF ventriculography	0.00	8.35	6.91	NA	NA	0.14	XXX
78635	26	A	CSF ventriculography	0.61	0.24	0.24	0.24	0.24	0.02	XXX
78645		A	CSF shunt evaluation	0.57	8.45	7.26	NA	NA	0.20	XXX
78645	TC	A	CSF shunt evaluation	0.00	8.23	7.04	NA	NA	0.18	XXX
78645	26	A	CSF shunt evaluation	0.57	0.22	0.22	0.22	0.22	0.02	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.54	7.98	NA	NA	0.35	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.21	7.65	NA	NA	0.31	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.33	0.33	0.33	0.33	0.04	XXX
78650		A	CSF leakage imaging	0.61	8.55	7.64	NA	NA	0.27	XXX
78650	TC	A	CSF leakage imaging	0.00	8.31	7.41	NA	NA	0.24	XXX
78650	26	A	CSF leakage imaging	0.61	0.24	0.23	0.24	0.23	0.03	XXX
78660		A	Nuclear exam of tear flow	0.53	4.24	3.77	NA	NA	0.14	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.04	3.57	NA	NA	0.12	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.20	0.20	0.20	0.20	0.02	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	4.34	4.06	NA	NA	0.18	XXX
78700	TC	A	Kidney imaging, morphol	0.00	4.16	3.89	NA	NA	0.16	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.18	0.17	0.18	0.17	0.02	XXX
78701		A	Kidney imaging with flow	0.49	5.31	4.92	NA	NA	0.20	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.12	4.74	NA	NA	0.18	XXX
78701	26	A	Kidney imaging with flow	0.49	0.19	0.18	0.19	0.18	0.02	XXX
78707		A	K flow/funct image w/o drug	0.96	5.47	5.31	NA	NA	0.27	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	5.10	4.95	NA	NA	0.23	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.37	0.36	0.37	0.36	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.49	3.85	NA	NA	0.28	XXX
78708	TC	A	K flow/funct image w/drug	0.00	3.02	3.39	NA	NA	0.23	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.47	0.46	0.47	0.46	0.05	XXX
78709		A	K flow/funct image, multiple	1.41	8.86	7.90	NA	NA	0.29	XXX
78709	TC	A	K flow/funct image, multiple	0.00	8.31	7.37	NA	NA	0.23	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.55	0.53	0.55	0.53	0.06	XXX
78710		A	Kidney imaging (3D)	0.66	5.25	5.48	NA	NA	0.34	XXX
78710	TC	A	Kidney imaging (3D)	0.00	4.99	5.23	NA	NA	0.31	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.26	0.25	0.26	0.25	0.03	XXX
78725		A	Kidney function study	0.38	2.32	2.22	NA	NA	0.13	XXX
78725	TC	A	Kidney function study	0.00	2.19	2.09	NA	NA	0.11	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.13	0.13	0.02	XXX
78730		A	Urinary bladder retention	0.15	1.92	1.85	NA	NA	0.10	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.86	1.77	NA	NA	0.08	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.06	0.08	0.06	0.08	0.02	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78740		A	Ureteral reflux study	0.57	5.67	4.84	NA	NA	0.15	XXX
78740	TC	A	Ureteral reflux study	0.00	5.44	4.62	NA	NA	0.12	XXX
78740	26	A	Ureteral reflux study	0.57	0.23	0.22	0.23	0.22	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.08	4.68	NA	NA	0.20	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.80	4.41	NA	NA	0.17	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.28	0.27	0.28	0.27	0.03	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	4.30	4.13	NA	NA	0.22	XXX
78800	TC	A	Tumor imaging, limited area	0.00	4.06	3.90	NA	NA	0.18	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.24	0.23	0.24	0.23	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	6.00	5.64	NA	NA	0.27	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.71	5.35	NA	NA	0.22	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.29	0.29	0.29	0.29	0.05	XXX
78802		A	Tumor imaging, whole body	0.86	8.12	7.57	NA	NA	0.34	XXX
78802	TC	A	Tumor imaging, whole body	0.00	7.79	7.25	NA	NA	0.30	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.33	0.32	0.33	0.32	0.04	XXX
78803		A	Tumor imaging (3D)	1.09	8.58	8.18	NA	NA	0.40	XXX
78803	TC	A	Tumor imaging (3D)	0.00	8.15	7.77	NA	NA	0.35	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.43	0.41	0.43	0.41	0.05	XXX
78804		A	Tumor imaging, whole body	1.07	14.78	13.97	NA	NA	0.34	XXX
78804	TC	A	Tumor imaging, whole body	0.00	14.36	13.56	NA	NA	0.30	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.42	0.41	0.42	0.41	0.04	XXX
78805		A	Abscess imaging, ltd area	0.73	4.21	4.08	NA	NA	0.21	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.93	3.81	NA	NA	0.18	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.28	0.27	0.28	0.27	0.03	XXX
78806		A	Abscess imaging, whole body	0.86	8.32	7.94	NA	NA	0.39	XXX
78806	TC	A	Abscess imaging, whole body	0.00	7.99	7.62	NA	NA	0.35	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.33	0.32	0.33	0.32	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.59	8.20	NA	NA	0.39	XXX
78807	TC	A	Nuclear localization/abscess	0.00	8.17	7.78	NA	NA	0.35	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.42	0.42	0.42	0.42	0.04	XXX
78808		A	Iv inj ra drug dx study	0.18	1.01	1.01	NA	NA	0.04	XXX
78811		C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.60	0.58	0.60	0.58	0.11	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.76	0.73	0.76	0.73	0.11	XXX
78813		C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.78	0.76	0.78	0.76	0.11	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.85	0.83	0.85	0.83	0.11	XXX
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.95	0.92	0.95	0.92	0.11	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.97	0.95	0.97	0.95	0.11	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.90	2.24	NA	NA	0.22	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.25	1.60	NA	NA	0.14	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.65	0.64	0.65	0.64	0.08	XXX
79101		A	Nuclear rx, iv admin	1.96	2.37	2.61	NA	NA	0.22	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.45	1.75	NA	NA	0.14	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.92	0.86	0.92	0.86	0.08	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.40	2.64	NA	NA	0.23	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.64	1.89	NA	NA	0.14	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.76	0.75	0.76	0.75	0.09	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.58	0.58	0.58	0.58	0.13	XXX
79403		A	Hematopoietic nuclear tx	2.25	3.04	3.58	NA	NA	0.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.18	2.71	NA	NA	0.14	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.86	0.87	0.86	0.87	0.10	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.92	2.28	NA	NA	0.22	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.16	1.53	NA	NA	0.14	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.76	0.75	0.76	0.75	0.08	XXX
79445		C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.94	0.91	0.94	0.91	0.12	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.18	0.19	0.11	0.12	0.01	XXX
80502		A	Lab pathology consultation	1.33	0.37	0.41	0.31	0.37	0.04	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.12	0.13	0.12	0.13	0.01	XXX
83912	26	A	Genetic examination	0.37	0.11	0.11	0.11	0.11	0.01	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.12	0.12	0.12	0.12	0.01	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.12	0.12	0.12	0.12	0.01	XXX
84181	26	A	Western blot test	0.37	0.12	0.12	0.12	0.12	0.01	XXX
84182	26	A	Protein, western blot test	0.37	0.12	0.13	0.12	0.13	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.15	0.15	0.15	0.15	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.22	1.40	0.27	0.31	0.04	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.13	0.13	0.01	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.10	0.12	0.04	XXX
85576	26	A	Blood platelet aggregation	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86077		A	Physician blood bank service	0.94	0.38	0.38	0.30	0.32	0.03	XXX
86078		A	Physician blood bank service	0.94	0.38	0.40	0.30	0.32	0.03	XXX
86079		A	Physician blood bank service	0.94	0.39	0.41	0.31	0.33	0.03	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.12	0.13	0.12	0.13	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
86256	26	A	Fluorescent antibody, titer	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.12	0.12	0.12	0.12	0.01	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.14	0.15	0.14	0.15	0.02	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.12	0.12	0.12	0.12	0.01	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.12	0.12	NA	NA	0.02	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.12	0.17	NA	NA	0.02	XXX
86510		A	Histoplasmosis skin test	0.00	0.12	0.17	NA	NA	0.02	XXX
86580		A	TB intradermal test	0.00	0.15	0.18	NA	NA	0.02	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.12	0.12	0.01	XXX
87207	26	A	Smear, special stain	0.37	0.12	0.13	0.12	0.13	0.01	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.15	1.08	NA	NA	0.04	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	0.99	0.90	NA	NA	0.02	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.16	0.18	0.16	0.18	0.02	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.53	1.49	NA	NA	0.04	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.37	1.31	NA	NA	0.02	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.16	0.18	0.16	0.18	0.02	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.91	1.82	NA	NA	0.05	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.68	1.56	NA	NA	0.02	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.23	0.26	0.23	0.26	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.43	1.38	NA	NA	0.04	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.27	1.20	NA	NA	0.02	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.16	0.18	0.16	0.18	0.02	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.44	1.57	NA	NA	0.04	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.14	1.22	NA	NA	0.02	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.30	0.35	0.30	0.35	0.02	XXX
88125		A	Forensic cytopathology	0.26	0.31	0.31	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.23	0.22	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.08	0.09	0.08	0.09	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.37	0.31	0.37	0.31	0.02	XXX
88160		A	Cytopath smear, other source	0.50	0.89	0.88	NA	NA	0.04	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.75	0.72	NA	NA	0.02	XXX
88160	26	A	Cytopath smear, other source	0.50	0.14	0.16	0.14	0.16	0.02	XXX
88161		A	Cytopath smear, other source	0.50	0.94	0.94	NA	NA	0.04	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.81	0.79	NA	NA	0.02	XXX
88161	26	A	Cytopath smear, other source	0.50	0.13	0.15	0.13	0.15	0.02	XXX
88162		A	Cytopath smear, other source	0.76	1.44	1.33	NA	NA	0.05	XXX
88162	TC	A	Cytopath smear, other source	0.00	1.21	1.08	NA	NA	0.02	XXX
88162	26	A	Cytopath smear, other source	0.76	0.23	0.25	0.23	0.25	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.83	0.80	NA	NA	0.04	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.65	0.60	NA	NA	0.02	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.18	0.20	0.18	0.20	0.02	XXX
88173		A	Cytopath eval, fna, report	1.39	2.19	2.19	NA	NA	0.07	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.79	1.74	NA	NA	0.02	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.40	0.45	0.40	0.45	0.05	XXX
88182		A	Cell marker study	0.77	1.94	1.96	NA	NA	0.07	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88182	TC	A	Cell marker study	0.00	1.81	1.78	NA	NA	0.04	XXX
88182	26	A	Cell marker study	0.77	0.13	0.18	0.13	0.18	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.43	2.15	NA	NA	0.02	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.48	1.27	NA	NA	0.02	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.39	0.41	0.39	0.41	0.01	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.47	0.49	0.47	0.49	0.01	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.48	0.55	0.48	0.55	0.01	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.28	0.25	0.28	0.25	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.56	0.54	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.54	0.51	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.02	0.03	0.02	0.03	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.23	1.18	NA	NA	0.03	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.19	1.14	NA	NA	0.02	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.04	0.04	0.04	0.04	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.48	1.45	NA	NA	0.03	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.42	1.38	NA	NA	0.02	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.06	0.07	0.06	0.07	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	2.10	2.06	NA	NA	0.07	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.88	1.81	NA	NA	0.04	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.22	0.25	0.22	0.25	0.03	XXX
88307		A	Tissue exam by pathologist	1.59	4.33	4.05	NA	NA	0.12	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.84	3.51	NA	NA	0.06	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.49	0.54	0.49	0.54	0.06	XXX
88309		A	Tissue exam by pathologist	2.80	6.15	5.72	NA	NA	0.14	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.29	4.83	NA	NA	0.06	XXX
88309	26	A	Tissue exam by pathologist	2.80	0.86	0.89	0.86	0.89	0.08	XXX
88311		A	Decalcify tissue	0.24	0.24	0.24	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.17	0.16	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.07	0.08	0.07	0.08	0.01	XXX
88312		A	Special stains	0.54	2.34	2.14	NA	NA	0.03	XXX
88312	TC	A	Special stains	0.00	2.19	1.97	NA	NA	0.01	XXX
88312	26	A	Special stains	0.54	0.15	0.17	0.15	0.17	0.02	XXX
88313		A	Special stains	0.24	1.88	1.72	NA	NA	0.02	XXX
88313	TC	A	Special stains	0.00	1.82	1.65	NA	NA	0.01	XXX
88313	26	A	Special stains	0.24	0.06	0.07	0.06	0.07	0.01	XXX
88314		A	Histochemical stain	0.45	1.88	1.93	NA	NA	0.04	XXX
88314	TC	A	Histochemical stain	0.00	1.74	1.78	NA	NA	0.02	XXX
88314	26	A	Histochemical stain	0.45	0.14	0.15	0.14	0.15	0.02	XXX
88318		A	Chemical histochemistry	0.42	2.46	2.27	NA	NA	0.03	XXX
88318	TC	A	Chemical histochemistry	0.00	2.35	2.14	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.11	0.13	0.11	0.13	0.02	XXX
88319		A	Enzyme histochemistry	0.53	3.14	3.21	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.98	3.04	NA	NA	0.02	XXX
88319	26	A	Enzyme histochemistry	0.53	0.16	0.17	0.16	0.17	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88321		A	Microslide consultation	1.63	0.72	0.74	0.48	0.50	0.05	XXX
88323		A	Microslide consultation	1.83	2.09	2.02	NA	NA	0.07	XXX
88323	TC	A	Microslide consultation	0.00	1.64	1.54	NA	NA	0.02	XXX
88323	26	A	Microslide consultation	1.83	0.45	0.48	0.45	0.48	0.05	XXX
88325		A	Comprehensive review of data	2.50	2.54	2.64	0.78	0.82	0.07	XXX
88329		A	Path consult introp	0.67	0.67	0.66	0.21	0.23	0.02	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.22	1.19	NA	NA	0.08	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.83	0.77	NA	NA	0.04	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.39	0.42	0.39	0.42	0.04	XXX
88332		A	Path consult intraop, addÆl	0.59	0.46	0.47	NA	NA	0.04	XXX
88332	TC	A	Path consult intraop, addÆl	0.00	0.28	0.27	NA	NA	0.02	XXX
88332	26	A	Path consult intraop, addÆl	0.59	0.18	0.20	0.18	0.20	0.02	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.29	1.24	NA	NA	0.08	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.92	0.83	NA	NA	0.04	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.37	0.41	0.37	0.41	0.04	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.79	0.75	NA	NA	0.04	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.56	0.51	NA	NA	0.02	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.23	0.24	0.23	0.24	0.02	XXX
88342		A	Immunohistochemistry	0.85	1.94	1.82	NA	NA	0.05	XXX
88342	TC	A	Immunohistochemistry	0.00	1.71	1.56	NA	NA	0.02	XXX
88342	26	A	Immunohistochemistry	0.85	0.23	0.26	0.23	0.26	0.03	XXX
88346		A	Immunofluorescent study	0.86	1.89	1.82	NA	NA	0.05	XXX
88346	TC	A	Immunofluorescent study	0.00	1.65	1.55	NA	NA	0.02	XXX
88346	26	A	Immunofluorescent study	0.86	0.24	0.27	0.24	0.27	0.03	XXX
88347		A	Immunofluorescent study	0.86	1.25	1.25	NA	NA	0.05	XXX
88347	TC	A	Immunofluorescent study	0.00	1.07	1.03	NA	NA	0.02	XXX
88347	26	A	Immunofluorescent study	0.86	0.18	0.22	0.18	0.22	0.03	XXX
88348		A	Electron microscopy	1.51	17.47	15.48	NA	NA	0.13	XXX
88348	TC	A	Electron microscopy	0.00	17.05	15.00	NA	NA	0.07	XXX
88348	26	A	Electron microscopy	1.51	0.42	0.48	0.42	0.48	0.06	XXX
88349		A	Scanning electron microscopy	0.76	8.52	7.30	NA	NA	0.09	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.29	7.04	NA	NA	0.06	XXX
88349	26	A	Scanning electron microscopy	0.76	0.23	0.26	0.23	0.26	0.03	XXX
88355		A	Analysis, skeletal muscle	1.85	3.16	4.57	NA	NA	0.13	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.78	4.09	NA	NA	0.06	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.38	0.48	0.38	0.48	0.07	XXX
88356		A	Analysis, nerve	3.02	4.91	4.73	NA	NA	0.19	XXX
88356	TC	A	Analysis, nerve	0.00	4.40	4.04	NA	NA	0.07	XXX
88356	26	A	Analysis, nerve	3.02	0.51	0.69	0.51	0.69	0.12	XXX
88358		A	Analysis, tumor	0.95	1.09	1.03	NA	NA	0.17	XXX
88358	TC	A	Analysis, tumor	0.00	0.93	0.81	NA	NA	0.07	XXX
88358	26	A	Analysis, tumor	0.95	0.16	0.22	0.16	0.22	0.10	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.24	2.11	NA	NA	0.08	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.95	1.78	NA	NA	0.02	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.29	0.33	0.29	0.33	0.06	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.73	2.82	NA	NA	0.17	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.46	2.49	NA	NA	0.07	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.27	0.33	0.27	0.33	0.10	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88362		A	Nerve teasing preparations	2.17	4.92	4.87	NA	NA	0.15	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.32	4.19	NA	NA	0.06	XXX
88362	26	A	Nerve teasing preparations	2.17	0.60	0.68	0.60	0.68	0.09	XXX
88365		A	Insitu hybridization (fish)	1.20	3.34	3.03	NA	NA	0.05	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.02	2.67	NA	NA	0.02	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.32	0.36	0.32	0.36	0.03	XXX
88367		A	Insitu hybridization, auto	1.30	5.52	5.16	NA	NA	0.12	XXX
88367	TC	A	Insitu hybridization, auto	0.00	5.23	4.81	NA	NA	0.06	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.29	0.35	0.29	0.35	0.06	XXX
88368		A	Insitu hybridization, manual	1.40	4.89	4.27	NA	NA	0.12	XXX
88368	TC	A	Insitu hybridization, manual	0.00	4.63	3.93	NA	NA	0.06	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.26	0.34	0.26	0.34	0.06	XXX
88371	26	A	Protein, western blot tissue	0.37	0.12	0.12	0.12	0.12	0.01	XXX
88372	26	A	Protein analysis w/probe	0.37	0.11	0.12	0.11	0.12	0.01	XXX
88380		A	Microdissection, laser	1.56	3.69	3.69	NA	NA	0.14	XXX
88380	TC	A	Microdissection, laser	0.00	3.19	3.19	NA	NA	0.07	XXX
88380	26	A	Microdissection, laser	1.56	0.50	0.50	0.50	0.50	0.07	XXX
88381		A	Microdissection, manual	1.18	4.61	4.61	NA	NA	0.08	XXX
88381	TC	A	Microdissection, manual	0.00	4.23	4.23	NA	NA	0.02	XXX
88381	26	A	Microdissection, manual	1.18	0.38	0.38	0.38	0.38	0.06	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	14.59	12.74	NA	NA	0.12	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	14.35	12.40	NA	NA	0.06	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.24	0.34	0.24	0.34	0.06	XXX
88386		A	Eval molecul probes, 251-500	1.88	19.41	16.35	NA	NA	0.16	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	18.72	15.63	NA	NA	0.08	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.69	0.72	0.69	0.72	0.08	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.56	5.07	0.47	0.42	0.06	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.12	0.13	0.12	0.13	0.01	XXX
89100		A	Sample intestinal contents	0.60	7.36	5.99	0.52	0.44	0.03	XXX
89105		A	Sample intestinal contents	0.50	7.62	6.28	0.46	0.39	0.02	XXX
89130		A	Sample stomach contents	0.45	6.45	5.29	0.38	0.32	0.02	XXX
89132		A	Sample stomach contents	0.19	7.95	6.36	0.37	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	8.69	7.01	0.69	0.58	0.04	XXX
89136		A	Sample stomach contents	0.21	6.53	5.34	0.31	0.25	0.01	XXX
89140		A	Sample stomach contents	0.94	6.66	5.53	0.51	0.45	0.04	XXX
89141		A	Sample stomach contents	0.85	6.85	5.85	0.52	0.47	0.03	XXX
89220		A	Sputum specimen collection	0.00	0.37	0.39	NA	NA	0.02	XXX
89230		A	Collect sweat for test	0.00	0.08	0.09	NA	NA	0.02	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.43	0.40	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.13	0.13	0.04	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.21	0.20	0.07	0.08	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.12	0.12	0.04	0.05	0.01	ZZZ
90471		A	Immunization admin	0.17	0.43	0.40	NA	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.13	0.13	0.04	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.21	0.20	0.05	0.05	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.09	0.09	0.04	0.05	0.01	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649		E	Hpv vaccine 4 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90669		X	Pneumococcal vacc, ped <5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.45	1.38	0.61	0.69	0.06	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90802		A	Intac psy dx interview	3.01	1.51	1.44	0.66	0.74	0.07	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.54	0.53	0.23	0.26	0.03	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.59	0.57	0.25	0.29	0.03	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.53	0.57	0.34	0.40	0.04	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.70	0.37	0.43	0.05	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.69	0.78	0.51	0.61	0.06	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.86	0.90	0.54	0.64	0.07	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.53	0.52	0.24	0.28	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.70	0.67	0.27	0.32	0.04	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.64	0.68	0.36	0.43	0.04	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.82	0.81	0.39	0.46	0.05	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.88	0.94	0.61	0.70	0.06	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	0.99	1.01	0.56	0.66	0.07	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	NA	0.33	0.36	0.03	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	NA	0.36	0.38	0.03	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	NA	0.45	0.51	0.04	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	NA	0.47	0.52	0.05	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	NA	0.61	0.71	0.06	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	NA	0.64	0.72	0.08	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	NA	0.35	0.38	0.03	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	NA	0.38	0.41	0.04	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	NA	0.46	0.53	0.05	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	NA	0.49	0.54	0.05	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	NA	0.63	0.74	0.06	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	NA	0.66	0.74	0.07	XXX
90845		A	Psychoanalysis	1.79	0.40	0.44	0.33	0.39	0.04	XXX
90846		R	Family psytx w/o patient	1.83	0.51	0.55	0.43	0.49	0.04	XXX
90847		R	Family psytx w/patient	2.21	0.73	0.75	0.50	0.57	0.05	XXX
90849		R	Multiple family group psytx	0.59	0.31	0.30	0.21	0.22	0.02	XXX
90853		A	Group psychotherapy	0.59	0.26	0.26	0.20	0.21	0.01	XXX
90857		A	Intac group psytx	0.63	0.35	0.33	0.21	0.22	0.01	XXX
90862		A	Medication management	0.95	0.61	0.56	0.27	0.28	0.02	XXX
90865		A	Narcosynthesis	2.84	1.32	1.33	0.67	0.73	0.12	XXX
90870		A	Electroconvulsive therapy	1.88	1.85	1.87	0.39	0.44	0.04	000
90875		N	Psychophysiological therapy	1.20	0.67	0.73	0.40	0.42	0.04	XXX
90876		N	Psychophysiological therapy	1.90	0.90	0.96	0.64	0.66	0.05	XXX
90880		A	Hypnotherapy	2.19	0.58	0.70	0.41	0.48	0.05	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.32	0.34	0.32	0.34	0.02	XXX
90887		B	Consultation with family	1.48	0.79	0.80	0.50	0.51	0.04	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.45	0.50	0.11	0.12	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.39	1.43	0.33	0.32	0.06	000
90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.54	0.58	0.04	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	0.79	0.84	0.07	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.56	0.59	0.04	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90947		A	Dialysis, repeated eval	2.16	NA	NA	0.81	0.86	0.07	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	7.27	7.60	7.27	7.60	0.61	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	5.49	5.31	5.49	5.31	0.56	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.07	3.29	3.07	3.29	0.31	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	1.93	2.24	1.93	2.24	0.20	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	4.68	4.62	4.68	4.62	0.41	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.07	3.23	3.07	3.23	0.28	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	1.81	2.10	1.81	2.10	0.17	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.31	2.46	2.31	2.46	0.17	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	1.73	1.90	1.73	1.90	0.14	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.10	1.30	1.10	1.30	0.10	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	3.14	4.14	3.14	4.14	0.36	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	2.79	3.08	2.79	3.08	0.33	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	2.70	2.95	2.70	2.95	0.29	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	1.64	1.83	1.64	1.83	0.14	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.16	0.18	0.16	0.18	0.01	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.11	0.11	0.11	0.11	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.11	0.11	0.11	0.11	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.06	0.07	0.06	0.07	0.01	XXX
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.52	0.56	0.06	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.09	1.65	NA	NA	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.86	1.41	NA	NA	0.01	000
91000	26	A	Esophageal intubation	0.73	0.23	0.24	0.23	0.24	0.03	000
91010		A	Esophagus motility study	1.25	3.53	3.76	NA	NA	0.12	000
91010	TC	A	Esophagus motility study	0.00	2.96	3.22	NA	NA	0.06	000
91010	26	A	Esophagus motility study	1.25	0.57	0.54	0.57	0.54	0.06	000
91011		A	Esophagus motility study	1.50	5.22	5.23	NA	NA	0.13	000
91011	TC	A	Esophagus motility study	0.00	4.46	4.53	NA	NA	0.06	000
91011	26	A	Esophagus motility study	1.50	0.76	0.70	0.76	0.70	0.07	000
91012		A	Esophagus motility study	1.46	5.24	5.38	NA	NA	0.13	000
91012	TC	A	Esophagus motility study	0.00	4.53	4.72	NA	NA	0.07	000
91012	26	A	Esophagus motility study	1.46	0.71	0.66	0.71	0.66	0.06	000
91020		A	Gastric motility studies	1.44	4.69	4.66	NA	NA	0.13	000
91020	TC	A	Gastric motility studies	0.00	4.04	4.05	NA	NA	0.06	000
91020	26	A	Gastric motility studies	1.44	0.65	0.61	0.65	0.61	0.07	000
91022		A	Duodenal motility study	1.44	3.26	3.56	NA	NA	0.13	000
91022	TC	A	Duodenal motility study	0.00	2.54	2.89	NA	NA	0.06	000
91022	26	A	Duodenal motility study	1.44	0.72	0.67	0.72	0.67	0.07	000
91030		A	Acid perfusion of esophagus	0.91	2.87	2.76	NA	NA	0.06	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.41	2.34	NA	NA	0.02	000
91030	26	A	Acid perfusion of esophagus	0.91	0.46	0.42	0.46	0.42	0.04	000
91034		A	Gastroesophageal reflux test	0.97	3.95	4.29	NA	NA	0.12	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.52	3.88	NA	NA	0.06	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
91034	26	A	Gastroesophageal reflux test	0.97	0.43	0.41	0.43	0.41	0.06	000
91035		A	G-esoph reflx tst w/electrod	1.59	10.93	10.92	NA	NA	0.12	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.19	10.23	NA	NA	0.06	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.74	0.69	0.74	0.69	0.06	000
91037		A	Esoph imped function test	0.97	3.32	3.23	NA	NA	0.12	000
91037	TC	A	Esoph imped function test	0.00	2.86	2.80	NA	NA	0.06	000
91037	26	A	Esoph imped function test	0.97	0.46	0.43	0.46	0.43	0.06	000
91038		A	Esoph imped funct test > 1h	1.10	2.70	2.59	NA	NA	0.12	000
91038	TC	A	Esoph imped funct test > 1h	0.00	2.18	2.10	NA	NA	0.06	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.52	0.49	0.52	0.49	0.06	000
91040		A	Esoph balloon distension tst	0.97	8.45	9.14	NA	NA	0.12	000
91040	TC	A	Esoph balloon distension tst	0.00	7.94	8.67	NA	NA	0.06	000
91040	26	A	Esoph balloon distension tst	0.97	0.51	0.47	0.51	0.47	0.06	000
91052		A	Gastric analysis test	0.79	2.49	2.48	NA	NA	0.05	000
91052	TC	A	Gastric analysis test	0.00	2.18	2.18	NA	NA	0.02	000
91052	26	A	Gastric analysis test	0.79	0.31	0.30	0.31	0.30	0.03	000
91055		A	Gastric intubation for smear	0.94	2.46	2.58	NA	NA	0.07	000
91055	TC	A	Gastric intubation for smear	0.00	2.16	2.29	NA	NA	0.02	000
91055	26	A	Gastric intubation for smear	0.94	0.30	0.29	0.30	0.29	0.05	000
91065		A	Breath hydrogen test	0.20	1.56	1.54	NA	NA	0.03	000
91065	TC	A	Breath hydrogen test	0.00	1.48	1.46	NA	NA	0.02	000
91065	26	A	Breath hydrogen test	0.20	0.08	0.08	0.08	0.08	0.01	000
91105		A	Gastric intubation treatment	0.37	1.61	1.74	0.07	0.07	0.03	000
91110		A	Gi tract capsule endoscopy	3.64	19.87	20.50	NA	NA	0.16	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	18.13	18.87	NA	NA	0.07	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.74	1.63	1.74	1.63	0.09	XXX
91111		A	Esophageal capsule endoscopy	1.00	17.92	17.92	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	17.45	17.45	NA	NA	0.02	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.47	0.47	0.47	0.47	0.03	XXX
91120		A	Rectal sensation test	0.97	8.84	9.40	NA	NA	0.11	XXX
91120	TC	A	Rectal sensation test	0.00	8.53	9.08	NA	NA	0.04	XXX
91120	26	A	Rectal sensation test	0.97	0.31	0.32	0.31	0.32	0.07	XXX
91122		A	Anal pressure record	1.77	4.03	4.31	NA	NA	0.21	000
91122	TC	A	Anal pressure record	0.00	3.41	3.69	NA	NA	0.08	000
91122	26	A	Anal pressure record	1.77	0.62	0.62	0.62	0.62	0.13	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.26	0.24	0.26	0.24	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.33	0.31	0.33	0.31	0.03	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	0.96	0.96	0.28	0.30	0.02	XXX
92004		A	Eye exam, new patient	1.82	1.62	1.64	0.61	0.63	0.04	XXX
92012		A	Eye exam established pat	0.92	1.01	1.02	0.34	0.33	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92014		A	Eye exam & treatment	1.42	1.41	1.41	0.51	0.50	0.03	XXX
92015		N	Refraction	0.38	0.14	0.48	0.13	0.13	0.01	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	0.94	0.97	0.07	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.37	0.42	0.03	XXX
92020		A	Special eye evaluation	0.37	0.26	0.28	0.14	0.14	0.01	XXX
92025		A	Corneal topography	0.35	0.49	0.49	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.36	0.36	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.13	0.13	0.13	0.13	0.01	XXX
92060		A	Special eye evaluation	0.69	0.78	0.77	NA	NA	0.03	XXX
92060	TC	A	Special eye evaluation	0.00	0.53	0.51	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.25	0.26	0.25	0.26	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.86	0.78	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.76	0.67	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.10	0.11	0.10	0.11	0.01	XXX
92070		A	Fitting of contact lens	0.70	0.91	0.95	0.24	0.26	0.02	XXX
92081		A	Visual field examination(s)	0.36	0.95	0.95	NA	NA	0.02	XXX
92081	TC	A	Visual field examination(s)	0.00	0.83	0.82	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.12	0.13	0.12	0.13	0.01	XXX
92082		A	Visual field examination(s)	0.44	1.31	1.30	NA	NA	0.02	XXX
92082	TC	A	Visual field examination(s)	0.00	1.16	1.14	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.15	0.16	0.15	0.16	0.01	XXX
92083		A	Visual field examination(s)	0.50	1.51	1.49	NA	NA	0.02	XXX
92083	TC	A	Visual field examination(s)	0.00	1.33	1.30	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.18	0.19	0.18	0.19	0.01	XXX
92100		A	Serial tonometry exam(s)	0.92	1.27	1.29	0.31	0.32	0.02	XXX
92120		A	Tonography & eye evaluation	0.81	0.99	1.01	0.27	0.29	0.02	XXX
92130		A	Water provocation tonography	0.81	1.17	1.20	0.29	0.31	0.02	XXX
92135		A	Ophth dx imaging post seg	0.35	0.79	0.80	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.66	0.66	NA	NA	0.01	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.13	0.14	0.13	0.14	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.42	1.48	NA	NA	0.08	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.21	1.26	NA	NA	0.07	XXX
92136	26	A	Ophthalmic biometry	0.54	0.21	0.22	0.21	0.22	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	0.90	0.93	0.16	0.17	0.01	XXX
92225		A	Special eye exam, initial	0.38	0.25	0.24	0.14	0.14	0.01	XXX
92226		A	Special eye exam, subsequent	0.33	0.24	0.23	0.13	0.13	0.01	XXX
92230		A	Eye exam with photos	0.60	0.69	0.90	0.21	0.21	0.02	XXX
92235		A	Eye exam with photos	0.81	2.26	2.35	NA	NA	0.08	XXX
92235	TC	A	Eye exam with photos	0.00	1.94	2.02	NA	NA	0.06	XXX
92235	26	A	Eye exam with photos	0.81	0.32	0.33	0.32	0.33	0.02	XXX
92240		A	Icg angiography	1.10	4.35	4.81	NA	NA	0.09	XXX
92240	TC	A	Icg angiography	0.00	3.92	4.36	NA	NA	0.06	XXX
92240	26	A	Icg angiography	1.10	0.43	0.45	0.43	0.45	0.03	XXX
92250		A	Eye exam with photos	0.44	1.29	1.35	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.14	1.19	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.15	0.16	0.15	0.16	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.23	0.24	0.07	0.08	0.01	XXX
92265		A	Eye muscle evaluation	0.81	0.96	1.10	NA	NA	0.06	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92265	TC	A	Eye muscle evaluation	0.00	0.72	0.85	NA	NA	0.02	XXX
92265	26	A	Eye muscle evaluation	0.81	0.24	0.25	0.24	0.25	0.04	XXX
92270		A	Electro-oculography	0.81	1.37	1.40	NA	NA	0.05	XXX
92270	TC	A	Electro-oculography	0.00	1.11	1.13	NA	NA	0.02	XXX
92270	26	A	Electro-oculography	0.81	0.26	0.27	0.26	0.27	0.03	XXX
92275		A	Electroretinography	1.01	2.43	2.31	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.05	1.91	NA	NA	0.02	XXX
92275	26	A	Electroretinography	1.01	0.38	0.40	0.38	0.40	0.03	XXX
92283		A	Color vision examination	0.17	1.00	0.96	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	0.94	0.90	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.06	0.06	0.06	0.06	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.08	1.28	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.01	1.21	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.07	0.07	0.07	0.07	0.01	XXX
92285		A	Eye photography	0.20	0.78	0.84	NA	NA	0.02	XXX
92285	TC	A	Eye photography	0.00	0.71	0.76	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.07	0.08	0.07	0.08	0.01	XXX
92286		A	Internal eye photography	0.66	2.07	2.32	NA	NA	0.04	XXX
92286	TC	A	Internal eye photography	0.00	1.83	2.07	NA	NA	0.02	XXX
92286	26	A	Internal eye photography	0.66	0.24	0.25	0.24	0.25	0.02	XXX
92287		A	Internal eye photography	0.81	1.91	2.03	0.30	0.31	0.02	XXX
92310		N	Contact lens fitting	1.17	1.26	1.23	0.39	0.41	0.04	XXX
92311		A	Contact lens fitting	1.08	1.30	1.25	0.34	0.34	0.03	XXX
92312		A	Contact lens fitting	1.26	1.49	1.39	0.38	0.41	0.03	XXX
92313		A	Contact lens fitting	0.92	1.42	1.33	0.33	0.32	0.02	XXX
92314		N	Prescription of contact lens	0.69	1.30	1.21	0.23	0.24	0.01	XXX
92315		A	Prescription of contact lens	0.45	1.28	1.18	0.14	0.14	0.01	XXX
92316		A	Prescription of contact lens	0.68	1.62	1.44	0.24	0.25	0.02	XXX
92317		A	Prescription of contact lens	0.45	1.33	1.23	0.13	0.13	0.01	XXX
92325		A	Modification of contact lens	0.00	0.82	0.72	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.72	0.95	NA	NA	0.06	XXX
92340		N	Fitting of spectacles	0.37	0.51	0.56	0.12	0.13	0.01	XXX
92341		N	Fitting of spectacles	0.47	0.55	0.60	0.16	0.16	0.01	XXX
92342		N	Fitting of spectacles	0.53	0.57	0.62	0.18	0.19	0.01	XXX
92352		B	Special spectacles fitting	0.37	0.65	0.66	0.12	0.13	0.01	XXX
92353		B	Special spectacles fitting	0.50	0.69	0.70	0.17	0.17	0.02	XXX
92354		B	Special spectacles fitting	0.00	0.32	2.46	NA	NA	0.10	XXX
92355		B	Special spectacles fitting	0.00	0.50	1.46	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.26	0.44	NA	NA	0.05	XXX
92370		N	Repair & adjust spectacles	0.32	0.45	0.48	0.11	0.11	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.27	0.36	NA	NA	0.02	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	0.93	0.97	0.05	000
92504		A	Ear microscopy examination	0.18	0.59	0.57	0.06	0.07	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.38	3.19	0.29	0.32	0.03	XXX
92507		A	Speech/hearing therapy	0.52	1.17	1.16	0.16	0.18	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92508		A	Speech/hearing therapy	0.26	0.55	0.54	0.09	0.10	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.07	3.14	0.68	0.70	0.03	000
92512		A	Nasal function studies	0.55	0.98	1.02	0.19	0.19	0.02	XXX
92516		A	Facial nerve function test	0.43	1.20	1.20	0.15	0.17	0.01	XXX
92520		A	Laryngeal function studies	0.75	0.95	0.84	0.25	0.29	0.03	XXX
92526		A	Oral function therapy	0.55	1.58	1.60	0.17	0.18	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.18	1.14	NA	NA	0.04	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	1.05	1.00	NA	NA	0.02	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.13	0.14	0.13	0.14	0.02	XXX
92542		A	Positional nystagmus test	0.33	1.33	1.28	NA	NA	0.03	XXX
92542	TC	A	Positional nystagmus test	0.00	1.22	1.16	NA	NA	0.02	XXX
92542	26	A	Positional nystagmus test	0.33	0.11	0.12	0.11	0.12	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.66	0.64	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.63	0.60	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.03	0.04	0.03	0.04	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	1.07	1.03	NA	NA	0.03	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.99	0.94	NA	NA	0.02	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.08	0.09	0.08	0.09	0.01	XXX
92545		A	Oscillating tracking test	0.23	1.04	0.98	NA	NA	0.03	XXX
92545	TC	A	Oscillating tracking test	0.00	0.97	0.90	NA	NA	0.02	XXX
92545	26	A	Oscillating tracking test	0.23	0.07	0.08	0.07	0.08	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	1.86	1.90	NA	NA	0.03	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.77	1.80	NA	NA	0.02	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.09	0.10	0.09	0.10	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.11	0.10	0.11	0.10	0.06	ZZZ
92548		A	Posturography	0.50	1.77	1.90	NA	NA	0.15	XXX
92548	TC	A	Posturography	0.00	1.62	1.72	NA	NA	0.13	XXX
92548	26	A	Posturography	0.50	0.15	0.18	0.15	0.18	0.02	XXX
92551		N	Pure tone hearing test, air	0.00	0.28	0.28	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.59	0.55	NA	NA	0.04	XXX
92553		A	Audiometry, air & bone	0.00	0.75	0.73	NA	NA	0.06	XXX
92555		A	Speech threshold audiometry	0.00	0.40	0.40	NA	NA	0.04	XXX
92556		A	Speech audiometry, complete	0.00	0.63	0.62	NA	NA	0.06	XXX
92557		A	Comprehensive hearing test	0.60	0.31	0.53	0.21	0.46	0.12	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.70	0.71	NA	NA	0.06	XXX
92562		A	Loudness balance test	0.00	0.64	0.58	NA	NA	0.04	XXX
92563		A	Tone decay hearing test	0.00	0.56	0.52	NA	NA	0.04	XXX
92564		A	Sisi hearing test	0.00	0.49	0.49	NA	NA	0.05	XXX
92565		A	Stenger test, pure tone	0.00	0.28	0.31	NA	NA	0.04	XXX
92567		A	Tympanometry	0.20	0.13	0.23	0.07	0.18	0.06	XXX
92568		A	Acoustic refl threshold tst	0.29	0.10	0.17	0.10	0.17	0.04	XXX
92569		A	Acoustic reflex decay test	0.20	0.07	0.16	0.07	0.16	0.04	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92571		A	Filtered speech hearing test	0.00	0.42	0.41	NA	NA	0.04	XXX
92572		A	Staggered spondaic word test	0.00	0.58	0.46	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.14	0.93	NA	NA	0.02	XXX
92576		A	Synthetic sentence test	0.00	0.56	0.53	NA	NA	0.05	XXX
92577		A	Stenger test, speech	0.00	0.30	0.41	NA	NA	0.07	XXX
92579		A	Visual audiometry (vra)	0.70	0.36	0.45	0.25	0.37	0.06	XXX
92582		A	Conditioning play audiometry	0.00	1.16	1.06	NA	NA	0.06	XXX
92583		A	Select picture audiometry	0.00	0.81	0.83	NA	NA	0.08	XXX
92584		A	Electrocochleography	0.00	1.38	1.65	NA	NA	0.21	XXX
92585		A	Auditor evoke potent, compre	0.50	2.08	2.09	NA	NA	0.17	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.92	1.91	NA	NA	0.14	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.16	0.18	0.16	0.18	0.03	XXX
92586		A	Auditor evoke potent, limit	0.00	1.48	1.57	NA	NA	0.14	XXX
92587		A	Evoked auditory test	0.13	0.63	0.82	NA	NA	0.12	XXX
92587	TC	A	Evoked auditory test	0.00	0.59	0.77	NA	NA	0.11	XXX
92587	26	A	Evoked auditory test	0.13	0.04	0.05	0.04	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.11	1.24	NA	NA	0.14	XXX
92588	TC	A	Evoked auditory test	0.00	0.99	1.11	NA	NA	0.13	XXX
92588	26	A	Evoked auditory test	0.36	0.12	0.13	0.12	0.13	0.01	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	0.98	0.89	NA	NA	0.06	XXX
92597		A	Oral speech device eval	0.86	1.96	1.89	0.30	0.34	0.03	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.28	1.84	0.80	1.48	0.07	XXX
92602		A	Reprogram cochlear implt < 7	1.30	0.90	1.27	0.46	0.94	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.24	1.47	0.80	1.14	0.07	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.80	0.94	0.44	0.67	0.07	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.45	4.12	NA	NA	0.05	XXX
92608		A	Ex for speech device rx addl	0.00	0.83	0.76	NA	NA	0.05	XXX
92609		A	Use of speech device service	0.00	2.37	2.18	NA	NA	0.04	XXX
92610		A	Evaluate swallowing function	0.00	1.63	2.08	NA	NA	0.08	XXX
92611		A	Motion fluoroscopy/swallow	0.00	1.88	2.27	NA	NA	0.08	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.93	2.89	0.45	0.50	0.04	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.25	0.29	0.25	0.29	0.05	XXX
92614		A	Laryngoscopic sensory test	1.27	2.40	2.43	0.45	0.50	0.04	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.22	0.26	0.22	0.26	0.05	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.13	3.20	0.64	0.73	0.06	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.27	0.31	0.27	0.31	0.05	XXX
92620		A	Auditory function, 60 min	1.50	0.74	0.844	0.74	0.84	0.04	XXX
92621		A	Auditory function, + 15 min	0.35	0.18	0.19	0.18	0.19	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.54	0.69	0.54	0.69	0.03	XXX
92626		A	Eval aud rehab status	1.40	0.73	1.10	0.73	1.10	0.04	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92627		A	Eval aud status rehab add-on	0.33	0.19	0.28	0.19	0.28	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	0.94	0.94	0.94	0.94	0.05	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	3.14	3.42	0.79	0.84	0.28	000
92953		A	Temporary external pacing	0.23	NA	NA	0.08	0.08	0.02	000
92960		A	Cardioversion electric, ext	2.25	4.21	4.75	1.45	1.38	0.07	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	2.49	2.39	0.29	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.48	1.37	0.16	000
92971		A	Cardioassist, external	1.77	NA	NA	1.10	1.04	0.06	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.77	1.65	0.23	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.63	1.52	0.21	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	3.84	3.59	0.50	000
92977		A	Dissolve clot, heart vessel	0.00	1.65	3.26	NA	NA	0.46	XXX
92978		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.97	0.90	0.97	0.90	0.06	ZZZ
92979		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.78	0.73	0.78	0.73	0.06	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	8.18	7.66	1.03	000
92981		A	Insert intracoronary stent	4.16	NA	NA	2.24	2.09	0.29	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	6.08	5.71	0.76	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.60	1.49	0.21	ZZZ
92986		A	Revision of aortic valve	22.70	NA	NA	15.17	14.36	1.51	090
92987		A	Revision of mitral valve	23.48	NA	NA	15.70	14.86	1.59	090
92990		A	Revision of pulmonary valve	18.12	NA	NA	11.90	11.40	1.20	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	6.72	6.30	0.84	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.75	1.64	0.10	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	5.38	5.25	0.40	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	2.98	2.79	0.28	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.33	0.38	NA	NA	0.03	XXX
93005		A	Electrocardiogram, tracing	0.00	0.26	0.31	NA	NA	0.02	XXX
93010		A	Electrocardiogram report	0.17	0.07	0.07	0.07	0.07	0.01	XXX
93012		A	Transmission of ecg	0.00	4.47	4.87	NA	NA	0.18	XXX
93014		A	Report on transmitted ecg	0.52	0.24	0.23	0.24	0.23	0.02	XXX
93015		A	Cardiovascular stress test	0.75	1.87	1.89	NA	NA	0.14	XXX
93016		A	Cardiovascular stress test	0.45	0.23	0.21	0.23	0.21	0.02	XXX
93017		A	Cardiovascular stress test	0.00	1.49	1.54	NA	NA	0.11	XXX
93018		A	Cardiovascular stress test	0.30	0.15	0.14	0.15	0.14	0.01	XXX
93024		A	Cardiac drug stress test	1.17	2.26	2.09	NA	NA	0.12	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.69	1.55	NA	NA	0.08	XXX
93024	26	A	Cardiac drug stress test	1.17	0.57	0.54	0.57	0.54	0.04	XXX
93025		A	Microvolt t-wave assess	0.75	4.15	5.02	NA	NA	0.14	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.77	4.66	NA	NA	0.11	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93025	26	A	Microvolt t-wave assess	0.75	0.38	0.36	0.38	0.36	0.03	XXX
93040		A	Rhythm ECG with report	0.16	0.18	0.19	NA	NA	0.02	XXX
93041		A	Rhythm ECG, tracing	0.00	0.13	0.14	NA	NA	0.01	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.05	0.05	0.05	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	2.19	2.55	NA	NA	0.24	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.80	0.91	NA	NA	0.08	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	1.12	1.39	NA	NA	0.14	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.27	0.25	0.27	0.25	0.02	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.17	0.17	0.17	0.17	0.02	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	2.17	2.61	NA	NA	0.26	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.67	0.89	NA	NA	0.11	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.27	1.50	NA	NA	0.13	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.23	0.22	0.23	0.22	0.02	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.23	0.21	0.23	0.21	0.02	XXX
93268		A	ECG record/review	0.52	6.24	6.56	NA	NA	0.28	XXX
93270		A	ECG recording	0.00	0.28	0.52	NA	NA	0.08	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.74	5.82	NA	NA	0.18	XXX
93272		A	Ecg/review, interpret only	0.52	0.22	0.22	0.22	0.22	0.02	XXX
93278		A	ECG/signal-averaged	0.25	0.59	0.76	NA	NA	0.12	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.49	0.66	NA	NA	0.11	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.10	0.10	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.88	0.84	NA	NA	0.06	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.54	0.51	NA	NA	0.04	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.34	0.33	0.34	0.33	0.02	XXX
93280		A	Pm device progr eval, dual	0.77	1.01	1.01	NA	NA	0.05	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.60	0.60	NA	NA	0.03	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.41	0.41	0.41	0.41	0.02	XXX
93281		A	Pm device progr eval, multi	0.90	1.18	1.18	NA	NA	0.06	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.70	0.70	NA	NA	0.04	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.48	0.48	0.48	0.48	0.02	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	1.07	1.06	NA	NA	0.07	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.62	0.63	NA	NA	0.04	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.45	0.43	0.45	0.43	0.03	XXX
93283		A	Icd device progr eval, dual	1.05	1.28	1.28	NA	NA	0.08	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.72	0.72	NA	NA	0.04	XXX
93283	26	A	Icd device progr eval, dual	1.05	0.56	0.56	0.56	0.56	0.04	XXX
93284		A	Icd device progr eval, mult	1.25	1.49	1.49	NA	NA	0.08	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.82	0.82	NA	NA	0.04	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.67	0.67	0.67	0.67	0.04	XXX
93285		A	Ilr device eval progr	0.52	0.76	0.76	NA	NA	0.06	XXX
93285	TC	A	Ilr device eval progr	0.00	0.48	0.48	NA	NA	0.04	XXX
93285	26	A	Ilr device eval progr	0.52	0.28	0.28	0.28	0.28	0.02	XXX
93286		A	Pre-op pm device eval	0.30	0.42	0.42	NA	NA	0.04	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.32	0.32	NA	NA	0.02	XXX
93286	26	A	Pre-op pm device eval	0.30	0.10	0.10	0.10	0.10	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93287		A	Pre-op icd device eval	0.45	0.50	0.50	NA	NA	0.05	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.35	0.35	NA	NA	0.04	XXX
93287	26	A	Pre-op icd device eval	0.45	0.15	0.15	0.15	0.15	0.01	XXX
93288		A	Pm device eval in person	0.43	0.72	0.72	NA	NA	0.05	XXX
93288	TC	A	Pm device eval in person	0.00	0.49	0.49	NA	NA	0.04	XXX
93288	26	A	Pm device eval in person	0.43	0.23	0.23	0.23	0.23	0.01	XXX
93289		A	Icd device interrogate	0.78	1.01	1.01	NA	NA	0.05	XXX
93289	TC	A	Icd device interrogate	0.00	0.60	0.60	NA	NA	0.03	XXX
93289	26	A	Icd device interrogate	0.78	0.41	0.41	0.41	0.41	0.02	XXX
93290		A	Icm device eval	0.43	0.40	0.40	NA	NA	0.06	XXX
93290	TC	A	Icm device eval	0.00	0.26	0.26	NA	NA	0.04	XXX
93290	26	A	Icm device eval	0.43	0.14	0.14	0.14	0.14	0.02	XXX
93291		A	Ilr device interrogate	0.43	0.67	0.67	NA	NA	0.05	XXX
93291	TC	A	Ilr device interrogate	0.00	0.44	0.44	NA	NA	0.03	XXX
93291	26	A	Ilr device interrogate	0.43	0.23	0.23	0.23	0.23	0.02	XXX
93292		A	Wcd device interrogate	0.43	0.56	0.56	NA	NA	0.05	XXX
93292	TC	A	Wcd device interrogate	0.00	0.33	0.33	NA	NA	0.04	XXX
93292	26	A	Wcd device interrogate	0.43	0.23	0.23	0.23	0.23	0.01	XXX
93293		A	Pm phone r-strip device eval	0.32	1.34	1.21	NA	NA	0.13	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	1.19	1.08	NA	NA	0.11	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.15	0.13	0.15	0.13	0.02	XXX
93294		A	Pm device interrogate remote	0.65	0.34	0.34	0.34	0.34	0.03	XXX
93295		A	Icd device interrogat remote	1.17	0.63	0.63	0.63	0.63	0.04	XXX
93296		A	Pm/icd remote tech serv	0.00	1.00	1.00	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.17	0.17	0.17	0.17	0.02	XXX
93298		A	Ilr device interrogat remote	0.52	0.28	0.28	0.28	0.28	0.02	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	4.51	4.48	NA	NA	0.27	XXX
93303	TC	A	Echo transthoracic	0.00	3.91	3.91	NA	NA	0.23	XXX
93303	26	A	Echo transthoracic	1.30	0.60	0.57	0.60	0.57	0.04	XXX
93304		A	Echo transthoracic	0.75	3.03	2.84	NA	NA	0.15	XXX
93304	TC	A	Echo transthoracic	0.00	2.71	2.53	NA	NA	0.13	XXX
93304	26	A	Echo transthoracic	0.75	0.32	0.31	0.32	0.31	0.02	XXX
93306		A	Tte w/doppler, complete	1.30	5.75	5.75	NA	NA	0.37	XXX
93306	TC	A	Tte w/doppler, complete	0.00	5.10	5.10	NA	NA	0.33	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.65	0.65	0.65	0.65	0.04	XXX
93307		A	Tte w/o doppler, complete	0.92	3.56	3.73	NA	NA	0.26	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	3.10	3.30	NA	NA	0.23	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.46	0.43	0.46	0.43	0.03	XXX
93308		A	Tte, f-up or lmtd	0.53	2.49	2.42	NA	NA	0.15	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	2.22	2.16	NA	NA	0.13	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.27	0.26	0.27	0.26	0.02	XXX
93312		A	Echo transesophageal	2.20	7.06	6.46	NA	NA	0.37	XXX
93312	TC	A	Echo transesophageal	0.00	6.08	5.52	NA	NA	0.29	XXX
93312	26	A	Echo transesophageal	2.20	0.98	0.94	0.98	0.94	0.08	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.12	0.14	0.06	XXX
93314		A	Echo transesophageal	1.25	6.81	6.19	NA	NA	0.33	XXX
93314	TC	A	Echo transesophageal	0.00	6.26	5.66	NA	NA	0.29	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93314	26	A	Echo transesophageal	1.25	0.55	0.53	0.55	0.53	0.04	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.33	1.25	1.33	1.25	0.09	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.26	0.26	0.05	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.64	0.65	0.64	0.65	0.08	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.89	0.79	0.89	0.79	0.14	XXX
93320		A	Doppler echo exam, heart	0.38	1.59	1.66	NA	NA	0.13	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.40	1.48	NA	NA	0.12	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.19	0.18	0.19	0.18	0.01	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.59	0.73	NA	NA	0.09	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.51	0.66	NA	NA	0.08	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.08	0.07	0.08	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.64	1.21	NA	NA	0.22	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.60	1.18	NA	NA	0.21	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.04	0.03	0.04	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	4.84	4.22	NA	NA	0.18	XXX
93350	TC	A	Stress tte only	0.00	4.08	3.51	NA	NA	0.13	XXX
93350	26	A	Stress tte only	1.46	0.76	0.71	0.76	0.71	0.05	XXX
93351		A	Stress tte complete	1.75	5.60	5.60	NA	NA	0.33	XXX
93352		A	Admin ecg contrast agent	0.19	0.84	0.84	NA	NA	0.04	XXX
93501		A	Right heart catheterization	3.02	17.93	18.00	NA	NA	1.27	000
93501	TC	A	Right heart catheterization	0.00	16.34	16.52	NA	NA	1.06	000
93501	26	A	Right heart catheterization	3.02	1.59	1.48	1.59	1.48	0.21	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.00	0.00	0.20	000
93505		A	Biopsy of heart lining	4.37	19.90	15.87	NA	NA	0.46	000
93505	TC	A	Biopsy of heart lining	0.00	17.61	13.73	NA	NA	0.16	000
93505	26	A	Biopsy of heart lining	4.37	2.29	2.14	2.29	2.14	0.30	000
93508		A	Cath placement, angiography	4.09	27.54	24.39	NA	NA	0.93	000
93508	TC	A	Cath placement, angiography	0.00	25.35	22.22	NA	NA	0.65	000
93508	26	A	Cath placement, angiography	4.09	2.19	2.17	2.19	2.17	0.28	000
93510		A	Left heart catheterization	4.32	26.93	30.05	NA	NA	2.61	000
93510	TC	A	Left heart catheterization	0.00	24.62	27.77	NA	NA	2.31	000
93510	26	A	Left heart catheterization	4.32	2.31	2.28	2.31	2.28	0.30	000
93511		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	2.68	2.63	2.68	2.63	0.35	000
93514		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	3.58	3.48	3.58	3.48	0.49	000
93524		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	3.75	3.61	3.75	3.61	0.48	000
93526		A	Rt & Lt heart catheters	5.98	33.59	38.02	NA	NA	3.46	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93526	TC	A	Rt & Lt heart catheters	0.00	30.40	34.91	NA	NA	3.04	000
93526	26	A	Rt & Lt heart catheters	5.98	3.19	3.11	3.19	3.11	0.42	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	26	A	Rt & Lt heart catheters	7.27	3.87	3.74	3.87	3.74	0.51	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	4.07	4.07	4.07	4.07	0.62	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	2.57	2.51	2.57	2.51	0.33	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	26	A	Rt heart cath, congenital	4.22	2.00	1.99	2.00	1.99	0.29	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	3.88	3.81	3.88	3.81	0.58	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	4.44	4.41	4.44	4.41	0.69	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	3.06	3.00	3.06	3.00	0.47	000
93539		A	Injection, cardiac cath	0.40	2.35	1.81	0.22	0.20	0.01	000
93540		A	Injection, cardiac cath	0.43	8.17	6.18	0.23	0.22	0.01	000
93541		A	Injection for lung angiogram	0.29	0.15	0.14	0.15	0.14	0.01	000
93542		A	Injection for heart x-rays	0.29	4.92	3.72	0.15	0.14	0.01	000
93543		A	Injection for heart x-rays	0.29	2.49	1.90	0.16	0.14	0.01	000
93544		A	Injection for aortography	0.25	1.75	1.34	0.13	0.13	0.01	000
93545		A	Inject for coronary x-rays	0.40	5.57	4.22	0.21	0.20	0.01	000
93555		A	Imaging, cardiac cath	0.81	0.59	2.09	NA	NA	0.37	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.16	1.69	NA	NA	0.34	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.43	0.40	0.43	0.40	0.03	XXX
93556		A	Imaging, cardiac cath	0.83	0.85	3.20	NA	NA	0.54	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.41	2.79	NA	NA	0.51	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.44	0.41	0.44	0.41	0.03	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.13	0.14	0.13	0.14	0.02	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.03	0.04	0.03	0.04	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.96	0.89	0.96	0.89	0.06	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.73	0.68	0.73	0.68	0.04	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93580		A	Transcath closure of asd	17.97	NA	NA	9.55	9.03	1.25	000
93581		A	Transcath closure of vsd	24.39	NA	NA	11.36	10.89	1.72	000
93600		C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	26	A	Bundle of His recording	2.12	1.10	1.03	1.10	1.03	0.16	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	1.07	1.01	1.07	1.01	0.17	000
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	1.07	1.01	1.07	1.01	0.18	000
93609		C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	2.63	2.46	2.63	2.46	0.35	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.51	1.43	1.51	1.43	0.24	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	1.48	1.40	1.48	1.40	0.25	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	3.71	3.48	0.49	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.53	0.47	0.53	0.47	0.03	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.33	0.35	0.33	0.35	0.09	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	2.31	2.15	2.31	2.15	0.30	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	3.92	3.75	3.92	3.75	0.51	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	6.11	5.81	6.11	5.81	0.80	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	1.11	1.04	1.11	1.04	0.15	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.58	1.49	1.58	1.49	0.22	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.51	1.41	1.51	1.41	0.20	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	2.55	2.47	2.55	2.47	0.33	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93631		C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.75	2.76	2.75	2.76	0.97	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.84	1.72	1.84	1.72	0.24	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	3.13	2.93	3.13	2.93	0.41	000
93642		A	Electrophysiology evaluation	4.88	7.06	7.66	NA	NA	0.57	000
93642	TC	A	Electrophysiology evaluation	0.00	4.46	5.15	NA	NA	0.42	000
93642	26	A	Electrophysiology evaluation	4.88	2.60	2.51	2.60	2.51	0.15	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	5.80	5.47	0.73	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	8.58	8.03	1.13	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	9.35	8.75	1.23	000
93660		A	Tilt table evaluation	1.89	2.90	2.78	NA	NA	0.08	000
93660	TC	A	Tilt table evaluation	0.00	1.91	1.85	NA	NA	0.02	000
93660	26	A	Tilt table evaluation	1.89	0.99	0.93	0.99	0.93	0.06	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.47	1.38	1.47	1.38	0.09	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.46	0.46	NA	NA	0.01	XXX
93701		A	Bioimpedance, thoracic	0.17	0.67	0.75	NA	NA	0.02	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.61	0.68	NA	NA	0.01	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.06	0.07	0.06	0.07	0.01	XXX
93720		A	Total body plethysmography	0.17	1.13	1.04	NA	NA	0.07	XXX
93721		A	Plethysmography tracing	0.00	1.09	0.99	NA	NA	0.06	XXX
93722		A	Plethysmography report	0.17	0.04	0.05	0.04	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	3.38	4.01	NA	NA	0.39	000
93724	TC	A	Analyze pacemaker system	0.00	0.85	1.63	NA	NA	0.24	000
93724	26	A	Analyze pacemaker system	4.88	2.53	2.38	2.53	2.38	0.15	000
93740		B	Temperature gradient studies	0.16	0.05	0.09	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	0.00	0.04	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.05	0.05	0.05	0.05	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	0.16	0.05	0.06	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	0.00	0.01	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.05	0.05	0.05	0.05	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	1.36	1.40	NA	NA	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.78	0.81	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.43	0.45	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.15	0.14	0.15	0.14	0.01	XXX
93797		A	Cardiac rehab	0.18	0.31	0.31	0.09	0.08	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.42	0.43	0.13	0.13	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.50	2.47	NA	NA	0.12	XXX
93875	TC	A	Extracranial study	0.00	2.43	2.39	NA	NA	0.11	XXX
93875	26	A	Extracranial study	0.22	0.07	0.08	0.07	0.08	0.01	XXX
93880		A	Extracranial study	0.60	5.99	5.90	NA	NA	0.39	XXX
93880	TC	A	Extracranial study	0.00	5.77	5.68	NA	NA	0.35	XXX
93880	26	A	Extracranial study	0.60	0.22	0.22	0.22	0.22	0.04	XXX
93882		A	Extracranial study	0.40	3.99	3.88	NA	NA	0.26	XXX
93882	TC	A	Extracranial study	0.00	3.87	3.75	NA	NA	0.22	XXX
93882	26	A	Extracranial study	0.40	0.12	0.13	0.12	0.13	0.04	XXX
93886		A	Intracranial study	0.94	6.90	6.87	NA	NA	0.45	XXX
93886	TC	A	Intracranial study	0.00	6.61	6.56	NA	NA	0.39	XXX
93886	26	A	Intracranial study	0.94	0.29	0.31	0.29	0.31	0.06	XXX
93888		A	Intracranial study	0.62	4.82	4.69	NA	NA	0.32	XXX
93888	TC	A	Intracranial study	0.00	4.61	4.47	NA	NA	0.27	XXX
93888	26	A	Intracranial study	0.62	0.21	0.22	0.21	0.22	0.05	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.09	5.81	NA	NA	0.45	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	5.79	5.48	NA	NA	0.39	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.30	0.33	0.30	0.33	0.06	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	6.72	6.35	NA	NA	0.45	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	6.39	5.98	NA	NA	0.39	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.33	0.37	0.33	0.37	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	6.74	6.33	NA	NA	0.45	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	6.39	5.95	NA	NA	0.39	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.35	0.38	0.35	0.38	0.06	XXX
93922		A	Extremity study	0.25	3.01	2.94	NA	NA	0.15	XXX
93922	TC	A	Extremity study	0.00	2.93	2.86	NA	NA	0.13	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.08	0.08	0.02	XXX
93923		A	Extremity study	0.45	4.58	4.45	NA	NA	0.26	XXX
93923	TC	A	Extremity study	0.00	4.43	4.30	NA	NA	0.22	XXX
93923	26	A	Extremity study	0.45	0.15	0.15	0.15	0.15	0.04	XXX
93924		A	Extremity study	0.50	5.78	5.55	NA	NA	0.30	XXX
93924	TC	A	Extremity study	0.00	5.60	5.37	NA	NA	0.25	XXX
93924	26	A	Extremity study	0.50	0.18	0.18	0.18	0.18	0.05	XXX
93925		A	Lower extremity study	0.58	7.84	7.58	NA	NA	0.39	XXX
93925	TC	A	Lower extremity study	0.00	7.63	7.38	NA	NA	0.35	XXX
93925	26	A	Lower extremity study	0.58	0.21	0.20	0.21	0.20	0.04	XXX
93926		A	Lower extremity study	0.39	5.04	4.80	NA	NA	0.27	XXX
93926	TC	A	Lower extremity study	0.00	4.91	4.67	NA	NA	0.23	XXX
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.13	0.13	0.04	XXX
93930		A	Upper extremity study	0.46	6.07	5.90	NA	NA	0.41	XXX
93930	TC	A	Upper extremity study	0.00	5.91	5.74	NA	NA	0.37	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.16	0.16	0.04	XXX
93931		A	Upper extremity study	0.31	4.09	3.95	NA	NA	0.27	XXX
93931	TC	A	Upper extremity study	0.00	3.99	3.85	NA	NA	0.24	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.10	0.10	0.03	XXX
93965		A	Extremity study	0.35	2.95	2.92	NA	NA	0.14	XXX
93965	TC	A	Extremity study	0.00	2.83	2.80	NA	NA	0.12	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93965	26	A	Extremity study	0.35	0.12	0.12	0.12	0.12	0.02	XXX
93970		A	Extremity study	0.68	6.10	5.90	NA	NA	0.46	XXX
93970	TC	A	Extremity study	0.00	5.87	5.67	NA	NA	0.40	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.23	0.23	0.06	XXX
93971		A	Extremity study	0.45	4.00	3.91	NA	NA	0.30	XXX
93971	TC	A	Extremity study	0.00	3.84	3.75	NA	NA	0.27	XXX
93971	26	A	Extremity study	0.45	0.16	0.16	0.16	0.16	0.03	XXX
93975		A	Vascular study	1.80	8.26	8.13	NA	NA	0.56	XXX
93975	TC	A	Vascular study	0.00	7.60	7.48	NA	NA	0.43	XXX
93975	26	A	Vascular study	1.80	0.66	0.65	0.66	0.65	0.13	XXX
93976		A	Vascular study	1.21	4.53	4.49	NA	NA	0.35	XXX
93976	TC	A	Vascular study	0.00	4.07	4.05	NA	NA	0.30	XXX
93976	26	A	Vascular study	1.21	0.46	0.44	0.46	0.44	0.05	XXX
93978		A	Vascular study	0.65	5.88	5.54	NA	NA	0.43	XXX
93978	TC	A	Vascular study	0.00	5.65	5.32	NA	NA	0.37	XXX
93978	26	A	Vascular study	0.65	0.23	0.22	0.23	0.22	0.06	XXX
93979		A	Vascular study	0.44	4.06	3.86	NA	NA	0.27	XXX
93979	TC	A	Vascular study	0.00	3.91	3.71	NA	NA	0.24	XXX
93979	26	A	Vascular study	0.44	0.15	0.15	0.15	0.15	0.03	XXX
93980		A	Penile vascular study	1.25	3.65	3.46	NA	NA	0.42	XXX
93980	TC	A	Penile vascular study	0.00	3.14	2.97	NA	NA	0.34	XXX
93980	26	A	Penile vascular study	1.25	0.51	0.49	0.51	0.49	0.08	XXX
93981		A	Penile vascular study	0.44	2.83	2.84	NA	NA	0.33	XXX
93981	TC	A	Penile vascular study	0.00	2.66	2.68	NA	NA	0.31	XXX
93981	26	A	Penile vascular study	0.44	0.17	0.16	0.17	0.16	0.02	XXX
93982		R	Aneurysm pressure sens study	0.30	0.79	0.79	NA	NA	0.01	XXX
93990		A	Doppler flow testing	0.25	5.12	4.84	NA	NA	0.26	XXX
93990	TC	A	Doppler flow testing	0.00	5.05	4.77	NA	NA	0.23	XXX
93990	26	A	Doppler flow testing	0.25	0.07	0.07	0.07	0.07	0.03	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.36	0.35	0.09	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.33	0.33	0.06	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.24	0.24	0.04	XXX
94005		B	Home vent mgmt supervision	1.50	0.89	0.89	NA	NA	0.06	XXX
94010		A	Breathing capacity test	0.17	0.72	0.71	NA	NA	0.03	XXX
94010	TC	A	Breathing capacity test	0.00	0.67	0.66	NA	NA	0.02	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.05	0.05	0.01	XXX
94014		A	Patient recorded spirometry	0.52	0.81	0.79	NA	NA	0.03	XXX
94015		A	Patient recorded spirometry	0.00	0.66	0.64	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.15	0.15	0.15	0.15	0.02	XXX
94060		A	Evaluation of wheezing	0.31	1.27	1.22	NA	NA	0.07	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.19	1.14	NA	NA	0.06	XXX
94060	26	A	Evaluation of wheezing	0.31	0.08	0.08	0.08	0.08	0.01	XXX
94070		A	Evaluation of wheezing	0.60	0.98	0.94	NA	NA	0.13	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.82	0.78	NA	NA	0.10	XXX
94070	26	A	Evaluation of wheezing	0.60	0.16	0.16	0.16	0.16	0.03	XXX
94150		B	Vital capacity test	0.07	0.54	0.53	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.52	0.50	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.02	0.03	0.02	0.03	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94200		A	Lung function test (MBC/MVV)	0.11	0.50	0.48	NA	NA	0.03	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.47	0.45	NA	NA	0.02	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.03	0.03	0.01	XXX
94240		A	Residual lung capacity	0.26	0.79	0.76	NA	NA	0.06	XXX
94240	TC	A	Residual lung capacity	0.00	0.73	0.69	NA	NA	0.05	XXX
94240	26	A	Residual lung capacity	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94250		A	Expired gas collection	0.11	0.51	0.54	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.48	0.51	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.03	0.03	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.73	0.69	NA	NA	0.05	XXX
94260	TC	A	Thoracic gas volume	0.00	0.70	0.66	NA	NA	0.04	XXX
94260	26	A	Thoracic gas volume	0.13	0.03	0.03	0.03	0.03	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.62	0.65	NA	NA	0.05	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.55	0.58	NA	NA	0.04	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.07	0.07	0.07	0.07	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.92	0.87	NA	NA	0.07	XXX
94360	TC	A	Measure airflow resistance	0.00	0.86	0.80	NA	NA	0.06	XXX
94360	26	A	Measure airflow resistance	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.60	0.63	NA	NA	0.03	XXX
94370	TC	A	Breath airway closing volume	0.00	0.53	0.56	NA	NA	0.02	XXX
94370	26	A	Breath airway closing volume	0.26	0.07	0.07	0.07	0.07	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.70	0.68	NA	NA	0.03	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.62	0.60	NA	NA	0.02	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.08	0.08	0.08	0.08	0.01	XXX
94400		A	CO2 breathing response curve	0.40	1.00	0.97	NA	NA	0.09	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.90	0.86	NA	NA	0.06	XXX
94400	26	A	CO2 breathing response curve	0.40	0.10	0.11	0.10	0.11	0.03	XXX
94450		A	Hypoxia response curve	0.40	0.99	0.95	NA	NA	0.04	XXX
94450	TC	A	Hypoxia response curve	0.00	0.89	0.85	NA	NA	0.02	XXX
94450	26	A	Hypoxia response curve	0.40	0.10	0.10	0.10	0.10	0.02	XXX
94452		A	Hast w/report	0.31	1.22	1.18	NA	NA	0.04	XXX
94452	TC	A	Hast w/report	0.00	1.15	1.10	NA	NA	0.02	XXX
94452	26	A	Hast w/report	0.31	0.07	0.08	0.07	0.08	0.02	XXX
94453		A	Hast w/oxygen titrate	0.40	1.62	1.60	NA	NA	0.04	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.52	1.49	NA	NA	0.02	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.10	0.11	0.10	0.11	0.02	XXX
94610		A	Surfactant admin thru tube	1.16	0.37	0.37	0.37	0.37	0.26	XXX
94620		A	Pulmonary stress test/simple	0.64	0.78	1.22	NA	NA	0.13	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.61	1.04	NA	NA	0.10	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.17	0.18	0.17	0.18	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.09	2.88	NA	NA	0.16	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.62	2.41	NA	NA	0.10	XXX
94621	26	A	Pulm stress test/complex	1.42	0.47	0.47	0.47	0.47	0.06	XXX
94640		A	Airway inhalation treatment	0.00	0.37	0.35	NA	NA	0.02	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	0.92	0.92	NA	NA	0.02	XXX
94645		A	Cbt, each addl hour	0.00	0.35	0.35	NA	NA	0.02	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.78	0.75	0.19	0.20	0.04	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.19	0.20	0.03	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.39	0.37	NA	NA	0.04	XXX
94667		A	Chest wall manipulation	0.00	0.52	0.52	NA	NA	0.05	XXX
94668		A	Chest wall manipulation	0.00	0.53	0.51	NA	NA	0.02	XXX
94680		A	Exhaled air analysis, o2	0.26	1.05	1.26	NA	NA	0.07	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	0.98	1.19	NA	NA	0.06	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.07	0.07	0.07	0.07	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.04	1.41	NA	NA	0.13	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	0.99	1.36	NA	NA	0.12	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.05	0.05	0.05	0.05	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.03	1.27	NA	NA	0.05	XXX
94690	TC	A	Exhaled air analysis	0.00	1.01	1.25	NA	NA	0.04	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.02	0.02	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.12	1.09	NA	NA	0.07	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.06	1.02	NA	NA	0.06	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	0.97	1.46	NA	NA	0.13	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.90	1.39	NA	NA	0.12	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.07	0.07	0.07	0.07	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.78	1.67	NA	NA	0.05	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.72	1.61	NA	NA	0.04	XXX
94750	26	A	Pulmonary compliance study	0.23	0.06	0.06	0.06	0.06	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.06	0.06	NA	NA	0.02	XXX
94761		T	Measure blood oxygen level	0.00	0.11	0.10	NA	NA	0.06	XXX
94762		A	Measure blood oxygen level	0.00	0.81	0.72	NA	NA	0.10	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.81	0.78	NA	NA	0.08	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.77	0.74	NA	NA	0.07	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.04	0.04	0.01	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.15	0.14	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.30	0.31	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.53	0.53	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.21	0.19	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.17	0.17	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.09	0.11	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.30	0.29	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.15	0.16	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.16	0.18	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.20	0.94	NA	NA	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95060		A	Eye allergy tests	0.00	0.71	0.62	0.71	0.62	0.02	XXX
95065		A	Nose allergy test	0.00	0.69	0.57	0.69	0.57	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.78	1.16	NA	NA	0.02	XXX
95071		A	Bronchial allergy tests	0.00	0.94	1.44	NA	NA	0.02	XXX
95075		A	Ingestion challenge test	0.95	0.71	0.74	0.30	0.32	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.22	0.27	NA	NA	0.02	XXX
95117		A	Immunotherapy injections	0.00	0.28	0.33	NA	NA	0.02	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.27	0.25	0.02	0.02	0.01	XXX
95145		A	Antigen therapy services	0.06	0.36	0.35	0.02	0.02	0.01	XXX
95146		A	Antigen therapy services	0.06	0.67	0.62	0.02	0.02	0.01	XXX
95147		A	Antigen therapy services	0.06	0.65	0.60	0.02	0.02	0.01	XXX
95148		A	Antigen therapy services	0.06	0.97	0.87	0.02	0.02	0.01	XXX
95149		A	Antigen therapy services	0.06	1.28	1.16	0.02	0.02	0.01	XXX
95165		A	Antigen therapy services	0.06	0.26	0.25	0.02	0.02	0.01	XXX
95170		A	Antigen therapy services	0.06	0.20	0.18	0.02	0.02	0.01	XXX
95180		A	Rapid desensitization	2.01	1.72	1.80	0.84	0.86	0.04	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	3.35	3.55	NA	NA	0.01	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.25	0.23	0.25	0.23	0.02	XXX
95803		C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95803	TC	C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95805		A	Multiple sleep latency test	1.88	6.72	9.38	NA	NA	0.43	XXX
95805	TC	A	Multiple sleep latency test	0.00	6.19	8.82	NA	NA	0.34	XXX
95805	26	A	Multiple sleep latency test	1.88	0.53	0.56	0.53	0.56	0.09	XXX
95806		A	Sleep study, unattended	1.66	3.87	3.75	NA	NA	0.39	XXX
95806	TC	A	Sleep study, unattended	0.00	3.39	3.25	NA	NA	0.31	XXX
95806	26	A	Sleep study, unattended	1.66	0.48	0.50	0.48	0.50	0.08	XXX
95807		A	Sleep study, attended	1.66	11.37	11.52	NA	NA	0.50	XXX
95807	TC	A	Sleep study, attended	0.00	10.91	11.04	NA	NA	0.42	XXX
95807	26	A	Sleep study, attended	1.66	0.46	0.48	0.46	0.48	0.08	XXX
95808		A	Polysomnography, 1-3	2.65	15.15	14.69	NA	NA	0.55	XXX
95808	TC	A	Polysomnography, 1-3	0.00	14.42	13.91	NA	NA	0.42	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.73	0.78	0.73	0.78	0.13	XXX
95810		A	Polysomnography, 4 or more	3.52	17.01	17.17	NA	NA	0.59	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.07	16.17	NA	NA	0.42	XXX
95810	26	A	Polysomnography, 4 or more	3.52	0.94	1.00	0.94	1.00	0.17	XXX
95811		A	Polysomnography w/cpap	3.79	18.93	19.04	NA	NA	0.61	XXX
95811	TC	A	Polysomnography w/cpap	0.00	17.93	17.97	NA	NA	0.43	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.00	1.07	1.00	1.07	0.18	XXX
95812		A	Eeg, 41-60 minutes	1.08	5.68	5.27	NA	NA	0.17	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95812	TC	A	Eeg, 41-60 minutes	0.00	5.36	4.92	NA	NA	0.11	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.32	0.35	0.32	0.35	0.06	XXX
95813		A	Eeg, over 1 hour	1.73	6.40	6.06	NA	NA	0.20	XXX
95813	TC	A	Eeg, over 1 hour	0.00	5.90	5.51	NA	NA	0.11	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.50	0.55	0.50	0.55	0.09	XXX
95816		A	Eeg, awake and drowsy	1.08	5.08	4.74	NA	NA	0.16	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	4.76	4.39	NA	NA	0.10	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.32	0.35	0.32	0.35	0.06	XXX
95819		A	Eeg, awake and asleep	1.08	5.90	5.18	NA	NA	0.16	XXX
95819	TC	A	Eeg, awake and asleep	0.00	5.58	4.83	NA	NA	0.10	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.32	0.35	0.32	0.35	0.06	XXX
95822		A	Eeg, coma or sleep only	1.08	5.30	5.13	NA	NA	0.19	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	4.98	4.78	NA	NA	0.13	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.32	0.35	0.32	0.35	0.06	XXX
95824		C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.22	0.24	0.22	0.24	0.04	XXX
95827		A	Eeg, all night recording	1.08	11.15	9.06	NA	NA	0.19	XXX
95827	TC	A	Eeg, all night recording	0.00	10.84	8.72	NA	NA	0.14	XXX
95827	26	A	Eeg, all night recording	1.08	0.31	0.34	0.31	0.34	0.05	XXX
95829		A	Surgery electrocorticogram	6.20	24.91	26.50	NA	NA	0.50	XXX
95829	TC	A	Surgery electrocorticogram	0.00	23.01	24.49	NA	NA	0.02	XXX
95829	26	A	Surgery electrocorticogram	6.20	1.90	2.01	1.90	2.01	0.48	XXX
95830		A	Insert electrodes for EEG	1.70	2.92	3.02	0.47	0.54	0.11	XXX
95831		A	Limb muscle testing, manual	0.28	0.40	0.41	0.09	0.10	0.01	XXX
95832		A	Hand muscle testing, manual	0.29	0.36	0.35	0.10	0.10	0.02	XXX
95833		A	Body muscle testing, manual	0.47	0.45	0.48	0.13	0.16	0.02	XXX
95834		A	Body muscle testing, manual	0.60	0.49	0.52	0.16	0.19	0.03	XXX
95851		A	Range of motion measurements	0.16	0.25	0.28	0.04	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.22	0.23	0.04	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.58	0.58	0.17	0.19	0.02	XXX
95860		A	Muscle test, one limb	0.96	1.13	1.20	NA	NA	0.07	XXX
95860	TC	A	Muscle test, one limb	0.00	0.80	0.85	NA	NA	0.02	XXX
95860	26	A	Muscle test, one limb	0.96	0.33	0.35	0.33	0.35	0.05	XXX
95861		A	Muscle test, 2 limbs	1.54	1.62	1.57	NA	NA	0.13	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.10	1.01	NA	NA	0.06	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.52	0.56	0.52	0.56	0.07	XXX
95863		A	Muscle test, 3 limbs	1.87	1.87	1.84	NA	NA	0.15	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.28	1.20	NA	NA	0.06	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.59	0.64	0.59	0.64	0.09	XXX
95864		A	Muscle test, 4 limbs	1.99	2.10	2.24	NA	NA	0.21	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.46	1.54	NA	NA	0.12	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.64	0.70	0.64	0.70	0.09	XXX
95865		A	Muscle test, larynx	1.57	1.41	1.42	NA	NA	0.11	XXX
95865	TC	A	Muscle test, larynx	0.00	0.88	0.83	NA	NA	0.03	XXX
95865	26	A	Muscle test, larynx	1.57	0.53	0.59	0.53	0.59	0.08	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.33	1.19	NA	NA	0.10	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	0.90	0.73	NA	NA	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95866	26	A	Muscle test, hemidiaphragm	1.25	0.43	0.46	0.43	0.46	0.07	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.12	1.08	NA	NA	0.07	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.87	0.80	NA	NA	0.04	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.25	0.28	0.25	0.28	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.43	1.38	NA	NA	0.10	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.06	0.97	NA	NA	0.05	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.37	0.41	0.37	0.41	0.05	XXX
95869		A	Muscle test, thor paraspinal	0.37	0.98	0.83	NA	NA	0.04	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.86	0.70	NA	NA	0.02	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.12	0.13	0.12	0.13	0.02	XXX
95870		A	Muscle test, nonparaspinal	0.37	0.95	0.80	NA	NA	0.04	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.83	0.67	NA	NA	0.02	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.12	0.13	0.12	0.13	0.02	XXX
95872		A	Muscle test, one fiber	2.88	1.64	1.54	NA	NA	0.13	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.72	0.69	NA	NA	0.05	XXX
95872	26	A	Muscle test, one fiber	2.88	0.92	0.85	0.92	0.85	0.08	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.00	0.85	NA	NA	0.04	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	0.85	0.69	NA	NA	0.02	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.15	0.16	0.15	0.16	0.02	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	0.91	0.78	NA	NA	0.04	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	0.79	0.64	NA	NA	0.02	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.12	0.14	0.12	0.14	0.02	ZZZ
95875		A	Limb exercise test	1.10	1.29	1.34	NA	NA	0.11	XXX
95875	TC	A	Limb exercise test	0.00	0.96	0.97	NA	NA	0.06	XXX
95875	26	A	Limb exercise test	1.10	0.33	0.37	0.33	0.37	0.05	XXX
95900		A	Motor nerve conduction test	0.42	0.90	0.99	NA	NA	0.04	XXX
95900	TC	A	Motor nerve conduction test	0.00	0.76	0.84	NA	NA	0.02	XXX
95900	26	A	Motor nerve conduction test	0.42	0.14	0.15	0.14	0.15	0.02	XXX
95903		A	Motor nerve conduction test	0.60	1.00	1.05	NA	NA	0.05	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.82	0.85	NA	NA	0.02	XXX
95903	26	A	Motor nerve conduction test	0.60	0.18	0.20	0.18	0.20	0.03	XXX
95904		A	Sense nerve conduction test	0.34	0.84	0.90	NA	NA	0.04	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.73	0.78	NA	NA	0.02	XXX
95904	26	A	Sense nerve conduction test	0.34	0.11	0.12	0.11	0.12	0.02	XXX
95920		A	Intraop nerve test add-on	2.11	1.68	1.82	NA	NA	0.23	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.04	1.11	NA	NA	0.07	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.64	0.71	0.64	0.71	0.16	ZZZ
95921		A	Autonomic nerv function test	0.90	1.16	1.05	NA	NA	0.06	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.89	0.76	NA	NA	0.02	XXX
95921	26	A	Autonomic nerv function test	0.90	0.27	0.29	0.27	0.29	0.04	XXX
95922		A	Autonomic nerv function test	0.96	1.58	1.38	NA	NA	0.07	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.30	1.07	NA	NA	0.02	XXX
95922	26	A	Autonomic nerv function test	0.96	0.28	0.31	0.28	0.31	0.05	XXX
95923		A	Autonomic nerv function test	0.90	2.26	2.19	NA	NA	0.07	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.99	1.89	NA	NA	0.02	XXX
95923	26	A	Autonomic nerv function test	0.90	0.27	0.30	0.27	0.30	0.05	XXX
95925		A	Somatosensory testing	0.54	3.06	2.58	NA	NA	0.10	XXX
95925	TC	A	Somatosensory testing	0.00	2.90	2.40	NA	NA	0.06	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95925	26	A	Somatosensory testing	0.54	0.16	0.18	0.16	0.18	0.04	XXX
95926		A	Somatosensory testing	0.54	2.98	2.53	NA	NA	0.09	XXX
95926	TC	A	Somatosensory testing	0.00	2.82	2.35	NA	NA	0.06	XXX
95926	26	A	Somatosensory testing	0.54	0.16	0.18	0.16	0.18	0.03	XXX
95927		A	Somatosensory testing	0.54	3.07	2.60	NA	NA	0.10	XXX
95927	TC	A	Somatosensory testing	0.00	2.90	2.41	NA	NA	0.06	XXX
95927	26	A	Somatosensory testing	0.54	0.17	0.19	0.17	0.19	0.04	XXX
95928		A	C motor evoked, uppr limbs	1.50	3.71	3.54	NA	NA	0.09	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	3.27	3.05	NA	NA	0.03	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.44	0.49	0.44	0.49	0.06	XXX
95929		A	C motor evoked, lwr limbs	1.50	4.01	3.82	NA	NA	0.09	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	3.56	3.32	NA	NA	0.03	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.45	0.50	0.45	0.50	0.06	XXX
95930		A	Visual evoked potential test	0.35	2.53	2.46	NA	NA	0.03	XXX
95930	TC	A	Visual evoked potential test	0.00	2.42	2.34	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.11	0.12	0.11	0.12	0.02	XXX
95933		A	Blink reflex test	0.59	1.08	1.07	NA	NA	0.10	XXX
95933	TC	A	Blink reflex test	0.00	0.90	0.87	NA	NA	0.06	XXX
95933	26	A	Blink reflex test	0.59	0.18	0.20	0.18	0.20	0.04	XXX
95934		A	H-reflex test	0.51	0.88	0.76	NA	NA	0.04	XXX
95934	TC	A	H-reflex test	0.00	0.71	0.58	NA	NA	0.02	XXX
95934	26	A	H-reflex test	0.51	0.17	0.18	0.17	0.18	0.02	XXX
95936		A	H-reflex test	0.55	0.59	0.56	NA	NA	0.05	XXX
95936	TC	A	H-reflex test	0.00	0.42	0.37	NA	NA	0.02	XXX
95936	26	A	H-reflex test	0.55	0.17	0.19	0.17	0.19	0.03	XXX
95937		A	Neuromuscular junction test	0.65	0.90	0.82	NA	NA	0.10	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.69	0.60	NA	NA	0.02	XXX
95937	26	A	Neuromuscular junction test	0.65	0.21	0.22	0.21	0.22	0.08	XXX
95950		A	Ambulatory eeg monitoring	1.51	4.77	4.56	NA	NA	0.51	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	4.32	4.07	NA	NA	0.43	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.45	0.49	0.45	0.49	0.08	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	1.76	1.96	1.76	1.96	0.32	XXX
95953		A	EEG monitoring/computer	3.30	6.99	7.16	NA	NA	0.60	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.02	6.11	NA	NA	0.43	XXX
95953	26	A	EEG monitoring/computer	3.30	0.97	1.05	0.97	1.05	0.17	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.05	4.11	NA	NA	0.19	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	3.66	3.55	NA	NA	0.06	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.39	0.56	0.39	0.56	0.13	XXX
95955		A	EEG during surgery	1.01	2.62	2.56	NA	NA	0.22	XXX
95955	TC	A	EEG during surgery	0.00	2.33	2.25	NA	NA	0.17	XXX
95955	26	A	EEG during surgery	1.01	0.29	0.31	0.29	0.31	0.05	XXX
95956		A	Eeg monitoring, cable/radio	3.08	15.82	15.75	NA	NA	0.59	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	14.91	14.74	NA	NA	0.43	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	0.91	1.01	0.91	1.01	0.16	XXX
95957		A	EEG digital analysis	1.98	5.66	4.90	NA	NA	0.23	XXX
95957	TC	A	EEG digital analysis	0.00	5.08	4.25	NA	NA	0.12	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95957	26	A	EEG digital analysis	1.98	0.58	0.65	0.58	0.65	0.11	XXX
95958		A	EEG monitoring/function test	4.24	6.68	5.89	NA	NA	0.34	XXX
95958	TC	A	EEG monitoring/function test	0.00	5.39	4.49	NA	NA	0.13	XXX
95958	26	A	EEG monitoring/function test	4.24	1.29	1.40	1.29	1.40	0.21	XXX
95961		A	Electrode stimulation, brain	2.97	2.98	2.90	NA	NA	0.55	XXX
95961	TC	A	Electrode stimulation, brain	0.00	2.07	1.88	NA	NA	0.07	XXX
95961	26	A	Electrode stimulation, brain	2.97	0.91	1.02	0.91	1.02	0.48	XXX
95962		A	Electrode stim, brain add-on	3.21	2.16	2.29	NA	NA	0.39	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.22	1.24	NA	NA	0.07	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	0.94	1.05	0.94	1.05	0.32	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	2.66	2.86	2.66	2.86	0.46	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.35	1.44	1.35	1.44	0.19	XXX
95967		C	Meg, evoked, each addÆl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each addÆl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each addÆl	3.49	1.14	1.16	1.14	1.16	0.16	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.89	0.88	0.13	0.13	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.73	0.72	0.27	0.26	0.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.14	1.16	0.46	0.47	0.14	XXX
95973		A	Analyze neurostim, complex	0.92	0.51	0.54	0.24	0.26	0.07	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.45	1.52	0.82	0.94	0.16	XXX
95975		A	Cranial neurostim, complex	1.70	0.74	0.78	0.49	0.55	0.12	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.86	1.88	1.07	1.13	0.18	XXX
95979		A	Analyz neurostim brain addon	1.64	0.74	0.77	0.49	0.54	0.08	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.25	0.25	0.07	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.44	0.44	0.12	0.12	0.02	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.49	0.49	0.20	0.20	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	1.58	1.56	NA	NA	0.06	XXX
95991		A	Spin/brain pump refil & main	0.77	1.59	1.57	0.18	0.18	0.06	XXX
95992		B	Canalith repositioning proc	0.75	0.36	0.36	0.25	0.25	0.02	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	NA	0.48	0.49	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.55	0.58	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.12	0.13	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.09	0.10	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.74	0.79	0.74	0.79	0.11	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.33	1.33	1.33	1.33	0.17	XXX
96040		B	Genetic counseling, 30 min	0.00	1.10	1.10	NA	NA	0.01	XXX
96101		A	Psycho testing by psych/phys	1.86	0.36	0.43	0.34	0.42	0.05	XXX
96102		A	Psycho testing by technician	0.50	1.00	0.91	0.10	0.12	0.01	XXX
96103		A	Psycho testing admin by comp	0.51	0.92	0.75	0.11	0.13	0.02	XXX
96105		A	Assessment of aphasia	0.00	1.89	1.86	NA	NA	0.18	XXX
96110		A	Developmental test, lim	0.00	0.17	0.18	NA	NA	0.18	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
96111		A	Developmental test, extend	2.60	0.76	0.83	0.64	0.75	0.18	XXX
96116		A	Neurobehavioral status exam	1.86	0.54	0.61	0.42	0.47	0.18	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.82	0.96	0.34	0.41	0.18	XXX
96119		A	Neuropsych testing by tec	0.55	1.43	1.33	0.10	0.13	0.18	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.58	1.37	0.11	0.13	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	0.77	0.77	0.38	0.38	0.16	XXX
96150		A	Assess hlth/behave, init	0.50	0.10	0.12	0.09	0.11	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.10	0.12	0.09	0.11	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.09	0.11	0.08	0.10	0.01	XXX
96153		A	Intervene hlth/behave, group	0.10	0.02	0.03	0.02	0.02	0.01	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.09	0.11	0.08	0.10	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.15	0.16	0.15	0.15	0.02	XXX
96360		A	Hydration iv infusion, init	0.17	1.29	1.33	NA	NA	0.07	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.31	0.33	NA	NA	0.04	ZZZ
96365		A	Ther/proph/diag iv inf, init	0.21	1.58	1.63	NA	NA	0.07	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.37	0.39	NA	NA	0.04	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.68	0.73	NA	NA	0.04	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.34	0.36	NA	NA	0.04	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	3.86	3.88	NA	NA	0.06	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.22	0.22	NA	NA	0.04	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.04	2.00	NA	NA	0.01	ZZZ
96372		A	Ther/proph/diag inj, sc/im	0.17	0.43	0.40	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.30	0.31	NA	NA	0.02	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.28	1.29	NA	NA	0.04	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.50	0.52	NA	NA	0.04	ZZZ
96376		X	Tx/pro/dx inj new drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.81	1.65	NA	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.75	0.82	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.56	1.79	0.25	0.25	0.03	000
96406		A	Chemo intralesional over 7	0.80	2.19	2.40	0.34	0.33	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.75	2.80	NA	NA	0.06	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.48	1.51	NA	NA	0.06	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	3.56	3.73	NA	NA	0.08	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.64	0.67	NA	NA	0.07	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	4.01	4.17	NA	NA	0.08	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.70	1.76	NA	NA	0.07	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.76	2.74	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.47	4.57	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.98	1.96	NA	NA	0.02	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.50	4.50	NA	NA	0.08	XXX
96440		A	Chemotherapy, intracavitary	2.37	15.97	14.04	1.09	1.13	0.17	000
96445		A	Chemotherapy, intracavitary	2.20	4.73	5.57	0.80	0.90	0.14	000
96450		A	Chemotherapy, into CNS	1.53	3.21	4.15	0.66	0.82	0.09	000
96521		A	Refill/maint, portable pump	0.21	3.07	3.25	NA	NA	0.06	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.73	2.72	NA	NA	0.06	XXX
96523		T	Irrig drug delivery device	0.04	0.63	0.65	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	2.44	2.90	0.37	0.44	0.07	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.61	3.20	NA	NA	0.04	XXX
96570		A	Photodynamic tx, 30 min	1.10	0.41	0.40	0.41	0.40	0.11	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.19	0.19	0.19	0.19	0.03	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.55	0.52	NA	NA	0.02	XXX
96902		B	Trichogram	0.41	0.16	0.16	0.14	0.14	0.01	XXX
96904		R	Whole body photography	0.00	1.77	1.77	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.93	1.70	NA	NA	0.04	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.48	2.18	NA	NA	0.05	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.44	3.00	NA	NA	0.10	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.51	3.27	0.60	0.59	0.02	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.32	3.15	0.55	0.55	0.03	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.55	4.30	1.10	0.98	0.04	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.67	0.69	NA	NA	0.05	XXX
97002		A	Pt re-evaluation	0.60	0.41	0.42	NA	NA	0.02	XXX
97003		A	Ot evaluation	1.20	0.77	0.80	NA	NA	0.06	XXX
97004		A	Ot re-evaluation	0.60	0.54	0.57	NA	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.07	0.06	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.14	0.14	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.18	0.18	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.24	0.23	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.16	0.15	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.33	0.30	NA	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.08	0.08	NA	NA	0.01	XXX
97026		A	Infrared therapy	0.06	0.07	0.07	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.09	0.08	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.20	0.19	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.44	0.40	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.20	0.19	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.10	0.10	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.44	0.41	NA	NA	0.01	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.32	0.31	NA	NA	0.02	XXX
97112		A	Neuromuscular reeducation	0.45	0.35	0.34	NA	NA	0.01	XXX
97113		A	Aquatic therapy/exercises	0.44	0.53	0.50	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.28	0.27	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.27	0.26	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.29	0.28	NA	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.22	0.21	NA	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.38	0.37	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.22	0.22	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.27	0.27	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.38	0.36	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.28	0.28	NA	NA	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
97542		A	Wheelchair mngment training	0.45	0.29	0.29	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.09	0.99	0.13	0.26	0.05	XXX
97598		A	Active wound care > 20 cm	0.80	1.27	1.15	0.18	0.33	0.05	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.41	0.39	0.13	0.15	0.02	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.42	0.40	0.14	0.16	0.03	XXX
97750		A	Physical performance test	0.45	0.33	0.33	NA	NA	0.02	XXX
97755		A	Assistive technology assess	0.62	0.28	0.28	NA	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.43	0.41	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.33	0.32	NA	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.73	0.65	NA	NA	0.02	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.21	0.27	0.14	0.22	0.01	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.18	0.25	0.11	0.20	0.01	XXX
97804		A	Medical nutrition, group	0.25	0.07	0.10	0.07	0.10	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.33	0.34	0.20	0.21	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.21	0.22	0.17	0.17	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.35	0.36	0.22	0.23	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.25	0.26	0.18	0.19	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.29	0.30	0.13	0.13	0.02	000
98926		A	Osteopathic manipulation	0.65	0.37	0.38	0.18	0.20	0.03	000
98927		A	Osteopathic manipulation	0.87	0.46	0.47	0.23	0.25	0.03	000
98928		A	Osteopathic manipulation	1.03	0.52	0.54	0.28	0.29	0.04	000
98929		A	Osteopathic manipulation	1.19	0.59	0.61	0.33	0.34	0.05	000
98940		A	Chiropractic manipulation	0.45	0.21	0.22	0.13	0.12	0.01	000
98941		A	Chiropractic manipulation	0.65	0.28	0.28	0.18	0.18	0.01	000
98942		A	Chiropractic manipulation	0.87	0.34	0.34	0.24	0.24	0.02	000
98943		N	Chiropractic manipulation	0.40	0.22	0.23	0.13	0.14	0.01	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.65	0.65	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.31	0.31	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.23	0.23	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.12	0.12	0.08	0.08	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.20	0.20	0.17	0.17	0.02	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.28	0.28	0.25	0.25	0.03	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.37	0.37	NA	NA	0.04	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	2.21	2.11	0.85	0.78	0.08	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.69	0.69	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.36	0.62	NA	NA	0.10	XXX
99183		A	Hyperbaric oxygen therapy	2.34	2.58	2.75	0.61	0.64	0.16	XXX
99185		A	Regional hypothermia	0.00	1.81	1.52	NA	NA	0.04	XXX
99186		A	Total body hypothermia	0.00	1.63	1.67	NA	NA	0.45	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.42	1.93	NA	NA	0.02	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.45	0.55	0.54	0.17	0.17	0.03	XXX
99202		A	Office/outpatient visit, new	0.88	0.85	0.83	0.32	0.32	0.05	XXX
99203		A	Office/outpatient visit, new	1.34	1.12	1.12	0.45	0.46	0.09	XXX
99204		A	Office/outpatient visit, new	2.30	1.51	1.51	0.75	0.74	0.12	XXX
99205		A	Office/outpatient visit, new	3.00	1.81	1.81	0.96	0.96	0.15	XXX
99211		A	Office/outpatient visit, est	0.17	0.32	0.34	0.06	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.45	0.55	0.55	0.16	0.16	0.03	XXX
99213		A	Office/outpatient visit, est	0.92	0.77	0.75	0.30	0.29	0.03	XXX
99214		A	Office/outpatient visit, est	1.42	1.10	1.09	0.46	0.45	0.05	XXX
99215		A	Office/outpatient visit, est	2.00	1.40	1.38	0.65	0.65	0.08	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.50	0.51	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.39	0.40	0.06	XXX
99219		A	Observation care	2.14	NA	NA	0.62	0.64	0.10	XXX
99220		A	Observation care	2.99	NA	NA	0.86	0.91	0.14	XXX
99221		A	Initial hospital care	1.88	NA	NA	0.56	0.54	0.07	XXX
99222		A	Initial hospital care	2.56	NA	NA	0.74	0.74	0.10	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99223		A	Initial hospital care	3.78	NA	NA	1.11	1.09	0.13	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.25	0.24	0.03	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.44	0.42	0.04	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.62	0.59	0.06	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	0.82	0.84	0.13	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.02	1.06	0.16	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.25	1.30	0.19	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.50	0.51	0.05	XXX
99239		A	Hospital discharge day	1.90	NA	NA	0.68	0.70	0.07	XXX
99241		A	Office consultation	0.64	0.66	0.66	0.24	0.23	0.05	XXX
99242		A	Office consultation	1.34	1.10	1.08	0.51	0.50	0.10	XXX
99243		A	Office consultation	1.88	1.46	1.45	0.71	0.69	0.13	XXX
99244		A	Office consultation	3.02	1.96	1.93	1.14	1.09	0.16	XXX
99245		A	Office consultation	3.77	2.30	2.30	1.38	1.35	0.21	XXX
99251		A	Inpatient consultation	1.00	NA	NA	0.32	0.30	0.05	XXX
99252		A	Inpatient consultation	1.50	NA	NA	0.52	0.51	0.09	XXX
99253		A	Inpatient consultation	2.27	NA	NA	0.84	0.80	0.11	XXX
99254		A	Inpatient consultation	3.29	NA	NA	1.23	1.17	0.13	XXX
99255		A	Inpatient consultation	4.00	NA	NA	1.44	1.42	0.18	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.09	0.09	0.02	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.18	0.17	0.04	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.25	0.27	0.09	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.48	0.47	0.14	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.68	0.69	0.23	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care, first hour	4.50	2.24	2.33	1.13	1.17	0.21	XXX
99292		A	Critical care, addÆl 30 min	2.25	0.79	0.82	0.56	0.58	0.11	ZZZ
99304		A	Nursing facility care, init	1.61	0.59	0.56	0.59	0.56	0.05	XXX
99305		A	Nursing facility care, init	2.30	0.76	0.73	0.76	0.73	0.07	XXX
99306		A	Nursing facility care, init	3.00	0.94	0.89	0.94	0.89	0.09	XXX
99307		A	Nursing fac care, subseq	0.76	0.32	0.31	0.32	0.31	0.03	XXX
99308		A	Nursing fac care, subseq	1.16	0.48	0.48	0.48	0.48	0.04	XXX
99309		A	Nursing fac care, subseq	1.55	0.62	0.62	0.62	0.62	0.06	XXX
99310		A	Nursing fac care, subseq	2.35	0.89	0.86	0.89	0.86	0.08	XXX
99315		A	Nursing fac discharge day	1.13	0.42	0.43	0.42	0.43	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.52	0.54	0.52	0.54	0.06	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.58	0.56	0.58	0.56	0.05	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.43	0.44	NA	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.56	0.59	NA	NA	0.07	XXX
99326		A	Domicil/r-home visit new pat	2.63	0.84	0.86	NA	NA	0.10	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.06	1.09	NA	NA	0.13	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.21	1.26	NA	NA	0.16	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.44	0.43	NA	NA	0.04	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.61	0.60	NA	NA	0.06	XXX
99336		A	Domicil/r-home visit est pat	2.46	0.80	0.80	NA	NA	0.09	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.08	1.10	NA	NA	0.13	XXX
99339		B	Domicil/r-home care supervis	1.25	0.74	0.74	NA	NA	0.06	XXX
99340		B	Domicil/r-home care supervis	1.80	0.99	0.99	NA	NA	0.07	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99341		A	Home visit, new patient	1.01	0.43	0.44	NA	NA	0.05	XXX
99342		A	Home visit, new patient	1.52	0.56	0.59	NA	NA	0.07	XXX
99343		A	Home visit, new patient	2.53	0.84	0.87	NA	NA	0.10	XXX
99344		A	Home visit, new patient	3.38	1.05	1.08	NA	NA	0.13	XXX
99345		A	Home visit, new patient	4.09	1.21	1.27	NA	NA	0.16	XXX
99347		A	Home visit, est patient	1.00	0.43	0.42	NA	NA	0.04	XXX
99348		A	Home visit, est patient	1.56	0.57	0.58	NA	NA	0.06	XXX
99349		A	Home visit, est patient	2.33	0.76	0.78	NA	NA	0.09	XXX
99350		A	Home visit, est patient	3.28	1.00	1.05	NA	NA	0.13	XXX
99354		A	Prolonged service, office	1.77	0.68	0.70	0.53	0.56	0.08	ZZZ
99355		A	Prolonged service, office	1.77	0.65	0.68	0.51	0.54	0.07	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.52	0.54	0.07	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.52	0.55	0.08	ZZZ
99358		B	Prolonged serv, w/o contact	2.10	0.74	0.74	0.74	0.74	0.09	ZZZ
99359		B	Prolonged serv, w/o contact	1.00	0.37	0.37	0.37	0.37	0.04	ZZZ
99360		X	Physician standby services	1.20	0.40	0.40	0.40	0.40	0.05	XXX
99363		B	Anticoag mgmt, init	1.65	1.56	1.56	0.55	0.55	0.07	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.47	0.47	0.21	0.21	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.29	0.29	0.27	0.27	0.06	XXX
99367		B	Team conf w/o pat by phys	1.10	0.37	0.37	0.37	0.37	0.05	XXX
99368		B	Team conf w/o pat by hc pro	0.72	0.24	0.24	0.24	0.24	0.03	XXX
99374		B	Home health care supervision	1.10	0.69	0.69	0.37	0.38	0.05	XXX
99375		I	Home health care supervision	1.73	0.97	1.11	0.58	0.82	0.07	XXX
99377		B	Hospice care supervision	1.10	0.69	0.69	0.37	0.38	0.05	XXX
99378		I	Hospice care supervision	1.73	0.97	1.21	0.58	0.92	0.07	XXX
99379		B	Nursing fac care supervision	1.10	0.69	0.69	0.37	0.38	0.04	XXX
99380		B	Nursing fac care supervision	1.73	0.97	0.97	0.58	0.60	0.06	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.19	1.27	0.40	0.41	0.05	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.25	1.32	0.46	0.47	0.05	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.24	1.30	0.46	0.47	0.05	XXX
99384		N	Prev visit, new, age 12-17	1.53	1.30	1.36	0.51	0.53	0.06	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.30	1.36	0.51	0.53	0.06	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.41	1.50	0.63	0.65	0.07	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.57	1.65	0.69	0.72	0.07	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.03	1.03	0.34	0.35	0.04	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.09	1.09	0.40	0.41	0.05	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.08	1.08	0.40	0.41	0.05	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.14	1.14	0.46	0.47	0.05	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.14	1.15	0.46	0.47	0.05	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.20	1.21	0.51	0.53	0.06	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.36	1.37	0.57	0.60	0.06	XXX
99401		N	Preventive counseling, indiv	0.48	0.44	0.48	0.16	0.17	0.01	XXX
99402		N	Preventive counseling, indiv	0.98	0.60	0.67	0.33	0.34	0.02	XXX
99403		N	Preventive counseling, indiv	1.46	0.76	0.85	0.49	0.51	0.04	XXX
99404		N	Preventive counseling, indiv	1.95	0.93	1.03	0.65	0.68	0.05	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.11	0.11	0.07	0.07	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.18	0.18	0.14	0.15	0.01	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.26	0.26	0.22	0.22	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99409		N	Audit/dast, over 30 min	1.30	0.48	0.48	0.44	0.44	0.03	XXX
99411		N	Preventive counseling, group	0.15	0.25	0.24	0.05	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.28	0.08	0.09	0.01	XXX
99420		N	Health risk assessment test	0.00	0.25	0.25	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.12	0.12	0.08	0.08	0.02	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.20	0.20	0.17	0.17	0.02	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.28	0.28	0.25	0.25	0.03	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	0.33	0.34	0.33	0.34	0.05	XXX
99461		A	Init nb em per day, non-fac	1.26	1.21	1.01	0.42	0.42	0.07	XXX
99462		A	Sbsq nb em per day, hosp	0.62	0.19	0.19	0.19	0.19	0.02	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.50	0.53	0.06	XXX
99464		A	Attendance at delivery	1.50	0.37	0.40	0.37	0.40	0.06	XXX
99465		A	Nb resuscitation	2.93	0.98	0.97	0.98	0.97	0.12	XXX
99466		A	Ped crit care transport	4.79	1.38	1.40	1.38	1.40	0.24	XXX
99467		A	Ped crit care transport addl	2.40	0.65	0.69	0.65	0.69	0.12	ZZZ
99468		A	Neonate crit care, initial	18.46	4.22	4.52	4.22	4.52	1.16	XXX
99469		A	Neonate crit care, subsq	7.99	2.09	2.21	2.09	2.21	0.32	XXX
99471		A	Ped critical care, initial	15.98	4.36	4.47	4.36	4.47	1.12	XXX
99472		A	Ped critical care, subsq	7.99	2.14	2.21	2.14	2.21	0.45	XXX
99475		A	Ped crit care age 2-5, init	11.25	2.83	2.83	2.83	2.83	0.79	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	1.70	1.70	1.70	1.70	0.38	XXX
99477		A	Init day hosp neonate care	7.00	2.05	2.05	2.05	2.05	0.32	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	0.90	0.91	0.90	0.91	0.17	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	0.66	0.71	0.66	0.71	0.16	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	0.64	0.69	0.64	0.69	0.15	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm, np, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm, est, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99607		X	Mtms by pharm, addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.48	0.49	NA	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.32	0.34	0.06	0.06	0.01	XXX
G0103		X	PSA screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.48	2.43	0.63	0.60	0.08	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.25	6.24	1.88	1.78	0.30	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.48	2.43	0.63	0.60	0.08	000
G0106		A	Colon CA screen;barium enema	0.99	4.92	4.34	NA	NA	0.17	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.54	3.97	NA	NA	0.13	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.38	0.37	0.38	0.37	0.04	XXX
G0108		A	Diab manage trn per indiv	0.00	0.57	0.63	NA	NA	0.01	XXX
G0109		A	Diab manage trn ind/group	0.00	0.30	0.35	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.75	0.75	NA	NA	0.01	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.67	0.64	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.92	4.34	NA	NA	0.17	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.54	3.97	NA	NA	0.13	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.38	0.37	0.38	0.37	0.04	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.25	6.24	1.88	1.78	0.30	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.48	2.43	0.63	0.60	0.08	000
G0122		N	Colon ca scrn; barium enema	0.99	6.29	5.37	NA	NA	0.18	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.96	5.03	NA	NA	0.13	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.33	0.34	0.33	0.34	0.05	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.37	0.31	0.37	0.31	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.37	0.34	0.04	0.05	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.18	0.14	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.53	0.62	NA	NA	0.06	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.47	0.56	NA	NA	0.05	XXX
G0130	26	A	Single energy x-ray study	0.22	0.06	0.06	0.06	0.06	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.37	0.31	0.37	0.31	0.02	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	4.24	4.08	NA	NA	0.01	XXX
G0168		A	Wound closure by adhesive	0.45	1.51	1.62	0.20	0.21	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	0.47	0.61	NA	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.55	0.73	NA	NA	0.03	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0181		A	Home health care supervision	1.73	0.82	0.98	NA	NA	0.07	XXX
G0182		A	Hospice care supervision	1.73	0.83	1.04	NA	NA	0.07	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.80	2.80	NA	NA	0.10	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.56	2.56	NA	NA	0.07	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0204		A	Diagnosticmammographydigital	0.87	3.40	3.25	NA	NA	0.11	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.10	2.96	NA	NA	0.07	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.30	0.29	0.30	0.29	0.04	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.67	2.57	NA	NA	0.09	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.43	2.33	NA	NA	0.06	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.20	0.27	NA	NA	0.02	XXX
G0238		A	Oth resp proc, indiv	0.00	0.22	0.29	NA	NA	0.02	XXX
G0239		A	Oth resp proc, group	0.00	0.29	0.30	NA	NA	0.02	XXX
G0245		R	Initial foot exam pt lops	0.88	0.85	0.83	0.32	0.32	0.04	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.55	0.55	0.16	0.16	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.66	0.62	0.16	0.17	0.02	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	3.26	4.11	NA	NA	0.01	XXX
G0249		R	Provide INR test mater/equip	0.00	3.33	3.49	NA	NA	0.01	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.08	0.08	NA	NA	0.01	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	PET imaging initial dx	1.50	0.00	0.60	0.00	0.60	0.04	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.67	0.66	0.21	0.22	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.37	0.18	0.25	0.11	0.20	0.01	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.07	0.10	0.07	0.10	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.13	0.13	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.14	0.13	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.14	0.13	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.14	0.13	NA	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.98	3.40	NA	NA	0.18	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.63	0.67	0.26	ZZZ

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.15	0.15	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.34	0.45	0.46	0.45	0.46	0.09	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	3.18	3.83	NA	NA	0.48	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	5.24	5.26	1.46	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	8.88	8.87	2.07	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.17	0.16	0.07	0.07	0.04	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.12	4.84	NA	NA	0.25	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.05	4.77	NA	NA	0.23	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.07	0.07	0.07	0.07	0.02	XXX
G0372		A	MD service required for PMD	0.17	0.05	0.13	0.05	0.05	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct admit hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.39	2.39	NA	NA	0.11	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	2.16	2.16	NA	NA	0.08	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.23	0.23	0.23	0.23	0.03	XXX
G0392		A	AV fistula or graft arterial	9.48	47.42	49.71	3.60	3.60	0.62	000
G0393		A	AV fistula or graft venous	6.03	36.66	38.77	2.35	2.36	0.34	000
G0394		X	Blood occult test,colorectal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.20	0.20	0.16	0.16	0.01	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.35	0.35	0.31	0.31	0.03	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	1.34	1.13	1.13	NA	NA	0.10	XXX
G0403		A	EKG for initial prevent exam	0.17	0.33	0.38	NA	NA	0.03	XXX
G0404		A	EKG tracing for initial prev	0.00	0.28	0.36	NA	NA	0.02	XXX
G0405		A	EKG interpret & report preve	0.17	0.05	0.05	0.05	0.05	0.01	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.25	0.24	0.03	XXX
G0407		A	Telheath inpt consult 25min	1.39	NA	NA	0.44	0.42	0.04	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	NA	0.62	0.59	0.06	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.23	0.23	NA	NA	0.01	XXX
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	6.57	6.71	1.98	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	9.48	9.53	2.64	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	9.00	9.31	2.42	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	11.73	11.68	3.49	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.54	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.30	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.24	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	1.06	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.60	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.46	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	1.80	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	1.03	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.77	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	2.16	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	1.23	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.93	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8489		X	CAD measures grp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8490		X	RA measures grp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8491		X	HIV/AIDS measures grp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8492		X	Prev Care measures grp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8493		X	Back pain measures grp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G8494		X	DM meas qual act perform	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G9033		X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.44	0.15	0.18	0.15	0.18	0.01	XXX
G9042		A	Low vision rehab orient/mobi	0.10	0.03	0.10	0.03	0.10	0.01	XXX
G9043		A	Low vision lowvision therapi	0.10	0.03	0.09	0.03	0.09	0.01	XXX
G9044		A	Low vision rehabilate teache	0.10	0.03	0.08	0.03	0.08	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.87	0.74	0.07	0.08	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.37	0.31	0.37	0.31	0.02	XXX
Q0035		A	Cardiokymography	0.17	0.29	0.33	NA	NA	0.03	XXX
Q0035	TC	A	Cardiokymography	0.00	0.24	0.28	NA	NA	0.02	XXX
Q0035	26	A	Cardiokymography	0.17	0.05	0.05	0.05	0.05	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.73	0.72	0.10	0.11	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.47	0.44	0.47	0.44	0.01	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM C: Codes with Interim RVUs

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
14000		A	Skin tissue rearrangement	6.19	8.60	8.43	5.81	5.74	0.59	090
14001		A	Skin tissue rearrangement	8.58	10.67	10.38	7.25	7.22	0.82	090
14020		A	Skin tissue rearrangement	7.02	9.71	9.46	6.68	6.66	0.64	090
14021		A	Skin tissue rearrangement	9.52	11.78	11.35	8.09	8.16	0.81	090
14040		A	Skin tissue rearrangement	8.44	10.26	9.92	7.15	7.18	0.62	090
14041		A	Skin tissue rearrangement	10.63	12.75	12.24	8.65	8.68	0.73	090
14060		A	Skin tissue rearrangement	9.07	9.79	9.56	7.36	7.40	0.68	090
14061		A	Skin tissue rearrangement	11.25	13.79	13.27	9.28	9.36	0.76	090
15570		A	Form skin pedicle flap	10.00	10.39	10.65	6.74	6.76	1.34	090
15572		A	Form skin pedicle flap	9.94	10.35	10.16	7.34	7.14	1.20	090
15574		A	Form skin pedicle flap	10.52	10.72	10.73	7.47	7.57	1.20	090
15576		A	Form skin pedicle flap	9.24	9.75	9.78	6.71	6.77	0.87	090
17106		A	Destruction of skin lesions	3.61	4.63	4.63	3.02	3.11	0.35	090
17107		A	Destruction of skin lesions	4.68	5.75	6.13	3.63	4.10	0.63	090
17108		A	Destruction of skin lesions	6.37	7.04	7.61	4.44	5.26	0.54	090
20696		A	Comp multiplane ext fixation	17.32	NA	NA	7.96	7.96	2.86	090
20697		A	Comp ext fixate strut change	0.00	33.08	33.08	0.00	0.00	0.01	000
20900		A	Removal of bone for graft	3.00	6.25	6.81	2.14	3.04	0.94	000
20902		A	Removal of bone for graft	4.58	NA	NA	2.70	3.75	1.30	000
21025		A	Excision of bone, lower jaw	9.87	10.70	11.11	7.37	7.88	1.32	090
22856		A	Cerv artific diskectomy	23.90	NA	NA	13.63	13.63	5.62	090
22861		A	Revise cerv artific disc	33.21	NA	NA	13.54	13.54	5.49	090
22864		A	Remove cerv artif disc	29.25	NA	NA	12.22	12.22	7.04	090
23120		A	Partial removal, collar bone	7.23	NA	NA	6.03	6.16	1.23	090
23410		A	Repair rotator cuff, acute	11.23	NA	NA	7.73	8.17	2.17	090
23412		A	Repair rotator cuff, chronic	11.77	NA	NA	7.97	8.47	2.32	090
23415		A	Release of shoulder ligament	9.07	NA	NA	6.82	7.13	1.74	090
23420		A	Repair of shoulder	13.35	NA	NA	9.05	9.52	2.32	090
25116		A	Remove wrist/forearm lesion	7.38	NA	NA	6.26	8.00	1.11	090
25310		A	Transplant forearm tendon	7.94	NA	NA	6.25	7.97	1.21	090
27027		A	Buttock fasciotomy	12.90	NA	NA	7.57	7.57	1.89	090
27057		A	Buttock fasciotomy w/dbrdmt	14.77	NA	NA	8.32	8.32	1.52	090
27062		A	Remove femur lesion/bursa	5.66	NA	NA	4.70	4.83	0.93	090
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	6.57	6.71	1.98	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	9.48	9.53	2.64	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	9.00	9.31	2.42	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	11.73	11.68	3.49	090
27244		A	Treat thigh fracture	18.00	NA	NA	10.79	10.95	2.78	090
27245		A	Treat thigh fracture	18.00	NA	NA	10.82	11.58	3.53	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.74	1.72	0.62	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27650		A	Repair achilles tendon	9.00	NA	NA	6.68	6.90	1.59	090
27654		A	Repair of achilles tendon	10.32	NA	NA	6.75	6.86	1.58	090
27690		A	Revise lower leg tendon	8.96	NA	NA	6.15	6.22	1.33	090
27691		A	Revise lower leg tendon	10.28	NA	NA	7.36	7.48	1.64	090
28120		A	Part removal of ankle/heel	5.64	7.89	7.75	3.94	4.06	0.77	090
28122		A	Partial removal of foot bone	7.56	8.29	7.95	4.75	4.89	0.98	090
28296		A	Correction of bunion	8.16	9.09	8.87	4.95	5.08	1.19	090
28725		A	Fusion of foot bones	11.97	NA	NA	6.84	7.21	1.87	090
28730		A	Fusion of foot bones	12.21	NA	NA	7.85	8.02	1.71	090
28825		A	Partial amputation of toe	5.85	7.90	7.69	4.09	3.95	0.50	090
29888		A	Knee arthroscopy/surgery	14.14	NA	NA	8.87	9.23	2.42	090
35535		A	Artery bypass graft	38.00	NA	NA	13.58	13.58	5.23	090
35570		A	Artery bypass graft	29.00	NA	NA	10.95	10.95	3.91	090
35632		A	Artery bypass graft	36.00	NA	NA	12.97	12.97	4.97	090
35633		A	Artery bypass graft	38.98	NA	NA	13.88	13.88	5.39	090
35634		A	Artery bypass graft	35.20	NA	NA	12.73	12.73	4.86	090
36820		A	Av fusion/forearm vein	14.39	NA	NA	5.46	5.71	1.95	090
36821		A	Av fusion direct any site	12.00	NA	NA	5.05	4.96	1.23	090
36825		A	Artery-vein autograft	10.00	NA	NA	4.39	4.56	1.35	090
38542		A	Explore deep node(s), neck	7.85	NA	NA	4.48	4.49	0.60	090
41512		A	Tongue suspension	6.75	NA	NA	8.46	8.46	0.45	090
41530		A	Tongue base vol reduction	4.38	73.12	73.12	5.57	5.57	0.31	010
42145		A	Repair palate, pharynx/uvula	9.63	NA	NA	7.54	7.55	0.65	090
42415		A	Excise parotid gland/lesion	17.99	NA	NA	9.01	9.50	1.43	090
42420		A	Excise parotid gland/lesion	20.87	NA	NA	10.01	10.63	1.65	090
42440		A	Excise submaxillary gland	7.05	NA	NA	4.29	4.42	0.59	090
43273		A	Endoscopic pancreatoscopy	2.24	1.08	1.08	1.08	1.08	0.16	ZZZ
43279		A	Lap myotomy, heller	22.00	NA	NA	8.07	8.07	2.62	090
46930		A	Destroy internal hemorrhoids	1.56	3.02	3.54	1.79	2.09	0.16	090
47525		A	Change bile duct catheter	1.54	13.38	13.84	1.29	1.67	0.33	010
49507		A	Prp i/hern init block >5 yr	9.97	NA	NA	4.59	4.56	1.27	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	NA	5.16	5.19	1.59	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	NA	3.96	3.91	0.99	090
49652		A	Lap vent/abd hernia repair	12.80	NA	NA	5.43	5.43	1.64	090
49653		A	Lap vent/abd hern proc comp	16.10	NA	NA	6.71	6.71	1.99	090
49654		A	Lap inc hernia repair	14.95	NA	NA	6.02	6.02	1.83	090
49655		A	Lap inc hern repair comp	18.00	NA	NA	7.23	7.23	2.22	090
49656		A	Lap inc hernia repair recur	15.00	NA	NA	6.03	6.03	1.86	090
49657		A	Lap inc hern recur comp	22.00	NA	NA	8.32	8.32	2.73	090
51102		A	Drain bl w/cath insertion	2.70	3.72	3.72	1.38	1.38	0.28	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.93	2.75	0.43	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	3.15	2.96	0.46	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	3.46	3.25	0.51	000

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	3.83	3.58	0.55	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	4.06	3.79	0.58	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	4.51	4.22	0.65	000
52400		A	Cystouretero w/congen repr	8.66	NA	NA	5.00	4.69	0.68	090
52500		A	Revision of bladder neck	7.99	NA	NA	5.85	5.38	0.60	090
52640		A	Relieve bladder contracture	4.73	NA	NA	3.68	3.51	0.47	090
53445		A	Insert uro/ves nck sphincter	15.21	NA	NA	9.63	9.01	0.99	090
54405		A	Insert multi-comp penis pros	14.39	NA	NA	8.57	7.93	0.95	090
54410		A	Remove/replace penis prosth	15.00	NA	NA	9.40	8.72	1.10	090
54530		A	Removal of testis	8.35	NA	NA	5.93	5.52	0.66	090
55706		A	Prostate saturation sampling	6.15	NA	NA	4.39	4.39	0.39	010
56620		A	Partial removal of vulva	7.35	NA	NA	4.71	4.74	0.90	090
57287		A	Revise/remove sling repair	10.97	NA	NA	7.03	6.66	0.90	090
57288		A	Repair bladder defect	12.00	NA	NA	6.56	6.41	1.12	090
60220		A	Partial removal of thyroid	12.29	NA	NA	5.89	5.97	1.32	090
60225		A	Partial removal of thyroid	14.67	NA	NA	7.16	7.24	1.64	090
61796		A	Srs, cranial lesion simple	10.79	NA	NA	6.85	6.85	2.64	090
61797		A	Srs, cran les simple, addl	3.48	1.34	1.34	1.34	1.34	0.72	ZZZ
61798		A	Srs, cranial lesion complex	10.79	NA	NA	6.85	6.85	2.64	090
61799		A	Srs, cran les complex, addl	4.81	1.85	1.85	1.85	1.85	1.00	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.11	1.11	0.57	ZZZ
61885		A	Insrt/redo neurostim 1 array	7.37	NA	NA	7.38	6.87	1.59	090
62263		A	Epidural lysis mult sessions	6.41	8.72	9.74	2.88	2.96	0.41	010
62267		A	Interdiscal perq aspir, dx	3.00	3.38	3.38	1.15	1.15	0.23	000
62350		A	Implant spinal canal cath	6.00	NA	NA	2.80	3.09	1.02	010
62355		A	Remove spinal canal catheter	4.30	NA	NA	2.35	2.56	0.71	010
62360		A	Insert spine infusion device	4.28	NA	NA	2.50	2.55	0.34	010
62361		A	Implant spine infusion pump	5.60	NA	NA	3.48	3.60	0.80	010
62362		A	Implant spine infusion pump	6.05	NA	NA	3.11	3.43	1.18	010
62365		A	Remove spine infusion device	4.60	NA	NA	2.72	2.94	0.86	010
63620		A	Srs, spinal lesion	10.79	NA	NA	6.85	6.85	2.64	090
63621		A	Srs, spinal lesion, addl	4.00	1.54	1.54	1.54	1.54	0.83	ZZZ
63650		A	Implant neuroelectrodes	7.15	NA	NA	2.71	2.83	0.53	090
63685		A	Insrt/redo spine n generator	6.00	NA	NA	2.90	3.22	1.05	090
63688		A	Revise/remove neuroreceiver	5.25	NA	NA	2.88	3.05	0.89	090
64416		A	N block cont infuse, b plex	1.81	NA	NA	0.22	0.36	0.31	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	NA	0.23	0.43	0.20	000
64448		A	N block inj fem, cont inf	1.63	NA	NA	0.19	0.35	0.18	000
64449		A	N block inj, lumbar plexus	1.81	NA	NA	0.26	0.44	0.15	000
64455		A	N block inj, plantar digit	0.75	0.52	0.52	0.24	0.24	0.09	000
64573		A	Implant neuroelectrodes	8.15	NA	NA	5.31	5.31	1.60	090
64632		A	N block inj, common digit	1.20	0.95	0.95	0.63	0.63	0.05	010
64708		A	Revise arm/leg nerve	6.22	NA	NA	5.04	5.00	0.96	090

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64831		A	Repair of digit nerve	9.00	NA	NA	6.77	6.86	1.41	090
65285		A	Repair of eye wound	14.43	NA	NA	8.85	8.96	0.64	090
65756		A	Corneal trnspl, endothelial	16.60	NA	NA	10.14	10.14	0.74	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
66982		A	Cataract surgery, complex	14.83	NA	NA	9.03	9.26	0.63	090
67225		A	Eye photodynamic ther add-on	0.47	0.22	0.23	0.18	0.19	0.02	ZZZ
68810		A	Probe nasolacrimal duct	2.09	3.16	3.29	2.04	2.20	0.10	010
69930		A	Implant cochlear device	17.60	NA	NA	12.24	12.90	1.36	090
77785	26	A	Hdr brachytx, 1 channel	1.42	0.49	0.49	0.49	0.49	0.07	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.12	1.04	1.12	1.04	0.17	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	1.68	1.71	1.68	1.71	0.25	XXX
78808		A	Iv inj ra drug dx study	0.18	1.01	1.01	NA	NA	0.04	XXX
90951		A	Esrd serv, 4 visits p mo, <2	18.46	7.27	7.60	7.27	7.60	0.61	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	5.49	5.31	5.49	5.31	0.56	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.07	3.29	3.07	3.29	0.31	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	1.93	2.24	1.93	2.24	0.20	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	4.68	4.62	4.68	4.62	0.41	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.07	3.23	3.07	3.23	0.28	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	1.81	2.10	1.81	2.10	0.17	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.31	2.46	2.31	2.46	0.17	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	1.73	1.90	1.73	1.90	0.14	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.10	1.30	1.10	1.30	0.10	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	3.14	4.14	3.14	4.14	0.36	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	2.79	3.08	2.79	3.08	0.33	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	2.70	2.95	2.70	2.95	0.29	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	1.64	1.83	1.64	1.83	0.14	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.16	0.18	0.16	0.18	0.01	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.11	0.11	0.11	0.11	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.11	0.11	0.11	0.11	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.06	0.07	0.06	0.07	0.01	XXX
92620		A	Auditory function, 60 min	1.50	0.74	0.84	0.74	0.84	0.04	XXX
92621		A	Auditory function, + 15 min	0.35	0.18	0.19	0.18	0.19	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.54	0.69	0.54	0.69	0.03	XXX
92626		A	Eval aud rehab status	1.40	0.73	1.10	0.73	1.10	0.04	XXX
92627		A	Eval aud status rehab add-on	0.33	0.19	0.28	0.19	0.28	0.01	ZZZ
92640		A	Aud brainstem implt programg	1.76	0.94	0.94	0.94	0.94	0.05	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.17	0.17	0.17	0.17	0.02	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.34	0.33	0.34	0.33	0.02	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.41	0.41	0.41	0.41	0.02	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.48	0.48	0.48	0.48	0.02	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.45	0.43	0.45	0.43	0.03	XXX
93283	26	A	Icd device progr eval, dual	1.05	0.56	0.56	0.56	0.56	0.04	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.67	0.67	0.67	0.67	0.04	XXX
93285	26	A	Ilr device eval progr	0.52	0.28	0.28	0.28	0.28	0.02	XXX
93286	26	A	Pre-op pm device eval	0.30	0.10	0.10	0.10	0.10	0.02	XXX
93287	26	A	Pre-op icd device eval	0.45	0.15	0.15	0.15	0.15	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.23	0.23	0.23	0.23	0.01	XXX
93289	26	A	Icd device interrogate	0.78	0.41	0.41	0.41	0.41	0.02	XXX
93290	26	A	Icm device eval	0.43	0.14	0.14	0.14	0.14	0.02	XXX
93291	26	A	Ilr device interrogate	0.43	0.23	0.23	0.23	0.23	0.02	XXX
93292	26	A	Wcd device interrogate	0.43	0.23	0.23	0.23	0.23	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.15	0.13	0.15	0.13	0.02	XXX
93294		A	Pm device interrogate remote	0.65	0.34	0.34	0.34	0.34	0.03	XXX
93295		A	Icd device interrogat remote	1.17	0.63	0.63	0.63	0.63	0.04	XXX
93296		A	Pm/icd remote tech serv	0.00	1.00	1.00	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.17	0.17	0.17	0.17	0.02	XXX
93298		A	Ilr device interrogat remote	0.52	0.28	0.28	0.28	0.28	0.02	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.65	0.65	0.65	0.65	0.04	XXX
93350	26	A	Stress tte only	1.46	0.76	0.71	0.76	0.71	0.05	XXX
93351		A	Stress tte complete	1.75	5.60	5.60	NA	NA	0.33	XXX
93352		A	Admin ecg contrast agent	0.19	0.84	0.84	NA	NA	0.04	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95992		B	Canalith repositioning proc	0.75	0.36	0.36	0.25	0.25	0.02	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.21	0.27	0.14	0.22	0.01	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.18	0.25	0.11	0.20	0.01	XXX
99475		A	Ped crit care age 2-5, init	11.25	2.83	2.83	2.83	2.83	0.79	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	1.70	1.70	1.70	1.70	0.38	XXX
G0402		A	Initial preventive exam	1.34	1.13	1.13	NA	NA	0.10	XXX
G0403		A	EKG for initial prevent exam	0.17	0.33	0.38	NA	NA	0.03	XXX
G0404		A	EKG tracing for initial prev	0.00	0.28	0.36	NA	NA	0.02	XXX
G0405		A	EKG interpret & report preve	0.17	0.05	0.05	0.05	0.05	0.01	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	6.57	6.71	1.98	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	9.48	9.53	2.64	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	9.00	9.31	2.42	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	11.73	11.68	3.49	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.54	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.30	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.24	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	1.06	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.60	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.46	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	1.80	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	1.03	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.77	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	2.16	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	1.23	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.93	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM D: 2009 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2009 GAF
00831	01	Alaska	1.288
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
00590	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.057
00590	03	Fort Lauderdale, FL	1.056
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
00528	01	New Orleans, LA	1.017
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00590	99	Rest of Florida	1.001
31144	40	New Hampshire	0.996
00952	12	East St. Louis, IL	0.995
04402	31	Austin, TX	0.992
31142	03	Southern Maine	0.991
00973	50	Virgin Islands	0.991
04402	15	Galveston, TX	0.991

Contractor	Locality	Locality name	2009 GAF
00835	01	Portland, OR	0.987
12302	99	Rest of Maryland	0.987
04402	09	Brazoria, TX	0.985
04402	28	Fort Worth, TX	0.984
05302	02	Metropolitan Kansas City, MO	0.983
04102	01	Colorado	0.982
00883	00	Ohio	0.977
00836	99	Rest of Washington	0.977
03102	00	Arizona	0.974
31145	50	Vermont	0.973
05392	01	Metropolitan St Louis, MO	0.973
12502	99	Rest of Pennsylvania	0.970
00953	99	Rest of Michigan	0.969
00954	00	Minnesota	0.963
00904	00	Virginia	0.961
03502	09	Utah	0.960
04402	20	Beaumont, TX	0.959
00952	99	Rest of Illinois	0.956
04202	05	New Mexico	0.955
05535	00	North Carolina	0.953
04402	99	Rest of Texas	0.950
00630	00	Indiana	0.948
00835	99	Rest of Oregon	0.948
13282	99	Rest of New York	0.943
00528	99	Rest of Louisiana	0.943
00511	99	Rest of Georgia	0.943
00951	00	Wisconsin	0.942
00884	16	West Virginia	0.938
00880	01	South Carolina	0.937
05440	35	Tennessee	0.936
31142	99	Rest of Maine	0.933
05202	00	Kansas	0.932
05130	00	Idaho	0.932
00512	00	Mississippi	0.929
03602	21	Wyoming	0.927
00660	00	Kentucky	0.926
05402	00	Nebraska	0.923
05392	99	Rest of Missouri*	0.922
05302	99	Rest of Missouri*	0.922
05102	00	Iowa	0.922
03202	01	Montana	0.921
04302	00	Oklahoma	0.920
03402	02	South Dakota	0.918
00510	00	Alabama	0.917
00520	13	Arkansas	0.912
03302	01	North Dakota	0.908

Contractor	Locality	Locality name	2009 GAF
00973	20	Puerto Rico	0.837

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI)+(0.038658 * mp GPCI).
GAF values contain a 1.000 floor on physician work GPCI (1.500 work floor in Alaska).
* Indicates multiple contractors.

ADDENDUM E: 2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality***

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.853	0.496
00831	01	Alaska	1.500	1.090	0.646
03102	00	Arizona	1.000	0.957	0.822
00520	13	Arkansas	1.000	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	1.000	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
00590	03	Fort Lauderdale, FL	1.000	1.018	2.250
00590	04	Miami, FL	1.000	1.069	3.167
00590	99	Rest of Florida	1.000	0.939	1.724
00511	01	Atlanta, GA	1.009	1.014	0.836
00511	99	Rest of Georgia	1.000	0.883	0.829
01202	01	Hawaii/Guam	1.000	1.161	0.665
05130	00	Idaho	1.000	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	1.000	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	1.000	0.880	1.219
00630	00	Indiana	1.000	0.918	0.599
05102	00	Iowa	1.000	0.870	0.434
05202	00	Kansas	1.000	0.882	0.557
00660	00	Kentucky	1.000	0.860	0.652
00528	01	New Orleans, LA	1.000	1.044	0.956
00528	99	Rest of Louisiana	1.000	0.878	0.892
31142	03	Southern Maine	1.000	1.025	0.492
31142	99	Rest of Maine	1.000	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	1.000	0.982	0.874
31143	01	Metropolitan Boston	1.029	1.291	0.764
31143	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	1.000	0.923	1.083

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00954	00	Minnesota	1.000	0.983	0.245
00512	00	Mississippi	1.000	0.854	0.808
05302	02	Metropolitan Kansas City, MO	1.000	0.945	1.188
05392	01	Metropolitan St Louis, MO	1.000	0.931	1.075
05392	99	Rest of Missouri*	1.000	0.821	0.997
05302	99	Rest of Missouri*	1.000	0.821	0.997
03202	01	Montana	1.000	0.847	0.673
05402	00	Nebraska	1.000	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	1.000	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	1.000	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	1.000	0.921	0.425
05535	00	North Carolina	1.000	0.925	0.634
03302	01	North Dakota	1.000	0.844	0.387
00883	00	Ohio	1.000	0.927	1.232
04302	00	Oklahoma	1.000	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	1.000	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	1.000	0.925	1.081
00973	20	Puerto Rico	1.000	0.694	0.250
00524	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	1.000	0.906	0.446
03402	02	South Dakota	1.000	0.864	0.420
05440	35	Tennessee	1.000	0.889	0.608
04402	31	Austin, TX	1.000	0.984	0.969
04402	20	Beaumont, TX	1.000	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	1.000	0.953	1.110
04402	15	Galveston, TX	1.000	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	1.000	0.879	1.065
03502	09	Utah	1.000	0.907	1.026
31145	50	Vermont	1.000	0.983	0.489
00904	00	Virginia	1.000	0.942	0.657
00973	50	Virgin Islands	1.000	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	1.000	0.974	0.693

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00884	16	West Virginia	1.000	0.827	1.353
00951	00	Wisconsin	1.000	0.921	0.409
03602	21	Wyoming	1.000	0.842	0.889

* Indicates multiple contractors.
** 2009 work GPCI reflects the 1.000 floor (1.500 floor in Alaska).
*** 2009 GPCIs are the second year of the update transition and reflect the fully implemented updated GPCIs.

ADDENDUM F: Multiple Procedure Payment Reduction Code List (Effective January 1, 2009)

Code	Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical
76604	Us exam, chest, b-scan
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)	
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye
71270	Ct thorax w/o & w/ dye
71275	Ct angiography, chest
72191	Ct angiography, pelv w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
74175	Ct angiography, abdom w/o & w/ dye
75635	Ct angio abdominal arteries
0067T	Ct colonography; dx
Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	
70450	Ct head/brain w/o dye
70460	Ct head/brain w/ dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/ dye
70482	Ct orbit/ear/fossa w/o & w/ dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/ dye
70488	Ct maxillofacial w/o & w/ dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/ dye

70492	Ct soft tissue neck w/o & w/ dye
70496	Ct angiography, head
70498	Ct angiography, neck
Family 4 MRI and MRA (Chest/Abd/Pelvis)	
71550	Mri chest w/o dye
71551	Mri chest w/ dye
71552	Mri chest w/o & w/ dye
71555	Mri angio chest w/ or w/o dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye
72198	Mri angio pelvis w/ or w/o dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
74185	Mri angio, abdom w/ or w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Cardiac mri w/stress img & dye
77058	Mri, one breast
77059	Mri, broth breasts
	Family 5 MRI and MRA (Head/Brain/Neck)
70336	mri, temporomandibular joint(s)
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/ dye
70543	Mri orbit/face/neck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiography head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiography neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
Family 6 MRI and MRA (spine)	
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye

72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
Family 7 CT (spine)	
72125	CT neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
Family 8 MRI and MRA (lower extremities)	
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
73725	Mr angio lower ext w or w/o dye
Family 9 CT and CTA (lower extremities)	
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
Family 10 Mr and MRI (upper extremities and joints)	
73218	Mri upper extr w/o dye
73219	Mri upper extr w/dye
73220	Mri upper extremity w/o & w/dye
73221	Mri joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
Family 11 CT and CTA (upper extremities)	
73200	Ct upper extremity w/o dye

73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye

ADDENDUM G: CY 2009 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8556
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.7397
10420	Akron, OH Portage County, OH Summit County, OH	0.9422
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9196
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9201
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9732

10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8591
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	1.0037
11020	Altoona, PA Blair County, PA	0.9004
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9433
11180	Ames, IA Story County, IA	1.0025
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2607
11300	Anderson, IN Madison County, IN	0.9257
11340	Anderson, SC Anderson County, SC	1.0113
11460	Ann Arbor, MI Washtenaw County, MI	1.1037
11500	Anniston-Oxford, AL Calhoun County, AL	0.8376
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9975
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9660
12020	Athens-Clarke County, GA Clarke County, GA	1.0135

	Madison County, GA Oconee County, GA Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	1.0307
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.2652
12220	Auburn-Opelika, AL Lee County, AL	0.7972
12260	Augusta-Richmond County, GA-SC Burke County, GA	1.0160

	Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0077
12540	Bakersfield, CA Kern County, CA	1.1823
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0625
12620	Bangor, ME Penobscot County, ME	1.0751
12700	Barnstable Town, MA Barnstable County, MA	1.3360
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8626
12980	Battle Creek, MI Calhoun County, MI	1.0694
13020	Bay City, MI	0.9772

	Bay County, MI	
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8960
13380	Bellingham, WA Whatcom County, WA	1.2300
13460	Bend, OR Deschutes County, OR	1.2020
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.1146
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9304
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9060
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9290
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7553
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8617
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9488

14060	Bloomington-Normal, IL McLean County, IL	0.9852
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9793
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2571
14500	Boulder, CO Boulder County, CO	1.0886
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8864
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0461
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1381
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3597
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9421
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.0109
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0078
15500	Burlington, NC Alamance County, NC	0.9231
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT	0.9779

	Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1714
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0933
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9342
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9929
16180	Carson City, NV Carson City, NV	1.0702
16220	Casper, WY Natrona County, WY	1.0122
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9425
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9997
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8744
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9731
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC	1.0139

	Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	1.0372
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9381
16940	Cheyenne, WY Laramie County, WY	0.9802
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0989
17020	Chico, CA Butte County, CA	1.1515
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY	1.0236

	Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8768
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8464
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9765
17660	Coeur d'Alene, ID Kootenai County, ID	0.9850
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9876
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0543
17860	Columbia, MO Boone County, MO Howard County, MO	0.9024
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC	0.9439

	Lexington County, SC Richland County, SC Saluda County, SC	
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9234
18020	Columbus, IN Bartholomew County, IN	1.0291
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0507
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9085
18700	Corvallis, OR Benton County, OR	1.1945
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8259
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0509

19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9198
19180	Danville, IL Vermilion County, IL	0.9905
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8871
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8913
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9725
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8245
19500	Decatur, IL Macon County, IL	0.8607
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9394
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1431
19780	Des Moines-West Des Moines, IA Dallas County, IA	1.0076

	Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0523
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8045
20100	Dover, DE Kent County, DE	1.0910
20220	Dubuque, IA Dubuque County, IA	0.8855
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0950
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0284
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0216
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1923
20940	El Centro, CA Imperial County, CA	0.9242
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.9008
21140	Elkhart-Goshen, IN	1.0110

	Elkhart County, IN	
21300	Elmira, NY Chemung County, NY	0.8715
21340	El Paso, TX El Paso County, TX	0.9187
21500	Erie, PA Erie County, PA	0.9207
21660	Eugene-Springfield, OR Lane County, OR	1.1688
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9183
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1937
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.7397
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8629
22140	Farmington, NM San Juan County, NM	0.8507
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9869
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9479
22380	Flagstaff, AZ Coconino County, AZ	1.2409
22420	Flint, MI	1.2073

	Genesee County, MI	
22500	Florence, SC Darlington County, SC Florence County, SC	0.8591
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8317
22540	Fond du Lac, WI Fond du Lac County, WI	0.9820
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0426
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0510
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8133
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9266
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9696
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0259
23420	Fresno, CA Fresno County, CA	1.1633
23460	Gadsden, AL Etowah County, AL	0.8436
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9840

23580	Gainesville, GA Hall County, GA	0.9625
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9774
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8953
24140	Goldsboro, NC Wayne County, NC	0.9661
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7994
24300	Grand Junction, CO Mesa County, CO	1.0368
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9705
24500	Great Falls, MT Cascade County, MT	0.9282
24540	Greeley, CO Weld County, CO	1.0233
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0259
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9522
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9984
24860	Greenville-Mauldin-Easley, SC	1.0562

	Greenville County, SC Laurens County, SC Pickens County, SC	
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.7397
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9541
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9507
25260	Hanford-Corcoran, CA Kings County, CA	1.1486
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9672
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9398
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1696
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7753
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9485
25980	Hinesville-Fort Stewart, GA[1]	0.9626

	Liberty County, GA Long County, GA	
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9519
26180	Honolulu, HI Honolulu County, HI	1.2481
26300	Hot Springs, AR Garland County, AR	0.9630
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8198
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0396
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9779
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9597
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9595
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN	1.0470

	Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0021
27060	Ithaca, NY Tompkins County, NY	1.0159
27100	Jackson, MI Jackson County, MI	0.9837
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8524
27180	Jackson, TN Chester County, TN Madison County, TN	0.9006
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9509
27340	Jacksonville, NC Onslow County, NC	0.8641
27500	Janesville, WI Rock County, WI	1.0210
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.9272

27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8423
27780	Johnstown, PA Cambria County, PA	0.8369
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8365
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9939
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.1413
28100	Kankakee-Bradley, IL Kankakee County, IL	1.1079
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0155
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0473
28660	Killeen-Temple-Fort Hood, TX Bell County, TX	0.9262

	Coryell County, TX Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8182
28740	Kingston, NY Ulster County, NY	0.9906
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8328
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9879
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0311
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9744
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8849
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7984
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0978
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0352
29460	Lakeland-Winter Haven, FL	0.9014

	Polk County, FL	
29540	Lancaster, PA Lancaster County, PA	0.9894
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0494
29700	Laredo, TX Webb County, TX	0.8840
29740	Las Cruces, NM Dona Ana County, NM	0.9435
29820	Las Vegas-Paradise, NV Clark County, NV	1.2650
29940	Lawrence, KS Douglas County, KS	0.8816
30020	Lawton, OK Comanche County, OK	0.8676
30140	Lebanon, PA Lebanon County, PA	0.9462
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	1.0002
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9722
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9626
30620	Lima, OH Allen County, OH	0.9961
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0312
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR	0.9164

	Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9262
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8844
31020	Longview, WA Cowlitz County, WA	1.1842
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2900
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9773
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9226
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA	0.9271

	Lynchburg City, VA	
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0119
31460	Madera, CA Madera County, CA	0.8389
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1589
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0946
31900	Mansfield, OH[1] Richland County, OH	0.9859
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.7397
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9520
32780	Medford, OR Jackson County, OR	1.0825
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9755
32900	Merced, CA Merced County, CA	1.2937
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0387

33140	Michigan City-La Porte, IN LaPorte County, IN	0.9678
33260	Midland, TX Midland County, TX	1.0384
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0651
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1782
33540	Missoula, MT Missoula County, MT	0.9482
33660	Mobile, AL Mobile County, AL	0.8356
33700	Modesto, CA Stanislaus County, CA	1.2885
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8348
33780	Monroe, MI Monroe County, MI	0.9448
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL	0.8753

	Montgomery County, AL	
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.9017
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7665
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0875
34620	Muncie, IN Delaware County, IN	0.8970
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0625
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9142
34900	Napa, CA Napa County, CA	1.5343
34940	Naples-Marco Island, FL Collier County, FL	1.0220
34980	Nashville-Davidson—Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	1.0043
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3159
35084	Newark-Union, NJ-PA	1.2396

	Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	
35300	New Haven-Milford, CT New Haven County, CT	1.2408
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9619
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3615
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9580
35980	Norwich-New London, CT New London County, CT	1.2044
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7004
36100	Ocala, FL Marion County, FL	0.8995
36140	Ocean City, NJ	1.2148

	Cape May County, NJ	
36220	Odessa, TX Ector County, TX	1.0012
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9672
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9219
36500	Olympia, WA Thurston County, WA	1.2191
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9976
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9627
36780	Oshkosh-Neenah, WI Winnebago County, WI	1.0011
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.9177
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2628

	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9861
37380	Palm Coast, FL Flagler County, FL	0.9471
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8834
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8313
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8561
37764	Peabody, MA Essex County, MA	1.1356
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8709
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9550
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1601
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0967
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR	0.8375

	Lincoln County, AR	
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9170
38340	Pittsfield, MA Berkshire County, MA	1.1037
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9873
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.7397
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0506
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2105
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0430
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1539
39140	Prescott, AZ Yavapai County, AZ	1.0800

39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1302
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9913
39380	Pueblo, CO Pueblo County, CO	0.9207
39460	Punta Gorda, FL Charlotte County, FL	0.9485
39540	Racine, WI Racine County, WI	0.9567
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0374
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0142
39740	Reading, PA Berks County, PA	0.9766
39820	Redding, CA Shasta County, CA	1.4509
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0902
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA	0.9894

	Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2118
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9151
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1850
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9310
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0393
40484	Rockingham County, NH Rockingham County, NH	1.0489

	Strafford County, NH	
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9543
40660	Rome, GA Floyd County, GA	0.9652
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4341
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9195
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1598
41100	St. George, UT Washington County, UT	0.9532
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0968
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO	0.9517

	Warren County, MO Washington County, MO St. Louis City, MO	
41420	Salem, OR Marion County, OR Polk County, OR	1.1501
41500	Salinas, CA Monterey County, CA	1.5837
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9770
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9677
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8902
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9358
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2192
41780	Sandusky, OH Erie County, OH	0.9373
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6409
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR	0.7397

	Sabana Grande Municipio, PR San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7056
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR	0.7397

	Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3146
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2673
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2584
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7360
42140	Santa Fe, NM Santa Fe County, NM	1.1211
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6408
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9671
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8805
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2421
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9740
43100	Sheboygan, WI Sheboygan County, WI	0.9426
43300	Sherman-Denison, TX Grayson County, TX	0.9536

43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8921
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9420
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9884
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0314
43900	Spartanburg, SC Spartanburg County, SC	0.9537
44060	Spokane, WA Spokane County, WA	1.1158
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9618
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0995
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8902
44220	Springfield, OH Clark County, OH	0.9379
44300	State College, PA Centre County, PA	0.9444

44700	Stockton, CA San Joaquin County, CA	1.2696
44940	Sumter, SC Sumter County, SC	0.8725
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0342
45104	Tacoma, WA Pierce County, WA	1.1878
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9472
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9354
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9600
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8606
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9940
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS	0.9252

	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ Mercer County, NJ	1.1205
46060	Tucson, AZ Pima County, AZ	0.9752
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8924
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8978
46340	Tyler, TX Smith County, TX	0.9303
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8880
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8482
46700	Vallejo-Fairfield, CA Solano County, CA	1.5173
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8585
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0954
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA	0.9388

	Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	
47300	Visalia-Porterville, CA Tulare County, CA	1.0719
47380	Waco, TX McLennan County, TX	0.9083
47580	Warner Robins, GA Houston County, GA	0.9499
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0465
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA	1.1441

	Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8971
48140	Wausau, WI Marathon County, WI	1.0160
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8537
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.0085
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0310
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7397
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9583
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9333
48700	Williamsport, PA	0.8555

	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1302
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9604
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0357
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9527
49340	Worcester, MA Worcester County, MA	1.1450
49420	Yakima, WA Yakima County, WA	1.0512
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.7397
49620	York-Hanover, PA York County, PA	1.0058
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9420
49700	Yuba City, CA	1.1768
49740	Yuma, AZ Yuma County, AZ	0.9807

ADDENDUM H: CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.8017
2	Alaska	1.2572
3	Arizona	0.8932
4	Arkansas	0.7897
5	California	1.2971
6	Colorado	1.0113
7	Connecticut	1.1640
8	Delaware	1.0527
10	Florida	0.8986
11	Georgia	0.8044
12	Hawaii	1.1623
13	Idaho	0.8085
14	Illinois	0.8861
15	Indiana	0.8953
16	Iowa	0.9303
17	Kansas	0.8508
18	Kentucky	0.8245
19	Louisiana	0.7869
20	Maine	0.9134
21	Maryland	0.9387
22	Massachusetts	1.2332
23	Michigan	0.9391
24	Minnesota	0.9573
25	Mississippi	0.8014
26	Missouri	0.8434
27	Montana	0.9149
28	Nebraska	0.9225
29	Nevada	0.9914
30	New Hampshire	1.0798
31	New Jersey[1]	------
32	New Mexico	0.9312
33	New York	0.8607

CBSA Code	Nonurban Area	Wage Index
34	North Carolina	0.9062
35	North Dakota	0.7613
36	Ohio	0.9075
37	Oklahoma	0.8170
38	Oregon	1.0797
39	Pennsylvania	0.8839
40	Puerto Rico	0.7397
41	Rhode Island[1]	------
42	South Carolina	0.9022
43	South Dakota	0.9091
44	Tennessee	0.8231
45	Texas	0.8342
46	Utah	0.8736
47	Vermont	1.0650
48	Virgin Islands	0.7397
49	Virginia	0.8307
50	Washington	1.0758
51	West Virginia	0.7928
52	Wisconsin	0.9904
53	Wyoming	0.9843

[1] All counties within the State are classified as urban.

ADDENDUM I: CPT/HCPCS Imaging Codes Defined by Section 5102(b) of the DRA

HCPCS	Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye

HCPCS	Descriptor
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye

HCPCS	Descriptor
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye

HCPCS	Descriptor
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert

HCPCS	Descriptor
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75558	Cardiac MRI w/ flow/velocity
75559	Cardiac MRI w/ stress imaging
75560	Cardiac MRI w/ flow/velocity/stress
75561	Cardiac MRI w/ & w/o contrast
75562	Cardiac MRI w/ flow velocity
75563	Cardiac MRI w/ stress imaging
75564	Cardiac MRI w/ flow/velocity/stress
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt

HCPCS	Descriptor
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage

HCPCS	Descriptor
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus

HCPCS	Descriptor
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization

HCPCS	Descriptor
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density/v-fracture
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging

HCPCS	Descriptor
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78478	Heart wall motion add-on
78480	Heart function add-on
78481	Heart first pass, single
78483	Heart first pass, multiple

HCPCS	Descriptor
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78715	Renal vascular flow exam
78730	Urinary bladder retention
78740	Ureteral reflux study
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body

HCPCS	Descriptor
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92135	Scanning computer ophthalmic
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Echocardiography
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study

HCPCS	Descriptor
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	PET img wholbod melano nonco
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

ADDENDUM J: List of CPT[1]/HCPCS Codes Used to Define Certain Designated Health Service Categories[2] under Section 1877 of the Social Security Act (Effective Date: January 1, 2009)

CLINICAL LABORATORY SERVICES	
INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:	
86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86960	Vol reduction of blood/prod
86965	Pooling blood platelets
86985	Split blood or products
INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:	
0030T	Antiprothrombin antibody
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
0103T	Holotranscobalamin
0104T	At rest cardio gas rebreathe
0111T	RBC membranes fatty acids
0140T	Exhaled breath condensate ph
0194T	Procalcitonin (PCT)
36415	Routine venipuncture
78110	Plasma volume, single
78111	Plasma volume, multiple
78120	Red cell mass, single
78121	Red cell mass, multiple

78122	Blood volume
78130	Red cell survival study
78191	Platelet survival
78267	Breath tst attain/anal c-14
78268	Breath test analysis c-14
78270	Vit B-12 absorption exam
78271	Vit B-12 absrp exam, int fac
78272	Vit B-12 absorp, combined
78725	Kidney function study
G0027	Semen analysis
G0103	Psa, total screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
G0394	Blood occult test colorectal
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	

INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/outpatient speech-language pathology services:	
0019T	Extracorp shock wv tx,ms nos
0183T	Wound ultrasound
64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
95992	Canalith repositioning proc
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend

96125	Cognitive test by HC pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm

97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
INCLUDE the following CPT and HCPCS codes:	
0042T	Ct perfusion w/contrast, cbf
0067T	Ct colonography;dx
0144T	Ct heart wo dye; qual calc
0145T	Ct heart w/wo dye funct
0146T	Ccta w/wo dye
0147T	Ccta w/wo, quan calcium
0148T	Ccta w/wo, strxr
0149T	Ccta w/wo, strxr quan calc
0150T	Ccta w/wo, disease strxr
0151T	Ct heart funct add-on
0159T	Cad breast mri
0174T	Cad cxr with interp
0175T	Cad cxr remote
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses

70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye

70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
70555	Fmri brain by phys/psych
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine

72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow

73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye

73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75557	Cardiac MRI for morph
75559	Cardiac MRI w/stress img
75561	Cardiac MRI for morph w/dye
75563	Card MRI w/stress img & dye
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76010	X-ray, nose to rectum
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays

76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart

76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
77014	Ct scan for therapy guide
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77055	Mammogram, one breast
77056	Mammogram, both breasts
77057	Mammogram, screening
77058	Mri, one breast
77059	Mri, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone length studies
77074	X-rays, bone survey, limited
77075	X-rays, bone survey complete
77076	X-rays, bone survey, infant
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density, vert fx
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging

78075	Adrenal nuclear imaging
78099	Endocrine nuclear procedure
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78199	Blood/lymph nuclear exam
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78299	GI nuclear procedure
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78399	Musculoskeletal nuclear exam
78414	Non-imaging heart function
78428	Cardiac shunt imaging
78445	Vascular flow imaging

78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78478	Heart wall motion add-on
78480	Heart function add-on
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78499	Cardiovascular nuclear exam
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78599	Respiratory nuclear exam
78600	Brain image < 4 views
78601	Brain image w/flow < 4 views
78605	Brain image 4+ views
78606	Brain image w/flow 4 + views
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only

78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78699	Nervous system nuclear exam
78700	Kidney imaging, morphol
78701	Kidney imaging with flow
78707	K flow/funct image w/o drug
78708	K flow/funct image w/drug
78709	K flow/funct image, multiple
78710	Kidney imaging (3D)
78730	Urinary bladder retention
78740	Ureteral reflux study
78761	Testicular imaging w/flow
78799	Genitourinary nuclear exam
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	PET image, ltd area
78812	PET image, skull-thigh
78813	PET image, full body
78814	PET image w/ct, lmtd
78815	PET image w/ct, skull-thigh
78816	PET image w/ct, full body
78999	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
93303	Echo transthoracic
93304	Echo transthoracic
93306	TTE w/Doppler, complete
93307	TTE w/o Doppler, complete
93308	TTE, f-up or lmtd

93320	Doppler echo exam, heart [if used in conjunction with 93303-93304]
93321	Doppler echo exam, heart [if used in conjunction with 93303, 93304, 93308]
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827,76828, 93303, 93304, 93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A9500	Tc99m sestamibi
A9501	Technetium TC-99m teboroxime
A9502	Tc99m tetrofosmin
A9503	Tc99m medronate
A9504	Tc99m apcitide
A9505	TL201 thallium
A9507	In111 capromab
A9508	I131 iodobenguate, dx

A9509	Iodine I-123 sod iodide mil
A9510	Tc99m disofenin
A9512	Tc99m pertechnetate
A9516	Iodine I-123 sod iodide mic
A9521	Tc99m exametazime
A9524	I131 serum albumin, dx
A9526	Nitrogen N-13 ammonia
A9528	Iodine I-131 iodide cap, dx
A9529	I131 iodide sol, dx
A9531	I131 max 100uCi
A9532	I125 serum albumin, dx
A9536	TC99m depreotide
A9537	Tc99m mebrofenin
A9538	Tc99m pyrophosphate
A9539	Tc99m pentetate
A9540	Tc99m MAA
A9541	Tc99m sulfur colloid
A9542	In111 ibritumomab, dx
A9544	I131 tositumomab, dx
A9546	CO57/58
A9547	In111 oxyquinoline
A9548	In111 pentetate
A9550	Tc99m gluceptate
A9551	Tc99m succimer
A9552	F18 fdg
A9553	Cr51 chromate
A9554	I125 iothalamate, dx
A9555	Rb82 rubidium
A9556	Ga67 gallium
A9557	Tc99m bicisate
A9558	Xe133 xenon 10mci
A9559	Co57 cyano
A9560	Tc99m labeled rbc
A9561	Tc99m oxidronate
A9562	Tc99m mertiatide
A9566	Tc99m fanolesomab
A9567	Technetium TC-99m aerosol
A9568	Technetium tc99m arcitumomab
A9569	Technetium TC-99m auto WBC
A9570	Indium In-111 auto WBC

A9571	Indium In-111 auto platelet
A9572	Indium In-111 pentetreotide
A9576	Inj prohance multipack
A9577	Inj multihance
A9578	Inj multihance multipack
A9579	Gad-base MR contrast NOS,1ml
A9580	Sodium fluoride F-18
A9700	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
G0389	Ultrasound exam AAA screen
Q0092	Set up port xray equipment
Q9951	LOCM>=400 mg/ml iodine,1ml
Q9953	Inj Fe-based MR contrast,1ml
Q9954	Oral MR contrast, 100ml
Q9955	Inj perflexane lip micros,ml
Q9956	Inj octafluoropropane mic,ml
Q9957	Inj perflutren lip micros,ml
Q9958	HOCM <=149 mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine,1ml
Q9960	HOCM 200-249mg/ml iodine,1ml
Q9961	HOCM 250-299mg/ml iodine,1ml
Q9962	HOCM 300-349mg/ml iodine,1ml
Q9963	HOCM 350-399mg/ml iodine,1ml
Q9964	HOCM>= 400mg/ml iodine, 1ml
Q9965	LOCM 100-199mg/ml iodine,1ml
Q9966	LOCM 200-299mg/ml iodine,1ml
Q9967	LOCM 300-399mg/ml iodine,1ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl
RADIATION THERAPY SERVICES AND SUPPLIES	
INCLUDE the following CPT and HCPCS codes:	
0073T	Delivery, comp imrt
0182T	HDR elect brachytherapy

0190T	Place intraoc radiation src
0197T	Intrafraction track motion
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
20555	Place ndl musc/tis for rt
31643	Diag bronchoscope/catheter
41019	Place needles h&n for rt
55875	Transperi needle place, pros
55876	Place rt device/marker, pros
55920	Place needles pelvic for rt
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61796	SRS, cranial lesion simple
61797	SRS, cran les simple, addl
61798	SRS, cranial lesion complex
61799	SRS, cran les complex, addl
61800	Apply SRS headframe add-on
63620	SRS, spinal lesion
63621	SRS, spinal lesion, addl
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)

77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77370	Radiation physics consult
77371	Srs, multisource
77372	Srs, linear based
77373	Sbrt delivery
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx, simple
77423	Neutron beam tx, complex
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77435	Sbrt management
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment

77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77785	HDR brachytx, 1 channel
77786	HDR brachytx, 2-12 channel
77787	HDR brachytx over 12 chan
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy
79005	Nuclear rx, oral admin
79101	Nuclear rx, iv admin
79200	Nuclear rx, intracav admin
79300	Nuclr rx, interstit colloid
79403	Hematopoietic nuclear tx
79440	Nuclear rx, intra-articular
79445	Nuclear rx, intra-arterial
79999	Nuclear medicine therapy
92974	Cath place, cardio brachytx
A9517	I131 iodide cap, rx
A9527	Iodine I-125 sodium iodide
A9530	I131 iodide sol, rx
A9543	Y90 ibritumomab, rx
A9545	I131 tositumomab, rx
A9563	P32 Na phosphate
A9564	P32 chromic phosphate
A9600	Sr89 strontium
A9605	Sm 153 lexidronm
A9699	Radiopharm rx agent noc
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C2616	Brachytx, non-str,Yttrium-90
C2634	Brachytx, non-str, HA, I-125
C2635	Brachytx, non-str, HA, P-103
C2636	Brachy linear, non-str,P-103

C2638	Brachytx, stranded, I-125
C2639	Brachytx,non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C2698	Brachytx, stranded, NOS
C2699	Brachytx, non-stranded, NOS
G0173	Linear acc stereo radsur com
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001	Brachytherapy Radioelements
EPO AND OTHER DIALYSIS-RELATED DRUGS	
The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:	
J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg
J0882	Darbepoetin alfa, esrd use
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Inj iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q4081	Epoetin alfa, 100 units ESRD

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):	
77052	Comp screen mammogram add-on
77057	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82270	Occult blood, feces
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	PSA screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
G0328	Fecal blood scrn immunoassay
G0389	Ultrasound exam AAA screen

P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 3 yrs, im
90658	Flu vaccine, 3 yrs & >, im
90660	Flu vaccine, nasal
90669	Pneumococcal vacc, ped <5
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

[1] CPT codes and descriptions only are copyright 2008 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to §411.351. For more information, refer to the CMS Web site at http://www.cms.hhs.gov/PhysicianSelfReferral/.

[FR Doc. E8–26213 Filed 10–30–08; 4:15 pm]
BILLING CODE 4120–01–P