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Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; and Revisions to the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

[CMS–1403–P]

RIN 0938–AP18

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; and Revisions to the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Proposed Rule

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would address proposed changes to Medicare Part B payment policy. We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This proposed rule also discusses refinements to resource-based practice expense (PE) relative value units (RVUs); geographic practice cost indices (GPCI) changes; malpractice RVUs; requests for additions to the list of telehealth services; several coding issues; payment for covered outpatient drugs and biologicals; the competitive acquisition program (CAP); application of health professional shortage area (HPSA) bonus payments; payment for renal dialysis services; performance standards for mobile independent diagnostic testing facilities; and physician and nonphysician practitioners furnishing diagnostic testing services; a solicitation for comments regarding the use of the Federal Payment Levy Program to recover delinquent Federal tax debts; a proposed amendment to the exemption for computer-generated facsimile 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; conforming and clarifying changes for comprehensive outpatient rehabilitation facilities (CORFs); revisions for rehabilitation agencies; therapy-related technical corrections; the physician quality reporting initiative; physician self-referral issues and anti-markup; beneficiary signature for nonemergency ambulance transport; the chiropractic services demonstration; educational requirements for nurse practitioners and clinical nurse specialists; qualifications of portable x-ray supplier personnel; the expiration of provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007; bonus payments for long ambulance transports; the annual update for clinical laboratory fees under the clinical laboratory fee schedule; physician certification/recertification for home health services; a prohibition concerning providers of sleep tests; organ retrieval; a 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; and, potentially misvalued services under the physician fee schedule.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than August 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1403–P. 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 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 (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–1403–P, P.O. Box 8013, Baltimore, MD 21244–8013.

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

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

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

a. 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.)

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

Corrine 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.

August Nemec, (410) 786–0612, for issues related to independent diagnostic testing facilities and 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, for issues related to incentive payment and shared saving programs.

Don Romano, (410) 786–1401, for issues related to anti-markup provisions.

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 non-emergency 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.

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 all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code [CMS–1403–P] and the specific ''issue identifier'' that precedes the section 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 VI. of this proposed rule.

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
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
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
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
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)
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
NPI National Provider Identifier
NPP Nonphysician practitioner
NQF National Quality Forum
NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
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
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POC Plan of care
PPI Producer price index
PPS Prospective payment system
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PSG Polysomnography
PT Physical therapy
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
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

[If you choose to comment on issues in this section, please include the

caption ''BACKGROUND'' at the beginning of your comments.]

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. This approach is consistent with the method we use to make BN adjustments to the PE RVUs to reflect the changes in these PE RVUs.

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 × budget neutrality adjustor (round product to two decimal places) × GPCI work) + (RVU PE x 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 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 requirement 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 initial estimate for the sustainable growth rate (SGR) for CY 2008 is 2.2 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. Therefore, for the first half of 2008 (that is, January through June), the Medicare PFS conversion factor was $38.0870. For the remaining portion of 2008 (July through December), the Medicare PFS conversion factor will be $34.0682 (as published in the 2008 PFS final rule with comment period).

II. Provisions of the Proposed Regulation

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

[If you choose to comment on issues in this section, please include the caption ''RESOURCE-BASED PE RVUs'' at the beginning of your comments.]

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 Practice Expense Advisory Committee (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 almost all of which we have accepted. As a result, the current PE inputs differ markedly from those originally recommended by the CPEPs. The PEAC has now been replaced by the Practice Expense Review Committee (PERC), which acts to assist the RUC in recommending PE inputs.

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. Then, we 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 are proposing to use the 2007 procedure-specific utilization data crosswalked to 2008 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 proposed 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 proposed 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 proposed rule.

(vi) Equipment Cost per Minute

The equipment cost per minute is calculated as:

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

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); 150,000 minutes.
usage = equipment utilization assumption; 0.5.
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 $34.0682 which was published in the CY 2008 PFS final rule with comment *period.*

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

	Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single Facility	71020 Chest x-ray Nonfacility	71020TC Chest x-ray Nonfacility	7102026 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(1) Labor cost (Lab)	Step 1	AMA		$13.32	$77.52	$5.74	$5.74	$—	$6.12	$6.12	$—
(2) Supply cost (Sup).	Step 1	AMA		$2.98	$7.34	$3.39	$3.39	$—	$1.19	$1.19	$—
(3) Equipment cost (Eqp).	Step 1	AMA		$0.19	$0.65	$8.17	$8.17	$—	$0.12	$0.12	$—
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	$16.50	$85.51	$17.31	$17.31	$—	$7.43	$7.43	$—
(5) Direct adjustment (Dir Adj).	Steps 2–4.	See footnote*		0.592	0.592	0.592	0.592	0.592	0.592	0.592	0.592
(6) Adjusted labor	Steps 2–4.	=Lab*Dir Adj	=(1)*(5)	$7.88	$45.88	$3.40	$3.40	$—	$3.62	$3.62	$—
(7) Adjusted supplies.	Steps 2–4.	=Sup*Dir Adj	=(2)*(5)	$1.77	$4.34	$2.01	$2.01	$—	$0.71	$0.71	$—
(8) Adjusted equipment.	Steps 2–4.	=Eqp*Dir Adj	=(3)*(5)	$0.12	$0.39	$4.84	$4.84	$—	$0.07	$0.07	$—
(9) Adjusted direct	Steps 2–4.		=(6)+(7)+(8)	$9.76	$50.61	$10.24	$10.24	$—	$4.40	$4.40	$—
(10) Conversion Factor (CF).	Step 5	MFS		$34.0682	$34.0682	$34.0682	$34.0682	$34.0682	$34.0682	$34.0682	$34.0682
(11) Adj. labor cost converted.	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	$0.23	$1.35	$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	$1.49	$0.30	$0.30	$—	$0.13	$0.13	$—
(15) Wrk RVU* Wrk Scaler.	Setup File.	MFS		$0.81	$29.62	$0.19	$—	$0.19	$0.15	$—	$0.15
(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	$3.07	$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)	$0.81	$29.62	$0.29	$0.10	$0.19	$0.25	$0.11	$0.15
(22) Indirect Allocator (1st+2nd).	Step 8		=(19)+(21)	$1.37	$32.69	$0.73	$0.53	$0.19	$0.47	$0.32	$0.15
(23) Indirect Adjustment (Ind Adj).	Steps 9–11.	See footnote**		0.364	0.364	0.364	0.364	0.364	0.364	0.364	0.364
(24) Adjusted Indirect Allocator.	Steps 9–11.	=Ind Alloc * Ind Adj		$0.50	$11.89	$0.26	$0.19	$0.07	$0.17	$0.12	$0.05
(25) Ind.Practice Cost Index (PCI).	Steps 12–16.	See Steps 12–16		$0.973	$0.934	$1.075	$1.075	$1.075	$1.281	$1.281	$1.281
(26) Adjusted Indirect.	Step 17	= Adj. Ind Alloc*PCI.	=(24)*(25)	$0.49	$11.11	$0.28	$0.21	$0.07	$0.22	$0.15	$0.07
(27) PE RVU	Steps 18–19.	=(Adj Dir+Adj Ind) *budn.	=((14)+(26)) *budn	$0.77	$12.60	$0.59	$0.51	$0.07	$0.35	$0.28	$0.07

* The direct adj = [current pe rvus * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3].
** The indirect adj = [current pe rvus * avg ind pct] / [sum of ind allocators] = [Step 9]/[Step 10.
Note: Final PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

2. PE Proposals for CY 2009

a. RUC Recommendations for Direct PE Inputs

The RUC provided recommendations for PE inputs for the codes listed in the Table 2.

TABLE 2.—CODES WITH RUC PE RECOMMENDATIONS

CPT [1] code	Description
29805	Shoulder arthroscopy, dx.
29830	Elbow arthroscopy.
29840	Wrist arthroscopy
29870	Knee arthroscopy, dx.
29900	Mcp joint arthroscopy, dx.
90465	Immune admin 1 inj, <8 yrs.
90466	Immune admin addl inj, <8 y.
90467	Immune admin o/n, addl <8 yrs.
90468	Immune admin o/n, addl <8 y.
90471	Immunization admin.
90472	Immunization admin, each admin
90473	Immune admin oral/nasal
90474	Immune admin oral/nasal addl.
93510	Left heart catheterization.
96405	Chemo intralesional, up to 7.
96406	Chemo intralesional over 7.
96440	Chemotherapy, intracavitary.
96445	Chemotherapy, intracavitary.
96450	Chemotherapy, into CNS.
96542	Chemotherapy injection.
99174	Ocular photoscreening.
99185	Regional hypothermia.
99186	Total body hypothermia.

[1] CPT codes and descriptions are copyright 2008 American Medical Association.

We are in agreement with the RUC recommendations, (including the recommendation that no change be made to the direct inputs for CPT 93510, a cardiac catheterization code), except for inclusion of the clinical staff time related to quality activities for the following immunization codes: CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474. While we allow this time for mammography services due to the specific regulatory requirements required by the Mammography Quality Standards Act of 1992 (Pub. L. 102–539) (MQSA), such MQSA time is not a regulatory requirement for immunization 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 are proposing 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. The PE RVUs would increase from 5.28 to 5.98 as a result of this change.

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

The direct PE inputs for CPT code 93025, *Microvolt T-wave alternans for assessment of ventricular arrhythmias,* for clinical labor are not consistent with the other cardiac stress tests, CPT codes 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, and* 93017, *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report.* These codes were refined by the PEAC in January 2002, the same year that CPT code 93025 was implemented. Because of this overlap in timing, the codes that the PEAC refined utilize registered nurses (RNs) while CPT 93025 uses a ''blend'' of RNs and physicians.

To provide consistency across the family, we are proposing to designate the RN as the labor type for CPT code 93025. In addition, we are proposing to add the specific Micro-volt T-wave testing equipment, priced at $40,000, to replace the two different cardiac stress testing treadmill devices that are currently assigned to this code and reflected in the PE database. We are also proposing to assign the service period time, 53 minutes, to the exam table and the Micro-volt T-wave testing treadmill because neither piece of equipment is available for use by others during the testing interval. The T-wave stress test must be done in quiet room. Using this rationale for the other two stress testing CPT codes (that is, 93015 and 93017), we are also proposing to revise the PE database for these services and allocate the 55-minute service period time to the exam table and the stress testing equipment rather than the 41 minutes currently assigned.

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—facility and nonfacility—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 are proposing to revise § 414.22(b)(5)(i) (A) and (B) to remove this language.

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

[If you choose to comment on issues in this section, please include the caption ''GPCI: LOCALITY DISCUSSION'' at the beginning of your comments.]

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), in CY 2008 we established new GPCIs for each Medicare locality and implemented them. The CY 2008 adjustment to the GPCIs reflected the first year of the 2-year phase-in.

We note that the proposed CY 2009 physician work GPCIs do not reflect the 1.000 floor that was in place during CY 2006 through June 30, 2008. As discussed in section II.S. of this preamble, ''Expiring Provisions and Related Discussion'', the 1.000 work GPCI floor expired as of January 1, 2008 in accordance with section 102 of the MIEA-TRHCA. However, section 103 of the MMSEA extended application of 1.000 floor to the physician work GPCI through June 30, 2008. See Addenda D and E for the proposed 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. 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 final rule (61 FR 59494).

Although there have been no changes to the locality structure since 1997, we have considered and proposed making changes in recent years. 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.

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 proposed rule, we described three options for changing the payment localities in California. A detailed discussion of the options for changing the payment localities in California may be found in both 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 intend 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

As a follow-up to the CY 2008 PFS final rule with comment period, we have 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. The discussion that follows provides a brief description of the alternative payment locality configurations currently under consideration. An interim report on the results of this research will be posted on the CMS Web site following the publication of this proposed rule.

At this time, we are not proposing to make any changes to our payment localities. When we are ready to propose a change to the locality configuration, we will provide extensive opportunities for public comment (for example, town hall meetings or open door forums, as well as soliciting public comments in a proposed rule) before implementing any change. If we would make changes to the locality structure, we anticipate applying any locality reconfiguration uniformly to all States.

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

Option 1 would use the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban core-based statistical areas (CBSAs). Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the inpatient hospital prospective payment system (IPPS) pre-reclassification CBSA assignments and with the geographic payment adjustments used in other payment systems such as ESRD facilities, SNFs, ASCs, and home health agencies (HHAs). Under this method, GPCI payment localities would be defined by MSAs (urban CBSAs) and ''rest of State'' areas (non-urban CBSAs) and the number of localities would increase.

Option 2: Separate High Cost Counties From Existing Localities

This method for reconfiguring payment localities was suggested by MedPAC as part of its comments on the CY 2008 PFS proposed rule. Under this approach, we would begin with the existing 89 GPCI localities and create new localities based on an iterative comparison process using the GAF as a proxy for costs. (As discussed above, the GAF is used as a general proxy for area practice costs. The GAFs are used only to make comparisons across localities or other geographic subdivision and do not reflect an absolute measure of costs.) For example, the county with the highest GAF in a given locality is compared to the average GAF for all other counties in the locality. If the GAF for the highest county exceeds the average GAF for all other counties in the locality by more than 5 percent, the highest county is assigned its own locality. The GAF of the second highest county is then compared to the average GAF for all other *remaining* counties in the locality. If the GAF for the second highest county exceeds the average GAF for the other remaining counties by more than 5 percent, the second highest county is also assigned its own locality. The process is repeated for the next highest county(ies) until the difference between the GAF for the highest remaining county and the average GAF for the other remaining counties is less than 5 percent. This approach is similar to an option we presented last year for California except that under this option, the GAF of higher counties is compared to the average GAF of all other remaining lower GAF counties, rather than to the entire locality's GAF. As such, this approach would remove higher cost counties from their existing locality structure and they would each be placed into their own locality.

Option 3: Separate MSAs From Statewide Localities

Option 3 was also suggested by MedPAC. This alternative for payment locality configuration begins with Statewide localities (for every State) and creates separate localities for higher cost (higher GAF) MSAs. Under this approach, localities are determined within each State based on the same iterative process as described above in option 2. The GAF of the highest MSA in a given State is compared to the average GAF of all other areas within the State. For example, the highest cost MSA would be compared to an average GAF for all other MSAs in the State and the counties in the ''rest of State'' area. If the GAF of the highest MSA is more than 5 percent greater than the average GAF for all other areas in that State, then the highest MSA becomes a separate locality. This iterative process continues with the second highest MSA. The process stops when the GAF of the highest remaining MSA is not more than 5 percent greater than the average of the other remaining areas within the State. This option is similar to option 2; however, it removes higher cost MSAs from the ''rest of State'' locality rather than removing higher cost counties from their existing payment locality.

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

This approach combines counties within a State into tiers (or groupings) based on similar GAFs. (This alternative is similar to an option we considered for California last year). Under this approach, counties in each State are sorted in descending order by GAFs. The highest county GAF is compared to the second highest. If the difference is less than 5 percent, the counties are included in the same locality. The third highest county GAF is then compared to the highest county GAF. This process continues until a county has a GAF difference from the highest county GAF that is more than 5 percent. When this occurs, that county becomes the highest county in a new payment locality and the process is repeated for all counties in the State. This methodology creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs.

c. Solicitation of Comments

As noted earlier in this section, we will be posting an interim report of our locality study on the CMS Web site after publication of this proposed rule. Information on how to access the report will be made available through the PFS home page on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/.* Additionally, we plan to update our Web site periodically as our research progresses.

We encourage interested parties to submit comments on the options presented both here and in our interim report to the address for comments listed on our Web site. We are also interested in receiving comments and suggestions on other potential alternative locality configurations (in addition to the options described in this section). Additionally, we are requesting comments on the administrative and operational issues associated with the various options under consideration. As previously discussed, we are not

proposing any changes to the payment locality configurations at this time. When we are ready to propose any changes to the locality configuration, we will provide extensive opportunities for public comment (for example, town hall meetings or open door forums) on specific proposals before implementing any change.

C. Malpractice RVUs (PC/TC Issue)

[If you choose to comment on issues in this section, please include the caption ''MALPRACTICE RVUs'' at the beginning of your comments.]

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 technical component (TC) MP RVUs that are greater than the professional component (PC) MP RVUs. Suggesting that it is illogical for the MP RVUs for the TC of a service to be higher than the MP RVUs for the PC, the PLI workgroup requested that we make changes to these MP RVUs.

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 any such change. We asked for information about how, and if, technicians employed by facilities purchase PLI or how their professional liability is insured. We also asked for comments on what types of PLI are carried by facilities that perform these technical services.

In comments submitted in response to the proposed rule, the American College of Cardiology (ACC) suggested that we ''flip'' the MP RVUs between the PCs and TCs. This proposal would reduce the MP RVUs for the TC and increase the MP RVUs for the PC. We also received comments from the American College of Radiology (ACR) suggesting that we make the TC RVUs equal to the PC RVUs. The ACR stated that there was clearly some professional liability associated with these codes and using the resource-based MP RVUS of the PC maintains the resource-based methodology and eliminates the logical inequities of the TC having more RVUs than 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.

In the CY 2008 PFS final rule with comment period (72 FR 66248), we stated, in response to the suggestions from the AMA, ACR, and ACC, that we 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 have undergone a resource-based review, are derived from actual data, and are consistent with the resource-based methodology for PFS payments. We also 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. In response to the suggestion of the PLI workgroup, we stated that we are not able to evaluate whether sufficient data exists or to make a judgment on the RUC's assertion that there are no such identifiable costs (and therefore, no data are available).

We also received several comments supporting our 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. In response, in the CY 2008 PFS final rule with comment period, we stated that we would continue to solicit, collect, and analyze appropriate data on this subject and 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.

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 did not receive a response to our request for additional data on this issue. This issue is one of importance to CMS because the lack of available PLI data affects our ability to make a resource-based evaluation of the TC MP RVUs for these codes. As part of our work to update the MP RVUs in CY 2010, we will instruct our contractor to research available data sources for the MP costs associated with the TC portion of these codes. We will also ask the contractor to look at what is included in general liability insurance versus PLI for physicians and other professional staff. If data sources are available, we will 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.

D. Medicare Telehealth Services

[If you choose to comment on issues in this section, please include the caption ''MEDICARE TELEHEALTH SERVICES'' at the beginning of your comments.]

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. For more information on submitting a request for an addition to the list of Medicare telehealth services, visit our Web site at *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. The following is a discussion of these requests.

a. Diabetes Self-Management Training (DSMT)

The American Telemedicine Association (ATA) and the Marshfield Clinic submitted a request to add 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. In the CY 2006 PFS proposed rule (70 FR 45787) and final rule with comment period (70 FR 70157), we did not approve a previous request to add DSMT to the list of approved telehealth services. We approved a request to add individual medical nutrition therapy (MNT) to the list of approved telehealth services.

The current request asks us to evaluate and approve individual and group DSMT as Category 1 services because they are comparable to MNT. The requesters believe that MNT and DSMT are similar because both are designed to provide education in the primary care setting and to facilitate behavior modification on the part of the patient. The requesters asked us to examine the clinical outcomes of providing the service and evidence-based practice in determining whether the codes should be added to the list of approved telehealth services. The requesters also asked us to examine whether DSMT is appropriate care by those standards (clinical outcomes and evidence-based practice), and they provided evidence that DSMT has a direct effect on reducing HbA1c levels and improves outcomes for patients.

CMS Review

The requesters specifically asked us to evaluate DSMT as a Category 1 service based on clinical outcomes and evidence-based practice. This approach does not match the criteria we use to assign services to Category 1. To determine whether to assign a request to Category 1, we look for similarities between the service that is being considered for addition and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. Analysis of clinical outcomes and evidence-based practice alone are not sufficient to assign services to Category 1.

The requesters believe that DSMT services can be considered and approved for telehealth as Category 1 services because they are comparable to MNT services approved for telehealth. Section 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). Moreover, as noted in our previous review of DSMT, 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 (70 FR 45787 and 70 FR 70157). 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 need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. Most of the studies cited by the requesters focused on the value of DSMT in helping individuals with diabetes achieve successful health-related outcomes. Some of these studies documented clinical outcomes and evidence-based practice of the appropriateness of DSMT in treating diabetes, but they did not provide comparative analysis demonstrating that DSMT provided via telehealth is equivalent to the face-to-face delivery of such services. As such, these studies were not relevant to this review.

One study cited by the requesters which analyzed diabetes care provided via telehealth defined telehealth technologies to consist of messaging and monitoring devices. The telehealth technologies utilized in this study do not correspond with our definitions of telehealth as specified in § 410.78.

Another study cited by the requesters as examining the effectiveness of diabetes management provided via telehealth was intended to help diabetic participants manage their care with the help of a home-based telehealth support system. The study's authors note some interesting correlations that were observed without any claim of reliability or validity, and the study's

authors clearly state that no causal relationships can be referred from the data.

A third study cited by the requesters compared diabetes education provided through telemedicine technology to diabetes education provided in-person. The study design did not include training patients in the self-administration of injectable drugs, which is one of the elements of DSMT under section 1861(qq) of the Act. The success of one diabetes educator in teaching the self-administration of insulin to one of the participants was anecdotal; no conclusive evidence was provided that insulin administration can routinely be taught effectively as a telehealth service.

After reviewing these studies, we determined that we do not have sufficient comparative analysis or other compelling evidence that either individual or group DSMT delivered via telecommunications is equivalent to DSMT delivered face-to-face. We do not find evidence that providing DSMT via telehealth is an adequate substitute for the face-to-face encounter between the practitioner and the patient. Therefore, we are not proposing to add individual and group DSMT (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services.

b. Critical Care Services

The University of Pittsburgh Medical Center (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 critically injured or ill patients (specifically 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.''

CMS Review

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 need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. We have 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 do not propose to add critical care services (as defined by HCPCS codes 99291 and 99292) to the list of approved telehealth services.

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 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).

CMS Review

We considered the possibility of approving subsequent hospital care for telehealth with specific limitations, for example, approving subsequent hospital care for telehealth only when the codes are used for follow-up inpatient consultations. Given the potential acuity level of the patient in the hospital setting, we remain concerned that practitioners could misuse the codes and provide a broader range of subsequent hospital care services via telehealth than was formerly approved for telehealth with the follow-up inpatient consultation codes, including the on-going, day-to-day E/M of a hospital inpatient. (For a discussion of these issues, see 72 FR 38144 and 66249.) We were also concerned that it could be difficult to implement sufficient controls and monitoring to ensure that the telehealth use of the codes for subsequent hospital care is limited to the delivery of services that were formerly described as follow-up inpatient consultations.

We have considered this issue further, and for CY 2009, we are proposing 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. The new HCPCS codes will be limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions will be modified to limit the use of such services for telehealth. The HCPCS codes will clearly designate these as follow-up inpatient consultations provided via telehealth, and not subsequent hospital care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately. We also propose 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.

As defined below in this section, we are proposing 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 a 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 contractors that process claims for the service 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 15, Section 190.6.1 for instructions for submission of interactive telehealth claims.)

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the ''GQ'' modifier, ''via asynchronous telecommunications system.'' By using the ''GQ'' modifier, the distant site physician/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 15, Section 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 complete 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.

We are proposing to describe follow-up inpatient telehealth consultations to include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status. Counseling and coordination of care with other providers or agencies would be included as well, consistent with nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth may not 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.

Payment for follow-up telehealth inpatient consultations would include 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 propose to establish 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 GXX14. 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 GXX15. 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 GXX16. At this level of service, practitioners would typically spend 35 minutes or more communicating with the patient via telehealth.

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

- GXX14, *Follow-up inpatient telehealth consultation, limited,* typically 15 minutes communicating with the patient via telehealth.
- GXX15, *Follow-up inpatient telehealth consultation, intermediate,* typically 25 minutes communicating with the patient via telehealth.
- GXX16, *Follow-up inpatient telehealth consultation, complex,* typically 35 minutes or more communicating with the patient via telehealth.

E. Specific Coding Issues Related to the Physician Fee Schedule

[If you choose to comment on issues in this section, please include the caption ''CODING ISSUES'' at the beginning of your comments.]

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

Immune globulin is a complicated biological product that is purified from human plasma obtained from human plasma donors. Its purification is a complex process that occurs along a very long timeline, and therefore, only a small number of manufacturers provide commercially available products. 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.

The Medicare payment rates for IVIG products are established through the Part B average sales price (ASP) drug methodology. Payment for administration of the IVIG is made separately under the PFS. IVIG administration is billed using the CPT codes for the first hour and, as needed, additional hour CPT infusion codes for therapeutic, prophylactic, and diagnostic services.

In addition, a separate payment has been made under the PFS and the Hospital Outpatient Prospective Payment System (OPPS) for IVIG preadministration-related services since 2006. Separate payment for the preadministration-related services was implemented in 2006 largely because of reported instability in the IVIG marketplace due, in part, to the implementation of the new ASP payment methodology for IVIG drugs.

As discussed in the CY 2006 PFS final rule with comment period (70 FR 70219 through 70220), at that time the IVIG marketplace was one in which a significant portion of IVIG products previously available in CY 2005 were being discontinued and other products were expected to enter the market over the next year. For CY 2006, there were only 2 HCPCS codes describing all IVIG products based on either lyophilized (powdered) or liquid preparation.

To continue to ensure appropriate access to IVIG, in CY 2006 during this short-term period of market instability for IVIG, we temporarily initiated a separate payment to physicians to reflect the additional resources that may have been associated with locating and acquiring adequate IVIG product and preparing for an office infusion of IVIG.

In order to address what was considered to be an impermanent period of market instability, we created a separate G-code, G0332, *IVIG preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter.* As discussed in the CY 2006 PFS final rule with comment period, we expected the IVIG marketplace to stabilize through 2006 and that the atypical preadministration-related services relating to IVIG would be temporary and no longer necessary for physicians' offices that provided IVIG infusions to patients.

However, in the CY 2007 PFS final rule with comment period (71 FR 69678), we decided to continue the IVIG preadministration-related services payment for an additional year to help ensure patient access to IVIG. We stated in that rule that we were anticipating the results of the HHS Office of Inspector General (OIG) study on the availability and pricing of IVIG before changing this policy. In addition, we continued to receive comments from stakeholders that some beneficiaries were experiencing IVIG access issues such as delayed treatments and site of service shifts.

In the CY 2008 PFS proposed rule (72 FR 38146), we proposed to continue payment for G0332 through CY 2008 at the same level of PE RVUs as CY 2007. We referred to the OIG final report published in April 2007 titled, ''Intravenous Immune Globulin: Medicare Payment and Availability'' (OEI–03–05–00404). The OIG had conducted this study at the request of the Members of the Congressional subcommittees on Health within the House Energy and Commerce and Ways and Means Committees. The OIG examined the current state of IVIG which included analyzing the payment and supply. Specifically, the OIG determined whether hospitals and physicians could purchase IVIG at prices below the Medicare payment amounts in 2005 and 2006 and whether IVIG was readily available to physicians and distributors in 2005 and 2006.

The OIG found 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. 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 three distributors occurred at prices below the Medicare payment amounts. The findings of the OIG report suggest that stability in the IVIG market had improved in late 2006. No other comprehensive studies have been presented to show continued instability in market conditions or systematic problems with patient access.

Recent IVIG drug coding revisions and reporting have contributed to increased payments for IVIG products and, we believe, improved market stability. Beginning on July 1, 2007, six new HCPCS codes for specific IVIG products were adopted to implement separate payment for these products. From July 2007 to April 2008, the weighted average increase in payment, based on allowed charges by IVIG product code, was 2.9 percent for all liquid IVIG products and 3.4 percent for all IVIG products, both liquid and powder.

IVIG utilization continues to increase. National claims history data show allowed utilization in physicians' offices (that is, units of IVIG paid) increased from slightly over 3,000,000 units in 2006 to slightly over 3,600,000 units in 2007.

We continue to meet with representatives of the IVIG industry to discuss their concerns regarding the pricing of IVIG and Medicare beneficiary access to this important therapy. No additional studies have been published since the OIG report of April 2007 on IVIG pricing, supply or patient access issues with IVIG. We have reviewed national claims data for IVIG drug utilization, as well as utilization of the preadministration-related service codes. This data show modest increases in the utilization of IVIG drugs and the preadministration-related service code which suggests that pricing and access may be improving.

The G-code payment for IVIG preadministration-related services was intended to be a temporary stopgap policy. We continued these temporary payments for 3 years because we had received reports of market disruptions and were concerned about ensuring beneficiary access to these drugs. However, we now believe that the transient market conditions that led us to adopt the payment for IVIG preadministration-related services have improved. Therefore, we are proposing to discontinue separate payment for IVIG preadministration-related services by means of code G0332 furnished on or after January 1, 2009. The treatment of these services under the OPPS will be addressed separately in the OPPS proposed rule.

2. Multiple Procedure Payment Reduction for Diagnostic Imaging

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

- The professional component (PC) represents the physician's interpretation (PC-only services are billed with the 26 modifier).
- The technical component (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. We are proposing to subject several additional procedures to the MPPR. 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 are also removing CPT 76778, a deleted code, from the list. Table 3 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 budget neutrality requirement; therefore, we are proposing that expenditure reductions resulting from these changes be exempt from budget neutrality. (See section VI., Regulatory Impact Analysis, for a discussion of budget neutrality.) The complete list of procedures subject to the MPPR is in Addendum F of this proposed rule.

TABLE 3.—PROCEDURES PROPOSED FOR MULTIPLE PROCEDURE PAYMENT REDUCTION

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).
77059	Mri, both breasts	Family 4 MRI and MRA (Chest/Abd/Pelvis).

3. Proposed HCPCS Code for Prostate Saturation Biopsies

Prostate Saturation Biopsy is a technique currently described by Category III CPT code 0137T, *Biopsy, prostate, needle, saturation sampling for prostate mapping.* Typically, this service entails 40 to 80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a pathologist and this service is captured under CPT code 88305, *Surgical pathology, gross and microscopic examination,* which is separately billed by the physician for each core sample taken. CPT Code 88305 has a physician work value of 0.75 and a total nonfacility payment rate of $102.83. We believe that paying individually for review of each core sample submitted grossly overpays for the pathological interpretation and report for this service.

We are proposing the following four G codes to more accurately represent the pathologic evaluation, interpretation, and report for this service:

- GXXX1, *Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens*
- GXXX2, *Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens.*
- GXXX3, *Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens.*
- GXXX4, *Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens.*

We are proposing to carrier price these codes. We will gather information regarding the laboratory and clinical staff resources required to value these services.

F. Part B Drug Payment

1. Average Sales Price (ASP) Issues

[If you choose to comment on issues in this section, please include the caption ''ASP ISSUES'' at the beginning of your comments.]

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this proposed rule, 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 4 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 × 20 mg)/10 mg = 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.

Prior to April 1, 2008, manufacturers' ASP data for smaller and larger package sizes were given the same weight in our calculation of the payment amounts; that is, the ASP for one vial was weighted the same as the ASP for a box of 10 vials. For payment amounts in effect on or after April 1, 2008, manufacturers' ASPs for larger package sizes have greater impact on the payment amounts and their ASPs for smaller package sizes have less; that is, the ASP for a box of 10 vials is given 10 times the weight of a package containing a single vial. The payment allowance limits published on our Web site for dates of service on or after April 1, 2008 are determined using the new volume-weighting methodology and include application of the special payment rule described in the following paragraph. (See our Web site at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp#TopOfPage*.)

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. Inclusion of this topic in this proposed rule, is our first opportunity to propose conforming changes to the regulatory text at § 414.904. We propose to revise paragraphs (a) and (e) to codify the changes to the determination of payment amounts as required by section 112 of the MMSEA. We are soliciting comments on the proposed regulatory text that appears elsewhere in this proposed rule.

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. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2009, we propose to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its ongoing comparison of both the WAMP and the AMP. Furthermore, information on how recent changes to the ASP weighting methodology may affect the comparison of WAMP/AMP to ASP is not available at this time. Since we do not have data suggesting a more appropriate level at this time, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP 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 welcome comments on our proposal to continue the applicable threshold at 5 percent for both the WAMP and AMP for CY 2009.

2. Competitive Acquisition Program (CAP) Issues

[If you choose to comment on issues in this section, please include the caption ''CAP ISSUES'' at the beginning of your comments.]

Section 303(d) of the MMA requires the implementation of a competitive acquisition program for certain Medicare Part B drugs not paid on a cost or prospective payment system 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 (70 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 amount 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 this section, we are proposing 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. Our proposed refinements are based on the operational experience we have gained since the implementation of the program and we believe that they will improve this relatively new and growing program. Although we are currently evaluating bids for CY 2009 through CY 2011 approved CAP vendor contracts, we do not believe that the proposals in this rule will conflict with the evaluation of bids or the performance of the CAP vendor contracts because we do not expect these proposals to change the way payment is made under the CAP, to significantly change how prospective vendors are expected to furnish drugs under the CAP, or to significantly affect the number of participating CAP physicians.

a. Annual CAP Payment Amount Update Mechanism

Payment amounts for drugs furnished during the first year of an approved CAP vendor's contract are set through a competitive process using bidders' prices and limited by the ASP based payment amount. This process was described in detail in the July 6, 2005 IFC (70 FR 39069 through 39078). Section 414.906(c) provides for updates to an approved CAP vendor's payment amounts based on the vendor's reasonable net acquisition costs (RNAC).

In the July 6, 2005 IFC, we described a two-step process to recompute the single price for each drug in the single drug category if there is a change in the costs reported by a particular vendor. We stated that ''we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices'' (70 FR 39076). The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that no successful bidders would choose not to participate in the CAP.

However, during the first round of CAP contracting after offering more than one contract, we entered a contract with only one bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. We believe that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two step calculation based on the approved CAP vendors' RNAC, as well as the calculation of a median of adjusted bid prices.

This approach was posted on the Approved CAP Vendor page of the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp* . The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

We are proposing to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We would continue to use the average of the approved CAP vendor-supplied RNAC data as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendor's RNAC). Similarly, if there were five successful bidders but only three chose

to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated CAP payment amount.

We believe this approach would provide us with a flexible method for updating CAP prices that is consistent with our original policy as stated in the July 6, 2005 IFC, but that accounts for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. This would include bidders who choose not to participate at the beginning of a contract and those who drop out later. Our proposal clarifies the approach used to calculate the RNAC and does not seek to alter the general approach to the payment calculation update described in the July 6, 2005 IFC and existing regulation text. We welcome comments on this approach.

b. Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the CY 2006 PFS final rule with comment period (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as NPs, CNSs, and other professions such as PAs who may be able to legally prescribe medications and enroll in Medicare. Our 2005 CAP definition was not intended to exclude these practitioners who are appropriately billing Medicare for legally prescribed medications administered in a capacity that would be classified as incident to a physician's services if the medications were administered by a physician. We are concerned that the existing CAP definition of a physician is unnecessarily restrictive and could potentially affect access to the CAP for a small segment of providers that should be eligible for participation in the CAP in situations where they currently bill Medicare separately and appropriately.

Therefore, we are proposing to further clarify that, for the purposes of the CAP, the definition of a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believe that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it is not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

Our proposal is specific to the Part B Drug CAP and does not affect the definition of physician in section 1861(r) of the Act, or the definition of Medical and Other Health Services described in section 1861(s) of the Act. This proposal also does not seek to expand the scope of the CAP beyond what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains at this time a program that provides Part B drugs furnished incident to a physician's services.

We anticipate that a small number of NPs, CNSs, and PAs would be affected by the implementation of this proposal. We seek comment on how this clarification would affect the various professions that bill Medicare for drugs furnished incident to services that are typically provided by a physician. If this provision is implemented, we believe that the total number of CAP participants would not increase by more than 1 percent, and we seek comment on level of interest associated with the implementation of this proposal.

c. Easing the Restriction on Physician Transport of CAP Drugs Between Practice Locations

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. In the July 6, 2005 IFC (70 FR 39047), we described both comments that supported the idea of allowing participating CAP physicians to transport drugs to multiple office locations, and comments that raised concerns about the risk of damaging a drug that has not been kept under appropriate conditions while being transported. Specifically, one commenter pointed out that a physician may have several practice locations. If the beneficiary should change his or her site of treatment from the one to which the vendor originally shipped the drug, the physician would need an appropriate way of transporting the drugs from one location to another. Some potential vendors stated that, while drugs were being transported to an alternate location, spoilage and breakage could occur. They expressed concern that because the vendor retains ownership of the drug until it is administered to the beneficiary, they could be held liable if the drug deteriorates and is administered to the beneficiary in substandard condition.

Ultimately, we implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii).

However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). Several comments suggested either easing or removing the restriction on transporting drugs to other locations. Commenters believed that physicians, particularly those who specialize in oncology, and their staff are knowledgeable about drug stability and handling, and therefore, were capable of assuming this responsibility. Other commenters indicated that transporting the drug to another office location may allow for flexibility in scheduling patient visits.

We also received several comments discussing the impact of CAP delivery times on rural clinics and offices with satellite locations. Many of these responses discussed how easing the restriction on transporting CAP drugs between locations would be welcome in rural areas and for satellite offices with limited hours where personnel may not always be available to receive CAP drug shipments.

We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting

CAP drugs where this is permitted by State law and other applicable laws and regulations. We asked commenters to consider how such a policy could be constructed so that the approved CAP vendor could retain control over how the drugs that it owns are handled. We also requested comments on other issues that we should take into account concerning transportation of CAP drugs between the practice locations listed on a physician's CAP election agreement form. Additionally, we also solicited comments on the following areas for consideration in the possible development of future proposals:

- How to structure requirements so that drugs are not subjected to conditions that will jeopardize their integrity, stability or sterility while being transported, and steps to keep transportation activities consistent with all applicable laws and regulations;
- Whether any agreement allowing participating CAP physicians to transport CAP drugs to alternate practice locations should be voluntary. This means that approved CAP vendors would not be required to offer such an agreement and physicians who participate in the CAP would not be required to accept such an offer; and
- Whether such an agreement should be documented in writing, and whether it is necessary to create any restrictions on which CAP drugs could be transported.

We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268). Several comments supported the concept of easing the restriction on transporting CAP drugs if this could be done safely, and if changes were consistent with applicable rules, regulations, and within the limitations of product stability and integrity. The restriction on transporting CAP drugs was perceived as a barrier to physician participation in the program. One commenter stated that elimination of the restriction would result in the same flexibility as the ASP (buy and bill) method of acquiring drugs. Another commenter expressed a strong desire to implement these changes promptly.

A few commenters also cautioned us to implement appropriate safeguards if we chose to ease the transportation restriction. One commenter asked that the safeguards be available for public scrutiny before they are implemented. Conversely, other commenters stated that the risk of damage to CAP drugs would be minimal since a physician and his or her staff are knowledgeable about a given drug's stability, handling, and transportation requirements.

We are mindful of the concerns expressed by the commenters and are now proposing to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. We propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify which CAP drug(s) could be transported.

However, our proposal contains certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We propose to apply these standards to any agreement for the transport of CAP drugs.

We are also particularly concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we propose that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We welcome comments on these issues, including the identification who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that this proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who have office locations in rural areas and/or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We invite comments about this proposal.

d. Dispute Resolution Process

Section 1847B of the Act is generally silent with regard to the treatment of disputes surrounding the delivery of drugs and the denial of drug claims. However, section 1847B(b)(2)(A)(ii)(II) of the Act does contain a reference to a grievance process that is included among the quality and service requirements that must be met by approved CAP vendors. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

1. Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with CAP physicians. As stated at § 414.916(a), ''Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS.'' Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to ''[a] participating CAP physician.'' However, we believe that the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, we are proposing to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We are also making a conforming change in the regulation text in § 414.914(f)(12). These changes are in accord with the underlying intent of § 414.916, namely to provide a mechanism for vendors to address noncompliance problems with CAP physicians, and we believe that these changes will increase the clarity of our regulations. We note that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked. We welcome comments about this proposal.

2. Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 pertains to the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the ''approved CAP vendor may resume participation in CAP'' if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we propose to indicate that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We believe this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. We invite comments regarding this proposed clarification.

G. Application of the HPSA Bonus Payment

[If you choose to comment on issues in this section, please include the caption ''HPSA BONUS PAYMENT'' at the beginning of your comments.]

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 § 414.67, we are proposing to revise our regulations 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

[If you choose to comment on issues in this section, please include the caption ''ESRD PROVISIONS'' at the beginning of your comments.]

Since August 1, 1983, payment for dialysis services furnished by end-stage renal disease (ESRD) facilities has been based on a composite rate payment system that provides a fixed, prospectively determined amount per dialysis treatment, adjusted for geographic differences in area wage levels. In accordance with section 1881(b)(7) of the Act, separate composite rates have been established for hospital-based and independent ESRD facilities. The composite rate is designed to cover a package of goods and services needed to furnish dialysis treatments that include, but not be limited to, certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite rate, other injectable drugs and laboratory tests medically necessary for the care of the dialysis patient are separately billable. Effective on August 1, 1983, the base composite rates per treatment were $123 for independent ESRD facilities and $127 for hospital-based ESRD facilities. The Congress has enacted a number of

adjustments to the composite rate since that time. The current 2008 base composite rates are $132.49 for independent ESRD facilities and $136.68 for hospital-based ESRD facilities.

Section 623 of the MMA amended section 1881 of the Act to require changes to the composite rate payment methodology, as well as to the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities.

Section 1881(b)(12) of the Act, as added by the MMA, requires the establishment of a basic case-mix adjusted prospective payment system (PPS) that include services comprising the composite rate and an add-on to the composite rate component for the difference between current payments for separately billed drugs and the revised drug pricing specified in the statute. In addition, section 1881(b)(12) of the Act requires that the composite rate be adjusted for a number of patient characteristics (case-mix) and section 1881(b)(12)(D) of the Act gives the Secretary discretion to revise the wage indices and the urban and rural definitions used to develop them. Finally, section 1881(b)(12)(E) of the Act imposes a budget neutrality (BN) adjustment, so that aggregate payments under the basic case-mix adjusted composite payment system for CY 2005 equals the aggregate payments for the same period if section 1881(b)(12) of the Act does not apply.

Before January 1, 2005, payment to both independent and hospital-based facilities for the anti-anemia drug, erythropoietin (EPO) was established under section 1881(b)(11) of the Act at $10.00 per 1,000 units. For independent ESRD facilities, payment for all other separately billable drugs and biologicals are based on the lower of actual charges or 95 percent of the average wholesale price (AWP). Hospital-based ESRD facilities were paid based on the reasonable cost methodology for separately billed drugs and biologicals (other than EPO) furnished to dialysis patients. Changes to the payment methodology for separately billed ESRD drugs and biologicals that were established by the MMA effective January 1, 2005, are described in sections II.H.1. and II.H.2. These changes affected payments in both CY 2005 and CY 2006.

In addition, section 623(f)(1) of the MMA directs the Secretary to submit a Report to Congress detailing the elements and features for the design and implementation of a bundled PPS for services furnished by ESRD facilities to Medicare beneficiaries. This bundled PPS is a different way of payment for ESRD services since it includes not only composite rate services, but could also include separately billable drugs (including EPO), laboratory tests, and other separately billable items into one PPS payment rate. The Report to Congress was released February 20, 2008.

1. CY 2005 Revisions

In the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334), we implemented section 1881(b) of the Act, as amended by section 623 of the MMA, and revised payments to ESRD facilities. These revisions were effective January 1, 2005, and included implementation of a case-mix adjusted payment system that incorporated services that comprise the composite rate; an update of 1.6 percent to the composite rate component of the payment system; and a drug add-on adjustment of 8.7 percent to the composite rate to account for the difference between pre-MMA payments for separately billable drugs and payments based on revised drug pricing for 2005 which used acquisition costs. Effective April 1, 2005, the CY 2005 PFS final rule with comment period also implemented case-mix adjustments to the composite rate for certain patient characteristics (that is, age, low body mass index, and body surface area).

In addition, to implement section 1881(b)(13) of the Act, we revised payments for drugs billed separately by independent ESRD facilities, paying for the top 10 ESRD drugs based on acquisition costs (as determined by the OIG) and for other separately billed drugs at the average sales price +6 percent (hereafter referred to as ASP+6 percent). Hospital-based ESRD facilities continued to receive cost-based payments for all separately billable drugs and biologicals except for EPO which was paid based on average acquisition costs.

2. CY 2006 Revisions

In the CY 2006 PFS final rule with comment period (70 FR 70161), we implemented additional revisions to payments to ESRD facilities under section 623 of the MMA. For CY 2006, we further revised the drug payment methodology applicable to drugs furnished by ESRD facilities. All separately billed drugs and biologicals furnished by both hospital-based and independent ESRD facilities are now paid based on ASP+6 percent.

We recalculated the 2005 drug add-on adjustment to reflect the difference in payments between the pre-MMA AWP pricing and the revised pricing based on ASP+6 percent. The recalculation did not affect the actual add-on adjustment applied to payments in 2005, but provided an estimate of what the adjustment would have been had the 2006 payment methodology been in effect in CY 2005. The drug add-on adjustment was then updated to reflect the expected growth in expenditures for separately billable drugs in CY 2006.

As of January 1, 2006, we also implemented a revised geographic adjustment authorized by section 1881(b)(12) of the Act. As part of that change, we—

- Revised the labor market areas to incorporate the Core-Based Statistical Area (CBSA) designations established by the Office of Management and Budget (OMB);
- Eliminated the wage index ceiling and reduced the floor to 0.8500; and
- Revised the labor portion of the composite rate to which the geographic adjustment is applied.

We also provided a 4-year transition from the previous wage-adjusted composite rates to the current wage-adjusted rates. For CY 2006, 25 percent of the payment is based on the revised geographic adjustments, and the remaining 75 percent of payment is based on the old metropolitan statistical area-based (MSA-based) payments.

In addition, section 5106 of the DRA provided for a 1.6 percent update to the composite rate component of the basic case-mix adjusted payment system, effective January 1, 2006. As a result, the base composite rate was increased to $130.40 for independent ESRD facilities and $134.53 for hospital-based facilities. For 2006, the drug add-on adjustment (including the growth update) was 14.5 percent.

3. CY 2007 Updates

In the CY 2007 PFS final rule with comment period (71 FR 69681), we implemented the following updates to the basic case-mix adjusted payment system:

- An update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment of 1.052818 to the wage index for CY 2007.
- A method to annually calculate the growth update to the drug add-on adjustment required by section 1881(b)(12) of the Act, as well as a growth update to the drug add-on adjustment of 0.5 percent for CY 2007. Therefore, effective January 1, 2007 the drug add-on adjustment was increased to 15.1 percent.

In addition, section 103 of the MIEA–TRHCA established a 1.6 percent update to the composite rate portion of the payment system, effective April 1, 2007.

Therefore, the current base composite rate is $132.49 for independent facilities and $136.68 for hospital-based facilities. Also, the effect of this increase in the composite rate portion of the payment system was a reduction in the drug add-on adjustment to 14.9 percent, effective April 1, 2007. Since the statutory increase only applied to the composite rate, this adjustment to the drug add-on percent was needed to maintain the drug add-on amount constant.

4. CY 2008 Updates

In the CY 2008 PFS final rule with comment period (72 FR 66280), we implemented the following updates to the basic case-mix adjusted payment system:

- A growth update to the drug add-on adjustment of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate increased from 14.9 percent to 15.5 percent.
- An update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment of 1.055473 to the wage index for CY 2008.

For CY 2008, consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), we implemented the third year of the transition to the CBSA-based wage index. In addition, the wage index floor was reduced from 0.8000 to 0.7500. After applying a BN adjustment of 1.055473, the wage index floor was 0.7916.

5. Provisions of This Proposed Rule

For CY 2009, we are proposing the following updates to the composite rate payment system:

- A growth update to the drug add-on adjustment to the composite rates;
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment;
- 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. Proposed 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 establishing an add-on to the composite rate to account for changes in the drug payment methodology stemming from enactment of the MMA. Section 1881(b)(12)(c) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the AWP payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to ASP pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

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

The CY 2008 drug add-on adjustment to the composite rate is 15.5 percent. The drug add-on adjustment for CY 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).

(i) Estimating Growth in Expenditures for Drugs and Biologicals for CY 2009

Section 1881(b)(12)(F) of the Act specifies that the drug add-on update must reflect ''the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *'' By referring to ''expenditures'', we stated previously that we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

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

However, upon further contemplation, we believe that a better interpretation of the statutory reference to growth in expenditures contemplates that we would consider any change in drug pricing or utilization, not only increases, as we develop the update to the drug add-on adjustment. We have completed an analysis of ASP prices for ESRD drugs from 2006 through 2008, which shows a declining trend in ASP pricing for ESRD drugs. Accordingly, we are concerned that the use of the PPI as a proxy for ESRD drug pricing growth may no longer be appropriate. This is because the PPI is a general measure for all drugs and does not reflect price changes specific to ESRD drugs. We continue to lack sufficient expenditure data for trend analysis purposes. Given that we do have sufficient ASP pricing information on ESRD drug prices to establish a price forecast specific to ESRD drugs, and since this forecast is based on actual ESRD drug pricing data, we believe it is a more accurate measure of the price component changes for purposes of estimating the growth in total expenditures for ESRD drugs for 2009. Accordingly, for CY 2009, we propose revising the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation.

As detailed below in this section, we are proposing 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.

(ii) Estimating Growth in ESRD Drug Prices

To estimate price growth we used ASP pricing data for the four quarters of 2006 and 2007, and the two available quarters of 2008. We anticipate having at least three quarters of 2008 data available in time for the final rule. We calculated the weighted price change, for the original top ten ESRD drugs for which we had acquisition pricing, plus Aranesp. Tables 4 and 5 show the average ASP drug prices and the 2007 weights used. 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 proposed weighted average ESRD drug pricing change projected for CY 2009 is a reduction of 1.9 percent.

TABLE 4.—CY 2006, 2007 AND 2008 ESRD DRUG ASP PRICES

Independent drugs	2006	2007	2008
EPO	9.46	9.17	9.02
Paricalcitol	3.81	3.79	3.86
Sodium-ferric-glut	4.88	4.76	4.82
Iron-sucrose	0.36	0.37	0.36
Levocarnitine	9.44	8.07	5.81
Doxercalciferol	2.97	2.68	2.60
Calcitriol	0.55	0.54	0.38
Iron-dextran	11.94	11.69	11.61
Vancomycin	3.23	3.43	3.29
Alteplase	31.63	33.21	33.28
Aranesp	3.01	3.29	2.83

TABLE 5.—CY 2007 DRUG WEIGHTS FOR ESRD FACILITIES

Independent drugs	2007 weights (percent)
EPO	69.5
Paricalcitol	11.7
Sodium-ferric-glut	2.5
Iron-sucrose	6.1
Levocarnitine	0.2
Doxercalciferol	2.8
Calcitriol	0.1
Iron-dextran	0.0
Vancomycin	0.1
Alteplase	1.0
Aranesp	6.0

(iii) Estimating Growth in Per Patient Drug Utilization

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

First we had to estimate the total drug expenditures for all ESRD facilities. For this proposed rule, 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 the CY 2009 PFS final rule, we plan to use 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.

While the December 2007 update of CY 2007 claims used in this proposed rule is the most current available claims data, we recognize that it does not reflect a complete year, as claims with dates of service towards the end of the year have not all been processed. To more accurately estimate the update to the drug add-on, aggregate drug expenditures are required. Based on an analysis of the 2006 claims data, we inflated the CY 2007 drug expenditures to estimate the June 30, 2008 update of the 2007 claims file. We used the relationship between the December 2006 and the June 2007 versions of 2006 claims to estimate the more complete 2007 claims available in June 2008 and applied that ratio to the 2007 claims data from the December 2007 claims file. We did this separately for EPO, the other top 10 separately billable drugs, and the remaining separately billable drugs for independent and hospital-based ESRD facilities. We are using the top 11 drugs since they represent 99.7 percent of total expenditures in CY 2007 for separately billable drugs furnished to ESRD patients. All components were then combined to estimate aggregate CY 2007 ESRD drug expenditures. The net adjustment to the CY 2007 claims data was an increase of 12.6 percent to the 2007 expenditure data. This adjustment allows us to more accurately compare the 2006 and 2007 data to estimate utilization growth.

The next step is to remove the enrollment and price growth components from that total. As discussed previously in this section, in developing the per patient utilization growth for this proposed rule, we limited our analysis to the latest 2 years of available ESRD facility drug data (that is, 2006 and 2007). We believe that per patient utilization growth between these years would be a better proxy for future growth, as it best represents current utilization trends.

To calculate the 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 used the calculated 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. Table 4 shows the CY 2007 weights for each of the top eleven ESRD drugs billed by ESRD facilities.

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 (1.00/(1.03 * 0.982) = 0.99).

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

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

In CY 2006, we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dialysis treatments for CY 2006 into the projected dollar amount of the CY 2006 growth to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we

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

As discussed in detail below, for CY 2009, we are proposing no update to the per treatment drug add-on amount of $20.33 established in CY 2008.

c. Proposed Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 1 percent reduction in per patient utilization of ESRD drugs for CY 2009. Also, using historical ESRD drug pricing data specific to ESRD drugs, we project a 1.9 percent reduction in ESRD drug prices for CY 2009. To compute this estimate, we used ASP pricing data for the four quarters of 2006 and 2007, and the two available quarters of 2008. We calculated the weighted price change for the top ten ESRD drugs plus Aranesp over the period. Tables 4 and 5 show the average ASP drug prices and the 2007 weights used. As shown in Table 4, to the extent there were price changes during the trending period, increases as well as decreases have been reflected in the overall weighted average price reduction of 1.9 percent over the 3-year period. Had we continued to use the PPI for prescription drugs in our computation of the drug add-on update, the price component would have been a projected increase of 3.8 percent. Given the observed decline in ASP pricing for ESRD drugs, we believe the continued use of the PPI as a price proxy would have significantly overstated the price component of our computation of the projected change in per patient ESRD drug expenditures for CY 2009. This is because the PPI is a more general measure of price change for all drugs and does not reflect price changes specific to the drugs provided by ESRD facilities.

Therefore, we are projecting 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, as indicated above, we are proposing no update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that ''the Secretary shall annually increase'' the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates ''annually increase'' to mean a positive or zero update to the drug add-on. Therefore, we propose to apply a zero update and to maintain the $20.33 per treatment drug add-on amount for CY 2009 that reflects a proposed 15.5 percent drug add-on adjustment to the composite rate for CY 2009.

However, we also believe that an alternative reading of the statute is possible. We believe that the Congress may not have intended to provide an increase in the drug add-on adjustment in a year where the projected growth in expenditures for separately billable ESRD drugs is declining. There is potentially a gap in the statute, which specifies an ''increase'' to the drug add-on adjustment based upon the ''estimated growth in expenditures for drugs and biologicals'' that are separately billed ESRD drugs. However, an ''increase'' cannot be implemented when estimated ''growth'' is negative.

To resolve this seeming contradiction, another approach to the zero percent update that we are proposing would be to apply an adjustment of less than 1.0 to the drug add-on adjustment. Under this approach, for CY 2009, we would ''increase'' the drug add-on adjustment 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 proposed drug add-on adjustment to the composite rate for CY 2009 would be 15.0 percent.

We are seeking public comment on our proposal of a zero update, as well as the alternative approach presented above, so that we can make an informed decision with respect to the final update to the CY 2009 drug add-on adjustment to the composite rate.

Had we selected the other option of continuing to use the PPI for prescription drugs as a proxy for ESRD drug prices instead of using ASP pricing data, the resulting update factor would have been a 2.6 percent increase to the CY 2008 average per treatment drug add-on amount of $20.33, resulting in a weighted average increase to the composite rate of $0.57 or a 0.4 percent increase in the CY 2008 drug add-on percentage of 15.5 percent. As discussed above, however, we believe the PPI overstates the changes in ESRD drug prices given the observed trend in declining prices for those drugs over the past several years.

We note that for the CY 2010 update to the drug add-on adjustment we expect to estimate the growth in ESRD drug expenditures using 3 years' worth of ASP-based historical ESRD drug expenditure data that will be available at that time. This data will be used to conduct a trend analysis to estimate the growth in ESRD drug expenditures for CY 2010. As we discussed earlier with respect to computing the 2009 estimated growth in drug prices, to the extent there are price changes during the trending period, past increases as well as decreases would be reflected in future trend analyses and in future updates to the drug add-on adjustment.

d. Proposed Update to the Geographic Adjustments to the Composite Rates

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rates. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions as used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

i. 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*.

ii. 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. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. 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.

We propose 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 budget neutrality factor is 1.056672. (See section H.5.d.iii. of this proposed rule for details about this adjustment.) For a detailed description of the development of the proposed CY 2009 wage index values based on FY 2005 hospital data, see the FY 2009 ''Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2009 Rates'' proposed rule (73 FR 23630). Section III G. (Computation of the Proposed FY 2009 Unadjusted Wage Index) of the preamble to that proposed rule 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 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

(A) Fourth Year of the Transition

In the CY 2006 PFS final rule with comment period (70 FR 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. For each transition year, the share of the blended wage-adjusted base payment rate that is derived from the MSA-based and CBSA-based wage index values is shown in Table 6. 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, we are proposing that each ESRD facility's composite payment rate will be based entirely on the CBSA-based wage index.

In CY 2006, we eliminated the wage index cap of 1.30 and stated that we would implement a gradual reduction in the wage index floor of 0.90. Prior to January 1, 2006, the wage indexes were restricted to values no less than 0.90 and no greater than 1.30, meaning that payments to facilities in areas where labor costs fell below 90 percent of the national average, or exceeded 130 percent of that average, were not adjusted beyond the 90 percent or 130 percent level. Although we stated that the ESRD wage index values should not be constrained by the application of floors and ceilings, we also expressed concern that the immediate elimination of the floor could adversely affect ESRD beneficiary access to care. Therefore, we reduced the floor to 0.85 in CY 2006, to 0.80 in CY 2007, and to 0.75 in CY 2008.

For CY 2009, we are proposing to reduce the wage index floor 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 floors, caps, and blended shares of the composite rates applicable to all ESRD facilities for CY 2006 through CY 2008, and the proposed floor and blended share applicable for CY 2009, are shown in Table 6. They are identical to the values shown in Table 10 of the CY 2007 PFS final rule with comment period (71 FR 69686) for the applicable years.

TABLE 6.—WAGE INDEX TRANSITION BLEND

CY payment	Floor	Ceiling	Old MSA (percent)	New CBSA (percent)
2006	0.85	None	75	25
2007	0.80	None	50	50
2008	0.75	None	25	75
2009	*0.70	None	0	100

*Each wage index floor is multiplied by a BN adjustment factor. For CY 2009 the BN adjustment is 1.056672 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.

(B) 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 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 are proposing to use the same methodology for CY 2009. Under this methodology, the CY 2009 proposed wage index values for the counties of Barnstable (CBSA 12700, Barnstable Town, MA–1.2624) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI–MA–1.0573) were averaged resulting in an imputed proposed wage index value of 1.1599 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 proposed ESRD wage index floor of 0.70. Therefore, we propose to continue applying the proposed ESRD wage index floor of 0.70 to facilities that are located in rural Puerto Rico.

For Hinesville, GA (CBSA 25980), which is an urban area without specific hospital wage data, we propose to apply the same methodology used to impute a wage index value that we used in CY 2006, CY 2007, and CY 2008. Specifically, we utilize the average wage index value for all urban areas within the State of Georgia. That results in a proposed CY 2009 wage index value of 0.9123 for the Hinesville-Fort Stewart GA CBSA.

In the CY 2008 PFS final rule with comment period (72 FR 66283), 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 has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

(C) Evaluation of Wage Index Policies Adopted in the FY 2008 IPPS Final Rule

We also stated 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 use the hospital wage index with this modification because it is the best available measure effective of urban and rural differences in labor costs among dialysis facilities. Accordingly, in the following sections, we summarize the wage index changes implemented in connection with the IPPS, as they affect the ESRD wage index used under the composite payment system.

(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 be 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, 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 revised 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). However, for purposes of payment under the IPPS, acute-care hospitals located within those areas are treated as being reclassified to their deemed urban areas effective for discharges occurring on or after October 1, 2007 (see 72 FR 473337 through 47338). We note that the ESRD composite payment system does not provide for such geographic reclassification. Also, in the FY 2008 IPPS final rule with comment period (72 FR 47338), we explained that we have limited this policy change for the ''New England deemed counties'' only to IPPS hospitals, and any change to non-IPPS provider wage indexes would be

addressed in the respective payment system rules. Accordingly, we are taking this opportunity to clarify the treatment of ''New England deemed counties'' under the ESRD composite payment system in this proposed rule.

As discussed above, for purposes of the ESRD wage index, we have recognized the OMB's CBSA designations, as well as generally following the policies under IPPS with regard to the definitions for ''urban'' and ''rural'' for the wage index. Historical changes to the labor market area/geographic classifications and annual updates to the wage index values under the composite payment system are made effective January 1 each year. When we established the most recent composite payment system update, effective for dialysis services provided on or after January 1, 2008, we considered the ''New England deemed counties'' (including Litchfield County, CT and Merrimack County, NH) as urban for CY 2008, as evidenced by the inclusion of Litchfield County as one of the constituent counties of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and the inclusion of Merrimack County as one of the constituent counties of urban CBSA 31700 (Manchester-Nashua, NH).

Litchfield County, CT and Merrimack County, NH are not considered ''urban'' under § 412.64(b)(1)(ii)(A) through (B) as revised under the FY 2008 IPPS final rule and, therefore, are considered ''rural'' under § 412.64(b)(1)(ii)(C). Accordingly, to reflect our general policy for 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. We note that this policy is consistent with our other policy of not taking into account IPPS geographic reclassifications in determining payments under the composite payment system.

(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 are 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. The ESRD wage index values applicable for services provided on or after January 1, 2008 through December 31, 2008 are shown in Addendum G for urban areas and Addendum H for rural areas (72 FR 66552 through 66574) of the CY 2008 PFS final rule with comment period.

We are continuing to use IPPS data for CY 2009 because we believe that in the absence of dialysis facility specific wage data, using the hospital inpatient wage data is appropriate and reasonable for the ESRD composite payment system. We note 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, for the proposed 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), which allocated 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 Addendums G and H of this proposed rule.

In summary, for CY 2009, we propose 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. These data reflect the multi-campus and New England deemed counties policies discussed above.

iii. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, requires 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 are not proposing 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 propose to apply a BN adjustment factor (1.056672) 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 proposed CY 2009 wage index BN adjustment factor (1.056672), we used the FY 2005 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2007 outpatient claims (paid and processed as of December 31, 2007), and geographic location information for each facility which may be found through 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 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 the 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.

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 proposed 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 proposed BN adjustment factor for the CY 2009 wage index is 1.056672.

To ensure BN, we also must apply the BN adjustment factor to the proposed wage index floor of 0.7000 which results in a proposed adjusted wage index floor of 0.7397 (0.7500×1.056672) for CY 2009.

iv. ESRD Wage Index Tables

The proposed 2009 wage index tables are located in Addenda G and H of this proposed rule.

v. 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 Date 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.

The preventable hospital-acquired conditions (HAC) payment provision for IPPS hospitals is another of our value-based purchasing initiatives. The principal behind the HAC payment provision (Medicare not paying more for healthcare-associated conditions) 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 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 condition was not present on admission. That is, the case will be paid as though the secondary diagnosis 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—Medicare not paying for healthcare-associated 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; SNFs; HHAs; ESRD facilities; and physician practices. The implementation would be different for each setting, as each payment system is different and the reasonable preventability through the application of evidence-based guidelines would vary for candidate conditions over the different settings. However, alignment of incentives across settings of care is an important goal for all of our VBP initiatives, including the HAC 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 preventable condition acquired in the first setting but treated in the second setting.

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

I. Independent Diagnostic Testing Facility (IDTF) Issues

[If you choose to comment on issues in this section, please include the caption ''INDEPENDENT DIAGNOSTIC TESTING FACILITIES'' at the beginning of your comments.]

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 this proposed rule, we are again proposing 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 performing diagnostic testing services for Medicare beneficiaries, and who have enrolled in the Medicare program as a clinic, group practice, or physician 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.

In response to the public comments, we are concerned that—

- Certain physician entities, including physician group practices, and clinics, can enroll as a group practice or clinic and provide 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.

We are proposing 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 patient may issue 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 propose not to require physician entities 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 are proposing 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 propose 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 maintain 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 propose 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 are soliciting 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.

While we believe that most physician and NPP organizations utilize nonphysician personnel described in § 410.33(c) to furnish diagnostic testing services, we are also soliciting comments on whether physician or NPPs conduct diagnostic tests without benefit of qualified nonphysician personnel and under what circumstances the testing occurs.

While we are proposing to apply the IDTF requirement to all diagnostic testing services furnished in physicians' offices, we are 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 seek comment 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 seek comment 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 are also soliciting comments on what would be appropriate criteria to limit this provision.

Finally, since this change, if adopted, would take time to implement for suppliers that have enrolled in the Medicare program, we are proposing an effective date of September 30, 2009, rather than the effective date of the final rule. For newly enrolling suppliers, the effective date of this rule would be January 1, 2009.

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 are proposing 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 performed. 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 render.

While we understand that a mobile entity can furnish diagnostic testing services in various types of locations, we believe that it is essential that mobile entities use qualified physicians or nonphysician personnel to perform diagnostic testing procedures and that the enrolled mobile supplier bill for the services rendered. We maintain that it is essential to our program integrity and quality improvement efforts that an entity furnishing mobile diagnostic testing services comply with the performance standards for IDTFs and bill the Medicare program directly for the services provided 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, this proposed provision, if adopted, would be effective with the effective date of the final rule.

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 are proposing to limit the claims submission timeframe

after revocation. In § 424.535(g), we are proposing 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 maintain that this change is necessary to limit the Medicare program exposure to future vulnerabilities from physician and NPP organizations and individual practitioners that have had their billing privileges revoked. Accordingly, this 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 are also proposing to amend § 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.

J. Physician and Nonphysician Practitioner (NPP) Enrollment Issues

[If you choose to comment on issues in this section, please include the caption ''PHYSICIAN AND NONPHYSICIAN PRACTITIONER ENROLLMENT ISSUES'' at the beginning of your comments.]

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 for services that were rendered 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 proposed rule, we believe that a NPP includes, but is not limited to, the following individuals: Anesthesiology assistants, audiologists, certified nurse midwifes, certified registered nurse anesthetists, clinical social workers, NPs, occupational therapists in private practice, physical therapists in private practice, PAs, clinical psychologists, psychologists billing independently, 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 rendered 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 not prohibited from billing 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 rendered up to 27 months prior to their enrolling in the Medicare program. We are concerned 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 are seeking 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 rendered 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). The date of approval is the date that a designated Medicare contractor determines that the physician or NPP organizations or individual practitioner meets all Federal and State requirements for their supplier type.

Given this first approach, in § 424.520, 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 an NPI.''

We believe that this approach—

- Prohibits physician and 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 certain 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 are allowed to bill for service only after they are approved to participate in the Medicare program. Surveyed suppliers are 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 rendering 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,

a newly enrolling physician 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 § 424.520, 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 an FFS contractor; or (2) The date that the physician or NPP organization or individual practitioner first furnished services at a new practice location.''

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 physician 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 physician 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 Internet-based enrollment process known as Internet-based Provider Enrollment, Chain and Ownership System (PECOS). Internet-based PECOS is available to physician and NPP organizations and individual practitioners in all States, except California, Missouri, and New York, in early CY 2009. We expect that Internet-based PECOS will be available to physician and NPP organizations and individual practitioners in California, Missouri, and New York by September 30, 2009.

By using Internet-based PECOS, we expect that physician and NPP organizations and individual practitioners will be able reduce the time necessary to enroll in the Medicare program or 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 are also proposing 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 clinic or group practice. In addition to establishing 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 proposed definition above would include sole proprietorships that receive a type 1 NPI and any organizational entity that is required to obtain a type 2 NPI.

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 calendar year 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 which a tax delinquency exists and we are unable to directly levy future payments through the FPLP. While we are not proposing this change in this year's PFS, 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 that we are unable to directly levy future payments through the FPLP. In addition, we expect to conduct outreach regarding our implementation in advance of implementing 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 is 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 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 payment to an individual who has not met his or her obligation to pay their tax debts.

Finally, we are soliciting comments on whether we should consider revoking a physician 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 are also soliciting 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.

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

Currently, owners, authorized officials, and delegated officials of a 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 rendered 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 § 405.371, we will impose a payment suspension when we possesses reliable information that an overpayment or fraud, or willful misrepresentation exist, or that payments to be made may not be correct. While providers and suppliers do not have formal appeal rights to a payment suspension determination, providers and suppliers can 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 applying 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, the overpayment determination is upheld on appeal, we will initiate a recovery action. However, in some cases, physician and NPP organizations or individual practitioners will try to circumvent the recovery process by seeking additional billing privileges and billing under the new billing number.

Accordingly, we propose 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 are proposing that a Medicare FFS

contractor be allowed 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 administrative action is terminated or the Medicare overpayment has been repaid in full. Specifically, we are proposing 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 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, this change would allow—(1) 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.

4. Reporting Requirements for Providers and Suppliers (proposed § 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 adverse legal 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 or other adverse legal 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 adverse legal 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 adverse legal action after the fact, we lack 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 proposing a new § 424.516(d) which would establish more stringent reporting requirements for physician NPP organizations and individual practitioners. (We are proposing 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 are proposing to add § 424.516(d)(1)(ii) that requires all physician and NPP organizations and individual practitioners to notify CMS' designated contractor of any adverse legal action within 30 days. Adverse legal actions include, but are not limited to, felonies, license suspensions, and the 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 an adverse legal 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 adverse legal action.

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 an adverse legal 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 its Medicare billing privileges revoked effective retroactively back to June 30, 2007 as well.

Additionally, we are proposing 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 rendered by placing the physician and NPP organizations and individual practitioners into a new 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 an adverse legal 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 are proposing 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 are proposing 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 an adverse legal 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 adverse legal 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 one year.

5. Maintaining Ordering and Referring Documentation

We are proposing 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 are proposing to add § 424.535(a)(10) that would state that failure to comply with the documentation requirements specified in § 424.516(f) 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 are codifying 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 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 10 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.

6. Revocation of Enrollment and Billing Privileges in the Medicare Program (proposed § 424.535(g))

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 Medicare program, we are proposing to limit the claims submission timeframe after revocation. In § 424.535(g), we are proposing 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 maintain that this change is necessary to limit the Medicare program 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, this 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 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 submit claims on a nexus to the date of service, we believe that this proposed change will not impose a significant burden on physician organizations or individual practitioners. In addition, we are also proposing to add § 424.44(a)(3) to account for this provision related to the requirements for the timely filing of claims.

7. Technical Changes to Regulations Text

We propose to make the following technical changes:

- Existing § 424.510(d)(8) would be redesignated as § 424.517. This proposed 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 proposed 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 would 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, the phrase ''in the Medicare program'' would be added to the section heading to remain consistent with other headings in the subpart.

K. Proposed Amendment to the Exemption for Computer-Generated Facsimile Transmission From the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Eligible Individuals

[If you choose to comment on issues in this section, please include the caption ''COMPUTER-GENERATED FAX TRANSMISSIONS'' at the beginning of your comments.]

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 proposed rule 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 (Faxes)

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 (faxes generated by one computer and electronically transmitted to another computer or fax 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 fax 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 faxing retains 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 fax exemption would encourage prescribers and dispensers using this computer-generated fax technology to, where available, utilize true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard) capabilities.

We also believed that it might encourage those without such capabilities to upgrade their current software products, or, where upgrades are not available, to switch to new products that would enable true e-prescribing. In addition, because the elimination of the computer-generated facsimile exemption would encourage those prescribers that are already using e-prescribing software that is capable of true e-prescribing to utilize those capabilities, we believed that the elimination of the computer-generated fax exemption would increase the number of NCPDP SCRIPT transactions fairly significantly in a relatively short time period, and that this could, in turn, create a ''tipping point'' that could create economic incentives for independent pharmacies to adopt NCPDP SCRIPT capable software to begin to exchange true e-prescribing transactions with their prescriber partners.

We proposed to eliminate the computer-generated fax 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-fax transactions. We also believed the elimination of the exemption for computer-generated faxing would encourage e-prescribers and dispensers to move as quickly as possible to use of the NCPDP SCRIPT standard with what we perceived to be minimal impact.

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 faxes. The commenters indicated that lifting the exemption for computer-generated faxes would act as an incentive to move prescribers and dispensers toward true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard). Less than half of the commenters disagreed with

our proposal to eliminate the exemptions for computer-generated faxes, citing concerns about increased hardware/software costs, transaction fees, certification and other activation costs. Some commenters agreed that many prescribers who are already e-prescribing likely already possessed the ability to generate NCPDP SCRIPT compliant transactions using their software or could comply by obtaining a version upgrade under their maintenance agreements. Many commenters suggested that we continue to allow for the use of computer-generated faxes in the case of transmission failure and network outages.

During the CY 2008 PFS proposed rule comment period, we received several comments that 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 feedback on the impact of the elimination of computer-generated facsimiles on prescription refill requests, and not considering these 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 or transient network transmission failures. Taken in the aggregate, we determined that the 1-year time period was adequate time during which providers and dispensers would have the opportunity to convert to conducting true e-prescribing and that costs would be mitigated due to the growing volume of e-prescriptions and practice of e-prescribing, with a commensurate reduction in transmission, software and other costs during that 1-year time period. These changes were to become effective in January 2009.

3. Proposal

Following the publication of the CY 2008 PFS final rule with comment period, we received additional information regarding how the elimination of the exemption for computer-generated faxes would adversely impact the electronic transmission of prescription refill requests. These commenters relayed that the elimination of the exemption would force dispensers who e-prescribe and use these transactions to revert to paper prescribing. These commenters substantiated their assertions by providing us with more specific information regarding the economic and workflow impacts associated with the elimination of computer-generated faxes that was not forthcoming in the prior public comment period for the proposed rule. We also received unsolicited comments on this issue during the comment period for the November 16, 2007 proposed rule (72 FR 64900). In light of this new information, we are now re-examining this issue in this proposed rule.

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 fax) 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 re-sent 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 prescription 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 is this counterproductive to the advances and efficiencies made in pharmacy practice, it would impose an undue administrative burden on dispensing pharmacies and pharmacists.

In light of this additional information regarding the larger than anticipated impact of the elimination of computer—generated facsimiles for the prescription refill request transaction, we propose 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 propose to retain the current exemption in instances of temporary network transmission failures. We propose that this change will be effective January 1, 2009. We will periodically revisit the exemption for the purpose of ultimately eliminating it for the prescription refill request transaction as described in § 423.160(b)(1)(vii), and solicit comments regarding what constitutes an adequate time to allow the industry to transition to the use of the NCPDP SCRIPT standard.

We are also soliciting comments on the impact of the proposed exclusion of the prescription refill request transaction from this exemption. Specifically, we are soliciting information on any other e-prescribing transaction that may be similarly adversely impacted by the elimination of computer-generated facsimiles. As the use of e-prescribing increases, the need for computer-generated facsimiles in Part D e-prescribing would decrease, except in cases of temporary or transient network transmission failures. We believe that this proposal to allow computer-generated facsimiles for the prescription refill request transaction, and in cases of network transmission failures, would not slow the ongoing adoption of e-prescribing using NCPDP SCRIPT enabled transactions, and that the industry should continue to move as quickly as possible to use of the NCPDP SCRIPT standard.

L. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

[If you choose to comment on issues in this section, please include the caption ''CORF AND REHABILITATION ISSUES'' at the beginning of your comments.]

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 66222 and 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 services 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 this CY 2009 PFS proposed rule, we address the comments received in response to the CY 2008 final rule with comment (72 FR 66222), as well as add new provisions and revise some provisions. We welcome your comments on all of these 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. The American Association for Respiratory Care (AARC) believes 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.

For CY 2009, we are proposing to revise § 485.70(j)—setting forth the personnel qualifications for respiratory therapists in CORFs— to be consistent with current qualification requirements for RRTs, as recommended by the AARC.

We are also proposing 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 believe 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 are proposing to amend the material addressing personnel qualifications in § 485.70. Specifically, we are amending 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. We welcome your comments on these proposed changes.

Also, at 485.58(a)(1)(i), we propose 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. We welcome your comments on this proposed change.

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 code range 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 last year, 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 is 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 our revised regulations at § 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, for CY 2009, we are proposing 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 propose to use salary and wage data from the Bureau of Labor and Statistics to institute a blended social worker/psychologist clinical labor category using a price per minute rate of $0.45 for the practice expense component of GXXX5. We would 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 would not allocate a work RVU for these services.

We also propose 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 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 propose 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.

We also propose to remove § 410.155(b)(1)(ii) regarding the application of mental health limitations to CORF social and psychological services. As 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 are not ''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 do not apply. We are proposing changes to § 410.155(b) to reflect our view regarding the limited nature of these 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.

We are proposing 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 are proposing to clarify that the alternate premises for provision of physical therapy, occupational therapy, and speech-language pathology services may be the patient's home.

4. Extension Location

We are proposing 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 propose 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. We welcome your comments on this proposed definition.

5. Emergency Care

We are proposing to revise § 485.711(c), Standard: Emergency care, to reflect current medical practice. We propose 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 are proposing the revised standard to require each rehabilitation agency to establish procedures to be followed by personnel in an emergency to cover immediate care of the patient, persons to be notified, and reports to be prepared. We are soliciting comments on this proposal.

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 CORF, 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 are proposing to delete the requirement in paragraph (2)(ii) of the rehabilitation agency definition requiring a rehabilitation agency to provide social or vocational services. We are also proposing to make a conforming change at § 485.717.

At § 485.711(b)(3), we are proposing to remove the reference to § 410.61(e), since § 410.61(e) no longer exists in regulation.

M. Technical Corrections for Therapy-Related Issues

[If you choose to comment on issues in this section, please include the caption ''THERAPY-RELATED ISSUES'' at the beginning of your comments.]

We are proposing the following technical changes to the regulations concerning therapy services:

- In § 409.17(a), we are proposing to delete the reference to paragraph (a)(1)(ii) which no longer exists.
- In § 409.23, we are proposing to revise the title of this section from ''Physical, occupational and speech therapy'' to ''Physical therapy, occupational therapy and speech-language pathology services.''

N. Physician Self-Referral and Anti-Markup Issues

[If you choose to comment on issues in this section, please include the caption ''PHYSICIAN SELF-REFERRAL AND ANTI-MARKUP ISSUES'' at the beginning of your comments.]

1. Changes to Reassignment Rules Related to Diagnostic Tests (Anti-Markup Provision)

a. CY 2008 PFS Final Rule With Comment Period

The CY 2008 PFS final rule with comment period (72 FR 66222) amended the anti-markup provision in § 414.50 for certain diagnostic tests. We revised the anti-markup provision to apply to the technical component (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 also imposed an anti-markup provision 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. The anti-markup provision in § 414.50 applies to the TCs and PCs of 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). 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 revised § 414.50(a)(2)(iii), we defined 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 of this chapter), 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. (For purposes of the anti-markup provision, the office of a billing physician or other supplier has its common meaning—that is, it is space in which the physician or other supplier regularly furnishes patient care services, and does not include a ''centralized building'' as defined at § 411.351).

We effectuated our changes primarily by modifying § 414.50, although we also modified § 424.80 by adding paragraph (d)(3) to alert the reader that, in a case of the reassignment of the TC and/or PC of a diagnostic test, the reader should consult § 414.50 to investigate whether the anti-markup provision applies to the TC and/or PC. We also amended the definition of ''entity'' at § 411.351 to exclude a physician's practice when it bills Medicare for the PC of a diagnostic test in accordance with § 414.50. (Prior to the CY 2008 PFS final rule with comment period, the definition of ''entity'' at § 411.351 excluded a physician's practice when it bills Medicare for the TC of a diagnostic test in accordance with § 414.50.)

b. Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Delay of the Date of Applicability of the Revised Anti-Markup Provision for Certain Services Furnished in Certain Locations (§ 414.50) Final Rule (73 FR 404)

Subsequent to the publication of the CY 2008 PFS final rule with comment period (72 FR 66222), we received informal comments from various stakeholders that stated that the application of the rule was unclear with respect to whether certain types of space arrangements meet the definition of the ''office of the billing physician or other supplier.'' Further, some of these stakeholders stated that patient access may be significantly disrupted due to the alleged inability of physician groups to render services in a cost-effective manner if medical office space that satisfies the ''same building'' test in § 411.355(b)(2)(i) of this chapter for purposes of the physician self-referral rules in Part 411, Subpart J of this chapter, and other medical office space in which patients are seen and that complies with the physician self-referral rules, are subject to the anti-markup provision in revised § 414.50. That is, physician groups stated that, in situations in which they are subject to the anti-markup provision and are limited to billing Medicare the net charge imposed by the performing supplier, they will not be able to continue to provide diagnostic testing services to the same extent that they are currently providing such services, because they will not be able to recoup their overhead costs.

We were concerned that the definition of ''office of the billing physician or other supplier'' may not have been entirely clear and that it could have unintended consequences. Accordingly, in order for us to study the issues further, we issued a final rule entitled ''Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Delay of the Date of Applicability of the Revised Anti-Markup Provisions for Certain Services Furnished in Certain Locations (§ 414.50)'' (the ''Delay Rule''), which delayed, until January 1, 2009, the applicability of the revised anti-markup provision in § 414.50, *except* for anatomic pathology diagnostic testing services furnished in space that: (1) Is utilized by a physician group practice as a ''centralized building'' for purposes of complying with the physician self-referral rules; and (2) does not qualify as a ''same building'' under § 411.355(b)(2)(i) (73 FR 404). We stated that, during this period, we planned to issue clarifying guidance as to what constitutes the ''office of the billing physician or other supplier'' or propose additional rulemaking, or both. Because anatomic pathology diagnostic testing arrangements precipitated our proposal for revision of the anti-markup provision and remained our core concern, we did not delay the date of applicability with respect to anatomic pathology diagnostic testing services furnished in certain space (as described above). In addition, we did not delay the applicability of the revised anti-markup rule for the TC of *any* purchased diagnostic test. The anti-markup prohibition for the TC of purchased diagnostic tests is longstanding and was incorporated into the expanded and revised provisions of § 414.50. Accordingly, the regulation remained applicable to the TC of any purchased diagnostic test.

c. Challenge to the CY 2008 PFS Final Rule With Comment Period and the Subsequent Delay of the Date of Applicability Final Rule

On January 25, 2008, a group of plaintiffs filed suit against the Secretary (*Atlantic Urological Associates PA* v. *Leavitt,* Civil Action No. 08–141–(RMC) (D.D.C.), challenging the validity of the CY 2008 PFS final rule with comment period and the subsequent Delay Rule, and asking the Court to enjoin the application of the CY 2008 PFS final rule with comment period as to them. The plaintiffs included the following: (1) Three urology physician group practices that own pathology laboratories; (2) a self-employed pathologist who performs testing services for other physician groups; (3) Uropath, LLC, a limited liability company that manages various pathology laboratories; and (4) Uropath's Director of Clinical Operations. The Secretary moved to dismiss the complaint for lack of standing and lack of jurisdiction. The Secretary agreed to withhold implementation of the anti-markup rule, as amended by the Delay Rule, for claims submitted between February 1, 2008 and April 1, 2008, so that the parties could fully brief the issues. Subsequently, a preliminary injunction was granted by the Court until the date of its final order.

On May 5, 2008, the Court vacated the preliminary injunction order and granted the Secretary's motion to dismiss the suit. The Court found that the plaintiffs did not have standing to challenge the delay of the applicability of the anti-markup provisions for some arrangements. The Court further found that Uropath and its Director of Clinical Operations lacked standing to challenge either the CY 2008 PFS final rule with comment period or the subsequent Delay Rule due to the fact that they are not Medicare providers or suppliers and, thus, had no legally protected interest at stake. Finally, the Court found that, even if the plaintiffs had standing, the physician groups and the self-employed pathologist must exhaust the administrative claims process before the matter could be heard in Federal court.

d. Specific Proposals

As finalized in the CY 2008 PFS final rule with comment period, the anti-markup provision applies to the TCs or PCs of diagnostic tests that are either purchased from an outside supplier or are performed outside of the ''office of the billing physician or other supplier.''

Here, we are proposing two alternative approaches for revising the anti-markup provision in § 414.50. In addition, we are seeking comments regarding any other possible approaches that would address our concerns regarding overutilization motivated by the ability of a physician or physician organization to profit from diagnostic testing services not actually performed by or supervised by a physician who should be considered to ''share a practice'' with the billing physician or other supplier.

Under our first proposal, the anti-markup provision in § 414.50 would apply in all cases where the PC or TC 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 physician organization (as defined at § 411.351). We would specify 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 believe 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. Under this proposal, a physician who is an employee of, or independent contractor with, more than one billing physician or physician organization would not ''share a practice'' for purposes of § 414.50 with any of the physicians or physician organizations with which he or she is affiliated.

We believe that this proposal offers a simpler, more bright-line approach preventing potentially abusive arrangements while preserving the viability of nonabusive arrangements involving diagnostic testing facilities that might not be considered to be in the ''office of the billing physician or other supplier,'' as defined under the current regulation (for example, a centralized laboratory staffed with full-time employees that is used by a physician practice with multiple office locations, sometimes referred to as a ''hub and spoke'' arrangement). We are not proposing regulation text for this proposal.

We recognize that circumstances may exist under which it is beneficial, if not necessary, for a physician to provide diagnostic testing services to more than one physician practice. For example, a physician in one practice may contract to provide physician services on a *locum tenens* basis to another practice while a physician in that practice is on vacation or maternity leave. We are interested in comments regarding whether and, if so, how 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 his or her physician organization for purposes of applying the anti-markup provision. We note that we do not consider providing services at a free clinic or moonlighting in a hospital emergency department or as a hospitalist to be ''sharing a practice.'' Such activity would not require the application of the anti-markup provisions with respect to the services the physician provides for his or her physician organization.

Alternatively, we propose to maintain much of the current regulation text and its ''site-of-service'' approach to determine whether a physician ''shares a practice'' with the billing physician or other supplier. In other words, we are re-proposing to apply the anti-markup provision to TCs and PCs of non-purchased tests that are performed outside the ''office of the billing physician or other supplier''. We are soliciting comments on whether this is the best approach or whether we should employ a different approach. As discussed in more detail below in this section, we are also proposing 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 of the office of the billing physician or other supplier; (3) clarify that a TC of a diagnostic test is not purchased from an outside supplier if the TC is supervised by a physician located in the office of the billing physician or other supplier; (4) clarify that, for purposes of applying the payment limitation in § 414.50(a)(1)(i) only, the ''performing supplier'' with respect to the TC is the physician who supervised the TC and, with respect to the PC, the ''performing supplier'' is the physician who performed the PC; (5) propose 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; and (6) solicit 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.

i. Definition of the ''Office of the Billing Physician or Other Supplier''

We received informal comments from various stakeholders who alleged that the application of the CY 2008 PFS final rule with comment period was unclear with respect to whether certain types of space arrangements meet the definition of the ''office of the billing physician or other supplier.'' In addition, some of these stakeholders stated that patient access may be significantly disrupted due to the alleged inability of physician groups to render services in a cost-effective manner if the anti-markup provision applies to arrangements in which diagnostic testing services are performed in the same building as, but in space separate from, where patients are seen. Stakeholders pointed to arrangements in which the office where a physician group sees patients is located on, for example, the third floor of a medical arts building, but the diagnostic imaging services are housed, for example, in the basement of the building. Stakeholders also cited arrangements in which two or more group practices in the same building may share a lab or other diagnostic testing facility in that building.

After further review, we are proposing to clarify the definition of ''the office of the billing physician or supplier'' in § 414.50(a)(2)(iv) to include space, in which diagnostic testing services are performed, that is in the ''same building,'' (as defined at § 411.351), as where the ordering physician or other ordering supplier regularly furnishes patient care (and more specifically, for physician organizations, in the same building as where the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally). Note that the definition of ''same building'' at § 411.351 specifically excludes a ''mobile vehicle, van, or trailer''. Therefore, diagnostic services provided in the parking lot of a building in which a physician group sees patients would be subject to the anti-markup provisions.

We are soliciting comments that describe current business arrangements (such as those that take place on a ''campus'') and that suggest any additional or alternative criteria that would permit such arrangements to avoid application of the anti-markup provision while addressing our concerns for the potential for overutilization.

We have received questions as to whether, for purposes of the definition of the ''office of the billing physician or other supplier'' a physician or other supplier may have more than one location at which it regularly furnishes patient care. We propose to clarify in § 414.50(a)(2)(iv) that it may. In addition, some stakeholders responded to the requirement that, with respect to a billing physician or other supplier that is a ''physician organization'', 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. According to the stakeholders, a physician organization, such as a multi-specialty physician group, may not provide substantially its full range of services 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 difficulty for physician organizations, we are proposing to revise § 414.50(a)(2)(iv) to read ''with respect to a billing physician or other supplier that is a physician organization (as defined at § 411.351 of this chapter), the ''office of the billing physician or other supplier'' is medical office space where the *ordering* physician provides substantially the full range of patient care services that the *ordering* physician provides generally.

Examples of Application of Our Proposed Definition of the ''Office of the Billing Physician or Other Supplier''.

We are providing the following examples in order to illustrate the effect of our proposals. For purposes of the following examples, assume that neither the TC nor the PC is purchased from an outside supplier.

Example 1. A physician group practice treats patients in space located on one floor of a building, and, in that space, provides substantially the full range of services that it provides generally. The group practice conducts diagnostic testing on another floor of the same building. The anti-markup would not apply because the office of the billing physician or other supplier includes the space on both floors.

Example 2. One or more physician group practices share space that is used for diagnostic testing and is located in the same building in which the group practices have their respective offices for seeing patients (and within those offices each group practice provides substantially the full range of patient care services that it provides generally). Again, the anti-markup provision would not apply because the office of the billing physician or other supplier (with respect to each group practice) includes the space on both floors.

Example 3. 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. If we finalize the definition of the ''office of the billing physician or other supplier'' to include space in which diagnostic testing is performed that is located in the same building as where the ordering physician or other ordering supplier regularly furnishes patient care, the anti-markup provision would not apply to the diagnostic testing performed in Building B but would apply to the diagnostic testing performed in Building C.

We recognize that, unlike the first alternative proposal described above, our second alternative proposal may adversely affect certain ''hub and spoke'' and similar diagnostic testing services arrangements (see description above) in which a physician providing services in a centralized diagnostic testing facility owned by and serving a multi-site group practice has a significant nexus to the physician organization that employs or contracts with the physician. Therefore, we are proposing to provide an exception in § 414.50(b) to the anti-markup provision that would be applicable 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. The exception would not apply to TCs purchased from an outside supplier, in recognition of the statutory command in section 1842(n)(1) of the Act and our longstanding rule. We are seeking comments as to whether the exception is sufficient to address any potential impediments to nonabusive ''hub and spoke'' arrangements caused by this second alternative approach, whether the exception is too narrow or too broad, and whether an exception to the application of the anti-markup rule under this second alternative approach is necessary at all.

ii. Performed at a Site Other Than the Office of the Billing Physician or Other Supplier

Section 414.50(a) provides that the anti-markup provision applies to the TC of a diagnostic test if the TC is performed outside of the office of the billing physician or other supplier. We propose to clarify that, if the TC is conducted outside of 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. We also propose to clarify that the anti-mark-up provision applies if the supervision of the TC takes place outside the office of the billing physician or other supplier, even if the TC is conducted in the office of the billing physician or other supplier. In other words, we would take the position that ''performance'' of the TC includes both the technician's work in conducting the test and the physician's supervision of the technician. Therefore, 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, the anti-markup provision would apply.

iii. Outside Supplier

In the CY 2008 PFS final rule with comment period, we defined an outside supplier as ''someone who is not an employee of the billing physician or other supplier and who does not furnish the test or interpretation to the billing physician under a reassignment that meets the requirements of § 424.80'' (72 FR 66401). Subsequent to publication of the final rule with comment period, we received questions as to whether the TC of a diagnostic test would be purchased from an outside supplier if the technician conducting the TC is not an employee of the billing group but the physician supervising the technician is an employee or contractor of the billing group. We are proposing to provide in new § 414.50(a)(2)(iii) that the TC of a diagnostic test is not purchased from an outside supplier if the TC is both conducted and supervised within 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. We believe that the presence of the technician and the supervising physician in the office of the billing physician or other supplier, and the fact that the supervising physician is an employee or independent contractor of the billing physician or other supplier may establish a sufficient nexus between the supervising physician and the billing physician or other supplier so as to constitute ''sharing a practice'' within the meaning of section 1842(n)1) of the Act. We are providing proposed regulatory text in new § 414.50(a)(2)(iii) for this proposal. We are also making two alternative proposals (each without proposed regulatory text). We propose, in the first alternative, that 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. As a second alternative, we propose that, 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 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. We note that, if we were to adopt this second alternative, the TC would still be subject to the anti-markup provision under our proposal that the anti-markup provision applies 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, unless an exception applies (see section II.N.1.d.i. of this proposed rule).

iv. The Performing Supplier's Net Charge

Section 414.50(a)(1) provides that, where the anti-markup provision applies, Medicare payment to the billing physician or other supplier is limited to the lowest of three specified amounts, one of which, in § 414.50(a)(1)(i), is ''the performing supplier's net charge to the billing physician or other supplier.'' We have received comments concerning what the performing supplier's net charge would be in the situation in which a physician in a group practice

supervises the performance of a TC but the group practice bills for the TC directly, that is, without a reassignment from the supervising physician. Stakeholders have questioned whether there are two suppliers, that is, the physician supervising the TC and the group practice billing for it, or whether there is only one supplier, that is, the group practice, given that the supervising physician is not effecting a reassignment.

We propose to clarify that for purposes of § 414.50(a)(1)(i) only, the ''performing supplier'' of the TC is the physician who supervised the TC, and the ''performing supplier'' of the PC is the physician who performed the PC. Therefore, where the anti-markup provision applies, the billing physician or other supplier would need to determine what it paid the physician for supervising the TC or for performing the PC.

v. Specific Solicitation of Comments

We are interested in receiving comments concerning the calculation of net charge for the PC when the anti-markup rules apply. In the CY 2008 PFS final rule with comment period, commenters objected that it would be difficult to calculate the net charge of the performing supplier. We stated that we did not believe that most suppliers would experience significant difficulty in calculating the net charge, despite the fact that some physicians are paid an aggregate monthly or annual amount for their services. In addition, we stated that suppliers could also choose to restructure their arrangements so that the anti-markup provision does not apply (72 FR 66318). Despite these responses in the final rule, we have received comments and questions concerning how to calculate the net charge. We are soliciting comments as to whether and how we should provide specific regulatory guidance for calculating the net charge.

Commenters specifically stated that our decision to exclude the overhead costs of the billing supplier in the net charge would have a detrimental financial impact upon their practice and, ultimately, patient access to care. We are also soliciting comments on whether we should allow some overhead costs to be recovered by billing suppliers for services to which the anti-markup provision applies, and how our concerns about the potential for overutilization would be addressed if we were to allow some recovery of overhead.

We note that several States have enacted direct billing laws, under which physicians (primarily pathologists) are required to directly bill payors for their services and are prohibited from reassigning their right to payment to the ordering supplier. We are soliciting 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.

Finally, we are soliciting comments on whether the revisions made by the CY 2008 PFS final rule with comment period should go into effect on January 1, 2009, as planned, and whether any proposals contained herein that may be finalized should go into effect on that date, or whether some or all of the revisions should be delayed past January 1, 2009.

2. Exception for Incentive Payment and Shared Savings Programs (Proposed § 411.357(x))

a. Background

The Medicare program and private industry stakeholders are increasingly exploring the benefits of various types of gainsharing, pay-for-performance (''P4P''), value-based purchasing, and similarly-styled programs that use economic incentives to foster high quality, cost-effective care. Many of these programs involve payments from hospitals to physicians. These payments potentially implicate the fraud and abuse laws, including the physician self-referral statute. Existing exceptions to the physician self-referral statute, while useful, may not be sufficiently flexible to encourage a variety of nonabusive and beneficial gainsharing, P4P, and similar programs.

For this reason, as described in greater detail below, we are proposing a new, targeted exception to the physician self-referral statute for such programs. The design of the new exception presents a particular challenge: Crafting an exception that offers broad flexibility for innovative, effective programs, while at the same time protecting the Medicare program and beneficiaries from abuses. 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.

The variety and complexity of these programs make them potential vehicles for the unscrupulous to disguise payments for referrals or compromise quality of care for patients in the interest of maximizing revenues. Therefore, our approach to drafting a proposed exception is a cautious one. Our proposal is relatively narrow, and we acknowledge at the outset that it is unlikely to cover as many arrangements as interested stakeholders would like. As described below, we are considering various ways that we might expand the proposed exception, if we can do so without a risk to the programs and their beneficiaries. We are interested in public comments specifically addressing areas of possible expansion, the potential abuses that could occur, and the conditions necessary to ensure that such expansion does not pose a risk of program or patient abuse. It is our goal to promulgate an exception that is as broad as possible 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. We note that section 1877 of the Act is not implicated by quality or cost savings programs that do not involve remuneration to physicians. Hospitals are free to implement quality protocols, cost savings measures, and the like without regard to section 1877 of the Act, provided that the arrangements do not involve financial relationships with referring physicians.

Although ''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 for the purpose of achieving quality standards, generating cost savings, and reducing waste. In this proposed rule, we refer to these programs as ''incentive payment and shared savings programs.'' We describe below in more detail the characteristics of programs we consider to fall within these categories. Successful programs often result in improved quality outcomes or cost savings (or both) for the hospital sponsoring the program. To achieve these goals, hospitals make financial payments to the physicians whose efforts contribute to the success of the program. As noted above, these payments may implicate the physician self-referral statute.

Section 1877(a)(1) of the Act states that, except as provided in section 1877(b) of the Act, if a physician (or an immediate family member of such physician) has a financial relationship

with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS) for which payment otherwise may be made under title XVIII of the Act. The provision of monetary or nonmonetary remuneration by a hospital to a physician through a gainsharing arrangement or other incentive payment or shared savings program would constitute a financial relationship with an entity for purposes of the physician self-referral statute.

Incentive payment and shared savings programs also potentially implicate two additional specific fraud and abuse statutes. First, sections 1128A(b)(1) and (b)(2) of the Act, commonly referred to as the Civil Monetary Penalty (CMP) statute, prohibit a hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under the physician's direct care, and a physician from knowingly accepting such payment. Second, these arrangements potentially implicate section 1128B(b) of the Act (the anti-kickback statute) if one purpose of the quality improvement or cost savings payment is to influence referrals of Federal health care program business.

i. Incentive Payment Programs

''Pay for performance'' (P4P), also known as quality-based purchasing, is a quality improvement and reimbursement methodology aimed at moving towards payments that create stronger financial support for patient focused, high value care. There are many models for financial and non-financial incentives used in P4P and other quality-focused programs. We refer to these types of programs, which may be payer-based or provider-based, as ''incentive payment programs.'' Through collaborative efforts with a wide range of other public agencies and private organizations that have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum (NQF), The Joint Commission, the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and the American Medical Association (AMA), we are developing and implementing a set of P4P initiatives to support quality improvement in the care of Medicare beneficiaries. The objective measures used in incentive payment programs to determine whether providers are offering high quality care are commonly referred to as ''quality standards.'' This term is also used in many provider-based incentive payment programs. We use the term ''quality standards'' in this proposed rule as well.

When payer-based, P4P attempts to use reimbursement to promote quality, efficiency in providing access to needed services, and successful outcomes. In many payer-based models, payers make available to hospitals financial incentives tied to achieving certain quality or performance goals (for example, adopting health information technology, furnishing preventive care services, achieving patient satisfaction targets, or measurably improving patient health indicators). Hospitals often need physician collaboration to meet performance goals. In order to align incentives, hospitals may want to share with physicians a portion of the P4P payments they receive from the payers. In the absence of or in addition to a payer-based incentive payment program, hospitals may also sponsor quality-focused programs in which objective improvements in quality or individual patient care outcomes are rewarded with payments to physicians responsible for the improvements.

In both circumstances, payments made by a hospital to the physicians whose efforts promoted the achievement of targets (or benchmarks) for one or more performance measures create a financial relationship between the hospital and the physician that implicates the physician self-referral statute. These payments also potentially implicate the anti-kickback statute and the CMP statute. (We note that, depending on the nature of the performance measure, incentive payment programs might not implicate the CMP statute because they might not involve any reduction or limitation in patient care services.)

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. We observe that payer-based programs in which the performance measures are set by a wholly independent, arms-length party with a clear financial incentive to make P4P payments prudently may pose somewhat less risk than non-payer based programs, where there is no third-party payer that sets the performance measures and monitors compliance. We note further that payments made directly from a payer to a physician, at the payer's sole discretion, may not implicate the physician self-referral statute or other fraud and abuse statutes.

ii. Shared Savings Programs

Many programs, such as ''gainsharing'' and other cost savings and waste reduction programs, seek to align physician economic incentives with those of hospitals by offering physicians a share of the hospitals' variable cost savings attributable to the physicians' efforts in controlling the costs of providing patient care. For purposes of this proposed rulemaking, we refer to these types of programs as ''shared savings programs.'' When a participating physician receives a portion of the cost savings attributable to his or her efforts in reducing waste and achieving the goals of a shared savings program, a financial relationship is created between the hospital sponsoring the shared savings program and the participating physician, and the physician self-referral statute is implicated.

The Medicare Part A DRG system of hospital reimbursement, under which a hospital receives a prospectively determined, fixed payment that covers all hospital items and services provided to a Medicare beneficiary during his or her inpatient stay or outpatient service, provides a significant incentive for hospitals to control costs. Hospitals are also motivated to reduce costs because of the growth of managed care. However, because physicians are paid separately under Medicare Part B (and by many managed care and other payers), they do not share necessarily the hospital's motivation to control patient care costs. Physicians who perform their professional services at a hospital use the hospital's equipment, supplies and services, and prescribe drugs, devices and other items and services which the hospital must provide. In short, physicians are not financially at risk for the items and services that they use and prescribe, and therefore, do not have a financial stake in controlling the hospital's patient care costs.

As part of many shared savings programs, physicians study how colleagues perform their procedures and then determine the best processes to adopt, in order to increase efficiency while ensuring quality. In other situations, outside experts are hired to analyze hospital and regional or national data to determine appropriate

opportunities for cost savings that do not jeopardize patient care. Shared savings programs are sometimes described as collaborations between physicians and hospitals to determine the best approach to providing quality patient care services. Shared savings programs have been recognized by stakeholders as an effective means of controlling costs, improving efficiency, and promoting quality in the delivery of health care services. Government stakeholders have recognized similar potential benefits when shared savings programs are properly structured to ensure compliance with Federal health care program requirements.

Empirical evidence suggests that the goal of patient care quality maintenance or improvement can be achieved through a properly-designed shared savings program. An independent study of data from 13 separate, 1-year gainsharing programs [1] designed and administered by the organization responsible for the design of all of the gainsharing programs that, to date, have received favorable advisory opinions from OIG (see discussion below and in the FY 2009 Hospital IPPS proposed rule (73 FR 23692 through 23693)), found that the incentives for cost reduction in the gainsharing models studied did not result in reductions in quality and, for certain quality measures, resulted in improved quality of patient care. (See Jonathan D. Ketcham and Michael F. Furukawa ''Hospital-Physician Gainsharing in Cardiology.'' *Health Affairs*, Vol. 27, No. 3 (May/June 2008), 808.) Specifically, according to the study, gainsharing slowed the growth of average in-lab cost per coronary stent patient, reducing costs relative to non-gainsharing hospitals; yet, in-lab complications did not increase during gainsharing, and three complications significantly decreased. (*Id.* at 808.) With respect to gainsharing's positive impact on patient care quality, the authors of the study asserted that the economic incentive for physicians participating in gainsharing programs to collaborate in defining and adopting best practices might improve the physicians' incorporation of clinical evidence into patient care decisionmaking. This is, at least in part, because the gainsharing programs studied provided participating physicians and physician organizations with information about other physicians' practice patterns. (*Id.* at 809.)

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 one year to the next) without accountability for specific cost reduction measures.

We are concerned about physicians responding to a shared savings program by limiting their use of quality-improving but more costly devices, tests or treatments (''stinting''), by treating only healthier patients (''cherry picking''), by avoiding sicker patients (''steering'') at the hospital, or by discharging patients earlier than clinically indicated either to home or to post acute care settings (''quicker-sicker'' discharge). We are concerned also about arrangements which provide for payments in exchange for patient referrals or result in unfair competition among hospitals offering shared savings programs to foster physician loyalty and to attract more referrals. We are concerned that, because of pressures from competition or physicians, hospitals may increase the percentage of savings shared with the physicians, manipulate hospital accounts to generate phantom savings, or otherwise game the arrangement to generate income for referring physicians in order to retain them for or attract them to the hospital. (These same concerns may be present with incentive payment programs.) We are incorporating safeguards into the proposed exception that are intended to address these risks.

iii. DHHS Initiatives: Incentive Payment and Shared Savings Programs

Patient care quality improvement is a laudable goal and a priority of the Department of Health and Human Services (the Department or DHHS). Patient care should be safe, effective, efficient, patient-centered, timely and equitable. Establishing partnerships is a critical step towards achieving our goals of improving patient care quality and avoiding unnecessary costs. Incentive payment and shared savings programs, when properly structured, by design establish such partnerships.

Since 1991, we have sponsored a variety of demonstration projects and other initiatives to explore the connection between payments and the quality of care. These initiatives include the evaluation of both gainsharing (in various forms) and P4P programs affecting providers of health care to beneficiaries in diverse care settings. Although we decline to provide detailed descriptions of individual initiatives here, gainsharing demonstrations include: (1) The Medicare Participating Heart Bypass Center Demonstration which was conducted to assess the feasibility and cost effectiveness of a negotiated all-inclusive bundled payment arrangement for coronary artery bypass graft (CABG) surgery while maintaining high quality care; (2) a 3-year demonstration under section 1866C of the Act, which has been established, but not yet implemented, to test gainsharing models involving physicians, and collaborations between hospitals working with physicians, in a single geographic area to improve the quality of inpatient hospital care; and (3) a demonstration project under section 5007 of the DRA that would involve arrangements between a hospital and physicians and practitioners under which the hospital provides remuneration (to certain physicians and to certain practitioners (as defined in 1842(b)(18)(C) of the Act)) that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and a particular physician (or practitioner) to improve overall quality and efficiency. In addition, we recently announced a new demonstration, the Acute Care Episode Demonstration, for hospitals to test the use of a bundled payment for both hospital and physician services for a select set of episodes of care (orthopedic and cardiac) to improve the quality of care delivered through Medicare FFS. We note that some of the demonstration programs are proceeding under a statutory provision that waived application of section 1877 of the Act, the anti-kickback statute, and the CMP statute.

In addition to these gainsharing demonstrations, we have developed a number of P4P and other value-based purchasing initiatives across patient care settings, including: The Premier Hospital Quality Incentive Demonstration; the Medicare Care Management Performance Demonstration; the Home Health Pay-for-Performance Demonstration; and the Better Quality Information Pilots.

[1] Although we refer herein to ''shared savings programs,'' the study cited referred to these programs as ''gainsharing programs.'' We retain that nomenclature for purposes of discussing the study.

iv. Potential Statutory and Regulatory Applications to Incentive Payment and Shared Savings Programs

Section 1877 of the Act, also known as the physician self-referral statute: (1) Prohibits a physician from making referrals for certain DHS payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity or third party payer) for those referred services. The statute establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

A financial relationship is created where an incentive payment or shared savings program results in a direct or indirect payment from the hospital to a physician. Unless the arrangement satisfies the requirements of an applicable exception, the incentive payment or shared savings payment would violate the physician self-referral prohibition if the physician receiving the payment makes referrals for DHS to the hospital making the incentive payment or shared savings payment. In many cases, incentive payment and shared savings programs can be structured to satisfy the requirements of existing exceptions (for example, the exceptions for *bona fide* employment relationships, personal service arrangements, fair market value compensation, or indirect compensation arrangements). In some cases, no exception may be necessary (for example, incentive payments paid directly from a payer at the payer's sole discretion to a physician for the physician's efforts in improving quality). However, in other circumstances, the existing exceptions to the physician self-referral prohibition may not be sufficiently flexible to protect payments to physicians under incentive payment and shared savings programs.

As noted above, incentive payment and shared savings programs also implicate two additional specific fraud and abuse statutes—the CMP statute and the anti-kickback statute. An incentive payment or shared savings program could run afoul of the anti-kickback statute if one purpose of the payment from the hospital to the physician is to influence referrals of Federal health care program business. In contrast, the intent of the parties does not dictate compliance with the physician self-referral statute. If an arrangement fails to satisfy all of the requirements of an exception, it would violate section 1877 of the Act.

v. Solicitation of Comments in the FY 2009 Hospital Inpatient Prospective Payment System Proposed Rule

In the FY 2009 IPPS proposed rule, we solicited comments as to whether we should issue an exception specific to gainsharing arrangements, which we stated ''typically refer[] to an arrangement under which a hospital gives physicians a share of the reduction in the hospital's costs (that is, the hospital's cost savings) attributable in part to the physicians' efforts'' (73 FR 23692). Although we noted general concerns with arrangements that involve the use of a percentage-based compensation formula (as many gainsharing arrangements involve), we solicited comments regarding a potential exception to the physician self-referral prohibition for gainsharing arrangements in recognition of ''the value to the Medicare program and its beneficiaries where the alignment of hospital and physician incentives results in improvements in quality of care'' (73 FR 23694). Specifically, we solicited comments on the following: (1) What types of requirements and safeguards should be included in any exception for gainsharing arrangements; and (2) whether certain services, clinical protocols, or other arrangements should not qualify for the exception (73 FR 23694).

b. Public Response to Solicitation of Comments

The following discussion describes comments received in response to the solicitation of comments on gainsharing arrangements that we have reviewed to date. In addition, we have reviewed comments received in connection with our proposal in the CY 2008 PFS proposed rule to revise § 411.354(d) to permit the use of percentage-based compensation formulae (such as the type often used for making cost sharing payments) for personally performed physician services only (72 FR 38184). In that proposal, we specifically noted that the revisions, if finalized, could potentially affect payment methodologies used in gainsharing programs. Generally, commenters strongly supported the establishment of an exception for gainsharing and other programs that compensate physicians and physician organizations for improving patient care quality and decreasing the cost of providing patient care when those achievements can be tied to the physician's or physician organization's participation in the program. Commenters urged that an exception contain safeguards to ensure patient access to necessary items and services, improve patient care quality, and avoid improper influencing of physician referral patterns due to the constraints or incentives of the program's design. One commenter suggested that the availability of the exception be contingent upon the parties obtaining a favorable advisory opinion from OIG prior to the implementation of the gainsharing program. In addition, commenters requested that an exception provide flexibility to allow an entity to design an incentive payment or shared savings program that is specific to the entity's goals and needs, as well as to modify the program as necessary. One commenter also provided recommendations regarding the types of cost savings measures (in addition to supply cost reduction measures) that should be addressed by the exception, as well as particular services, clinical protocols, and other arrangements that we should exclude from the protection of an exception for incentive payment and shared savings programs. The commenter suggested that an exception to the physician self-referral prohibition should permit more types of arrangements (and within additional medical specialties) than thus far have been explicitly approved in OIG advisory opinions. Specifically, the commenter urged that an exception for incentive payment and shared savings programs allow a program covered by the exception to reward: (1) Decreasing delays in patient care; (2) reconsidering ordering patterns for all types of testing and services (in order to reduce medically unnecessary services and reduce cost); (3) reducing consultation of other physicians when value is not added to the patient's care through the consultation; (4) establishing long-term management of chronic patient conditions; and (5) using alternative care (for example, outpatient care instead of inpatient care).

Specific recommendations for safeguards to be included in an exception for incentive payments and shared savings programs included: (1) Permitting the duration of the program to exceed 1 year (the term of the arrangements approved under the OIG advisory opinions to date); (2) requiring mechanisms to ensure that the program will not affect patient care in an adverse manner; (3) limitations on the amount of payments to participating physicians; (4) requiring periodic review of the impact of the program on clinical care;

(5) a written agreement that clearly identifies the services or actions for which payment may be made to the participating physicians; (6) permitting payments only for documented and verified quality improvement and waste or cost reduction; (7) determining compensation to participating physicians (or a formula for such compensation) prior to the implementation of the program or the physician's participation in the program, and prohibiting modification to the compensation during the term of the arrangement; (8) requiring written disclosure regarding the program to all patients affected by the program to promote transparency and accountability; and (9) prohibiting payment to a physician or physician organization that is determined in any way based on a reduction in the length of stay for hospital patients.

c. Proposal

Although we solicited comments in the FY 2009 IPPS proposed rule regarding an exception to the physician self-referral prohibition for gainsharing arrangements (73 FR 23692), we believe that a broader exception that includes incentive payment programs is needed to facilitate the full array of nonabusive, beneficial incentive payment and shared savings programs that we consider important for promoting the highest quality of care for our beneficiaries while achieving cost savings for the program. Section 1877(b)(4) of the Act authorizes the Secretary to create regulatory exceptions for financial relationships that he determines do not pose a risk of program or patient abuse. Therefore, using our authority under section 1877(b)(4) of the Act, we are proposing here an exception in new § 411.357(x) for payments provided to a physician participant in an incentive payment or shared savings program that includes certain safeguards and satisfies certain conditions.

i. General Considerations With Respect to the Proposed Exception

As we described above in greater detail, we have concerns about physicians responding to incentive payment and shared savings programs by stinting, cherry picking, steering, and making quicker-sicker discharges. The criteria included in the proposed exception are focused on three aspects that we consider critical to a properly structured, nonabusive incentive payment or shared savings program: transparency, quality controls (for example, controls to prevent reductions in resource utilization that lead to a diminution in quality), and safeguards against payments for referrals (or influencing referrals). We are proposing requirements with respect to the structure of the incentive payment and shared savings program itself, limitations and conditions regarding the payments provided to the physicians participating in the program, and requirements for the arrangement between the hospital and the physicians participating in the program. We are seeking comments on each requirement in the exception, as well as comments regarding the exception in its entirety. With respect to the latter, we are interested in comments regarding the effect of incentive payment and shared savings programs on marketplace competition, specifically with regard to whether shared savings programs that include product standardization measures disadvantage small manufacturers of items, supplies and devices due to the selection and preferred utilization of a limited number of items, supplies and devices included in the shared savings program, the ordering of which qualifies for program payments. (We note that, although we expect that the initial selection of the preferred products would be based on clinical efficacy, safety and medical appropriateness, we recognize that the final selection of products in a product standardization program is likely to be based on price when quality and utility are comparable). We are interested in comments on how product standardization can be achieved without limiting patient access to items, supplies and devices considered beneficial to improved patient care. We are also concerned about the potential for fraud and abuse if manufacturers attempt to influence the design or implementation of hospital incentive payment or shared savings programs.

We note that, for most of the requirements and safeguards discussed in this proposal, we have proposed regulation text. However, we have not provided proposed regulation text for a limited number of the proposed requirements and safeguards described, but rather have solicited comments regarding how best to incorporate them into the regulatory text of the exception.

We are proposing a single set of requirements that would apply equally to incentive payment and shared savings programs. In many cases, programs may include both patient care quality measures and cost savings measures, or a particular performance measure may be both a quality measure and cost savings measure. We believe that one set of requirements would ease administration and assist with hospitals' and physicians' compliance efforts. Further, similar risks of program or patient abuse exist regardless of whether a hospital pays a physician a share of its internal cost savings, a share of external funds earned by meeting quality goals (in a payer-sponsored program), or a share of its general revenues to promote quality. We are interested in comments with respect to whether separate exceptions for incentive payment programs and shared savings programs would be preferable and, if so, how they should be structured, and which requirements should appear in each.

The requirements of the proposed exception include a number of program integrity safeguards, consistent with our longstanding concern, first noted in the Phase I final rule with comment period, that a patient's choice can be affected when physicians steer patients to less convenient or lower quality items or services because the physicians are sharing profits with, or receiving remuneration from, the provider (63 FR 1659 and 1662). We are also concerned about systems that incentivize the delivery of less expensive care at the cost of patient care quality and systems that limit patient access to beneficial new technology. The proposed exception prohibits payment to physicians based in whole or in part on a reduction in the length of stay for a particular patient or in the aggregate for the hospital operating the program. However, we recognize that reduced length of stay may occur as an incidental effect of quality improvement efforts.

ii. Scope of the Proposed Exception

As noted above, we used the term ''incentive payment and shared savings program'' to encompass a wide variety of gainsharing and P4P programs. We do not propose to limit the exception to traditional gainsharing programs or supply cost/waste reduction programs. We are seeking comments regarding whether this approach is too limited or expansive, and whether different terminology would better describe the range of nonabusive programs we intend to cover under the proposed exception.

Our proposed exception protects only incentive payment and shared savings programs offered by hospitals. It is our understanding that these arrangements are the most common, and, as described above, are the type with which we have the most experience. We are concerned that, unlike hospitals that are reimbursed on a prospective payment basis, other types of providers and suppliers that are reimbursed on a fee schedule or other FFS basis might have an incentive to create quality measures that mandate the furnishing of more

items and services, without regard to costs to the Medicare program or its beneficiaries. In many cases, it might be relatively easy to characterize a program that offers beneficiaries more items and services as a ''quality'' incentive program, even in the absence of actual quality improvement. However, we are soliciting comments on whether incentive payment or shared savings programs (or similar programs) offered by other DHS entities should be protected and under what circumstances. In particular, we are interested in comments regarding the structure and design of non-hospital arrangements and the safeguards that we could include in an exception to meet the statutory standard of no risk of program or patient abuse.

We are proposing to protect remuneration only in the form of cash (or cash equivalent) payments made by a hospital. Nonmonetary remuneration, such as additional staff members or new equipment, offered to reward achievement of quality or cost savings goals would not be protected. In addition, the proposed exception would be limited to payments to physicians who actually participate (''participating physicians'') in the achievement of the patient care quality measures or cost savings measures (collectively referred to in this proposal as the ''performance measures'') that are the subject of the particular program. We note that the physician self-referral statute applies only to physicians. Nothing in this proposal is intended to limit or prohibit the participation of NPPs in incentive payment and shared savings programs. Moreover, the participation of NPPs in an incentive payment or shared savings program would not require the protection of an exception to the physician self-referral prohibition unless the practitioner's referrals are directed by, controlled by, or attributed to a physician with whom or for whom the practitioner works.

We are proposing that protected payments could be made to participating physicians individually or to physician organizations composed entirely of participating physicians (referred to in this proposal as ''qualified physician organizations'') (for example, a group practice composed entirely of cardiac surgeons participating in a cardiac surgery shared savings program could be a qualified physician organization). With respect to qualified physician organizations, we are considering whether such organizations could include physicians who are eligible to participate in the program, even if the individual physicians elect not to participate in the program (for example, a group practice composed entirely of cardiac surgeons could be a qualified physician organization in a cardiac surgery shared savings program, even if some surgeons elect not to participate in the program). As discussed further below, qualified physician organizations would need to distribute incentive or shared savings payments received from the hospital on a *per capita* basis to the physicians in the physician organization who participated in the incentive payment or shared savings program. In any case, payments made to physicians who refer patients to the hospital but do not otherwise participate in the program would not be protected. For example, payments to cardiac surgeons for changing their operating room procedures would be protected (provided that all of the other requirements of the exception were satisfied), whereas payments to the cardiologists who referred the patients for cardiac surgery but did not perform the surgery or contribute to the achievement of the performance measures through their personal efforts would not be protected.

iii. Requirements Related to the Design of an Incentive Payment or Shared Savings Program

To be protected, the incentive payment or shared savings program must be a documented program that seeks 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, without an adverse affect on or diminution in the quality of hospital patient care services.

We are proposing to require that, in order for payments made as part of an incentive payment or shared savings program to qualify for the protection of the exception, the program must include patient care quality or cost savings measures (or both) supported by objective, independent medical evidence indicating that the measures would not adversely affect patient care. Specifically, all performance measures must use an objective methodology, be verifiable, be supported by credible medical evidence, and be individually tracked. The measures must reasonably relate to the hospital's practices and patient population. In the interest of creating clear, bright-line rules, we are proposing specifically that patient care quality measures be listed in CMS' Specifications Manual for National Hospital Quality Measures. In the alternative, rather than require programs to include the patient care quality measures listed in CMS' Specifications Manual for National Hospital Quality Measures, we would deem such measures to satisfy that requirement.

With respect to cost savings measures, we are proposing to require that cost savings measures included in the incentive payment or shared savings program use an objective methodology, be verifiable, be supported by credible medical evidence indicating that the measures would not adversely affect patient care, be individually tracked, and reasonably relate to the services provided. We are seeking comment regarding this approach and the described alternative for patient care quality measures in general, and we are interested specifically in comments regarding other appropriate performance measures (or lists of performance measures, particularly with respect to cost savings measures to the extent such a list might exist) that might be deemed to satisfy such a requirement if we finalize this alternative proposal, as well as whether parties could satisfy this requirement by including criteria deemed by the Secretary in an advisory opinion to meet the requirement. We are including this requirement to safeguard against programs that incorporate sham standards that are designed to reward physicians for referrals rather than the achievement of legitimate benchmarks for quality maintenance or improvement or cost savings. We believe that appropriate performance measures should derive from broad, objective, widely-recognized criteria and not merely result from the subjective views of the parties to the arrangement. We also are proposing a specific requirement that the program ensure that the quality of patient care services is not impacted adversely as a result of the program.

We are proposing 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 believe that such vigilance is critical to ensure that quality of hospital patient care is not impacted adversely. Under this proposal, the reviews must be conducted by a person or organization with relevant clinical expertise, and they must be independent medical reviews. By ''independent medical reviews,'' we mean reviews by an individual or organization that is not: (1) Affiliated with the hospital operating the program under review; (2) not affiliated with any

participating physician or with any physician organization with which a participating physician is affiliated; and (3) at the time of the review, not participating in any incentive payment or shared savings program operated by the hospital. We are seeking comments specifically regarding the appropriate frequency for review of incentive payment and shared savings programs to ensure that quality of hospital patient care is not impacted adversely and to protect against program or patient abuse. We are also seeking comments addressing the circumstances, if any, under which the periodic review could be conducted by an individual or organization that does not fall within the definition of ''independent medical review'' outlined above.

Any reviews would need to be objective, accurate and complete and result in written findings. We are proposing that the initial and periodic reviews should be contemporaneously documented, and that all documentation related to the incentive payment or shared savings program and the reviews thereof be made available to the Secretary upon request. We are further proposing that incentive payment and shared savings programs must provide for immediate and appropriate corrective action in the event a periodic review reveals an adverse impact on quality. Corrective actions could include termination of the program, removal of the relevant measure from the program, removal of the relevant measure from the calculation of physician payments, or termination of the physician from the program. We are considering whether corrective actions could also include modification of a performance measure and, if so, under what conditions. However, we would prohibit the discontinuation of a performance measure for the purpose of increasing the payment to the participating physicians in the next period. Also, although we do not want to encourage practice patterns that result in reduced or poor quality patient care, we do not believe it is appropriate to permit the discontinuation of a performance measure because the participating physicians are unable to earn a shared savings payment related to that measure. We are interested in comments addressing the appropriate corrective actions and how best to incorporate a corrective action requirement into the regulatory text of the exception.

We are proposing to require that participation in the program be limited to those physicians who are members of the hospital's medical staff at the commencement of the program. We believe that this would protect against abusive programs that serve as inducements to attract physicians from competing hospitals. However, we are soliciting comments on whether and, if so, how a physician who joins the medical staff at the hospital as part of the normal cycle of workforce demands for care delivery could be permitted to participate in an incentive payment or shared savings program (either individually or as part of a qualified physician organization, as described below) that began before he or she joined the medical staff of the hospital. We are also proposing that physicians participating in an incentive payment or shared savings program, or in a particular performance measure or measures within an incentive payment or shared savings program, must do so in ''pools'' of five or more participating physicians among whom the aggregate incentive payment available for, or cost savings that result from, the efforts of the physicians in the ''pool'' with respect to a particular measure would be shared on a *per capita* basis. A qualified physician organization could itself constitute an eligible pool, provided that it is comprised of at least five participating physicians. Otherwise, participating physicians in the qualified physician organization would need to be grouped by the hospital into pools of at least five participating physicians.

The distribution of incentive payment and shared savings program payments must be supported by written documentation. As an additional safeguard, we are proposing to require that physician ''pools'' be formed at the commencement of the program. We are interested in comments about our proposal to require hospitals to create pools for purposes of physician participation in incentive payment and shared savings programs and the minimum number of physicians needed to comprise a ''pool'' that adequately reduces the risk of program or patient abuse. Specifically, we are interested in comments on whether and, if so, how we should address the ''pooling'' of funds for payment purposes in an incentive payment or shared savings program targeted at a specific medical specialty or hospital department in which the physicians on the medical staff in that specialty or department or in the physician organization total fewer than five physicians.

We are proposing also that a hospital may not determine eligibility for physician participation in a program based on the volume or value of referrals or other business generated between the parties. We are also considering, and soliciting comments about, conditioning protection under the exception on the hospital offering the opportunity to participate in the incentive payment or shared savings to all physicians on the medical staff who belong to the department or practice in the specialty relevant to the program (for example, the opportunity to participate in a shared savings program for cardiac surgery would have to be offered to all cardiac surgeons on the hospital's medical staff).

To qualify for protection under the proposed exception, an incentive payment or shared savings program may not limit the discretion of physicians to make medically appropriate decisions for their patients, including, but not limited to, decisions about tests, treatments, procedures, services, supplies or discharge. Although incentive payment and shared savings programs may condition program payments on particular physician choices, to be protected under the proposed exception, such programs could not limit other choices for which physicians would not receive program payments. In particular, a hospital must not limit the availability of any specific item, supply or device, including new technology that is linked through objective evidence to improved outcomes and is clinically appropriate for a particular patient, and must permit individual physicians access to the same selection of items, supplies and devices that was available to them prior to the physician's participation in the program. We are not requiring physician access to items, supplies and devices that were not available prior to the commencement of the incentive payment or shared savings program. Rather, a hospital must make available to a participating physician at least the same selection available to the physician prior to his or her participation in the incentive payment or shared savings program, which already may have been restricted by hospital policy, but without payment to physicians based on such situations.

We recognize that some shared savings programs are designed to channel the physician's selection of physician preference items toward a limited number of choices; however, we believe that, to safeguard the program and its beneficiaries against abuse, physicians participating in a shared savings program must have access to items or supplies that they deem medically necessary for an individual patient's care. This would include new technology, provided that it meets the same Federal regulatory standards (for example, approval by the Food and Drug Administration (FDA) and

Medicare or Medicaid coverage decisions) as the items or supplies included in the program. By including this requirement, we intend that programs would ensure access to clinically appropriate new technology while, at the same time, protect patient safety. For example, if a program includes three alternative, FDA-approved devices for a particular procedure, the hospital sponsoring the program could limit access to new technology that is experimental (that is, not FDA-approved), but could not limit access to FDA-approved alternative devices/technology. We note also that items, supplies and devices in a product standardization program (that is a cost savings action under a shared savings program) should not be selected on the basis of a participating physician's ownership or investment interest in, or compensation arrangement with, the manufacturer or distributor of the item, supply or device, or his or her interest in a group purchasing organization (GPO) that arranges for the purchase of the item, supply or device. In this regard, we would strongly recommend, and may require, that such physicians be barred from participating in any manner in the design or implementation of an incentive payment or shared savings program that involves items, supplies or devices in which the physician has a financial interest. We are proposing that a physician (or qualified physician organization) could not receive a payment under an incentive payment or shared savings program for the use of an item, supply or device if he or she (or the qualified physician organization) has an ownership or investment interest in, or a compensation arrangement with, a manufacturer or distributor of the item, supply or device, or GPO that arranges for the purchase of the item, supply or device.

iv. Requirements Related to Payments Made Under an Incentive Payment or Shared Savings Program

To reduce the risk that incentive or shared savings program payments might be used to encourage or reward referrals to the hospital or provide incentives to engage in other abusive practices, such as stinting or cherry picking, we are proposing that payments made to physicians participating in the incentive payment or shared savings program be distributed on a *per capita* basis. We are interested in public comments that may 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 incentive payment or shared savings program.

We believe that safeguards are necessary to ensure that incentive payment and shared savings programs do not result in altered referral patterns and to reduce the risk that programs will become vehicles used to reward referring physicians. To address this, we are proposing that remuneration paid to a participating physician or a qualified physician organization may not include any amount that takes into account the provision a greater volume of Federal health care patient procedures or services than the volume provided by the participating physician or qualified physician organization during the period of the same length immediately preceding the commencement of the program as that covered by the payment. We are interested in comments regarding whether and, if so, how to account for volume changes due to market forces and physician practice growth.

We are also proposing that the amount of the remuneration paid to the physician or qualified physician organization be limited in duration and amount. With respect to duration, we are proposing that protected programs be no shorter than 1 year and no longer than 3 years. With respect to a limit on the amount of payments, we are proposing two types of limits, which we might adopt separately or together.

First, we are proposing a limit on payments expressed as a set percentage of the savings available to the hospital as a result of the changes in clinical or administrative practices of the participating physicians. Although not incorporated into the proposed regulation text, we are specifically considering a flat 50 percent limit on the sharing of cost savings (regardless of the length of the program), and are considering whether to require ''re-basing,'' depending on the length of the program. We are interested in comments regarding whether this ''cap'' on payments is appropriate, too high, or too low. We are interested also in comments regarding whether and, if so, how we should limit payments under a multi-year incentive payment or shared savings program to an amount that would be actuarially equivalent to the amount of the payments made under a 1-year program. We are considering also ''scaled'' limits for programs longer than 1 year. Under the scaled limits approach, we would not require re-basing (as further described below), but would require that payments to physicians decrease over the course of the performance measure. For purposes of calculating the actual payments to the physician, we are proposing that cost savings be measured by comparing the hospital's actual acquisition costs for the items and supplies or costs of delivering the specified services that are subject to the incentive payment or shared savings program to the hospital's baseline costs for the same items, supplies or services during the 1-year period immediately preceding the commencement of the program.

Second, we are proposing a limit on payments to address the risk that physicians will continue to receive financial rewards for already implemented changes in clinical or administrative practices. This second limit would require that payments made under an incentive payment or shared savings program must take into account any payments that have already been made for performance measures already achieved (''re-basing''). We are considering a re-basing approach under which, at the end of year one, the hospital would re-base performance measures such that available payment would be based on the difference between the hospital's then-current level for a particular performance measure and the goal established for that performance measure. This approach would apply similarly to incentive payments made exclusively for improvements in patient care quality that are unrelated to the achievement of cost savings. We are soliciting comments specifically as to whether requiring the re-basing of ''quality-only'' payments is a necessary safeguard against program or patient abuse, or whether a different approach for limiting such payments could be implemented that would safeguard against risk to the Medicare program or its beneficiaries. We are also soliciting comments on whether we should require re-basing at all and, if so, under what parameters and whether parties should be free to choose the frequency of the payment and re-basing periods under the incentive payment or shared savings program. In no event would a hospital be permitted to increase the incentive payment or shared savings payment potentially available to physicians as a result of the re-basing.

By way of illustration, assume that one objective cost saving measure in the program is to decrease from 80 percent utilization of a specified item during a particular surgical procedure (the hospital's historical utilization rate for the item) to 20 percent utilization (the national average for utilization of the item). Under an approach that requires re-basing, if, after completion of the first

year of the program, the hospital's utilization of the specified item decreased to 60 percent of surgical procedures, for year 2 of the arrangement, the participating physicians could receive payment only for any reduction below 60 percent utilization of the specified item, that is, the new ''historical'' baseline utilization rate would be 60 percent and all cost savings and waste reduction for the upcoming year would be measured against the new baseline utilization rate. If, after completion of year one, the hospital's utilization of the specified item *increased* to 90 percent, the hospital would be prohibited from re-basing the utilization rate higher than the initial 80 percent utilization rate determined at the commencement of the incentive payment or shared savings program. The participating physicians would, in the aggregate, be eligible to receive as a shared savings payment the same percentage of cost savings throughout the term of the program.

Using the same figures, under an approach that requires scaling of the payments over the course of the arrangement, the physicians participating in the program would be eligible for a decreasing percentage of cost savings over the course of the arrangement. Assume, for example, we adopted an approach that permitted shared savings payments of up to 50 percent for year one, up to 35 percent for year two, and up to 20 percent for year three. If a particular cost savings measure generated savings of $100,000 the first year, $150,000 the second year, and $200,000 the third year (all relative to the historical baseline utilization rate established at commencement of the program), the participating physicians would be eligible for a total of 50 percent of $100,000 (or $50,000) the first year, a total of 35 percent of $150,000 (or $52,500) the second year, and 20 percent of $200,000 (or $40,000) the third year. We are also considering protecting programs in which dollar limits are expressed as fixed dollar amounts rather than percentages.

Each of the approaches described above could be adopted to the exclusion of or in concert with each other. We are interested in comments regarding whether the exception should include one or more of the payment limit alternatives, as well as comments regarding other appropriate limitations for the amount and nature of the payments made under an incentive payment or shared savings program. Regardless of which approach we adopt, we are proposing to require that payments based on cost savings be calculated on the hospital's actual 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 (subject to the cap on payment for Federal health care program beneficiaries described above). We are seeking comments regarding whether these conditions are appropriate and whether we should permit modification under other or different circumstances.

We do not intend to protect arrangements in which physicians receive payments for actions taken that result in a reduction below a predetermined target. For example, in the first hypothetical (under the required re-basing approach), no payments could be made for reductions below 20 percent utilization. We intend to require that the target thresholds use objective historical and clinical measures that are reasonably related to the practices and the patient population at the hospital. We are mindful that some performance measures may not be amendable to such utilization ''floors'' or ''ceilings.'' We are considering including comparable safeguards for measures that may not be readily amenable to percentage ''floors'' and ''ceilings'', such as measures related to product substitution and product standardization. For example, the fact that the substitution of one product for another would not adversely impact quality might need to be supported by substantial objective medical evidence. We are soliciting comments on what kinds of quality controls are appropriate for performance measures that are not amendable to utilization ''floors'' and ''ceilings.'' We are considering whether and, if so, how this concern can be addressed by requiring that the parties obtain a fully independent clinical review by a qualified party of the program measures prior to implementing the program. We are soliciting comments on appropriate quality safeguards in such situations.

We recognize that parties might want to structure arrangements so that payments are made by the hospital to a physician organization that would not meet our proposed definition of a qualified physician organization. This might be the case if incentive payment or shared savings payments are made by a hospital to a multi-specialty physician practice composed of participating and non-participating physicians (for example, a group composed of cardiac surgeons and cardiologists, in the case of a cardiac surgery shared savings program). We are considering whether to extend the proposed exception to cover payments from a hospital to such physician organizations and, if so, under what conditions we could do so that would pose no risk of program or patient abuse. We are concerned that payments made to such physician organizations may become conduits to reward non-participating physicians for referrals. On the other hand, we recognize that programs structured so that hospitals make payments to physician organizations rather than to individual physicians may be administratively easier for hospitals to operate. (We note that, in some cases, payments from hospitals to physician organizations that are not qualified physician organizations might fit in the existing exception for indirect compensation arrangements, depending on the circumstances.)

We are considering several options to address this issue. First, we are considering an approach that would allow hospitals to make incentive payment or shared savings payments to individual physicians indirectly by passing the payment through the physician's physician organization. Under this approach, the total amount of the payment earned by the physician under the incentive payment or shared savings program would need to be passed through to the physician, except amounts required for income tax and other regular withholding. Under this approach, the physician organization would simply operate as a pass-through entity. The physician organization would be prohibited from retaining any portion of the incentive payment or shared savings payment (except, potentially, for required withholdings to be paid on behalf of the participating physician). We are soliciting comments about this approach and what types of payments the physician organization could withhold (for example, whether the physician organization should be permitted to withhold required contributions to a qualified retirement plan).

We are concerned about the difficulty hospitals might encounter in ensuring that the physician organization accurately and fully passes through the full payment to the participating physician, and we are concerned about the risk of fraud and abuse if the payment mechanism were manipulated so that the physician organization retains a portion of the payments for its own benefit. Such gaming of the payment structure could result in improper remuneration from the hospital to the physician organization for referrals (and would not fit in the proposed or any other exception to section 1877 of the Act). We are interested in comments about how to

craft safeguards for the exception to prevent this type of potential abuse. In this regard, we are considering requiring that the physician organization document all amounts received and distributed to participating physicians, as well as any income tax or regular withholding payments made on behalf of the participating physician. In addition, we would require that the physician organization's obligations with respect to ''pass through'' payments be included in the written agreement between the parties and that the physician organization be a signatory (in addition to the hospital and the participating physician) to the agreement. We are soliciting comment on these and any other safeguards necessary to ensure that payments are appropriately passed through to participating physicians.

Second, we are considering whether, without posing a risk of program or patient abuse, we could expand the definition of a ''qualified physician organization'' to which protected payments can be made to include physician organizations comprised of some physicians who are not participating physicians. This approach, if implemented, would have the effect of protecting payments made directly to such physician organizations (rather than directly to individual physicians or ''passed through'' the physician organization), provided that all other requirements of the exception were satisfied. We would adopt this approach only if we could do so in a manner that would not result in payments to physicians whose only contributions to the hospital's incentive payment or shared savings program are potential referrals. If we expand the definition of a qualified physician organization, we envision a requirement that would permit only participating physicians to share in the incentive or shared savings payments. Our concerns described above about the difficulty hospitals would experience in monitoring the payments and the risk of manipulation to benefit referral source physicians or the physician organization as a whole are heightened with this approach. If we were to adopt this approach, we would include the proposed safeguards described above in connection with the pass-through payments proposal. In any event, we do not intend to protect arrangements that reward passive physicians who receive payments but do not participate in the achievement of the patient care quality or cost savings measure goals.

One benefit of protecting programs that are structured so that payments are made from the hospital to a physician organization would be to avoid potential confusion that might be caused by the physician ''stand in the shoes'' provisions in § 411.354(c)(2) (under which a physician is considered to have the same compensation arrangements with the same parties and on the same terms as his or her physician organization with respect to whether remuneration is permissible under an exception). We are interested in comments on the relationship of the proposed exception to the ''stand in the shoes'' provisions. We are also interested in comments regarding whether the new exception, if adopted, should be included in § 411.357, or whether it would be preferable to include it in § 411.355 or elsewhere in the physician self-referral regulatory scheme.

v. Requirements Related to the Arrangement Between a Hospital and the Participating Physician or Qualified Physician Organization

We are proposing to include in the exception certain criteria that are common to most of the exceptions to the physician self-referral prohibition for compensation arrangements, namely, that the arrangement be set out in writing, signed by the parties, have a minimum term of 1 year and a maximum term of 3 years, and specify compensation that is set in advance, does not vary during the term of the arrangement, and is not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties. We are proposing to require that the written agreement between the hospital offering the program and the physicians participating in the program document the performance measures against which the performance of the participating physicians will be measured. In addition, we are proposing that each performance measure (including, for example, specific cost savings measures) and the payments resulting from the achievement of established targets must be delineated separately and clearly. We believe transparency is crucial to ensure that the incentive payment or shared savings program does not pose a risk of program or patient abuse. However, we are interested in comments regarding whether and, if so, how total (or ''global'') savings for a particular department or service line can be included in the program and sufficiently monitored, accounted for, and distributed so as not to pose a risk of program or patient abuse and to permit transparency of the program.

As in all exceptions issued using our authority under section 1877(b)(4) of the Act, we are proposing to include a requirement that the arrangement does not violate the anti-kickback statute or any Federal or State law or regulation governing billing or claims submission. This is necessary to ensure that the arrangement does not pose a risk of program or patient abuse, the standard for all exceptions issued using this authority.

In order to promote transparency and foster accountability, we are proposing to require that the arrangement between the parties require written disclosure to patients affected by the program regarding the nature of the program and the physician's or qualified physician organization's participation in the program prior to admission to the hospital, or, if pre-admission disclosure is not feasible, prior to the procedure or other treatment to which the program is applicable. Affected patients include those patients whose patient care at the hospital relates to any of the measures that are part of the program. For example, a patient being admitted to a hospital for cardiac surgery should receive a disclosure if the hospital operates an incentive payment or shared savings program related to cardiac surgery and his or her physician participates in that program. We are considering whether patients should be permitted to opt out of a measure that might otherwise apply to their care and are seeking comments regarding whether and how this would work in practice.

Finally, we are proposing the following additional safeguards. We are interested in comments regarding how to incorporate these requirements into the regulation text. First, to guard against cherry picking or other abuse, the case severity, and the ages and payers of the patient population treated by the participating physician under the arrangement must be monitored using generally-accepted standards. The monitoring could be conducted by an independent outside party or by a committee composed of representatives of the hospital and participating physicians. If there are significant changes from the hospital's historical measures, the physician at issue must be terminated from participation in the arrangement. The monitor should also assess these characteristics in the aggregate across all participating physicians; if there are significant changes, the program should be terminated. Second, physicians are only eligible for payments that are related to their own efforts, combined with the efforts of the other physicians in their

pool, at meeting cost savings measures or achieving patient care quality measures; that is, a physician is eligible to receive only a *per capita* share of that portion of an available incentive payment or shared savings payment attributable to the efforts of his or her pool. Third, all measures should be uniformly applied to all patients including Medicare beneficiaries (that is, the measures should not be applied disproportionately to Medicare beneficiaries). Procedures or treatments subject to the incentive payment or shared savings program should not be performed disproportionally on Federal health care program beneficiaries. We are also considering and interested in comments regarding a requirement that the hospital offering an incentive payment or shared savings program audit the calculation of cost savings and payments made under the program. To this end, we are interested in comments regarding the formality of such an audit; that is, should we permit the hospital to complete the audit internally, or should we require an independent financial audit of the books and records related to the incentive payment or shared savings program.

We would also require that incentive payment and shared savings programs must not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law. In addition, we are proposing that the full range of documentation developed and maintained in connection with compliance with the new exception be retained and made available to the Secretary upon request.

O. Physician Quality Reporting Initiative (PQRI)

[If you choose to comment on issues in this section, please include the caption ''PQRI'' at the beginning of your comments.]

1. Program Background and Statutory Authority

a. Division B of the Tax Relief and Health Care Act of 2006—Medicare Improvements and Extension Act of 2006 (MIEA–TRHCA): Requirements for the PQRI Program

Section 101(b) of the MIEA–TRHCA 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 101(b) 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.

b. PQRI for 2007

For 2007, the Secretary is authorized to pay an incentive payment equal to 1.5 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. The reporting period for the PQRI for 2007 is defined by MIEA–TRHCA as the period beginning on July 1, 2007, and ending on December 31, 2007. For 2007, PQRI data submission was limited to claims-based submission based upon specifications and instructions posted on the CMS Web site for 74 PQRI measures.

Preliminary PQRI participation information through November 2007 indicates that approximately 100,000 professionals, or about 16 percent, of eligible professionals who could have reported quality data on one or more of the 74 2007 PQRI quality measures submitted PQRI quality data at least once during the 2007 reporting period. This number includes professionals from all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. In our regions with the highest participation, reporting rates are approaching 20 percent, with some States achieving reporting rates of around 30 percent. Nationally, there were above average rates of participation by eligible professionals furnishing services relevant to the following three types of care: anesthesia services; eye care; and emergency care. Participation rates have trended upwards during the 2007 reporting period. Based on expanded measures, new reporting options and other factors, we anticipate that trend will continue for 2008. Further details of the PQRI for 2007 are provided on the PQRI section of the CMS Web site at: *http://www.cms.hhs.gov/PQRI/33_2007_General_Info.asp#TopOfPage*. Incentive payments and access to confidential reports on measures reporting rates and measures performance rates for 2007 are scheduled to begin in mid-July 2008.

c. PQRI for 2008

Section 1848(k)(2)(B)(ii) of the Act, as added by the MIEA–TRHCA, required the Secretary to publish a proposed set of quality measures for 2008 by August 15, 2007 and provide for a period of public comment. Section 1848(k)(2)(B)(i) of the Act, as added by the MIEA–TRHCA provides that for purposes of reporting data on quality measures for covered professional services furnished in 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 Alliance (AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. In addition, the measures shall include structural measures, such as the use of electronic health records (EHRs) and electronic prescribing technology.

In the CY 2008 PFS proposed rule (72 FR 38196 through 38199), we provided a detailed discussion of the MIEA–TRHCA requirements and the PQRI. We explained our interpretation of applicable statutory and government-wide policies relevant to defining a consensus-based measure development process, as well as our policy for determining which measures meet requirements for inclusion in PQRI for 2008.

To meet the MIEA–TRHCA requirement to publish proposed 2008 PQRI measures by August 15, 2007, we published 148 proposed 2008 PQRI quality measures in the CY 2008 PFS proposed rule (72 FR 38199 through 38202). We invited comments on the proposed measures and on our plans to explore mechanisms for submission of electronic clinical performance measurement information and summary measure results information extracted from EHRs and clinical data registries.

In the CY 2008 PFS final rule with comment period (72 FR 66336 through 66359), we responded to public comments received on the PQRI section of the CY 2008 PFS proposed rule (72 FR 38196 through 38204) and we finalized 119 measures that we determined under the MIEA–TRHCA and other applicable statutory requirements to be appropriate for

eligible professionals to use to submit such data under the 2008 PQRI. In addition, we described our plans to test quality measures data submission mechanisms, other than claims, based on clinical data registries and EHRs in 2008.

The 2008 measures specifications are available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage*. These detailed specifications include instructions for reporting and identify the circumstances in which each measure is applicable.

d. Extension of and Enhancements to the PQRI Program Authorized by the MMSEA

The MMSEA, which was enacted on December 29, 2007, authorizes us to make incentive payments for satisfactorily reporting quality measures data on covered professional services furnished in 2008 equal to 1.5 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. For 2008, the reporting period is defined to mean the entire calendar year. In addition, while MIEA–TRHCA established a cap on incentive payments for the 2007 PQRI, based on an average per measure payment amount, there is no cap on incentive payments under MMSEA for the 2008 PQRI.

MMSEA also introduced enhancements that result in more opportunities for eligible professionals to participate in the PQRI for 2008. For 2008 and 2009, section 101(c)(5)(F) of the MIEA–TRHCA, as added by the MMSEA, requires 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, these alternative reporting periods and reporting criteria were posted on April 16, 2008 in ''2008 PQRI: Establishment of Alternative Reporting Periods and Reporting Criteria'' document found on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIalterrptperiods.pdf*. They supplement the single reporting period and the reporting criteria previously set forth in the CY 2008 PFS final rule with comment period (72 FR 66357 through 66359) which were limited to claims-based submission of individual 2008 PQRI measures.

For 2008, each eligible professional who satisfactorily reports under any of the options set forth in the ''2008 PQRI: Establishment of Alternative Reporting Periods and Reporting Criteria'' document or for the reporting period and under the reporting criteria set forth in the CY 2008 PFS final rule with comment period will be eligible for a 1.5 percent incentive payment for services furnished during the applicable reporting period. An eligible professional may potentially qualify as satisfactorily reporting under more than one of the reporting criteria and for more than one reporting period. However, this will result in only one incentive payment for 2008, which will be equivalent to 1.5 percent of allowed charges for PFS covered professional services furnished during the longest reporting period for which the eligible professional satisfactorily reports.

e. PQRI 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 NQF or the AQA, that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. In addition, the measures shall include structural measures, such as the use of EHRs and electronic prescribing technology.

The measures proposed for the 2009 PQRI are outlined in section II.O.4. of this proposed rule, ''Proposed 2009 PQRI Quality Measures.'' Section 1848(k)(2)(B)(iii) of the Act, as amended by the MMSEA, requires the Secretary to publish the final set of measures in the **Federal Register** no later than November 15, 2008. The final set of 2009 PQRI quality measures will be identified in the CY 2009 PFS final rule with comment period.

The MIEA–TRHCA does not statutorily define a specific reporting period for 2009. However, as for 2008, the Secretary is required to establish alternative reporting periods and alternative reporting criteria for reporting measures groups and for registry-based reporting for 2009. For the 2009 PQRI, we propose to define the reporting period for PQRI to mean the entire 2009 calendar year but also propose additional reporting options for satisfactorily reporting quality measures data based on alternative reporting criteria and reporting periods authorized by MMSEA for measures groups and registry-based reporting, which are described in section II.O.2. of this proposed rule, ''Satisfactory Reporting Criteria and Reporting Periods—Reporting Options in the 2009 PQRI.''

Unlike 2007 and 2008, MIEA–TRHCA does not authorize an incentive payment for PQRI for 2009. Currently, no legislation exists that authorizes us to make incentive payments for satisfactorily reporting data on quality measures for services furnished in 2009 or beyond. Given that currently there is no specific authorization for an incentive payment for the 2009 PQRI, meeting the satisfactory reporting criteria of this proposed rule will not result in an incentive payment for satisfactorily reporting data for covered professional services furnished in 2009.

2. Satisfactory Reporting Criteria and Reporting Periods—Reporting Options in the 2009 PQRI

For the 2009 PQRI, we propose to define the reporting period to mean the entire year (January 1, 2009—December 31, 2009.) We also propose to establish two alternative reporting periods: (1) January 1, 2009 through December 31, 2009; and (2) July 1, 2009 through December 31, 2009 for reporting measures groups and for registry-based reporting. As proposed, this results in several reporting options available to eligible professionals that vary by the reporting mechanism selected. We believe that the availability of several reporting options will increase opportunities for eligible professionals to satisfactorily report quality data for the PQRI and will augment the amount of information submitted about the quality of care provided by eligible professionals to Medicare beneficiaries. The reporting mechanisms and reporting options proposed for the 2009 PQRI are described in the following section.

a. Claims-Based Submission of Data for Reporting Individual Measures

Under Section 101(c)(2) of the MIEA–TRHCA the criteria for satisfactorily submitting data on quality measures 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, only data on applicable measures are required to be submitted.

For the 2009 PQRI, we propose to retain these criteria for claims-based reporting of individual measures for the January 1, 2009—December 31, 2009 reporting period. As summarized in Table 7, an eligible professional could

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 7:—PROPOSED 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 fewer 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

b. Satisfactory Reporting of Data on Quality Measures and Reporting Periods for Measures Groups, Through Claims-Based Reporting and Registry-Based Reporting

Section 101(c)(5)(F) of the MIEA–TRHCA, as added by the MMSEA, requires that for the 2008 and 2009 PQRI the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. In establishing these alternatives, CMS has 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.

We believe that reporting measures groups is an important step to advance the PQRI program toward a more holistic and comprehensive assessment of patient care. By addressing several aspects of care for a particular clinical condition or clinical focus, measures groups results can help assure that patients are receiving a range of care appropriate for a given clinical condition or clinical focus. Because of this, we believe that groups of measures may often provide more meaningful information about the care being furnished to Medicare beneficiaries than can individual measures in isolation. Measures groups also allow physicians and other eligible professionals to more broadly demonstrate their clinical performance for particular services and thereby provide a better basis for comparison among professionals. Measures groups can also decrease complexity of reporting by identifying related measures applicable to the same services furnished to the same beneficiaries by the same professional and highlighting a common set of denominator codes across all the measures of a group that help identify those patients.

As described in the ''2008 PQRI: Establishment of Alternative Reporting Periods and Reporting Criteria'' document (*http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIalterrptperiods.pdf*), there are four measures groups for the 2008 PQRI: (1) Diabetes Mellitus, (2) End-Stage Renal Disease (ESRD), (3) Chronic Kidney Disease (CKD), and (4) Preventive Care. For the 2009 PQRI, we propose to expand the available measures groups to a total of nine, as well as propose a variety of reporting options for reporting on measures groups. In addition to carrying forward three of the four 2008 measures groups, we propose to add six new measures groups for the 2009 PQRI. The ESRD Measures Group for the 2008 PQRI is not being proposed for 2009 because one of the measures in the group is no longer NQF-endorsed and there are no other ESRD measures proposed for the 2009 PQRI that could be added to this group. We propose to retain the remaining three measures in the 2008 ESRD measures group to be available to be reported individually in the 2009 PQRI.

Similar to the 2008 measures groups, we propose that the measures that make up five of these new measures groups could be reported either individually or as part of a measures group. These five new measures groups address the following:

(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); and

(5) Perioperative care.

We also propose one new measures group for the 2009 PQRI in which the measures would be reportable only as a measures group, not as individual measures. This measures group addresses quality of services furnished to treat back pain. The measures proposed for inclusion in each of the proposed 2009 measures groups are listed in section II.O.4. of this proposed rule, ''Proposed 2009 PQRI Quality Measures.''

We welcome comments on these proposed new measures groups, including suggestions for other measures groups based on individual measures included in the proposed 2009 PQRI measure set. For the 2009 PQRI, measures groups must contain at least 4 measures. All measures in each measures group suggested by commenters must be included in the proposed measures cited in section II.O.4. of this proposed rule, ''Proposed 2009 PQRI Quality Measures.'' 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 PQRI 2009, as identified in the CY 2009 PFS final rule with comment period.

As in the 2008 PQRI, we are proposing for the 2009 PQRI that measures groups be reported through claims-based or registry-based submission for the 2009 PQRI. The form and manner of quality data submission for 2009 measures groups will 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. Please note that 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 may be different from specifications and submission instructions for the same measures group used for 2008. Additionally, the specifications for measures groups will 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.

For the 2009 PQRI, we are proposing three options for satisfactorily reporting measures groups using claims-based reporting and three options for satisfactorily reporting measures groups using registry-based submission. The proposed options for satisfactorily reporting on measures groups are described in Table 8. The details of the requirements for registries are contained in section II.O.2.c., ''Registry-Based Submission for Reporting Individual Measures.''

TABLE 8.—PROPOSED 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% 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% 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.

There are two basic criteria for satisfactory reporting of measures groups. For claims-based reporting, the two criteria are: (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 are: (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).

The 30 consecutive patients reporting criteria apply only to the entire year (January 1, 2009 through December 31, 2009) reporting period, but apply to both claims-based submission and registry-based submission mechanisms. While claims are submitted to CMS on Medicare patients only (for claims-based reporting), consecutive patients 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.

We propose that the alternative criteria for measures groups based on reporting on 80 percent of patients for which one measures group 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 periods (with a minimum of 15 patients) and for either claims-based or registry-based reporting of measures groups.

We have included the reporting option for 30 consecutive patients (for claims-based reporting, the consecutive patients must all be Medicare FFS patients) as a means to achieve a reasonably valid sample of patients for performance rate calculation yet place an upper limit on the number of patients on which reporting would be required, compared to the 80 percent of patients criteria. However, unlike 2008, we do not propose an option for 15 consecutive patients for the 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. We invite comments on our 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 sample under these criteria during the full-year 2009 reporting period.

c. Registry-Based Submission for Reporting Individual Measures

Under section 1848(k)(4) of the Act, ''as part of the publication of proposed and final quality measures for 2008 under clauses (i) and (iii) of paragraph (2)(B), the Secretary shall address a

mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry.'' In the CY 2008 PFS final rule with comment period, we described using different options to test the receipt of data from registries in 2008 (72 FR 66350 through 66352). The two options being tested in 2008 are data submission options 2 and 3 as described in the CY 2008 PFS final rule with comment period (72 FR 66352). This testing process is ongoing, but submissions for the testing process are expected to conclude by September 1, 2008. Information regarding the registry submission testing process is available on the CMS Web site at *http://www/cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*.

As we indicated previously, section 101(c)(5)(F) of the MIEA–TRHCA, as added by MMSEA, authorizes us to establish alternative criteria for satisfactorily reporting PQRI quality data through medical registries for 2008 and 2009. For 2008, we have established the requirements a registry must meet to qualify to submit data on quality measures on behalf of eligible professionals seeking incentive payments in 2008. The data to be submitted includes the reporting and performance rates on PQRI measures or PQRI measures groups; and, numerators and denominators for the reporting rates and performance rates. The requirements that we established for 2008 include a registry self-nomination process. The document ''2008 PQRI Registry Requirements for Submission Under New Options'' describes the requirements for a registry to qualify to submit under the registry-based reporting alternatives for 2008. This document is available on the PQRI section of the CMS Web site at *http://www/cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*. On or before August 31, 2008, we will announce the names of self-nominated registries that are determined by CMS to meet necessary technical and other requirements to submit quality measures results and numerator and denominator data on quality measures on behalf of eligible professionals seeking an incentive under the alternative reporting periods and criteria applicable to registry-based submission for reporting quality measures on services furnished during 2008.

For 2009, we propose that eligible professionals would be able to report 2009 PQRI quality measures data 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. As for 2008, the data to be submitted for 2009 includes the reporting and performance rates on PQRI measures or PQRI measures groups; and, numerators and denominators for the reporting rates and performance rates. To do so, eligible professionals would need to enter into and maintain an appropriate legal arrangement with an eligible clinical registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on behalf of the eligible professional to CMS for the PQRI. Thus, the registry would act as a 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, would submit registry-derived measures information to the CMS designated database within the Quality Reporting System, using a CMS-specified record layout. The record layout will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* as soon as practical, and no later than April 1, 2009.

To maintain compliance with applicable statutes and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (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.

For the 2009 PQRI, we propose 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 propose to accept quality measures results and numerator and denominator data on quality measures from registries that qualify as data submission vendors. We propose these criteria would be available for each of the two alternative reporting periods. Thus, the proposed reporting options for registry-based submission of at least three individual PQRI measures are listed in Table 9.

TABLE 9.—PROPOSED 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.O.2.b. of this proposed rule, ''Satisfactory Reporting of Data on Quality Measures and Reporting Periods for Measures Groups, Through Claims-Based Reporting and Registry-Based Reporting,'' we also propose the three reporting options for registry-based submission of quality measures results and numerator and denominator data on PQRI measures groups summarized in Table 8.

To submit on behalf of eligible professionals pursuing incentive payment for reporting clinical quality information on services furnished during 2008 for reporting both on individual measures and measures groups, we required registries to complete a self-nomination process and to meet certain technical and other requirements in order to be considered ''qualified'' to submit on behalf of eligible professionals pursuing the 2008 PQRI incentive payment. These 2008 requirements are detailed in section (g) of the document titled: ''2008 Physician

Quality Reporting Initiative: Establishment of Alternative Reporting Periods and Reporting Criteria,'' which is posted at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIalterrptperiods.pdf*, and in a further document titled ''Registry Requirements to Qualify as an Acceptable Registry for Submission of PQRI Data On Behalf of Eligible Professionals Seeking Payment in 2008,'' which is posted at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIRegistryRequirements.pdf*).

For 2009, we propose to again require a self-nomination process based on meeting specific technical and other requirements in order to qualify to submit data on 2009 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished in 2009. This self-nomination will be required regardless of whether or not the registry participated in any way in PQRI in 2008. As in 2008, 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 on behalf of their professionals. By listing a registry as ''qualified,'' however, we cannot guarantee or assume responsibility for the successful submission of data on PQRI quality measures or measures groups. We propose that the 2009 registry technical requirements will be substantially the same as for 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 National Provider Identifier (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 PQRI Measure Numbers.
- Provide the measure titles.
- 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 a ''validation strategy'' to CMS by May 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 verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method.
- Be able to include in its overall submission whether the results for each NPI are validated by the registry.
- 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 measure groups will be doing so for the 6- or 12-month period.
- Include only patients who were cared for during the twelve-month measurement period (reporting period) of January through December 2009 or the 6-month measurement period (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 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.

However, for 2009, we may modify certain aspects of the registry technical requirements listed above, which are based on the 2008 registry requirements that are described in the ''Registry Requirements to Qualify as an Acceptable Registry for Submission of PQRI Data On Behalf of Eligible Professionals Seeking Payment in 2008'' document available on the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIRegistryRequirements.pdf*) based on our experience during the 2008 registry testing process and any comments received on the 2009 registry technical requirements proposed above. We will post the final 2009 registry technical requirements, including the

exact date by which registries that wish to qualify for 2009 must submit a self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri* by November 15, 2008. We anticipate that registries that wish to self-nominate for 2009 will be required to do so by the end of the first quarter of 2009, but not later than the end of the second quarter of 2009.

We invite comments on the proposed options for registry-based PQRI reporting of data on measures and measures groups for services furnished in 2009.

d. EHR-Based Submission for Reporting Individual Measures

In addition to the testing of registry-based submission, we are currently preparing for testing the submission of clinical quality data extracted from EHRs for five 2008 PQRI measures. We anticipate this testing will begin July 1, 2008 and conclude by December 31, 2008. For the 2009 PQRI, we propose to accept PQRI data from EHRs for a limited subset of the proposed 2009 PQRI quality measures identified in Tables 11 and 13 (section II.O.4., ''Proposed 2009 PQRI Quality Measures''), contingent upon the successful completion of our 2008 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2009 PQRI is practical and feasible. Provided our 2008 EHR data submission testing process is successful, we propose to begin accepting submission of clinical quality data extracted from EHRs on January 1, 2009 or as soon thereafter as is technically feasible. The date on which we would begin to accept quality data submission on services furnished in 2009 is contingent upon when we can have 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. (Because EHR-based data submission need not be accomplished concurrently with the dates services are furnished or billed, there is some latitude to begin accepting EHR-extracted data later than January 1, 2009, without precluding accepting data for the proposed 2009 PQRI reporting periods.)

The electronic specifications for the proposed 2009 PQRI measures identified in Tables 11 and 13 that are under consideration for EHR-based submission in 2009 will be posted on a public Web site when available. We will broadly announce the availability and exact location of these specifications through familiar CMS communications channels including the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.* The posting of the electronic specifications for any particular measure prior to publication of the final rule does not signify that the measure will be necessarily selected for the 2009 PQRI measure set, nor that EHR-based data submission will be accepted for that measure even if it may otherwise be included in the 2009 PQRI. However, by posting the specifications, we seek to allow sufficient time for EHR vendors to adapt their products to support EHR-based capture and submission of data for these measures prior to the start of any 2009 PQRI reporting periods.

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 will use Certification Commission for Healthcare Information Technology (CCHIT) criteria and Secretarially-recognized Healthcare Information Technology Standards Panel (HITSP) interoperability standards where possible and we encourage vendors to do so also. These are the specifications that will be available on a publicly accessible Web site to be identified by CMS.

Prior to the beginning of EHR-based quality measures data submission for any 2009 PQRI reporting period, we will publish (through familiar mechanisms such as CMS e-mail lists and the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri*) information on the process eligible professionals will need to use to actually submit to the CMS-designated clinical data warehouse the 2009 PQRI quality measures data extracted from their practices' EHRs. The process will comply with applicable laws, regulations, and policies for privacy, data security, and interoperability—including but not limited to HIPAA requirements. The data submission process will also require that the persons (eligible professionals, other practice staff, or vendors acting on the professionals' behalf) who actually exchange data with the clinical warehouse system obtain and use an account (user identification and password) on a CMS-designated user authentication and identity management system. We will not charge 2008 or 2009 PQRI participants any processing or licensing fees to obtain or maintain the required user account. More details on the required account and how to obtain it will be published prior to January 1, 2009.

We cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional wishing to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product has been updated to facilitate PQRI quality measures data submission. Such professionals should also begin attempting submission promptly after CMS announces in early 2009 that the clinical data warehouse is ready to accept 2009 PQRI quality measures data through the EHR mechanism in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR.

To maintain compliance with applicable statutes and regulations, including but not limited to HIPAA, our program and its data system must comply with applicable requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also must maintain compliance with the HIPAA requirements.

We encourage the use of EHRs that have been certified by the CCHIT for data submission. CCHIT certified EHRs must meet specific standards for functionality, privacy, security and interoperability. More information about CCHIT certified EHRs can be found at *http://www.cchit.org.* However, we do recognize that there will 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. These programs must be capable of generating a medication list, generating a problem list and entering laboratory results as discrete searchable data elements to be able to be used for data submission under this reporting mechanism option.

We propose to utilize 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 successful reporting and the same reporting period that we propose for claims-based submission of data for individual 2009 PQRI measures. The reporting criteria for EHR-based submission of individual PQRI measures are summarized in Table 10.

TABLE 10.—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.

We do not propose any option to report measures groups through EHR-based data submission on services furnished during 2009. Because EHR submission to CMS of data on quality measures is new to PQRI, for 2009 we propose to make available only the criteria applicable to reporting of individual PQRI measures. We invite comments on the proposed use of EHR-based data submission for PQRI.

3. Statutory Requirements for Measures Included in the 2009 PQRI

a. Overview of Requirements for the 2009 PQRI Quality Measures

Section 1848(k)(2)(B)(ii) of the Act, as added by the MMSEA, requires CMS to publish in the **Federal Register** no later than August 15, 2008, a proposed set of quality measures that would be appropriate for eligible professionals to use to submit data in 2009. 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, as amended by the MMSEA, 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 sections 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 must be included in the 2009 set of quality measures.

We discuss in the following section 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 set of measures for 2009 in the context of other applicable Federal law and policy. More information on the measure development process in general is available on the CMS Web site at *http://www.cms.hhs.gov/QualityInitiativesGenInfo*. The next section also discusses the policies used in proposing the initial set of quality measures for eligible professionals for use in 2009 and the policies we are proposing to apply in publishing the final set.

b. Consensus Organizations and Consensus-Based Process for Developing Measures

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 proposing that 2009 PQRI measures be limited 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 and amended by MMSEA 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. Consensus should be achieved based on at least a level of openness, balance of interest, and consensus reflected in the structures and processes of the NQF and AQA as of the date of enactment of MIEA–TRHCA, MMSEA, and the date of this proposed rule. More information on the structures and processes of the NQF and AQA can be found on the organizations' respective Web sites at *http://www.qualityforum.org* and *http://www.ambulatoryqualityalliance.org*.

Based on the considerations discussed in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), we are proposing to apply the following policies in identifying measures that meet the requirements for having used a consensus-based process for development and the requirement for having been endorsed or adopted by a consensus organization such as the NQF or AQA, and that are appropriate for inclusion as 2009 measures:

(1) We continue to interpret ''a consensus-based development process'' as meaning that in addition to the measure development, the measure has achieved adoption or endorsement by a consensus organization having at least the basic characteristics of the AQA as a consensus organization as of December 2006, when the MIEA–TRHCA incorporating reference to AQA was passed and signed into law. Those basic characteristics include a comparable level of openness, balance of interest, and consensus-based on voting participation. As discussed above in this section and further clarified in points (3) and (5), we do not interpret ''consensus-based development process'' per section 1848(k)(2)(B) of the Act to require that the consensus organization or process meet all of the criteria of the NTTAA and Office of Management and Budget Circular No. A–119 (OMB A–119) definition of a voluntary consensus standards body.

(2) ''Voluntary consensus standard'' is interpreted to mean a voluntary consensus standard that has been endorsed as such by a consensus organization that meets the requirements of the NTTAA, as implemented by OMB A–119, for a voluntary consensus standards body.

(3) Where there are available quality measures, and some of these measures meet the definition of ''voluntary consensus standards'' while others do not, those measures that meet the definition of ''voluntary consensus standards'' are preferred to other measures not meeting the requirements of the NTTAA.

(4) In view of the preference for voluntary consensus standards, if a measure has been specifically

considered by NQF for possible endorsement, but NQF has declined to endorse it as of August 31, 2008, we are proposing not to include it in the final set of 2009 PQRI Quality Measures.

(5) Although the AQA, as organized in December 2006, does not meet the requirements of the NTTAA for a voluntary consensus standards body, it is a consensus organization per section 1848(k)(2)(B) of the Act. In circumstances where no voluntary consensus standard (NQF-endorsed) measure is available, a quality measure that has been adopted by the AQA (or another consensus organization with comparable consensus-organization characteristics) would meet the requirements under the Act and we propose that it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.

(6) We are unaware of other consensus organizations that are comparable to the NQF in terms of meeting the formal requirements of the NTTAA or of organizations other than AQA that do not strictly meet the requirements of the National Institute of Standards and Technology Act (NISTA) as amended by the NTTAA but that feature the breadth of stakeholder involvement in the consensus process necessary to meet the intent of the Act. However, the Act does not limit consensus organizations to the NQF or the AQA, nor restrict the field of potential consensus organizations. 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.

(7) The basic steps for developing measures applicable to physicians and other eligible professionals at the individual level may be carried out by a variety of different organizations. We do not interpret section 1848(k)(2)(B) 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. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

(8) The policies we are proposing are based on the preference as articulated in NTTAA and OMB A–119 for ''voluntary consensus standards'' to government standards, and a preference for quality measures that have achieved broad consensus among stakeholders in the health care system. However, the Act does not require that quality measures meet the NTTAA or OMB A–119 definition of ''voluntary consensus standards'' to be used for PQRI.

4. Proposed 2009 PQRI Quality Measures

The measures identified for use in PQRI in 2009 will be selected from those we propose in this rule and will be finalized as of the date the CY 2009 PFS final rule with comment period goes on display at the Office of the Federal Register. No changes (that is, additions or deletions of measures) will be made after publication of the CY 2009 PFS 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.

For 2009, we are proposing that final PQRI quality measures will be selected from the 175 measures listed in Tables 11 through 14, which fall into 4 broad categories as set forth below in this section. The four categories are the following:

(1) 2008 PQRI Measures Proposed for 2009;

(2) Additional Proposed NQF-endorsed Measures;

(3) Additional Proposed AQA-adopted Measures; and

(4) Measures Proposed for 2009 Contingent Upon NQF Endorsement or AQA Adoption by August 31, 2008. Given that no legislation currently exists that authorizes us to make incentive payments for satisfactorily reporting data on quality measures on services furnished in 2009 or beyond, we invite comments on the advisability of expanding the number of PQRI quality measures beyond the 119 measures in the 2008 PQRI quality measure set.

In addition, we propose to carry forward three of the four measures groups we implemented in 2008. The measures proposed in eight of the nine total proposed measures groups are proposed to be available for reporting as individual measures or within measures groups and the measures in the ninth measures group (Back Pain) are proposed to be available for use in the 2009 PQRI solely within this proposed measures group. The measures proposed for inclusion in each of the proposed 2009 measures groups are listed in Tables 15 through 23.

a. Considerations for Identifying Proposed 2009 PQRI Quality Measures

We have applied several considerations in selecting measures to propose for the 2009 PQRI. We considered the following with respect to selecting the proposed measures for the 2009 PQRI:

(1) Measures that satisfy statutory criteria for selection. For purposes of selecting the proposed 2009 PQRI measures, we considered those measures that met the requirements of section 1848(k)(2) of the Act and other requirements discussed in section II.O.3.b. of this proposed rule, ''Consensus Organizations and Consensus-Based Process for Developing Measures.''

(2) Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2008 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those which can be most efficiently implemented for data collection and submission. For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible.

(3) Measures that increase the scope of applicability of measures to services rendered to Medicare beneficiaries and expand opportunities for eligible

professionals to participate in PQRI (for example, clinical topics such as skin care, where there are no 2008 PQRI measures). We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least three measures applicable to their practice and measures that help expand the number of measures groups with at least 4 measures in a group.

(4) Measures that support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infection and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable Health Information Technology (HIT).

(5) Measures that are in, or facilitate, alignment with other Medicare, Medicaid, and SCHIP programs in furtherance of overarching healthcare goals.

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

In developing the list of proposed 2009 PQRI quality measures, we also have reviewed and considered measure suggestions including comments received in response to the CY 2008 PFS proposed rule and final rule with comment period, and inquiries and suggestions received through less formal venues, such as an invitation for measures suggestions posted on the CMS Web site in March 2008.

We welcome comments on the implication of including or excluding any given measure or measures proposed herein in the final 2009 PQRI quality measure set and to our approach in selecting measures. We recognize that some commenters may also wish to recommend additional measures for inclusion in the 2009 PQRI measures that we have not herein proposed. While we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2009 measure set.

As discussed above, section 1848(k)(2)(B)(ii) of the Act requires that the measures proposed for use in the 2009 PQRI be published in the **Federal Register** not later than August 15, 2008. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2009 PQRI that are recommended to CMS via comments on this proposed rule have not been placed before the public with opportunity for the public to comment on them within the rulemaking process. Even when measures have been published in the **Federal Register** , but in other contexts and not specifically proposed as PQRI measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in PQRI. Thus, such additional measures recommended via comments on this proposed rule cannot be included in the 2009 measure set. Section 1848(k)(2)(B)(iii) of the Act requires that the measures be finalized via publication in the **Federal Register** not later than November 15, 2008. However, as discussed above, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2009 PQRI measures, for purposes of identifying measures for possible use in future years' PQRI or other initiatives to which those measures may be pertinent.

b. Proposed Measures Selected From the 2008 PQRI Quality Measures Set

We are proposing to include in the 2009 PQRI quality measure set the 2008 PQRI measures identified in Table 11 contingent on NQF endorsement of each such included measure by August 31, 2008. All 2008 PQRI measures have been adopted by the AQA and have been considered or are currently under consideration for endorsement by the NQF. Those 2008 PQRI measures that have been specifically considered and declined for endorsement are not included in the list of proposed measures for 2009. The six 2008 PQRI measures not included in the proposed measures for 2009 for this reason are: Measure #74, Radiation Therapy Recommended for Invasive Breast Cancer Patients who have Undergone Breast Conserving Surgery; Measure #75, Prevention of Ventilator-Associated Pneumonia—Head Elevation; Measure #80, Plan of Care for ESRD Patients with Anemia; Measure #103, Review of Treatment Options in Patients with Clinically Localized Prostate Cancer; Measure #129, Universal Influenza Vaccine Screening and Counseling; and Measure #133 Screening for Cognitive Impairment. Also, in some instances, those 2008 PQRI measures intended or requested by the measure developer to be retired from PQRI and replaced by new AQA-adopted or NQF-endorsed measures are not included in the list of proposed measures for 2009. The two 2008 PQRI measures not proposed for this reason are: Measure #4, Screening for Future Fall Risk; and Measure #88, Hepatitis A and B Vaccination in Patients with HCV.

TABLE 11.—2008 PQRI MEASURES PROPOSED FOR 2009

Measure number and title	Measure source
1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus*	National Committee for Quality Assurance (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).
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.

TABLE 11.—2008 PQRI MEASURES PROPOSED FOR 2009—Continued

Measure number and title	Measure source
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.	AMAPCPI/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.
73. Cancer: Plan for Chemotherapy Documented	AMA–PCPI/ASCO.
76. Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter Insertion Protocol.	AMA–PCPI.
77. Gastroesophageal Reflux Disease (GERD): Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD.	AMA–PCPI/NCQA.
78. End-Stage Renal Disease (ESRD): Vascular Access for Patients Undergoing Hemodialysis	AMA–PCPI.

TABLE 11.—2008 PQRI MEASURES PROPOSED 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.
96. Otitis Media with Effusion (OME): Antihistamines or Decongestants—Avoidance of Inappropriate Use.	AMA–PCPI.
97. Otitis Media with Effusion (OME): Systemic Antimicrobials—Avoidance of Inappropriate Use	AMA–PCPI.
98. Otitis Media with Effusion (OME): Systemic Corticosteroids—Avoidance of Inappropriate Use.	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.
101. Prostate Cancer: Appropriate Initial Evaluation	AMA–PCPI.
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.
120. Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy.	AMA–PCPI.
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. Health Information Technology (HIT): Adoption/Use of Electronic Medical Records (EMR)*	Quality Insights of Pennsylvania (QIP)/CMS.
125. Health Information Technology (HIT): Adoption/Use of Medication e-Prescribing*	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.
132. Patient Co-Development of Treatment Plan/Plan of Care	QIP/CMS.
134. Screening for Clinical Depression	QIP/CMS.

*This measure is one fifteen measures for which data may potentially be accepted through the EHR mechanism in 2009.

Please note that detailed measure specifications for 2008 PQRI measures may be updated or modified during the NQF endorsement process or for other reasons prior to 2009. The 2009 PQRI measure specifications for any given measure may, therefore, be different from specifications for the same measure used for 2008. Specifications for all 2009 measures, whether or not included in the 2008 PQRI program, must be obtained from the specifications document for 2009 measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2008.

c. Additional Proposed NQF-Endorsed Measures

We propose to include in the 2009 PQRI quality measure set a number of measures endorsed by the NQF that were not included in the 2008 PQRI quality measures, which are identified in Table 12, provided that the measure retains NQF endorsement as of August 31, 2008 and its detailed specifications are completed and ready for implementation in PQRI by October 15, 2008. Besides having NQF endorsement, the development of a measure is considered complete for the purposes of the 2009 PQRI if by October 15, 2008—(1) the final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2009.

Measures designated as T### in Table 12 indicate that the measure was included in the 2008 Measure Testing Process. For 2008, we implemented a measures testing process for eleven measures that had completed consensus adoption or endorsement but which were not included in the final measures for use in satisfying reporting criteria to earn an incentive under the 2008 PQRI. These 2008 test measures have completed measures and specification development, have, as of the publication of this proposed rule, been adopted by the AQA and/or endorsed by the NQF, and have available CPT II codes that permit claims-based data submission. For the 2008 Measure Testing Process, eligible professionals may report any of these test measures by submitting the quality data codes identified, and as directed, in the test measure specifications on Part B claims for dates of services from July 1, 2008 through September 30, 2008. No financial incentive is associated with the reporting of these test measures for 2008.

We plan to analyze the number of quality data codes submitted for each specific test measure and engage in other summary analysis for the measures. No feedback reports regarding reporting and performance rates will be provided to eligible professionals who report on these test measures in 2008. Information from the analysis of the data submitted on the 2008 measure testing process will be utilized in a preliminary evaluation of the measures for data submission. This information can be used to inform us of a measure's readiness for implementation in future CMS programs.

TABLE 12.—ADDITIONAL PROPOSED NQF-ENDORSED MEASURES

Measure title	Measure source
T142 Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	AMA–PCPI.
Use of Imaging Studies in Low Back Pain	NCQA.
Back Pain: Initial Visit	NCQA.
Back Pain: Physical Exam	NCQA.
Back Pain: Advice for Normal Activities	NCQA.
Back Pain: Advice Against Bed Rest	NCQA.
Foot Exam	NCQA.
Selection of Antibiotic Administration for Cardiac Surgery Patients	STS.
Prolonged Intubation	STS.
Deep Sternal Wound Infection Rate	STS.
Stroke/Cerebrovascular Accident	STS.
Post-operative Renal Insufficiency	STS.
Surgical Re-exploration	STS.
Anti-platelet Medications at Discharge	STS.
Beta Blockade at Discharge	STS.
Anti-lipid Treatment at Discharge	STS.
Hemodialysis Vascular Access Decision-making by Surgeons to Maximize Placement of Autogenous Arterial Venous Fistula.	Society for Vascular Surgeons (SVS).

d. Additional Proposed AQA-Adopted Measures

As discussed in section II.O.3.b. of this proposed rule, Consensus Organizations and Consensus-Based Process for Developing Measures, 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 propose to include in the final 2009 PQRI quality measure set measures adopted by AQA that have not yet been reviewed or endorsed by the NQF and that were not included in the final set of 2008 PQRI quality measures.

We propose to include in the 2009 PQRI quality measures each of the AQA-adopted measures identified in Table 13, provided that, as of August 31, 2008, the measure retains AQA adoption, has not been reviewed and declined for endorsement by NQF, and its detailed specifications are completed and ready for implementation in PQRI by October 15, 2008. Besides being adopted by the AQA, a measure is 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 data submission on or before January 1, 2009. As explained above in section II.O.4.c., ''Additional Proposed NQF-Endorsed Measures,'' measures designated as T### in Table 13 indicate that the measure is one of eleven measures included in the 2008 Measure Testing Process. As also explained above in

section II.O.4.c., ''Additional Proposed NQF-Endorsed Measures,'' measures in the table below that are not designated as T### are not part of the 2008 PQRI measures testing activity. Such measures may have CPT II codes identified or specified, but those codes may or may not be recognized as active, valid codes in the Medicare claims-processing system.

TABLE 13.—ADDITIONAL PROPOSED AQA-ADOPTED MEASURES

Measure title	Measure source
T135 Chronic Kidney Disease (CKD): Influenza Immunization*	AMA–PCPI.
T136 Melanoma: Follow-Up Aspects of Care	AMA–PCPI/NCQA.
T137 Melanoma: Continuity of Care—Recall System	AMA–PCPI/NCQA.
T138 Melanoma: Coordination of Care	AMA–PCPI/NCQA.
T139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement.	AMA–PCPI/NCQA.
T140 Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA–PCPI/NCQA.
T141 Primary Open-Angle Glaucoma (POAG) : Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care.	AMA–PCPI/NCQA.
T143 Cancer Care: Medical and Radiation—Plan of Care for Pain	AMA–PCPI.
T144 Radiology: Computed Tomography (CT) Radiation Dose Reduction	AMA–PCPI/NCQA.
T145 Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA–PCPI/NCQA.
Cancer Care: Pain Intensity 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.
Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	AMA–PCPI.
Falls: Plan of Care	AMA–PCPI.
Falls: Risk Assessment	AMA–PCPI.
Cancer Care: Radiation Dose Limits to Normal Tissues	AMA–PCPI.
Hepatitis C: Hepatitis A Vaccination	AMA–PCPI.
Hepatitis C: Hepatitis B Vaccination	AMA–PCPI.
Cancer Care: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer	STS.

*This measure is one fifteen measures for which data may potentially be accepted through the EHR mechanism in 2009.

e. Additional Proposed Measures Contingent Upon NQF Endorsement or AQA Adoption by August 31, 2008

We are proposing to include in the 2009 PQRI measure set certain measures that are not yet NQF-endorsed or AQA-adopted, provided that the measure will be so endorsed or adopted as of August 31, 2008, and its detailed specifications are completed and ready for implementation in PQRI by October 15, 2008.

The measures we propose to include in the 2009 PQRI quality measure set are identified in Table 14. Besides being NQF-endorsed or AQA-adopted, a measure is 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.

TABLE 14.—MEASURES PROPOSED 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.
Unhealthy Alcohol Use: Screening & Brief counseling	AMA–PCPI.
Lipid Screening	AMA–PCPI.
Pediatric ESRD: Adequacy of Hemodialysis	AMA–PCPI.
Pediatric ESRD: Influenza Immunization	AMA–PCPI.
Rheumatoid Arthritis: Tuberculosis Screening	AMA–PCPI.
Rheumatoid Arthritis: Appropriate Use of Biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs).	AMA–PCPI.
Rheumatoid Arthritis: Periodic Assessment of Disease Activity	AMA–PCPI.
Rheumatoid Arthritis: Functional Limitation Assessment	AMA–PCPI.
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis	AMA–PCPI.
Rheumatoid Arthritis: Glucocorticoid Management	AMA–PCPI
Endoscopy & Polyp Surveillance: Surveillance Colonoscopy Interval in Patients with History of Adenomatous Polyps.	AMA–PCPI.
Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA–PCPI.
Chronic Wound Care: Offloading of Diabetic Foot Ulcers	AMA–PCPI.
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 Six Months of Potent Antiretroviral Therapy	AMA–PCPI/NCQA.

TABLE 14.—MEASURES PROPOSED FOR 2009 CONTINGENT UPON NQF ENDORSEMENT OR AQA ADOPTION BY AUGUST 31, 2008—Continued

Measure title	Measure source
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Arterial Disease—Ankle Brachial Index.	APMA
Participation by Physician or Other Clinician in a Systematic Clinical Database Registry that includes Consensus Endorsed Quality Measures.	CMS
Elder Maltreatment Screen and Follow-up Plan	QIP/CMS.
Chiropractic Care	QIP/CMS.
Palliative Care: Dyspnea Screening and Management	NCQA
Endarterectomy: Peri-operative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy (CEA).	SVS.
Endarterectomy: Postoperative Stroke or Death in Asymptomatic Patient Undergoing Carotid Endarterectomy (CEA).	SVS
Endarterectomy: Use of Patch During Conventional Endarterectomy	SVS

f. Measures Proposed for Inclusion in 2009 Measures Groups

As discussed previously in this section, we propose to retain three of the four 2008 PQRI measures groups for the 2009 PQRI—(1) Diabetes Mellitus, (2) CKD, and (3) Preventive Care. We also are not proposing to retain all of the measures contained in those groups as 2009 PQRI measures. In some cases, we may propose different or additional measures 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 proposed for inclusion in the 2009 Diabetes Mellitus, CKD, and Preventive Care measures groups are listed in Tables 15 through 17.

Some measures proposed 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 15 through 23. 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. 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.O.2.b., Satisfactory Reporting of Data on Quality Measures and Reporting Periods for Measures Groups, Through Claims-Based Reporting and Registry-Based Reporting'').

TABLE 15.—MEASURES PROPOSED 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.
Foot Exam	NCQA.

TABLE 16.—MEASURES PROPOSED FOR 2009 CKD MEASURES GROUP

Measure title	Measure source
120. Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy.	AMA–PCPI.
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.

TABLE 17.—MEASURES PROPOSED 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.

TABLE 17.—MEASURES PROPOSED FOR 2009 PREVENTIVE CARE MEASURES GROUP—Continued

Measure title	Measure source
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.
128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	QIP/CMS.

In addition to these three measures groups retained from 2008 with applicable modifications, there are 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 proposed measures groups contains at least four PQRI measures. Except for the Back Pain measures group, all measures included in a measures group can be reported individually or as part of a group. Measures in the Back Pain measures group will be reportable only as a part of this measures group.

Tables 18 through 23 list the measures proposed for inclusion in each of these new measures groups. The final composition of measures groups for the 2009 PQRI will be contingent upon the final measures for the 2009 PQRI and will be finalized in the CY 2009 PFS final rule with comment period. We invite comments on the measures proposed for inclusion in the measures groups proposed for 2009.

TABLE 18.—MEASURES PROPOSED 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.
Selection of Antibiotic Administration for Cardiac Surgery Patients	STS.
Prolonged Intubation	STS.
Deep Sternal Wound Infection Rate	STS.
Stroke/Cerebrovascular Accident	STS.
Post-operative Renal Insufficiency	STS.
Surgical Re-exploration	STS.
Anti-platelet Medications at Discharge	STS.
Beta Blockade at Discharge	STS.
Anti-lipid Treatment at Discharge	STS.

TABLE 19.—MEASURES PROPOSED FOR 2009 CAD MEASURES GROUP

Measure 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.
18. 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.
Lipid Screening	AMA–PCPI.

TABLE 20.—MEASURES PROPOSED FOR 2009 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure title	Measure source
108. Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy	AMA–PCPI.
Rheumatoid Arthritis: Tuberculosis Screening	AMA–PCPI.
Rheumatoid Arthritis: Appropriate Use of Biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs).	AMA–PCPI.
Rheumatoid Arthritis: Periodic Assessment of Disease Activity	AMA–PCPI.
Rheumatoid Arthritis: Functional Limitation Assessment	AMA–PCPI.
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis	AMA–PCPI.
Rheumatoid Arthritis: Glucocorticoid Management	AMA–PCPI.

TABLE 21.—MEASURES PROPOSED FOR 2009 HIV/AIDS MEASURES GROUP

Measure title	Measure source
HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA–PCPI/NCQA.
HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA–PCPI/NCQA.

TABLE 21.—MEASURES PROPOSED FOR 2009 HIV/AIDS MEASURES GROUP—Continued

Measure title	Measure source
HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS who are Prescribed Potent Antiretroviral Therapy.	AMA–PCPI/NCQA.
HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA–PCPI/NCQA.

TABLE 22.—MEASURES PROPOSED 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 23.—MEASURES PROPOSED FOR 2009 BACK PAIN MEASURES GROUP

Measure title	Measure source
Use of Imaging Studies in Low Back Pain	NCQA.
Back Pain: Initial Visit	NCQA.
Back Pain: Physical Exam	NCQA.
Back Pain: Advice for Normal Activities	NCQA.
Back Pain: Advice Against Bed Rest	NCQA.

g. Quality Measures Reviewed and Not Proposed for 2009 PQRI

In developing the list of proposed 2009 PQRI quality measures, we have reviewed both formal and informal measure suggestions ranging from comments received in response to the CY 2008 PFS proposed rule and final rule with comment period to inquiries and suggestions received through less formal venues, including but not limited to an invitation posted on the CMS Web site in March 2008 for suggestions of measures for consideration for potential inclusion in PQRI. For those quality measures reviewed but not included in the list of proposed 2009 PQRI quality measures, we may consider including such measures in a 2009 Measure Testing Process similar to the 2008 Measure Testing Process described above.

Measures selected for inclusion in the 2009 Measure Testing Process will be limited to measures that have completed development, including having achieved consensus endorsement or adoption, and for which CPT II codes are available by January 1, 2009. The 2009 Measure Testing Process is planned for April 1, 2009 through June 30, 2009. We plan to analyze the number of quality data codes submitted for the specific test measures and engage in other summary analysis for the measures. No calculations will be made at the individual or physician level.

As discussed previously, no legislation exists that authorizes us to make incentive payments for satisfactorily reporting data on quality measures on services furnished in 2009. No financial incentive payment will be associated with the reporting of these test measures for 2009. Information from this analysis of the data submitted on measures identified for the 2009 Measure Testing Process will be utilized in a preliminary evaluation of the measures. This information can be used to inform us of a measure's readiness for implementation in future CMS programs.

5. Summary of Program Considerations for the PQRI in 2009 and Beyond

In summary, we have invited public comment on the following areas for the 2009 PQRI through this proposed rule:

- Implications of including or excluding any given measure from the set of proposed 2009 quality measures as listed in Tables 11, 12, 13, and 14. Suggestions to include measures for the 2009 PQRI other than those we have proposed for inclusion will not be considered for 2009. However, any such suggestions may be considered in future years for use in PQRI or for other initiatives to which those measures may be pertinent.
- The new measures groups proposed for 2009 including suggestions for other measures groups based on individual measures included in the proposed 2009 PQRI measures 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 measures set given that there is no specific authorization for an incentive payment for the 2009 PQRI and beyond.

6. Uses of PQRI Information

On August 22, 2006, President Bush issued an Executive Order, ''Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs,'' which requires the Federal Government, to the extent permitted by law, to—

- Ensure that Federal health care programs promote quality and efficient delivery of health care using interoperable health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers.

• Make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector.

To support this mandate, the Secretary has embraced ''four cornerstones'' for building a value-driven health care system:

(1) Connecting the health system through the use of interoperable health information technology;

(2) Measuring and publishing information about quality;

(3) Measuring and publishing information about price; and

(4) Using incentives to promote high-quality and cost-effective care (see *http://www.hss.gov/valuedriven*).

Building on these four cornerstones, we have articulated a vision for health care—the right care, for every person, every time. To achieve this vision, we seek to implement policies that will promote the delivery of care that is safe, effective, timely, patient-centered, efficient, and equitable. In working to achieve this vision, and in support of the four cornerstones, we have launched an initiative, of which PQRI is a part, directed toward measuring the quality of care for services provided to Medicare beneficiaries and to make such information publicly available. We currently have Web pages 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). On these Web pages, we make performance results on standardized quality measures for the various facilities publicly available. This information is used by the facilities for their own quality improvement purposes, by the public to make informed healthcare decisions, and, in some cases, for our payment incentive programs that are designed to promote the delivery of high quality services and to ensure high value for Medicare beneficiaries. To date, we have not made information on the quality of care for services provided by physicians to Medicare beneficiaries publicly available. However, we are contemplating a similar ''Physician Compare'' Web site that would enhance the information found on the Physician 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 in the future. 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.

With respect to the PQRI, the data on PQRI quality measures is submitted at the individual (that is, NPI) level by physicians and other eligible professionals. Such data could be the basis for public reporting of quality measurement performance results at either the individual or group (that is, TIN) level. Our plans with respect to public reporting of PQRI data have been a subject of public interest. In response to public comments received on the issue of public reporting of PQRI data, we stated in the CY 2008 PFS final rule with comment period (72 FR 66337) that ''[w]e do not at this time plan to make results publicly available in a format or with content that would enable identification of individual professionals or specific practices' specific reporting or performance results. We have not made a determination as to the most appropriate venue(s) for making PQRI evaluation information available to the public.''

Nevertheless, in 2007, we published a notice of a new system of records (SOR) under the Privacy Act entitled, ''Performance Measurement and Reporting System,'' System No. 09–70–0584 (72 FR 52133 through 52140) for the public release of PQRI data. Under the SOR we established a routine use that would enable us to make individual physician-level performance measurement results information available to Medicare beneficiaries, by posting it on a public Web site and by various other methods of data dissemination, which may include performance information that is reported by physicians pursuant to PQRI.

Although not required by the statute authorizing PQRI we have, from the beginning, regarded providing physicians and other eligible professionals an opportunity to review their data on reporting rates and performance rates on PQRI quality measures as an important aspect of the program. This derives from the fundamental interest in quality improvement that underlies the program. Thus, we included a confidential feedback mechanism for physicians as part of the Physician Voluntary Reporting Program which preceded PQRI. We extended and expanded the confidential feedback mechanism for the 2007 PQRI. These feedback reports are scheduled to be available starting in mid-July 2008 at the time the incentive payments for 2007 PQRI are made. The feedback reports will not only assist eligible professionals in quality improvement but will also provide us with an important source of input for evaluation of PQRI measures, the performance calculation methods, and the PQRI program. For the 2008 PQRI data that is currently being submitted, we will continue to provide a confidential feedback process. For the 2008 PQRI data, consistent with information that we have previously provided, we do not intend to publicly report performance results at the individual or group level; but we may publicly report the names of eligible professionals who report and/or satisfactorily report quality data under the 2008 PQRI.

As part of our broader goal to measure and make the quality of care for services provided to Medicare beneficiaries publicly available and in support of the four cornerstones, we anticipate making information on the quality of care for services provided by professionals to Medicare beneficiaries publicly available in the future. In future years, we will also explore using information collected from the PQRI, including performance results, for this purpose. To assist us in determining the most appropriate uses of PQRI data, we invite 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.

P. Discussion of Chiropractic Services Demonstration

[If you choose to comment on issues in this section, please include the caption ''CHIROPRACTIC SERVICES

DEMONSTRATION'' at the beginning of your comments.]

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 budget neutrality 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 budget neutrality. We will assess budget neutrality 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 budget neutrality and the proposed offset during the CY 2010 PFS rulemaking process.

Q. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists

[If you choose to comment on issues in this section, please include the caption ''EDUCATIONAL REQUIREMENTS FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS'' at the beginning of your comments.]

We are proposing 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 ever on or after January 1, 2003, must be a registered professional nurse who is authorized by State law to practice as a NP, must be nationally certified as a NP, and must have a master's degree in nursing. The current NP qualification standards under these Federal regulations include progressive requirements, but 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 for NPs in our July 22, 1999 proposed rule (64 FR 39625) and the subsequent final rule (64 FR 59411). We stated under this final rule that, ''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.''

We are also proposing to amend the requirement in our regulations at § 410.75(b)(4) that NPs must have a master's degree in nursing in order 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 are proposing 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.

We are aware that some educational institutions are offering programs to prospective NPs and CNSs that allow students who complete these nursing education programs to move from a baccalaureate degree in nursing directly to the doctoral degree in nursing where they earn a terminal clinical doctoral degree titled the DNP. 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 note that an April 2, 2008 article in the *Wall Street Journal* 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 Part B to recognize APNs with more extensive education and training. Therefore, we propose to permit qualified APNs with the DNP degree to enroll and receive Medicare Part B payment as NPs and CNSs.

R. Portable X-Ray Issue

[If you choose to comment on issues in this section, please include the caption ''PORTABLE X-RAY ISSUE'' at the beginning of your comments.]

The Conditions for Coverage (CfC) for Portable X-Ray services are authorized by section 1861(s)(3) of the Act and were adopted 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 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, referring organizations that no longer perform the stated function and requiring a specific duration of training that is no longer the community standard, we are proposing 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 propose that the requirement for formal training of not less than 24 months in duration be deleted, since this criterion is not part of the criteria established by entities that evaluate and approve x-ray technology programs since 1993.

We propose 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 propose 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.

S. Expiring Provisions and Related Discussions

[If you choose to comment on issues in this section, please include the caption ''EXPIRING PROVISIONS'' at the beginning of your comments.]

1. Physician Fee Schedule Update

As discussed in the CY 2008 PFS final rule with comment period, the update formula for payment for services under the PFS resulted in a reduction of 10.1 percent in the conversion factor (CF) for CY 2008. Section 101 of the MMSEA provides for a 0.5 percent increase in the CF for the period beginning on January 1, 2008 and ending on June 30, 2008, resulting in a CF of $38.0870. For the remaining portion of 2008 (July 1 through December 31, 2008), under current law the CF will reflect the −10.1 percent update, and the CF will be $34.0682, as published in the CY 2008 PFS final rule with comment period (72 FR 66222). This represents a 10.6 percent reduction from the payments in the first half of 2008. Section 101 of the MMSEA also modifies the Physician Quality Reporting System for CY 2008 and 2009.

2. Medicare Incentive Payment for Physician Scarcity Areas

Section 1833(u) of the Act provides for a 5 percent incentive payment to physicians furnishing services in physician scarcity areas (PSAs) for physicians' services furnished on or after January 1, 2005, and before January 1, 2008. In the CY 2008 PFS final rule with comment period (72 FR 66293), we provided notification that these incentive payments authorized by section 1833(u) of the Act would no longer be made for services furnished on or after January 1, 2008. Section 102 of the MMSEA provides for an extension of these bonus payments through June 30, 2008. During this 6-month extension period, the MMSEA required that we use the primary care scarcity counties and specialty care scarcity counties that we were using for purposed of these incentive payments on December 31, 2007.

Because under current law the provisions of section 1833(u) of the Act do not apply to services furnished after June 30, 2008, we are providing notice that these 5 percent incentive payments will no longer be made for services furnished on or after July 1, 2008.

3. Extension of Floor for Work GPCI

As discussed in the CY 2008 PFS final rule with comment period (72 FR 66243), section 102 of the MIEA–TRHCA requires application of a 1.000 floor on the work GPCI in fee schedule areas where the work GPCI is less than 1.000. This provision concerning the work GPCI was set to expire on December 31, 2007. Section 103 of the MMSEA provides for an extension of this 1.000 floor on the work GPCI through June 30, 2008. Under current law, the 1.000 floor on the work GPCI will no longer be used to calculate payment for services furnished on after July 1, 2008.

4. Extension of Treatment of Certain Physician Pathology Services Under Medicare

The technical component (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 professional component (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.

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 carrier 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 physician pathology service to a hospital patient and submitted claims to the carrier for payment. Through subsequent legislation (that is, section 732 of the MMA and section 104 of the MIEA–TRHCA), this provision had been extended through 2007. 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 reimbursed differently depending on the status of the laboratory.

In the CY 2008 PFS final rule with comment period (72 FR 66355),

consistent with section 104 of the MIEA–TRHCA, we amended § 415.130(d) to reflect that for services furnished after December 31, 2007, an independent laboratory may not bill the carrier for the technical component of physician pathology services furnished to a hospital inpatient or outpatient. Section 104 of the MMSEA allows independent laboratories to continue to bill the carrier for the TC of physician pathology services for hospital inpatients or outpatients through June 30, 2008. We are amending § 415.130(d) to reflect this change.

5. Therapy Cap and Extension of Exceptions Process

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 therapy services furnished as outpatient hospital services.

As discussed in the CY 2008 PFS final rule with comment period (72 FR 66356), an exceptions process for the therapy caps, which was authorized by section 5107 of the DRA, was extended through December 31, 2007 by section 201 of the MIEA–TRHCA. Section 105 of the MMSEA provides for a further extension of this exceptions process through the first 6 months of CY 2008 (that is, on or before June 30, 2008).

In accordance with the statute, we will continue to implement therapy caps, but the exceptions process will no longer be applicable, for services furnished beginning on July 1, 2008. The dollar amount of the therapy caps in CY 2009 will be the CY 2008 rate ($1,810) increased by the percentage increase in the MEI as required by section 1833(g)(2) of the Act.

6. Bonus Payment for Long Ambulance Transports

Section 414 of the MMA added section 1834(l)(11) of the Act which requires that, ''[i]n the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.'' Section 1834(l)(11) of the Act was implemented in § 414.610(c)(7), which states that for services furnished during the period July 1, 2004 through December 31, 2008, each loaded ambulance mile greater than 50 miles (that is, 51 miles and greater) for ambulance transports originating in either urban areas or in rural areas is paid at a rate that is 25 percent higher than otherwise would be applicable under § 414.610.

Because the provisions of section 1834(l)(11) of the Act do not apply to services furnished on or after January 1, 2009, we are providing a reminder that the 25 percent bonus payments provided under section 1834(l)(11) of the Act, and under § 414.610(c)(7), will no longer be paid for services furnished on or after January 1, 2009.

7. Clinical Laboratory Fee Schedule (CLFS) Update Factor

Outpatient clinical laboratory services are paid under the clinical laboratory fee schedule (CLFS) in accordance with section 1833(h) of the Act. Under section 1833 (a)(1)(D) of the Act, payment is the lesser of the following: The amount billed; the local fee for a geographic area; or a national limit. In accordance with the statute, the national limits are set at a percent of the median for all local fee schedule amounts for each laboratory test code. While section 1833(h)(2)(A)(i) of the Act specifies that the fees are to be updated for inflation based on the Consumer Price Index for All Urban Consumers (CPI–U), the Congress modified the update to zero percent for CY 2004 through CY 2008. Beginning January 1, 2009, this freeze expires. As a result, for CY 2009, the CLFS will be updated by the percentage increase in the CPI–U using the 12-month period ending with June of the previous year.

At this time, the CPI–U for the 12-month period ending June 30, 2008 is not available. We do not undertake notice and comment rulemaking to announce the CLFS update factor because the statute specifies the methods of computation of annual inflation updates, and we have no discretion in that matter. Thus, we merely apply the update methods specified in the statute. We will announce the CLFS update factor via CMS instructions by including a section in our annual CLFS Change Request instruction and by including the information on the CMS Clinical Laboratory Fee Schedule Web site in approximately November of each year so that the industry can remain aware of future CLFS update factors.

T. 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)

[If you choose to comment on issues in this section, please include the caption ''OTHER ISSUES—PHYSICIAN CERTIFICATION/RECERTIFICATION'' at the beginning of your comments.]

a. Background

Under the home health benefit, the statute requires that the physician review the plan of care (POC) for the home health eligible beneficiary. Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act require that a plan for furnishing home health services to such individuals has been established and that plan is periodically reviewed by a physician for Medicare payment to be made. Section 409.43(e) more specifically states that a home health POC must be reviewed, signed, and dated by the physician who reviews the POC (as specified in § 409.42(b)) in consultation with agency clinical staff at least every 60 days (or more frequently as specified in § 409.43(e)(i) through (iii)). Additionally, § 424.22(b) states that a recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the home health POC. These schedules, for the review of the POC and the recertification, coordinate well with the 60-day episode payment unit under the home health prospective payment system (HH PPS). In implementing the statutory requirement as well as these regulations, we believed that these requirements would encourage enhanced physician involvement in the home health POC and patient management, and would include more direct ''in-person'' patient encounters (as logistically feasible).

Currently, physicians are paid for both the certification and recertification of the home health POC under HCPCS codes G0180 and G0179, respectively. The basis for the payment amounts of these physicians' services is the relative resources in RVUs required to furnish these services. We believe physician involvement is key to maintaining quality of care under the HH PPS and payment for the required physician certification and recertification of home health POCs reflects this.

In the HH PPS proposed rule published in the October 28, 1999 **Federal Register** (64 FR 58196), we had also proposed to require the physician

to certify the appropriate case-mix weight/home health resource group (HHRG) as part of the required physician certification of the plan of care. This reflected our belief that the physician should be more involved in the decentralized delivery of home health services. However, in the final rule published in the July 3, 2000 **Federal Register** (65 FR 41163), we did not finalize that proposal and decided to focus our attention on physician certification and education in order to better involve the physician in the delivery of home health services.

b. Solicitation of Comments

It has come to our attention that there exists a vast array of differing levels of physician involvement in the certification and recertification of home health POCs. Although some physicians do have direct contact with their patients in the delivery of these services, we believe a significant number of physicians provide only a brief, albeit thorough, review of the home health POC, without any direct contact with the patient. Still, other physicians are involved to an even lesser degree in their review of the home health POC and/or direct contact with the patient in the delivery of these services. We continue to believe that the active involvement of the physician including ''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 are exploring a couple of different options. First, we are considering a review of the RVUs associated with the certification (G0180) and recertification (G0179) of the home health POC. As a result of that review, the payment amounts to physicians could be reduced based on a more accurate determination of the actual RVUs required to provide these services. Because we continue to believe that the active involvement of the physician is important in delivering these home health services, reducing the payment for these services may not encourage physicians to spend additional time reviewing and modifying beneficiaries' home health plans of care to assure that the plan addresses all of the beneficiaries' needs. We are also considering proposing new requirements to ensure more active physician involvement in the certification and recertification of the home health patient's POC, for example, a requirement for ''direct'' patient contact with the physician. We are specifically soliciting comments on these policy options in an effort to gather more information on this issue, and any other possible underlying issues that may exist.

2. Prohibition Concerning Providers of Sleep Tests

[If you choose to comment on issues in this section, please include the caption ''OTHER ISSUES-SLEEP TESTS'' at the beginning of your comments.]

a. Background

Obstructive Sleep Apnea Hypopnea Syndrome, also known as Obstructive Sleep Apnea (OSA), is the most common of the three different forms of sleep apnea (obstructive, central, or mixed). OSA is associated with significant morbidity and mortality, including excessive daytime sleepiness, concentration difficulty, cardiovascular disease, and stroke. Untreated OSA is associated with a ten-fold increase in the risk of motor vehicle accidents.

Diagnostic tests for OSA are based on detection of abnormal sleep patterns using sleep test devices that record a variety of cardiorespiratory and neurophysiologic signals during sleep time called polysomnography (PSG). Historically, such sleep tests have been furnished in a sleep laboratory attended by a sleep technologist. More recently, portable sleep test devices have been developed for the diagnosis of OSA in the home (either attended or unattended). Sleep test devices are classified into four types based primarily on the extent of sleep pattern data recorded. The most comprehensive is designated Type I: attended in-facility PSG. The remaining three types concern portable sleep test devices developed for the diagnosis of OSA and used both in attended and unattended settings, often in the home. Type II devices have a minimum of 7 monitored channels; for example, electroencephalogram (EEG), electro-oculogram (EOG), electromyogram (EMG), electrocardiogram (EKG)-heart rate, airflow, respiratory effort, and oxygen saturation. Type III devices have a minimum of 4 monitored channels including ventilation or airflow, at least two channels of respiratory movement or respiratory movement and airflow, heart rate or EKG, and oxygen saturation. Type IV devices do not meet the technical criteria defining the other types, and many measure only one or two parameters, for example, oxygen saturation or airflow, but some Type IV devices measure three or more parameters. There are other technologies that do not readily fall into the classification above.

Sleep testing, like other diagnostic tests, is subject to the provisions in § 410.32. Thus, it must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Sleep testing must be furnished under the required level of supervision by a physician. If the sleep testing is furnished by an independent diagnostic testing facility (IDTF) the provisions of § 410.33 also apply.

A number of treatment approaches have been recommended for persons diagnosed with OSA, depending on severity of the disorder and other clinical factors. Patients with moderate to severe OSA are usually treated at first with continuous positive air pressure (CPAP) devices. The regular use of a CPAP device in these cases has been shown to improve excessive sleepiness, cognitive performance, and quality of life.

A CPAP device is an item of durable medical equipment (DME) used in the home that typically uses air pressure to maintain an open airway and improve airflow to the lungs.

Medicare currently provides national coverage of CPAP only for beneficiaries whose diagnosis of OSA meets the criteria described in the national coverage determination at 240.4 of the National Coverage Determinations (NCD) Manual. We recently published a revised NCD that expands coverage of CPAP devices to beneficiaries when OSA has been diagnosed by specified home sleep testing. Prior Medicare policy had covered CPAP devices only for beneficiaries whose OSA had been diagnosed by facility-based attended PSG. During the process leading to the revised policy, we received many public comments expressing concern that financial incentives would lead to abusive practices that would harm Medicare beneficiaries and threaten the integrity of the Medicare program. These concerns were expressed not only with respect to home sleep tests, but also those performed in sleep laboratories and other facilities. Therefore, we are proposing to implement a provision that would limit potential abusive practices by removing a significant financial incentive for those practices.

b. Regulatory proposal

Based on public comment and prior agency experience, we believe that the interests of beneficiaries and the Medicare program can be harmed if the provider of a diagnostic test has a vested interest in the outcome of the test itself. In the specific context of this proposed

rule, we believe that the individual or entity that directly or indirectly administers the sleep test and/or provides the sleep test device used to administer the sleep test (referred to hereinafter as the 'provider of the sleep test') has a self-interest in the result of that test if that provider, or its affiliate, is also the supplier of the CPAP device.''

This provides 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.

Current medical evidence persuasively demonstrates that treatment with a CPAP device is safe for patients who have OSA. Similar evidence is lacking for treatment with a CPAP device of persons who do not in fact have obstructive sleep apnea. A test interpreted with bias or reported falsely may mislead the beneficiary's treating physician and divert the beneficiary from medically appropriate treatment. Moreover, supplying a medically unnecessary CPAP device is a waste of Medicare trust funds.

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 due to our concerns with respect to the potential for unnecessary utilization of sleep tests, we are proposing to prohibit payment to the supplier of the CPAP device when such supplier, or its affiliate, is directly or indirectly the provider of the sleep test that is used to diagnose a Medicare beneficiary with OSA.

As alternatives we had considered requiring pre-authorization for sleep tests or modifying payments for the services when they are furnished by the same entity but believe these options would either generate undue burden on both the Medicare beneficiary and the claims processing systems or be administratively burdensome.

Therefore, we are proposing 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 are proposing to add new definitions to paragraph (a) to define ''sleep test'' and ''CPAP device'' 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, is directly or indirectly the provider of the sleep test used to diagnose a beneficiary with OSA.

3. Beneficiary Signature for Nonemergency Ambulance Transport Services

[If you choose to comment on issues in this section, please include the caption ''OTHER ISSUES–BENEFICIARY SIGNATURE'' at the beginning of your comments.]

In the CY 2008 PFS final rule with comment period, we created an additional exception to the beneficiary signature requirements, in § 424.36(b)(6), for emergency ambulance transports (72 FR 66406). The exception allows ambulance providers and suppliers to sign on behalf of the beneficiary, at the time of transport, provided that certain documentation requirements are met. To take advantage of the new exception, 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 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, 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) (72 FR 66324). 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 anticipate that there would be little or no increased risk of fraud or program abuse in extending the exception in § 424.36(b)(6) to include nonemergency transports, we are proposing to do so through a revision of the language in § 424.36(b)(6) to refer specifically to nonemergency transports. We are also proposing 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 are proposing 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.

4. Solicitation of Comments and Data Pertaining to Physician Organ Retrieval Services

[If you choose to comment on issues in this section, please include the caption ''OTHER ISSUES—ORGAN RETRIEVAL'' at the beginning of your comments.]

Since 1987, we have limited the amount an 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 are soliciting public comments and data that are reflective of organ retrieval service costs. We are not limiting our solicitation to costs associated with kidney retrieval services, but are interested in receiving comments and data pertaining to retrieval services for all types of organs. We may use this information to determine the extent to which a recalculation of the payment for cadaveric organ retrieval services performed by a physician is warranted and to inform any future rulemaking on this subject. Any future rulemaking would provide for notice and public comment.

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

[If you choose to comment on issues in this section, please include the caption ''OTHER ISSUES—REVISIONS TO APPEALS FINAL RULE'' at the beginning of your comments.]

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 are proposing 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 are proposing to revise § 424.535(f) 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 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.''

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 are soliciting 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.

We believe that establishing an expedited reconsideration process will afford providers and suppliers with an administrative remedy similar to a corrective action plan, but allow CMS or our contractor to establish an effective date of revocation on the date of notification. In addition, we are soliciting 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.

III. Potentially Misvalued Services Under the Physician Fee Schedule

[If you choose to comment on issues in this section, please include the caption ''POTENTIALLY MISVALUED SERVICES UNDER THE PFS'' at the beginning of your comments.]

A. Valuing Services Under the Physician Fee Schedule

The American Medical Association's Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued under the Five-Year Review of Work. On an ongoing basis, the RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE 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 Five-Year Review of physician work, there continues to be concern that the presence of many overvalued procedures within the physician fee schedule disadvantages primary care services and creates distortion 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 Five-Year Reviews of work RVUs.

The RUC has created the Five-Year Review Identification Workgroup to respond to these concerns regarding the valuation of codes. The workgroup has 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. We plan to 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 in a manner consistent with the way we address other RUC recommendations. Each year in the PFS final rule with comment period, we describe the RUC's recommendations, state whether or not we accept them, and provide a rationale for our decision. The values for these services will be published as interim values for 2009.

We believe that there are certain steps we can take to help address the issue of potentially misvalued services. The following is a summary of these approaches:

1. Updating High Cost Supplies

We are proposing to create a process to update the prices for high cost supply items that are paid under the PE methodology.

The RUC and MedPAC have recommended that we establish an update process, at least every 5 years, to ensure the accuracy and completeness of the direct PE inputs. Both organizations have suggested that an update process for the new, higher-priced supply items should occur more frequently because prices for these items may decrease over time as competition increases. The RUC specifically requested the review of higher-price supply items (over $200) and that the re-pricing be carried out on an annual basis. In the CY 2006 and CY 2007 PFS proposed rule and final rule with comment period, we expressed concern that submitting more recent and reliable documentation for supply prices may be burdensome to the physician specialties involved.

Upon further review of this issue and examination of the PE database, we believe that the burden would be minimal and the result would be to better ensure that we are paying properly for these supplies. Therefore, we are proposing a process to update high cost supplies every 2 years. We would specifically focus on the supplies that cost $150 or more of which there are currently 65 supplies which are listed in Table 24. Every other year we would identify supply items in the PE database costing over $150 and list these supplies in the proposed rule. We would request that the specialty societies or other relevant organizations provide acceptable documentation supporting the pricing for the supply item during the 60-day comment period. Since it may not be necessary to require an annual price update for each supply item over $150, we are proposing to revalue the list of high cost supply items on a biennial basis, but are interested in receiving comments concerning this proposed timeframe.

Pricing for these higher-priced supplies would need to be supported by valid, reliable documentation that reflects the typical price in the marketplace. For the past several years in the proposed rule and final rule with comment period, we have outlined examples of acceptable documentation which include a detailed description (including system components), sources, and current pricing information, such as copies of catalog pages, hard copies from specific web pages, invoices, and quotes from manufacturer, vendors or distributors. Documentation that does not include specific pricing information such as phone numbers and addresses of manufacturer, vendors or distributors; Web site links without pricing information would not be acceptable.

If such acceptable documentation was not received within the 60-day comment period for the proposed rule, we would apply prices that we were able to obtain through the use of searches for retail pricing on the internet, supply catalogs or other sources available to determine the appropriate cost. We would use the lowest price identified by these sources.

In future years, we may consider initiating additional reviews of supplies that cost less than this amount.

We would also be interested in receiving comments on alternatives that could be used to update pricing information in the absence of information provided by the specialty societies and organizations.

TABLE 24.—TOP 65 HIGH COST SUPPLIES OVER $150—SUPPLIES NEEDING SPECIALTY INPUT FOR PRICE UPDATE

CMS supply code	Supply description	Unit	Unit price	Quantity per procedure	Cost per procedure	CPT [1] code	Medical specialties
SA087	tray, RTS applicator (MammoSite).	item	$2,550	1	$2,550	19296	General Surgery.
SL209	array kit, GenoSensor	item	2,121	0.16	339.36	88386	Independent Labs.
SD109	probe, radiofrequency, 3 array (StarBurstSDE).	item	1,995	1	1,995	50592, 32998, 20982	Diagnostic Radiology, Urology, Interventional Radiology.
	catheter, CVA, system, tunneled w-port, dual (LifeSite).	item	1,750	2	3,500	36566	General Surgery, Thoracic Surgery.
	stent, vascular, deployment system, Cordis SMART.	kit	1,645	1.5	2467.50	37205, 32506	Cardiology, Diagnostic Radiology, Vascular Surgery.
	probe, cryoablation (Visica ICE 30 or 40).	item	1,589	1	1,589	19105	General Surgery.
SA092	kit, gene, MLL fusion	kit	1,395	0.25	348.75	88385	Independent Labs.
	catheter, intradiscal (spineCATH).	item	1,380	1	1,380	22526, 22527	Orthopedic Surgery, Neurosurgery, Diagnostic Radiology, Interventional Radiology.
SD186	plasma LDL adsorption column (Liposorber).	item	1,300	1	1,300	36516	Internal Medicine, Cardiology.
SD215	probe, endometrial cryoablation (Her Option).	item	1,250	1	1,250	58356	OBGYN.
SA075	kit, hysteroscopic tubal implant for sterilization.	kit	1,245	1	1,245	58565	OBGYN.
	probe, cryoablation, renal.	item	1,175	2.5	2937.50	50593	Urology, Diagnostic Radiology.
SD185	plasma antibody adsorption column (Prosorba).	item	1,150	1	1,150	36515	Rheumatology, Internal Medicine, Nephrology.
SA036	kit, transurethral microwave thermotherapy.	kit	1,149	1	1,149	53850	Urology.
SD177	hysteroscope, ablation device.	item	1,146	1	1,146	58563	OBGYN.
SA037	kit, transurethral needle ablation (TUNA).	kit	1,050	1	1,050	53852	Urology.
SA024	kit, photopheresis procedure.	kit	858	1	858	36522	Dermatology and Pathology.
SF030	laser tip, diffuser fiber	item	850	1	850	52647, 52648	Urology.
SA091	tray, scoop, fast track system.	tray	750	1	750	31730	General Surgery, Pulmonology.
SD018	catheter, balloon, thermal ablation (Thermachoice).	tray	727	1	727	58353	OBGYN.
SD155	catheter, RF endovenous occlusion.	item	725	1	725	36475	General Surgery, Vascular Surgery.
SD191	plate, surgical, reconstruction, left, 5 x 16 hole.	item	719	1	719	21125, 21127, 21215	Maxillofacial Surgery, Otolaryngology, Oncology Surgery.
SA039	kit, vertebroplasty (LP2, CDO).	kit	696	1.5	1,044	22520, 22521	Diagnostic Radiology, Interventional Radiology, Orthopedics.
SA038	kit, transurethral water-induced thermotherapy.	kit	650	1	650	53853	Urology.
SA025	kit, PICC with subcut port.	kit	586	1	586	36570, 36571, 36585	General Surgery, Diagnostic Radiology.
SD073	fiducial screws (set of 4 uou).	item	558	1	558	77011, 77301	Diagnostic Radiology, Otolaryngology, IDTF.
SA074	kit, endovascular laser treatment.	kit	519	1	519	36478	General Surgery, Vascular Surgery, Diagnostic Radiology.
SA011	kit, CVA catheter, tunneled, with subcut port.	kit	495	1	495	36560, 36561, 36563, 36582, 36583	General Surgery, Vascular Surgery, Diagnostic Radiology, Pediatric Medicine.

TABLE 24.—TOP 65 HIGH COST SUPPLIES OVER $150—SUPPLIES NEEDING SPECIALTY INPUT FOR PRICE UPDATE—Continued

CMS supply code	Supply description	Unit	Unit price	Quantity per procedure	Cost per procedure	CPT [1] code	Medical specialties
SA015	kit, for percutaneous thrombolytic device (Trerotola).	kit	487.50	1	487.50	36870, 37184, 37186, 37187, 37188	Diagnostic Radiology, Vascular Surgery, Cardiology, Interventional Radiology.
SD058	electrode, grid	item	475	1	475	95829	General Practice.
SA093	kit, priming, random	kit	463	0.16	74.08	88385, 88386	Independent Labs, Pediatric Medicine.
SA005	kit, capsule endoscopy w-application supplies (M2A).	kit	450	1	450	91110	Gastroenterology.
	kit, capsule, ESO, endoscopy w-application supplies (ESO).	kit	450	1	450	91111	Gastroenterology.
SD151	catheter, balloon, low profile PTA.	item	431.50	2	863	35470, 35471, 35474	Cardiology, Vascular Surgery.
SD193	plate, surgical, rigid comminuted fracture.	item	389	1	389	21461, 21462	Oral Surgery, Maxillofacial Surgery.
SD020	catheter, CVA, tunneled, dual (Tesio).	item	355	1	355	36565	General Surgery, Vascular Surgery.
SD154	catheter, microcatheter (selective 3rd order).	item	337.88	1	337.88	36217, 36247, 37210	Diagnostic Radiology, Vascular Surgery, Cardiology.
SA077	kit, pleural catheter insertion.	kit	329	1	329	32550	Thoracic Surgery, Diagnostic Radiology.
SH079	collagen, dermal implant (2.5ml uou) (Contigen).	item	317	1	317	52330	Urology.
SA010	kit, CVA catheter, tunneled, without port-pump.	kit	308	1	308	36557, 36558, 36581	General Surgery, Interventional Radiology, Diagnostic Radiology, Pediatric Medicine, Nephrology.
	catheter, balloon, lacrimal.	item	306	1	306	68816	?
SA022	kit, percutaneous neuro test stimulation.	kit	305	1	305	63610, 64561	Urology, OBGYN, Anesthesiology.
SF028	laser tip (single use)	item	290	1	290	30117, 52214, 52224, 52317	Urology, Otolaryngology.
SA020	kit, loop snare (Microvena).	kit	275	1	275	36595, 37203	Diagnostic Radiology.
	agent, embolic, 2 ml uou	unit	258	5	1,290	37210	Diagnostic Radiology, Interventional Radiology.
SD152	catheter, balloon, PTA	item	243.50	2	487	35472, 35473, 35475, 35476, G0392, G0393	Cardiology, Vascular Surgery, Diagnostic Radiology, Nephrology.
	stent, ureteral, w-guidewire, 3cm flexible tip.	item	235	1	235	52332	Urology.
SD189	plate, surgical, mini-compression, 4 hole.	item	226	1	226	21208	Plastic Surgery, Oral Surgery.
SD207	suture device for vessel closure (Perclose A–T).	item	225	1	225	37184, 37205	Diagnostic Radiology, Vascular Surgery, Cardiology.
SD204	sensor, pH capsule (Bravo).	item	225	1	225	91035	Gastroenterology.

TABLE 24.—TOP 65 HIGH COST SUPPLIES OVER $150—SUPPLIES NEEDING SPECIALTY INPUT FOR PRICE UPDATE—Continued

CMS supply code	Supply description	Unit	Unit price	Quantity per procedure	Cost per procedure	CPT [1] code	Medical specialties
SD207	suture device for vessel closure (Perclose A–T).	item	225	1	225	35470, 35471, 35472, 35473, 35474, 35475, 37187, 37188, G0392	Cardiology, Vascular Surgery, Diagnostic Radiology, Nephrology, Interventional Radiology.
SD072	eyelid weight implant, gold.	item	217.50	1	217.50	67912	Ophthalmology, Otolaryngology.
SD216	catheter, balloon, esophageal or rectal (graded distention test).	item	217	1	217	91040, 91120	Colorectal Surgery, Gastroenterology, Physician Assistants.
SD094	Mammotome probe	item	200	1	200	19103	Diagnostic Radiology, General Surgery.
	tube, jejunostomy	item	195	1	195	49441, 49446, 49451, 49452	Gastroenterology.
SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0.	item	189.87	0.03	5.58	88385, 88386	Independent Labs.
SD023	catheter, enteroclysis	item	183.01	1	183.01	74251, 74260, 89100, 89105, 89130, 89132, 89135, 89136, 89140, 89141	Cardiovascular and Interventional Radiology, Diagnostic Radiology, Neurology, Pulmonary, Pathology.
SD175	guidewire, steerable (Transcend).	item	180	1	180	36217, 36247, 37205, 37206, 37210, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460	Diagnostic Radiology, Interventional Radiology, Cardiology, Vascular Surgery, General Surgery.
SC085	tubing set, plasma exchange.	item	173.33	1	173.33	36514	Hemotology, Nephrology.
SD019	catheter, balloon, ureteral-GI (strictures).	item	166	3	498	43456, 45303, 45340, 45386, 46604	Colorectal Surgery, Gastroenterology, General Surgery.
SD218	stent, ureteral, without guidewire.	item	162	1	162	50382, 50385	Diagnostic Radiology, Interventional Radiology.
SD205	sheath, endoscope ultrasound balloon.	item	154	1	154	31620	Pulmonary Medicine.
SL055	DNA stain kit (per test)	item	150	1	150	88358	Independent Labs.
SF029	laser tip, bare (single use).	item	150	1	150	46917, 46924	Colorectal Surgery, General Surgery.

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2. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Non-Surgical Procedures

We have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day. The policy is largely based on the efficiencies recognized in practice expenses for pre- and post-surgical services. Originally, payment was made in full for the highest priced procedure; at 50 percent for the second highest price procedure; and at 25 percent for the third through fifth procedures. In 1995, the policy was revised to pay the highest priced procedure in full and at 50 percent for the second through fifth procedures (59 FR 32767 through 32768 and 59 FR 63423 through 63426).

In 1995, the MPPR policy was also extended to six nuclear medicine diagnostic procedures performed on the same patient on the same day. Payment is made in full for the highest priced procedure, and at 50 percent for the second procedure. Prior to that time, no payment was generally made for the second procedure. We also indicated that we would consider applying the multiple procedure policy to other diagnostic tests in the future (59 FR 32769 and 59 FR 63427 through 63428).

In 2006, the policy was extended to certain diagnostic imaging procedures performed on contiguous areas of the body. In such cases, most clinical labor activities and most supplies are not performed or furnished twice. The payment reduction applies to 100 procedure codes within 11 families of codes. When two or more procedures within a family are performed on the same patient in a single session, the TC of the highest priced procedure is paid at 100 percent; the TC of each subsequent procedure is paid at 75 percent. The reduction does not apply to the PC (70 FR 45849 through 45851 and 70 FR 70261 through 70265).

Some observers have raised concerns that there may be inequities between specialties in the current coding and payment system regarding the extent to which there are opportunities for additional coding and payment for services performed on the same day. Physicians in some specialties, such as primary care physicians, typically bill for their services using evaluation and management (E/M) codes that represent a fairly broad package of services (that include a significant amount of pre- and post-service care, including coordination of care). Likewise, a significant portion of services performed by specialties such as general or cardiac surgeons are reported and paid through comprehensive global surgery policies which also include pre- and post-service work, reducing the possibilities for additional billings. In contrast, many other services under the PFS are paid for using codes that represent much smaller units of service, and in many cases the codes and payment amounts might represent fairly small portions of the total service provided on the same day.

We plan to perform a data analysis of non-surgical CPT codes that are often billed together (for example, 60 to 70 percent of the time) to determine if there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services or in the payment policies applied to each (for example, global surgery, MPPRs). As noted above, clinical labor activities, supplies and equipment may not be performed or furnished twice when multiple procedures are performed.

We invite comments and suggestions from the RUC and others on this important issue. As a result of reviewing the data and any suggestions we receive regarding these concerns, we may consider developing proposals to either bundle additional services or expand the application of the MPPR to additional procedures. Any proposed changes will be made through rulemaking and be subject to public comment at a later date.

B. Requested Approaches for the RUC to Utilize

We have also identified methods that we are requesting the RUC undertake to assist in identifying potentially misvalued services including: (1) Review the Fastest Growing Procedure Codes; (2) Review Harvard-Valued Codes; and (3) Review PE RVUs.

1. Review the Fastest Growing Procedure Codes

We have identified the fastest growing services as measured by growth in utilization from CY 2004 through CY 2007. The codes we identified were the following:

- Those that represent services that had three consecutive years of 10 percent (or more) annual growth in allowed services;
- Excluded if there was less than $1 million in 2007 allowed charges; and
- Included if still active in 2008.

This analysis has resulted in the identification of over 100 procedure codes, which are shown in Table 25. Some of the identified services are new, while others have been in the clinical arena for a number of years. These codes may warrant a reassessment to determine why there has been an increase in utilization. There may be a clinical rationale or there may have been changes in the relative resources involved with furnishing the service.

We have requested that the RUC immediately begin a review of the fastest growing services by examining the codes listed in Table 25, Fastest Growing Procedure Codes. We will work with the RUC on prioritizing the review of these codes.

TABLE 25.—FASTEST GROWING PROCEDURE CODES

CPT [1]/HCPCS code	Description	Allowed charges 2007 (millions)	Growth in allowed services 2004–2007 (percent)	Annual growth in allowed services 2005 (percent)	Annual growth in allowed services 2006 (percent)	Annual growth in allowed services 2007 (percent)	Screening criteria used by the AMA/RUC for codes reviewed between September 2007–April 2008
10022	Fna w/image	$12	88	31	21	19	
13121	Repair of wound or lesion.	23	45	15	14	11	
14021	Skin tissue rearrangement.	12	49	15	13	15	Site of Service Anomaly.
14300	Skin tissue rearrangement.	13	49	14	12	16	Site of Service Anomaly.
15740	Island pedicle flap graft	6	63	26	11	17	Site of Service Anomaly.

TABLE 25.—FASTEST GROWING PROCEDURE CODES—Continued

CPT [1]/HCPCS code	Description	Allowed charges 2007 (millions)	Growth in allowed services 2004–2007 (percent)	Annual growth in allowed services 2005 (percent)	Annual growth in allowed services 2006 (percent)	Annual growth in allowed services 2007 (percent)	Screening criteria used by the AMA/RUC for codes reviewed between September 2007–April 2008
19295	Place breast clip, percut.	9	43	10	13	14	
20551	Inj tendon origin/insertion.	7	101	17	21	41	
20926	Removal of tissue for graft.	4	63	10	16	27	
22214	Revision of lumbar spine.	2	110	34	19	32	
22533	Lat lumbar spine fusion	1	584	163	81	44	
22843	Insert spine fixation device.	3	55	20	15	13	
22849	Reinsert spinal fixation	2	116	47	18	24	
22851	Apply spine prosth device.	24	65	29	12	13	
23430	Repair biceps tendon ..	3	90	29	21	21	
23472	Reconstruct shoulder joint.	23	74	32	13	16	
26480	Transplant hand tendon	3	57	26	11	12	
27245	Treat hip fracture	88	68	27	18	12	High IWPUT.
27370	Injection for knee x-ray	2	173	48	59	16	High Volume Growth.
29822	Shoulder arthroscopy/surgery.	3	77	24	20	19	
29827	Arthroscop rotator cuff repr.	43	90	33	21	18	
31579	Diagnostic laryngoscopy.	8	51	15	14	15	
32663	Thoracoscopy, surgical	4	102	35	18	27	
33213	Insertion of pulse generator.	16	63	24	14	15	
35470	Repair arterial blockage	9	132	38	35	25	
35474	Repair arterial blockage	19	49	17	16	11	
36248	Place catheter in artery	1	70	22	20	15	
36516	Apheresis, selective	2	274	75	35	58	
37765	Phleb veins extrem 10–20.	3	158	76	25	17	High Volume Growth
37766	Phleb veins extrem 20+	3	200	94	23	26	High Volume Growth.
38571	Laparoscopy, lymphadenectomy.	2	295	49	69	57	
43236	Uppr gi scope w/submuc inj.	2	61	26	15	11	
43242	Uppr gi endoscopy w/us fn bx.	7	74	26	19	16	
43259	Endoscopic ultrasound exam.	7	42	14	12	11	
44205	Lap colectomy part w/ileum.	11	106	53	17	16	
44207	L colectomy/coloproctostomy.	9	142	67	24	17	
44970	Laparoscopy, appendectomy.	7	51	21	13	10	
45381	Colonoscopy, submucous inj.	6	105	36	23	22	
47490	Incision of gallbladder ..	3	42	10	14	13	
50542	Laparo ablate renal mass.	1	128	54	34	11	
50548	Laparo remove w/ureter.	2	56	18	13	17	
50605	Insert ureteral support	1	66	17	15	23	
51772	Urethra pressure profile	11	76	31	18	14	Codes Reported Together.
55866	Laparo radical prostatectomy.	18	329	87	55	48	New Technology.
61793	Focus radiation beam ..	13	53	15	16	15	
61795	Brain surgery using computer.	4	46	13	17	11	
63056	Decompress spinal cord.	6	58	21	11	18	

TABLE 25.—FASTEST GROWING PROCEDURE CODES—Continued

CPT [1]/HCPCS code	Description	Allowed charges 2007 (millions)	Growth in allowed services 2004–2007 (percent)	Annual growth in allowed services 2005 (percent)	Annual growth in allowed services 2006 (percent)	Annual growth in allowed services 2007 (percent)	Screening criteria used by the AMA/RUC for codes reviewed between September 2007–April 2008
63650	Implant neuroelectrodes.	9	159	47	29	37	Site of Service Anomaly.
63655	Implant neuroelectrodes.	2	106	29	23	30	
63660	Revise/remove neuroelectrode.	2	81	29	19	17	Site of Service Anomaly.
63685	Insrt/redo spine n generator.	3	125	53	24	19	Site of Service Anomaly.
64415	N block inj, brachial plexus.	6	56	22	12	15	
64445	N block inj, sciatic, sng	6	75	22	22	18	
64447	N block inj fem, single	5	116	57	16	19	
64448	N block inj fem, cont inf	6	232	86	35	33	Site of Service Anomaly/High Volume Growth.
64483	Inj foramen epidural l/s	157	62	24	15	14	
64484	Inj foramen epidural add-on.	46	75	34	15	13	
64555	Implant neuroelectrodes.	6	1498	63	135	316	High Volume Growth.
64561	Implant neuroelectrodes.	3	169	15	25	86	
64622	Destr paravertebrl nerve l/s.	32	89	32	24	15	High Volume Growth.
64626	Destr paravertebrl nerve c/t.	8	109	34	22	29	High Volume Growth.
64627	Destr paravertebral n add-on.	7	109	35	24	25	High Volume Growth.
65780	Ocular reconst, transplant.	3	200	46	60	28	
66982	Cataract surgery, complex.	148	103	34	27	19	High IWPUT.
67028	Injection eye drug	151	883	202	112	54	High Volume Growth.
69100	Biopsy of external ear	7	52	18	14	13	
69801	Incise inner ear	3	54	13	16	17	
70496	Ct angiography, head	11	184	61	42	24	High Volume Growth.
70498	Ct angiography, neck	18	216	70	50	23	High Volume Growth.
71250	Ct thorax w/o dye	140	42	15	11	11	
71275	Ct angiography, chest	56	115	51	23	16	
72125	Ct neck spine w/o dye	29	102	30	26	23	
72128	Ct chest spine w/o dye	6	71	23	20	16	
72191	Ct angiograph pelv w/o & w/dye.	15	146	55	36	17	High Volume Growth.
72192	Ct pelvis w/o dye	135	40	13	12	11	
72194	Ct pelvis w/o & w/dye	72	78	29	22	13	Codes Reported Together.
73200	Ct upper extremity w/o dye.	6	60	22	13	17	
73218	Mri upper extremity w/o dye.	8	58	23	12	15	
73580	Contrast x-ray of knee joint.	2	183	58	56	15	High Volume Growth.
73700	Ct lower extremity w/o dye.	13	57	22	15	12	
74175	Ct angio abdom w/o & w/dye.	27	123	50	31	13	
75635	Ct angio abdominal arteries.	16	251	71	66	23	High Volume Growth.
76513	Echo exam of eye, water bath.	1	420	17	187	55	High Volume Growth.
76536	Us exam of head and neck.	28	51	20	13	11	
76880	Us exam, extremity	14	58	23	13	13	
77301	Radiotherapy dose plan, imrt.	81	94	35	22	17	
77418	Radiation tx delivery, imrt.	681	111	37	25	24	

TABLE 25.—FASTEST GROWING PROCEDURE CODES—Continued

CPT [1]/HCPCS code	Description	Allowed charges 2007 (millions)	Growth in allowed services 2004–2007 (percent)	Annual growth in allowed services 2005 (percent)	Annual growth in allowed services 2006 (percent)	Annual growth in allowed services 2007 (percent)	Screening criteria used by the AMA/RUC for codes reviewed between September 2007–April 2008
77781	High intensity brachytherapy.	8	144	35	42	27	
77782	High intensity brachytherapy.	3	189	51	36	41	High Volume Growth.
90471	Immunization admin	20	213	77	41	25	CMS Request—Practice Expense Review.
92135	Ophth dx imaging post seg.	246	104	32	23	25	
92136	Ophthalmic biometry	57	78	34	17	14	
92285	Eye photography	10	53	21	11	14	
92587	Evoked auditory test	2	64	22	14	18	
92986	Revision of aortic valve	1	90	26	17	29	
93308	Echo exam of heart	6	45	17	11	11	
93613	Electrophys map 3d, add-on.	6	117	33	33	23	
93652	Ablate heart dysrhythm focus.	2	70	17	18	23	
93743	Analyze ht pace device dual.	38	139	52	29	22	
93922	Extremity study	43	53	21	13	12	
93976	Vascular study	9	38	10	11	12	
93990	Doppler flow testing	3	111	35	26	24	
94681	Exhaled air analysis, o2/co2.	8	141	52	27	24	High Volume Growth.
94762	Measure blood oxygen level.	6	125	46	30	19	
95922	Autonomic nerv function test.	3	247	74	48	35	High Volume Growth.
95956	Eeg monitoring, cable/radio.	4	102	50	12	21	
96567	Photodynamic tx, skin	2	479	115	72	57	High Volume Growth.
96920	Laser tx, skin < 250 sq cm.	3	137	16	50	36	
96921	Laser tx, skin 250–500 sq cm.	1	213	44	67	30	High Volume Growth.
G0179	MD recertification HHA PT.	52	59	19	19	12	
G0181	Home health care supervision.	31	49	15	17	11	
G0237	Therapeutic procd strg endur.	2	264	69	64	32	High Volume Growth.
G0238	Oth resp proc, indiv	3	944	407	77	17	High Volume Growth.
G0249	Provide test material, equipm.	4	325	117	75	12	High Volume Growth.
G0268	Removal of impacted wax md.	4	57	27	11	11	

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2. Review Harvard-Valued Codes

Currently, there are approximately 2900 codes that were originally valued using Harvard data and which have not subsequently been evaluated by the RUC. These codes represent about $5.0 billion in annual spending under the PFS and are still being paid on RVUs that were determined almost 20 years ago. Reviewing these codes will ensure that they are valued based upon the most up to date clinical practice and that they are not creating inappropriate incentives.

We have requested the RUC to undertake an ongoing (multi-year) effort to review the Harvard-valued codes that have not subsequently been evaluated by the RUC. As part of our request, we requested that the initial focus be given to high-volume, low intensity codes. We look forward to receiving the recommendations from the RUC.

3. Review PE RVUs

Practice expenses represent about 44 percent of total relative values for physicians' services. Indirect PEs are allocated in some measure based on direct PE inputs. Thus, ensuring the accuracy of direct PE inputs and that they are in agreement with the clinical aspects specific to each procedure may aid in the identification of misvalued services. We have requested that the RUC continue the review of direct PE inputs. We request that the initial focus be given to the high-volume codes where the PE payments are significantly increasing during the transition to the new PE methodology.

We recognize that the work outlined here will require significant effort by the RUC and specialty societies but believe

that this work is necessary to improve the PFS. We expect that all reviews and changes to RVUs would be conducted in tandem with our established regulatory process such as the annual review of new/revised codes and the Five-Year Review.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information (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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Independent Diagnostic Testing Facility (§ 410.33)

Section 410.33(j) states that a physician or NPP organization furnishing diagnostic testing services, except diagnostic mammography services, must enroll as an IDTF for each practice location furnishing these services. The burden associated with this requirement is the time and effort for a physician group practice or clinic to enroll each of the practice locations in the Medicare program. To enroll in the program, the physician or NPP organization must complete a Medicare enrollment application, the CMS–855B. 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.

B. ICRs Regarding Exception to the Referral Prohibition Related to Compensation Arrangements (§ 411.357)

As discussed in section II.N. of the preamble of this proposed rule, proposed § 411.357(x) would set forth an exception for incentive payment and shared savings programs. The programs would involve 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 reduction of waste or changes in physician clinical or administrative practices, without an adverse affect or diminution in quality of hospital patient care services. The hospital-administered program would be required to have performance measures that would be individually tracked and monitored throughout the term of the arrangement. In addition, the program would be required to have at least five physicians participating in each performance measure and the program would be required to undergo periodic independent medical review (once prior to the commencement of the program and annually thereafter) for its impact (or potential impact) on the quality of patient care services provided at the hospital. We anticipate that many hospitals seeking to create new incentive payment or shared savings programs would structure those arrangements to comply with the requirements set forth in § 411.357(x).

We have no way of knowing for certain the number of hospitals that currently utilize incentive payment or shared savings programs nor the nature and/or type of existing programs. However, we are aware that the Office of the Inspector General has issued 10 advisory opinions to date approving proposed incentive payment or shared savings programs from entities. While the OIG opinions were limited to specific arrangements, they did not afford providers any protection from the physician self-referral regulations. Based on information furnished by one private industry consulting firm, we are aware of approximately 50 incentive payment, shared savings or related programs currently in operation. We have also received anecdotal information from industry stakeholders that the number of programs in operation may be as high as 100. Therefore, we estimate that there are approximately 75 incentive payment, shared savings or similar programs currently in operation.

We believe that this proposed exception, if finalized, would result in an increase in the number of hospitals that would create these types of programs. We clarify that this collection of information burden would pertain to hospitals seeking to develop or modify incentive payment or shared savings programs. For purposes of this requirement, we are estimating that 150 hospitals would avail themselves of this proposed exception.

Proposed § 411.357(x)(1) and (2) specifies the elements that would be required in an incentive payment or shared savings program, including the determination of performance measures, and target measures to be achieved under the program. In addition, proposed § 411.357(x)(11) would require that payments made to a physician must not be based on patient care quality improvements or cost savings that were achieved during a prior period of the arrangement. To the extent that a hospital elected to distribute payments to physicians more frequently than the term of the agreement (for example, a 3-year arrangement that provides payment on an annual basis), these payments would be required to take into account previous payments made for performance measures already achieved. We believe that the burden associated with the provisions listed in § 411.357(x)(1) through (2) and § 411.357(x)(11) would involve the time and effort each hospital would put forth into creating its program, and would vary greatly, depending upon the performance measures (clinical or administrative practices), size of the program, the number of physicians or other medical staff participating in the creation of the program, and the methods used for physician payment. We estimate 100 burden hours for the development of each incentive payment or shared savings program including, but not limited to, the professional services of the following individuals; attorneys, medical directors, accountants, and database administrators. The total burden associated with this requirement would be 150 hospitals × 100 hours = 15,000 burden hours.

Proposed § 411.357(x)(5) would require independent medical review of a hospital's incentive payment or shared savings program's impact on the quality of patient care services provided at the hospital. In addition, corrective action would be required in instances where the independent medical review indicates a diminution in the quality of patient care services. The review would be required to take place prior to commencement of the program and at least annually thereafter. The burden associated with the requirements in proposed § 411.357(x)(5) would be the time and effort necessary for a hospital to obtain, both prior to and during the term of the program, a written independent medical review of the program and follow up on any recommended corrective action. We believe it would take 20 hours for each

hospital to initially obtain independent expert medical review. Thereafter, the independent medical review that would be required to be conducted periodically is estimated to impose a burden on the hospital of 10 hours. The total burden associated with this requirement would be 150 hospitals × 20 hours for the first year of a program and 150 hospitals × 10 hours annually thereafter = 4500 hours, assuming hospitals, on average, implement a 2-year incentive payment or shared savings program.

Proposed § 411.357(x)(7) would require hospitals to provide written disclosure to patients affected by the program regarding the program and the physician's participation in the program. The burden associated with this requirement would be time and effort necessary for the hospital to provide disclosure in writing to patients that would be affected by the program. We believe that it would take each hospital 1 hour to draft a standard disclosure. In addition, we believe it would take each hospital 1 minute to provide the written disclosure to potentially all patients. Based on anecdotal accounts of the number of patients involved historical gainsharing programs, we estimate that each hospital would need to provide standard disclosure to approximately 5,000 patients. However, we recognize that hospital size and patient volume will vary significantly from program to program. The total burden associated with this requirement would be 150 hospitals × 1 hour = 150 hours to draft a standard disclosure. We estimate the burden of providing the disclosure to patients to be (150 hospitals × (1 minute/60 minutes/hour) × 5,000 patients) = 12,500 hours. The total burden associated with the requirements contained in § 411.357(x)(7) is 12,650 hours.

Section 411.357(x)(8) would require that the incentive payment or shared savings program arrangements be set out in writing, signed by the parties, and specify the basis for the remuneration. Each specific performance measure and the resulting payment (or formula for payment) must also be clearly and separately identified. In addition, § 411.357(x)(15) would require that the hospital maintain accurate and contemporaneous documentation of the incentive payment or shared savings program and make documentation available to the Secretary upon request.

The burden associated with the requirements listed in § 411.357(x)(8) through (10) and § 411.357(x)(15) would be the time and effort necessary to draft an arrangement with the aforementioned information. While these requirements are subject to the PRA, we believe the burden associated with drafting and maintaining written arrangements detailing conditions of remuneration would be part of usual and customary business practices and thereby exempt from the PRA under 5 CFR 1320.3(b)(2).

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.

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. 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 10 years from the date of service. Physicians and NPPs are required to maintain written ordering and referring documentation for 10 years from the date of service. The burden associated with these recordkeeping requirements is the time and effort associated with maintaining the aforementioned documentation for 10 years. 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 26.—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 410.33	0938–0685	400,000	400,000	2.5	1,001,503
§ 411.357(x)(1–2) and (x)(11)	0938–New	150	150	100	15,000
§ 411.357(x)(5)	0938–New	150	150	20	4,500
	.....	150	150	10	1,500
§ 411.357(x)(7)	0938–New	150	150	1	150
	.....	150	750,000	.01666	12,500
Total	.....	400,150	1,150,150	133.51666	1,035,153

This proposed rule imposes COI requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text. The following is a discussion of these collections, which have already received OMB approval.

Part B Drug Payment

Section II.F.1 of the preamble of this proposed rule 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 proposed rule 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 July 31, 2008, respectively.

Physician Quality Reporting Initiative

Section II.O. of the preamble discusses the background of the reporting initiative 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.

As stated in section II.O.1, 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. This is a voluntary reporting initiative. Eligible professionals may choose whether to participate and satisfactorily submit data on quality measures for covered professional services.

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.

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. 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.

We estimate that the additional time required to put quality data codes on each claim is not a material increment to the time required to code the claim for payment. The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported.

For registry-based reporting, there would be no additional burden for eligible professionals to report data to a registry as eligible professionals are not required to report data to registries to participate in the PQRI and 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.

Similarly, registries are not required to participate in this voluntary initiative. 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.

For EHR-based submission, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical warehouse. Because this manner of reporting quality data to CMS is new to PQRI for 2009 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI through the EHR mechanism in CY 2009. Similar to the burden associated with claims-based reporting of quality data, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Once the EHR is programmed by the vendor to allow data

submission to CMS, the burden to the eligible professional should be minimal.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Mail copies to the address specified in the **ADDRESSES** section of this proposed rule and to the 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–P], Fax (202) 395–6974.

V. 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.

VI. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''IMPACT'' at the beginning of your comments.]

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 by Executive Order 13258 and 13422), 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 one year). As indicated in more detail below in this regulatory impact analysis, we estimate that the PFS provisions included in this proposed rule will redistribute more than $100 million in 1 year. 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 $6.5 million to $31.5 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 $6.5 million or less. 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.

The CAP provides alternatives to physicians who do not wish to purchase drugs directly or collect coinsurance. The impact of the CAP provisions on an individual physician is dependent on whether the drugs they provide to Medicare beneficiaries are included in the list of CAP drugs and whether the physician chooses to obtain drugs administered to Medicare beneficiaries through the CAP. The proposed CAP provisions in this proposed rule will also have a potential impact on entities that are involved in the dispensing or distribution of drugs, plan to become approved CAP vendors, or are approved CAP vendors.

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* .

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $6.5 million to $31.5 million or less in any year. We consider a substantial number of entities to be affected if the proposed rule is estimated to impact more than 5 percent of the total number of small entities. 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 proposed changes to payment for renal dialysis services included in this proposed rule would have a 0.2 percent increase in overall payments relative to current overall payments. The majority of small entities would 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, as well as elsewhere in this proposed rule, 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 proposed rule constitutes our initial regulatory flexibility analysis for the remaining provisions. Therefore, we are soliciting comments on our estimates and analysis of the impact of this proposed rule on those small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. 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 proposed rule would 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 proposed rule 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 proposed 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. It provides:

> (5) 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 proposed 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 proposed rule 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 proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we propose to use to minimize the burden on small entities. As indicated elsewhere in this proposed rule, we propose a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this proposed rule. The relevant sections of this proposed 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 budget neutrality (BN). In the CY 2007 PFS final rule with comment period, the $4 billion impact of changes in work RVUs resulting from the 5-Year Review required that a BN adjustment be made.

As stated in the CY 2007 PFS final rule with comment period, the work adjustor for 2008, was approximately 0.8806. Since there are no additional work RVU changes associated with the 5-Year Review of work RVUs, the work adjustor will remain at 0.8806. Table 27 shows the specialty-level impact of the work and PE RVU changes. This rule proposes the PE RVUs for CY 2009 which is the third year of a four-year transition to fully implemented resource based PE RVUs. There are no changes in work RVUs proposed in this rule. The process for changes in work RVUs is to publish these changes as interim final in the final rule with comment published later in the year.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2008 with proposed payment rates for CY 2009 using CY 2007 Medicare utilization for all years. We are using CY 2007 Medicare claims processed and paid through March 30, 2008, that we estimate are 98 percent complete. 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 27. 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 27 shows only the payment impact on PFS services. The following is an explanation of the information presented in Table 27.

- 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 provided by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- 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.

TABLE 27.—TOTAL ALLOWED CHARGE IMPACT FOR PRACTICE EXPENSE RVU CHANGES

Specialty	Allowed charges (mil)	Impact of PE RVU changes	
		2009 (PE trans. year 3) (percent)	2010 (PE full implement.) (percent)
1 TOTAL	$68,076	0	0
2 ALLERGY/IMMUNOLOGY	157	1	2
3 ANESTHESIOLOGY	1,579	−1	−2
4 CARDIAC SURGERY	327	−1	−1
5 CARDIOLOGY	6,535	−1	−2
6 COLON AND RECTAL SURGERY	112	1	2
7 CRITICAL CARE	181	0	−1
8 DERMATOLOGY	2,159	3	5
9 EMERGENCY MEDICINE	1,962	0	0
10 ENDOCRINOLOGY	317	0	0
11 FAMILY PRACTICE	4,396	0	1
12 GASTROENTEROLOGY	1,545	1	3
13 GENERAL PRACTICE	692	0	0
14 GENERAL SURGERY	1,974	0	0
15 GERIATRICS	142	0	0
16 HAND SURGERY	73	−1	−2
17 HEMATOLOGY/ONCOLOGY	1,709	0	−1
18 INFECTIOUS DISEASE	455	1	1
19 INTERNAL MEDICINE	8,727	0	0
20 INTERVENTIONAL RADIOLOGY	196	−1	−2
21 NEPHROLOGY	1,510	−1	−3
22 NEUROLOGY	1,231	0	0
23 NEUROSURGERY	510	−1	−1
24 NUCLEAR MEDICINE	66	0	−1
25 OBSTETRICS/GYNECOLOGY	520	0	0
26 OPHTHALMOLOGY	4,202	−1	−1
27 ORTHOPEDIC SURGERY	2,877	0	−1
28 OTOLARYNGOLOGY	824	−1	−1
29 PATHOLOGY	833	0	−1
30 PEDIATRICS	59	0	1
31 PHYSICAL MEDICINE	697	−1	−1
32 PLASTIC SURGERY	236	0	1
33 PSYCHIATRY	927	1	1
34 PULMONARY DISEASE	1,496	0	1
35 RADIATION ONCOLOGY	1,591	−1	−1
36 RADIOLOGY	4,697	0	1
37 RHEUMATOLOGY	439	0	−1
38 THORACIC SURGERY	353	−1	−1
39 UROLOGY	1,804	0	0
40 VASCULAR SURGERY	575	0	0
41 AUDIOLOGIST	28	−10	−20
42 CHIROPRACTOR	620	−1	−2
43 CLINICAL PSYCHOLOGIST	456	−2	−4
44 CLINICAL SOCIAL WORKER	301	−2	−3
45 NURSE ANESTHETIST	670	0	0
46 NURSE PRACTITIONER	781	0	1
47 OPTOMETRY	719	0	0
48 ORAL/MAXILLOFACIAL SURGERY	31	1	3
49 PHYSICAL/OCCUPATIONAL THERAPY	1,458	1	3
50 PHYSICIAN ASSISTANT	580	0	1
51 PODIATRY	1,433	2	4
52 DIAGNOSTIC TESTING FACILITY	1,029	−1	−1
53 INDEPENDENT LABORATORY	754	5	11
54 PORTABLE X-RAY SUPPLIER	51	2	5

*Components may not sum to total due to rounding.

2. Adjustments for Payments for Imaging Services

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 the TC for PFS imaging services from the PFS BN requirement. We estimate that the combined impact of the current BN exemptions instituted by section 5102 of the DRA, the proposed addition of 10 services and the removal of 1 deleted service from the list of services subject to the MPPR for diagnostic imaging services, and the proposed payment revisions to OPPS payment amounts (which serve as a cap on the TCs under the PFS) would result in no measurable changes in the specialty specific impacts for 2009. In addition, while the MPPR was implemented administratively, section 5102 of the Deficit Reduction Act of 2005 subsequently provided for the exemption of reduced expenditures resulting from this policy from the statutory BN requirement. We would

exempt from budget neutrality the reduced expenditures resulting from the additional 10 services proposed to be added and the 1 service proposed to be removed from the list of services subject to the MPPR list. See Table 3 in Section E.2. of this proposed rule for a listing of those services which are being added and removed from the list of services subject to the MPPR.

3. Combined Impact

Table 28 shows the specialty-level impact of the proposed work and PE RVU changes, and our most recent estimate (−5.4 percent) of the CY 2009 Medicare PFS update.

As indicated in Table 28, our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2008 with proposed payment rates for CY 2009 using CY 2007 Medicare utilization crosswalked to 2008 services. 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 28. 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.

Table 28 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 28.

- Specialty: The physician specialty or type of practitioner/supplier.
- Allowed Charges: Allowed charges are the Medicare Fee Schedule amounts for covered services and include copayments and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services provided by physicians, practitioners, or suppliers with a specialty to arrive at the total allowed charges for the specialty.
- Impact of the 2009 Work RVU (including the proposed addition of 10 services and deletion of 1 service from the list of services subject to the multiple procedure payment reduction for diagnostic imaging services)and PE RVU proposed changes using the methodology finalized in the CY 2007 PFS final rule with comment period and the revised data sources discussed in this proposed rule.
- CY 2009 Update: The percentage decrease in allowed charges attributed to the estimated CY 2009 PFS conversion factor update (−5.4 percent).
- Combined impact with CY 2009 update: The CY 2009 percentage decrease in allowed charges attributed to the impact of the work and PE RVU changes and the CY 2009 update.

TABLE 28.—COMBINED CY 2009 MEDICARE PHYSICIAN FEE SCHEDULE TOTAL ALLOWED CHARGE IMPACT

Specialty	Allowed charges (mil)	Impact of work and PE RVU changes* (percent)	2009 Update (Cur. Law)** (percent)	Combined impact with CY 2009 update*** (percent)
1. TOTAL	$68,076	0	−5	−5
2. ALLERGY/IMMUNOLOGY	157	1	−5	−4
3. ANESTHESIOLOGY	1,579	−1	−5	−6
4. CARDIAC SURGERY	327	−1	−5	−6
5. CARDIOLOGY	6,535	−1	−5	−7
6. COLON AND RECTAL SURGERY	112	1	−5	−5
7. CRITICAL CARE	181	0	−5	−6
8. DERMATOLOGY	2,159	3	−5	−3
9. EMERGENCY MEDICINE	1,962	0	−5	−6
10. ENDOCRINOLOGY	317	0	−5	−5
11. FAMILY PRACTICE	4,396	0	−5	−5
12. GASTROENTEROLOGY	1,545	1	−5	−4
13. GENERAL PRACTICE	692	0	−5	−5
14. GENERAL SURGERY	1,974	0	−5	−5
15. GERIATRICS	142	0	−5	−5
16. HAND SURGERY	73	−1	−5	−6
17. HEMATOLOGY/ONCOLOGY	1,709	0	−5	−6
18. INFECTIOUS DISEASE	455	1	−5	−5
19. INTERNAL MEDICINE	8,727	0	−5	−5
20. INTERVENTIONAL RADIOLOGY	196	−1	−5	−6
21. NEPHROLOGY	1,510	−1	−5	−7
22. NEUROLOGY	1,231	0	−5	−6
23. NEUROSURGERY	510	−1	−5	−6
24. NUCLEAR MEDICINE	66	0	−5	−6
25. OBSTETRICS/GYNECOLOGY	520	0	−5	−6
26. OPHTHALMOLOGY	4,202	−1	−5	−6
27. ORTHOPEDIC SURGERY	2,877	0	−5	−6
28. OTOLARYNGOLOGY	824	−1	−5	−6
29. PATHOLOGY	833	0	−5	−6
30. PEDIATRICS	59	0	−5	−5
31. PHYSICAL MEDICINE	697	−1	−5	−6
32. PLASTIC SURGERY	236	0	−5	−5
33. PSYCHIATRY	927	1	−5	−5
34. PULMONARY DISEASE	1,496	0	−5	−5
35. RADIATION ONCOLOGY	1,591	−1	−5	−6
36. RADIOLOGY	4,697	0	−5	−5
37. RHEUMATOLOGY	439	0	−5	−6
38. THORACIC SURGERY	353	−1	−5	−6
39. UROLOGY	1,804	0	−5	−5
40. VASCULAR SURGERY	575	0	−5	−5

TABLE 28.—COMBINED CY 2009 MEDICARE PHYSICIAN FEE SCHEDULE TOTAL ALLOWED CHARGE IMPACT—Continued

Specialty	Allowed charges (mil)	Impact of work and PE RVU changes* (percent)	2009 Update (Cur. Law)** (percent)	Combined impact with CY 2009 update*** (percent)
41. AUDIOLOGIST	28	−10	−5	−16
42. CHIROPRACTOR	620	−1	−5	−6
43. CLINICAL PSYCHOLOGIST	456	−2	−5	−7
44. CLINICAL SOCIAL WORKER	301	−2	−5	−7
45. NURSE ANESTHETIST	670	0	−5	−6
46. NURSE PRACTITIONER	781	0	−5	−5
47. OPTOMETRY	719	0	−5	−6
48. ORAL/MAXILLOFACIAL SURGERY	31	1	−5	−4
49. PHYSICAL/OCCUPATIONAL THERAPY	1,458	1	−5	−4
50. PHYSICIAN ASSISTANT	580	0	−5	−5
51. PODIATRY	1,433	2	−5	−4
52. DIAGNOSTIC TESTING FACILITY	1,029	−1	−5	−6
53. INDEPENDENT LABORATORY	754	5	−5	0
54. PORTABLE X−RAY SUPPLIER	51	2	−5	−3

*PE changes are CY 2009 third year transition changes. For fully implemented CY 2010 PE changes see Table 27.
**Under current law, the payment rates will decrease by −10.6 on July 1, 2008, in addition to the −5.4 CY 2009 update.
***Components may not sum to total due to rounding. Impacts as of May 20, 2008.

Table 29 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 provided by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE refer to Addendum A of this proposed rule.

TABLE 29.—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON PROPOSED 2009 PAYMENT FOR SELECTED PROCEDURES

CPT [1]/HCPCS	MOD	Description	Facility			Nonfacility		
			2008 [2]	Proposed [3] 2009	Percent change	2008 [2]	Proposed [3] 2009	Percent change
11721	.....	Debride nail, 6 or more ...	$24.53	$22.88	−7	$35.43	$34.48	−3
17000	.....	Destruct premalg lesion ..	41.56	40.93	−2	60.30	60.59	0
27130	.....	Total hip arthroplasty	1,195.11	1,118.97	−6	NA	NA	NA
27244	.....	Treat thigh fracture	963.45	898.53	−7	NA	NA	NA
27447	.....	Total knee arthroplasty ...	1,283.69	1,198.90	−7	NA	NA	NA
33533	.....	CABG, arterial, single	1,659.12	1,537.94	−7	NA	NA	NA
35301	.....	Rechanneling of artery	934.83	870.17	−7	NA	NA	NA
43239	.....	Upper GI endoscopy, biopsy.	140.36	136.33	−3	294.35	282.00	−4
66821	.....	After cataract laser surgery.	223.15	210.45	−6	238.14	223.99	−6
66984	.....	Cataract surg w/iol, 1 stage.	560.08	525.00	−6	NA	NA	NA
67210	.....	Treatment of retinal lesion.	488.20	460.22	−6	507.96	477.30	−6
71010	.....	Chest x-ray	NA	NA	NA	22.83	20.95	−8
71010	26	Chest x-ray	7.84	7.41	−5	7.84	7.41	−5
77056	.....	Mammogram, both breasts.	NA	NA	NA	93.69	93.78	0
77056	26	Mammogram, both breasts.	37.48	36.10	−4	37.48	36.10	−4
77057	.....	Mammogram, screening	NA	NA	NA	73.93	70.58	−5
77057	26	Mammogram, screening	30.32	29.01	−4	30.32	29.01	−4
77427	.....	Radiation tx management, x5.	158.42	151.47	−4	158.42	151.47	−4
78465	26	Heart image (3d), multiple	66.43	64.78	−2	66.43	64.78	−2
88305	26	Tissue exam by pathologist.	32.36	29.97	−7	32.36	29.97	−7
90801	.....	Psy dx interview	112.08	103.45	−8	131.50	126.98	−3
90862	.....	Medication management	39.18	36.74	−6	46.67	46.09	−1
90935	.....	Hemodialysis, one evaluation.	58.26	54.14	−7	NA	NA	NA
92012	.....	Eye exam established pat	38.50	36.74	−5	62.69	59.30	−5
92014	.....	Eye exam & treatment	59.28	56.40	−5	90.96	86.05	−5
92980	.....	Insert intracoronary stent	721.22	699.36	−3	NA	NA	NA

TABLE 29.—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON PROPOSED 2009 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT [1]/HCPCS	MOD	Description	Facility			Nonfacility		
			2008 [2]	Proposed [3] 2009	Percent change	2008 [2]	Proposed [3] 2009	Percent change
93000		Electrocardiogram, complete.	20.78	18.37	−12	20.78	18.37	−12
93010		Electrocardiogram report	7.50	7.41	−1	7.50	7.41	−1
93015		Cardiovascular stress test	93.01	89.27	−4	93.01	89.27	−4
93307	26	Echo exam of heart	42.24	40.93	−3	42.24	40.93	−3
93510	26	Left heart catheterization	215.65	204.97	−5	215.65	204.97	−5
98941		Chiropractic manipulation	25.55	24.17	−5	29.64	27.72	−6
99203		Office/outpatient visit, new.	58.60	55.11	−6	81.42	77.03	−5
99213		Office/outpatient visit, est	37.48	35.77	−5	53.49	51.24	−4
99214		Office/outpatient visit, est	58.60	55.76	−5	80.40	77.03	−4
99222		Initial hospital care	104.59	98.94	−5	NA	NA	NA
99223		Initial hospital care	153.65	145.67	−5	NA	NA	NA
99231		Subsequent hospital care	31.68	30.29	−4	NA	NA	NA
99232		Subsequent hospital care	56.55	53.82	−5	NA	NA	NA
99233		Subsequent hospital care	81.08	77.35	−5	NA	NA	NA
99236		Observ/hosp same date	179.20	167.91	−6	NA	NA	NA
99239		Hospital discharge day	83.13	78.32	−6	NA	NA	NA
99243		Office consultation	83.13	78.96	−5	109.36	104.10	−5
99244		Office consultation	130.14	124.40	−4	160.12	152.44	−5
99253		Inpatient consultation	97.09	92.82	−4	NA	NA	NA
99254		Inpatient consultation	140.02	134.39	−4	NA	NA	NA
99283		Emergency dept visit	52.81	49.31	−7	NA	NA	NA
99284		Emergency dept visit	97.44	92.17	−5	NA	NA	NA
99291		Critical care, first hour	182.61	171.13	−6	224.51	209.81	−7
99292		Critical care, add'l 30 min	91.64	85.73	−6	100.16	93.46	−7
99348		Home visit, est patient	NA	NA	NA	68.14	64.46	−5
99350		Home visit, est patient	NA	NA	NA	139.34	130.53	−6
G0008		Admin influenza virus vac	NA	NA	NA	18.40	18.37	0
G0317		ESRD related svs 4+mo 20+yrs.	245.63	227.21	−7	245.63	227.21	−7

[1] CPT codes and descriptions are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] Based on CF of 34.0682 published in the CY 2008 PFS Final rule with comment period (72 FR 66222). Used for PFS payment for services beginning July 1, 2008 through December 31, 2008.
[3] Based upon proposed −5.4 percent reduction in Conversion Factor.

B. Telehealth

In section II.D. of this proposed rule, we are proposing to create 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 would 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 to access to these services, we do not anticipate that this proposed change will have a significant budgetary impact on the Medicare program.

C. Payment for Covered Outpatient Drugs and Biologicals

1. ASP Issues

The proposed changes discussed in section II.F.1. of this proposed rule with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures.

2. CAP Issues

This proposed rule contains proposals and seeks comment on certain aspects of the CAP, specifically the annual CAP payment amount update mechanism, the definition of a CAP physician, easing the restriction on physician transport of CAP drugs between practice locations, and the dispute resolution process. Several of these minor refinements may improve compliance, promote program flexibility, improve the quality and potentially the number of services for participating CAP physicians, and increase available choices for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system.

D. Application of the HPSA Bonus Payment

As discussed in section II.G. of this proposed rule, 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 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 in this proposed rule are discussed in section II.H. of this proposed rule. To understand the impact of the proposed 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 proposed rule. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2008 payments and proposed 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 December 2007 update of CY 2007 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. While the December 2007 update of the 2007 claims is not complete, we wanted to use the most recent data available, and plan to use an updated version of the 2007 claims file for the final rule. Due to data limitations, we are unable to estimate current and proposed payments for 80 of the 4866 ESRD facilities that bill for ESRD dialysis treatments.

Table 30 shows the impact of this year's proposed changes to CY 2009 payments to hospital-based and independent ESRD facilities. The first column of Table 30 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 the proposed change to the wage index floor as it affects the composite rate payments to ESRD facilities for CY 2009. The fourth column compares aggregate ESRD wage adjusted composite rate payments in the fourth year of the transition (CY 2009) using the CY 2009 wage index with a 0.75 floor compared to aggregate ESRD wage adjusted composite rate payments in the fourth year of the transition (CY 2009) using the CY 2009 wage index with a 0.70 floor. Note that the fourth column only includes the effect of the proposed change to the wage index floor and does not include the effects of other wage index changes, such as, moving from the third to fourth year of the transition and updated wage index values from CY 2008 to CY 2009.

The fifth column shows the effect of all proposed changes to the ESRD wage index for CY 2009 as it affects the composite rate payments to ESRD facilities. It is inclusive of the changes in the fourth column. The fifth 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 proposed 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 sixth column shows the overall effect of the proposed changes in composite rate payments to ESRD providers. The overall effect is measured as the difference between the proposed 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 proposed payment is the transition year 4 wage-adjusted composite rate for each provider (with the 15.5 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 15.5 percent drug add-on) times dialysis treatments from CY 2007 claims.

The overall impact to ESRD providers in aggregate is 0.0 percent. This zero update corresponds to the proposed 0.0 percent update to the drug add-on. The variation shown in column 6 is due to variation in changes in the wage index (column 5). All provider types receive the same 0.0 percent increase to the drug add-on.

TABLE 30.—IMPACT OF CY 2009 PROPOSED CHANGES IN PAYMENTS TO HOSPITAL-BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities (both program and beneficiaries)]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in floor only [1]	Effect of changes in wage index [2]	Overall effect [3]
All Providers	4,786	32.7	0.0	0.0	0.0
Independent	4,231	29.4	0.0	0.0	0.0
Hospital Based	555	3.2	0.0	0.3	0.3
By Facility Size:					
Less than 5000 treatments	1,941	5.7	0.0	−0.1	−0.1
5000 to 9999 treatments	1,905	13.7	0.0	0.0	0.0
Greater than 9999 treatments	940	13.2	0.0	0.0	0.0
Type of Ownership:					
Profit	3,860	26.8	0.0	−0.1	−0.1
Nonprofit	926	5.9	0.0	0.2	0.2
By Geographic Location:					
Rural	1,298	6.8	0.0	−0.4	−0.4

TABLE 30.—IMPACT OF CY 2009 PROPOSED CHANGES IN PAYMENTS TO HOSPITAL-BASED AND INDEPENDENT ESRD FACILITIES—Continued

[Percent change in composite rate payments to ESRD facilities (both program and beneficiaries)]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in floor only [1]	Effect of changes in wage index [2]	Overall effect [3]
Urban	3,488	25.8	0.0	0.1	0.1
By Region:					
New England	153	1.1	0.0	1.2	1.2
Middle Atlantic	556	4.1	0.0	0.1	0.1
East North Central	756	5.2	0.0	−1.0	−1.0
West North Central	362	1.8	0.0	0.0	0.0
South Atlantic	1090	7.5	0.0	−0.1	−0.1
East South Central	375	2.5	0.0	−1.0	−1.0
West South Central	664	4.7	0.0	−0.5	−0.5
Mountain	255	1.5	0.0	0.0	0.0
Pacific	541	4.1	0.0	2.1	2.1
Puerto Rico	34	0.4	−3.1	−4.6	−4.6

[1] This column only shows the effect of the proposed wage index floor changes on ESRD providers for CY2009. Composite rate payments computed using the CY2009 wage index with a 0.75 floor are compared to composite rate payments using the CY2009 wage index with a 0.70 floor.

[2] 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 CY2009 wage index changes.

[3] This column shows the percent change between CY2009 and CY2008 composite rate payments to ESRD facilities. The CY2009 payments include the CY2009 wage adjusted composite rate, and the 15.5 percent drug add-on times treatments. The CY2008 payments to ESRD facilities includes the CY2008 wage adjusted composite rate and the 15.5 percent drug add-on times treatments.

G. IDTF Issues

We believe that our proposals regarding IDTFs as discussed in Section II.I. of this proposed rule would have minimal budgetary impact. However, we believe that these changes are necessary to ensure that only IDTFs enrolled in the Medicare program are billing for the services provided and that the services are provided by properly qualified individuals. Additionally, the provisions in this rule would require physicians, NPPs, and physician or NPP groups to enroll as an IDTF when they are performing diagnostic testing procedures. This requirement would help ensure that properly qualified individuals are performing these diagnostic testing procedures. Also, we believe that the proposed IDTF provisions contained in this rule will help ensure that beneficiaries receive quality care regardless of the setting in which they are provided. We are unable to determine the extent that IDTFS and physicians, NPPs, and physician or NPP groups currently providing diagnostic testing procedures will be unable to meet these requirements and therefore have their billing privileges revoked or be denied enrollment into the Medicare program. However, we do not believe that beneficiary access to these services will be affected.

H. Physician and Nonphysician Practitioner Enrollment Issues

We believe that our proposals regarding physicians, NPPs, and physician and nonphysician groups as discussed in section II.J. of this proposed rule would have minimal budgetary impact.

As a result of currently not having quantifiable data, we cannot effectively derive an estimate of the monetary impacts of these provisions. Accordingly, we are seeking public comment so that the public may provide any data available that provides a calculable impact or any alternative to the proposed provisions.

I. Proposed 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 proposed 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 proposed 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 proposed 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 proposed 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 as proposed here 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.[2]

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.[3]

According to industry reports in 2006 approximately 3.309 billion prescriptions[4] 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,[5] 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.

J. CORF Issues

The revisions to the CORF regulations discussed in section II.L. of this proposed rule update 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 proposed rule make technical corrections and update the regulations and are expected to have minimal impact on Medicare expenditures.

L. Physician Self-Referral Provisions

1. Incentive Payment and Shared Savings Programs

Our proposal in section II.N. of this proposed rule would provide an exception to the physician self-referral statute to permit incentive payments between physicians and entities furnishing designated health services (DHS), provided that certain conditions are satisfied. We are not proposing to implement new incentive payment and shared savings programs, but merely are proposing an exception in § 411.357(x) that would allow for remuneration provided by a hospital to a physician or to a qualified physician organization under an incentive payment or shared savings program that satisfies certain conditions. We believe that this exception would remove a barrier to participation in certain incentive payment and shared savings programs that may exist currently. We recognize the potential for an indirect, unquantifiable increase in the number of incentive payment and shared savings programs that, as a result of this exception, will be permitted to function as originally intended. However, because the purpose of incentive payment and shared savings programs is to increase quality while decreasing cost, we do not believe that our proposal would have a budgetary impact.

2. Anti-Markup Provisions

We anticipate that our proposal in section II.N. of this proposed rule concerning the anti-markup provisions in § 414.50 would 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.

M. Physician Quality Reporting Initiative

As discussed section II.O. of this proposed rule, the proposed 2009 PQRI measures satisfy the requirement of section 1848(k)(2)(B)(ii) of the Act that the Secretary publish in the **Federal Register** by August 15, 2008 a proposed set of 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.O. of this proposed rule, we are also offering options in 2009 for reporting some of the 2009 PQRI measures via submission of data to a clinical registry, options for reporting some of the 2009 PQRI measures via EHR-based submission, and options for reporting on measures groups rather than individual measures. Although there may be some cost incurred for maintaining the measures and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based data submission, we do not anticipate a significant cost impact on the Medicare program.

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 proposed changes discussed in section II.Q. of this proposed rule. However, we

[2] CVS/Caremark Discussion Points on E-Fax Ruling Exceptions, January 3, 2007.

[3] 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.

[4] *http://www.statehealthfacts.org.*

[5] CMS, November 16, 2007 Proposed Rule, 72 FR 64913.

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 practitioners independently treating beneficiaries and directly billing the Medicare program. Also, the proposed 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 proposed changes discussed in section II.R. of this proposed rule; however, we expect that the revisions to the regulations will have a positive impact on patient care.

P. Prohibition Concerning Providers of Sleep Tests

The proposal contained in section II.T.2 of this proposed rule 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 most providers as most providers are not DMEPOS suppliers who would be supplying CPAP devices. Only providers or other entities that perform both sleep testing and supply CPAP machines to beneficiaries they have tested will be impacted.

Q. Beneficiary Signature Requirements for Nonemergency Ambulance Services

We believe that our proposal in section II.T.3. of this proposed rule 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, would 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 proposal in section II.T.5. of this proposed rule 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 providers and suppliers whose billing privileges are revoked due to felony convictions, license suspensions or revocation, or because the provider or 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 providers and supplier 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 providers and suppliers that meet the proposed criteria for immediate revocation, we cannot effectively derive an estimate of the monetary impacts of this provision. Accordingly, we are seeking public comment so that the public may provide any data available that provides a calculable impact or any alternative to the proposed provision.

S. Alternatives Considered

This proposed rule 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, presents rationale for our decisions and, where relevant, alternatives that were considered.

T. Impact on Beneficiaries

There are a number of changes made in this proposed rule that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the modifications to personnel qualifications and the application of certain IDTF standards to physician and NPPs office practices 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 proposed changes with respect to Part B drugs and CAP 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 in aggregate beneficiary liability from 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) and 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 physician fee schedule services is estimated to be $558. In addition, the portion of the 2009 standard monthly Part B premium attributable to PFS services is estimated to be $32.50.

To illustrate this point, as shown in Table 26, the 2008 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is $81.42 which means that currently (July 1 through December 31) a beneficiary is responsible for 20 percent of this amount, or 16.28. Based on this proposed rule, the 2009 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 29, is $77.03 which means that, in 2009, the beneficiary coinsurance for this service would be $15.41.

Proposed policies discussed in this rule that do affect overall spending, such as the proposed additions to the list of codes that are subject to the multiple procedure payment reduction for diagnostic imaging, would similarly impact beneficiaries' coinsurance.

U. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 31, we have prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. This estimate includes the incurred benefit impact associated with the estimated CY 2009 PFS update, shown in this proposed rule, based on the 2008 Trustees Report baseline. All estimated impacts are classified as transfers.

TABLE 31.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2008 TO CY 2009

[In billions]

Category	Transfers
Annualized Monetized Transfers	Estimated decrease in expenditures of $5.9 billion.
From Whom To Whom?	Federal Government to physicians, other practitioners and suppliers who receive payment under the Medicare Physician Fee Schedule; ESRD Medicare Providers; and Medicare suppliers billing for Part B drugs and for Medicare Part D.

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

List of Subjects

42 CFR Part 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 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 415

Health facilities, Health professions, Medicare, 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.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 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 amended on June 27, 2008 (73 FR 36448) 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 410.33 is amended by adding paragraphs (a)(3), (g)(16), and (j) to read as follows:

§ 410.33 Independent diagnostic testing facility.

(a) * * *

(3) *Advanced diagnostic testing procedures.* Advanced diagnostic testing procedures include diagnostic magnetic resonance imaging, computed

tomography, 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).

* * * * *

(g) * * *

(16) Enrolls and bills Medicare for all mobile diagnostic services that it furnishes, regardless of whether the services are furnished in a mobile or fixed base location, including a physician office or fixed-based IDTF.

* * * * *

(j) A physician or nonphysician practitioner organization (as defined in § 424.502) furnishing diagnostic testing services, except diagnostic mammography services:

(1) Must enroll as an IDTF for each practice location furnishing these services; and

(2) Is subject to the provisions 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).

8. 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.

* * * * *

9. 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

* * * * *

10. Section 410.78 is amended by revising the introductory text of paragraph (b) to 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:

* * * * *

Subpart D—Comprehensive Outpatient Rehabilitation Facility (CORF) Services

11. Section 410.100 is amended by revising paragraphs (e)(1) and (h) to read as follows:

§ 410.100 Included services.

* * * * *

(e) * * *

(1) Respiratory therapy services are services provided by a respiratory therapist for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

* * * * *

(h) *Social and psychological services.*

Social and psychological services include the assessment of an individual's mental and emotional functioning, and the individual's response and rate of progress as they relate to the individual's rehabilitation plan of treatment, including physical therapy services, occupational therapy services, speech-language pathology services and respiratory therapy services.

* * * * *

Subpart I—Payment of SMI Benefits

12. Section 410.155 is amended by—

A. Revising paragraph (b)(1).

B. Adding paragraph (b)(2)(vi).

The revisions and additions are to read as follows:

§ 410.155 Outpatient mental health treatment limitation.

* * * * *

(b) *Application of the limitation.*

(1) *Services subject to the limitation.* Except as specified in paragraph (b)(2) of this section, the services furnished by physicians and other practitioners, whether furnished directly or as an 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.

(2) * * *

(vi) CORF social and psychological services (as defined at § 410.100(h) of this subpart) furnished by a CORF.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

13. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

14. Section 411.351 is amended by adding the following definition in alphabetical order:

§ 411.351 Definitions.

* * * * *

Qualified physician organization means a physician organization comprised entirely of physicians participating in the same incentive payment or shared savings program.

* * * * *

15. Section 411.357 is revised by adding paragraph (x) to read as follows:

§ 411.357 Exceptions to the referral prohibition related to compensation arrangements.

* * * * *

(x) *Incentive Payment and Shared Savings Programs.* Remuneration in the form of cash or cash equivalent payments, but not including nonmonetary remuneration, provided by a hospital to a physician on the hospital's medical staff or to a qualified physician organization (as defined at § 411.351) pursuant to an arrangement between the hospital and the physician or qualified physician organization, if all of the following conditions are met:

(1) The remuneration is provided as part of a documented incentive payment or shared savings program to achieve—

(i) The improvement of quality of hospital patient care services through changes in physician clinical or administrative practices; or

(ii) Actual cost savings for the hospital resulting from the reduction of waste or changes in physician clinical or administrative practices, without an adverse effect on or diminution in the quality of hospital patient care services.

(2) The incentive payment or shared savings program identifies patient care quality measures or cost saving measures (for purposes of this paragraph, collectively, ''performance measures'') or both that—

(i) Use an objective methodology, are verifiable, are supported by credible medical evidence, and are individually tracked;

(ii) Are reasonably related to the hospital's or comparable hospitals' practices and patient population;

(iii) With respect to patient care quality measures, are listed in CMS' Specification Manual for National Hospital Quality Measures; and

(iv) Are monitored throughout the term of the arrangement to protect against inappropriate reductions or limitations in patient care services.

(3) The incentive payment or shared savings program establishes—

(i) Baseline levels for the performance measures using the hospital's historical and clinical data; and

(ii) Target levels for the performance measures that are developed by comparing historical data for the hospital's practices and patient population to national or regional data for comparable hospitals' practices and patient populations; and

(iii) Thresholds above or below which no payments will accrue to physicians.

(4) At least five physicians participate in each performance measure (the ''participating physician pool''). Physicians participating in the incentive payment or shared savings program (''participating physicians'') must be on the medical staff of the hospital at the commencement of the program, and may not be selected in a manner that takes into account the volume or value of referrals or other business generated between the parties. A hospital may elect to make an incentive payment or shared savings program available to physicians in a particular department or specialty, provided that the hospital offers the opportunity to participate in the incentive payment or shared savings program to all physicians in the department or specialty on the same terms and conditions.

(5) The incentive payment or shared savings program requires independent medical review of the program's impact on the quality of patient care services provided at the hospital and corrective action if the independent medical review indicates a diminution in the quality of hospital patient care services. The independent medical review must be completed prior to the commencement of the incentive payment or shared savings program (with respect to the program's potential impact on the quality of patient care services provided at the hospital) and at least annually thereafter. For purposes of this paragraph, ''independent medical review,'' means written review by an individual or organization that is—

(i) Not affiliated with the hospital;

(ii) Not affiliated with any participating physician or any physician organization to which any participating physician belongs; and

(iii) At the time of the review, not participating in any incentive payment or shared savings program at the hospital.

(6) Under the incentive payment or shared savings program—

(i) Physicians must have access to the same selection of items, supplies or devices as was available at the hospital prior to the commencement of the program, and must not be restricted in their ability to make medically appropriate decisions for their patients, including, but not limited to, decisions about tests, treatments, procedures, services, supplies or discharge;

(ii) The hospital may not make a payment to a participating physician or a qualified physician organization for the use of an item, supply or device if the physician or qualified physician organization has an ownership or investment interest in, or a compensation arrangement with, the manufacturer, distributor or group purchasing organization that arranges for the purchase of the item, supply or device; and

(iii) The hospital may not limit the availability of new technology that—

(A) Is linked through objective evidence to improved outcomes and is clinically appropriate for a particular patient; and

(B) Meets the same Federal regulatory standards as technology available under the incentive payment or shared savings program (for example, approval by the Food and Drug Administration and Medicare or Medicaid coverage decisions).

(7) The hospital provides effective prior written notice to patients affected by the incentive payment or shared savings program that—

(i) Identifies the physicians participating in the program;

(ii) Discloses that participating physicians receive payments for meeting targets for performance measures; and

(iii) Describes the performance measures in a manner reasonably designed to inform patients about the program.

(8) The arrangement is set out in writing, is signed by the parties, and specifies the remuneration (or a formula for the remuneration) in detail sufficient to be independently verified, including a comprehensive description of the incentive payment or shared savings program in which the physician is participating, the applicable baseline measures, and the targets for performance measures to be achieved by the participating physician. To satisfy this requirement, each specific performance measure and the resulting payment (or a formula for the resulting payment) to the participating physician or qualified physician organization must be clearly and separately identified.

(9) The performance measures provided for under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law and, in the aggregate, are reasonable and necessary for the legitimate business purposes of the arrangement.

(10) The term of the arrangement is for no less than 1 year and no more than 3 years.

(11) Payments must take into account previous payments made for performance measures already achieved to ensure that the participating physician or qualified physician organization does not receive payment related to patient care quality improvements or cost savings that were achieved during a prior period of the arrangement. No payment may be made for the achievement of cost savings that results in a diminution in hospital patient care quality with respect to that performance measure.

(12) Payments are limited in duration and amount. For purposes of calculating the actual payments to the physician, cost savings are measured by comparing the hospital's actual acquisition costs for the items and supplies or costs of providing the specified services that are subject to the shared savings program to the hospital's baseline costs for the same items, supplies or services during the 1-year period immediately preceding the commencement of the program.

(13) The remuneration to be paid over the term of the arrangement (or the formula for the remuneration) is—

(i) Set in advance, does not vary during the term of the arrangement, and is not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties;

(ii) Not based in whole or in part on a reduction in the length of stay for a particular patient or in the aggregate for the hospital;

(iii) Distributed to the physicians in each participating physician pool or in each qualified physician organization if the qualified physician organization consists of at least five participating physicians on a *per capita* basis with respect to each performance measure; and

(iv) Paid directly to participating physicians or qualified physician organizations.

(14) The remuneration paid to a participating physician or qualified physician organization may not include any amount that takes into account the provision of a greater volume of Federal health care patient procedures or services than the volume provided by the participating physician or qualified physician organization during the period of the same length immediately preceding the commencement of the program as that covered by the payment.

(15) The hospital maintains accurate and contemporaneous documentation of the incentive payment or shared savings program and makes such documentation available to the Secretary upon request, including, but not limited to, the following:

(i) The written agreement between the parties;

(ii) The basis for the selection of the performance measures;

(iii) The selection and qualifications of the individual or organization designated as the independent medical reviewer;

(iv) The written findings of the independent medical reviewer;

(v) Corrective actions taken by the hospital based on the written findings of the independent medical reviewer (or any other review indicating that corrective action was needed);

(vi) The amount and calculation of payments made under the incentive payment or shared savings program, including the hospital's projected and actual acquisition costs where relevant;

(vii) The re-basing of performance measures; and

(viii) The written notification provided to hospital patients.

(16) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Social Security Act) or any Federal or State law or regulation governing billing or claims submission.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

16. 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

17. 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 practice expense 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 practice expense 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.

* * * * *

18. Section 414.50 is amended by—

A. Revising paragraph (a) introductory text.

B. Revising paragraphs (a)(1)(i), (a)(2)(ii) and (iii).

C. Redesignating paragraph (b) as paragraph (c).

D. Adding new paragraphs (a)(2)(iv) and (b).

The revisions and additions read as follows:

§ 414.50 Physician or other supplier billing for diagnostic tests performed or interpreted by an outside supplier or at a site other than the office of the billing physician or other supplier.

(a) *General rules.* Except as provided for in paragraph (b) of this section, for services covered under section 1861(s)(3) of the Act—

(1) * * *

(i) The performing supplier's net charge to the billing physician or other supplier's actual charge. 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.

* * * * *

(2) * * *

(ii) An ''outside supplier'' does not include a physician who is an employee or independent contractor of the billing physician or other supplier and who furnishes the test or interpretation to the billing physician or other supplier under a reassignment that meets the requirements of § 424.80 of this subchapter;

(iii) The TC of a diagnostic test is not subject to paragraph (a) if the TC is both conducted and supervised within 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.

(iv) 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.

(b) *Exception.* Except with respect to the purchase of a TC from an outside supplier, the requirements of paragraph (a) of this section do 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.

* * * * *

19. 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.

* * * * *

20. 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 HPSAs as of December 31 of the prior year. Physicians furnishing services in areas that are designated as 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 K—Payment for Drugs and Biologicals Under Part B

21. Section 414.904 is amended by revising paragraphs (b)(2), (c)(2), (d)(3), and (e)(1) 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.

* * * * *

22. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

* * * * *

23. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) are met;

* * * * *

24. Section 414.916 is amended by—

A. Redesignating paragraph (b)(4) as (b)(5).

B. Adding new paragraph (b)(4).

The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's suspension from the program, the approved CAP vendor shall cease delivery of CAP drugs to the suspended

participating CAP physician until the suspension has been lifted.

* * * * *

25. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

* * * * *

(b) * * *

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

26. 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]

27. In § 415.130(d), the phrase ''December 31, 2007'' is removed and the phrase ''June 30, 2008'' is added in its place.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

28. 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

29. Section 424.36 is amended by revising paragraphs (a) and (b)(6) introductory text 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. In order to utilize one of the provisions of paragraph (b)(1) through (b)(5), the provider, or where applicable, the supplier, must make reasonable efforts to obtain the signature of the beneficiary. 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 non-emergency ambulance transport services, if the following conditions and documentation requirements are met.

* * * * *

30. Section 424.44 is amended by adding paragraph (a)(3) to read as follows:

§ 424.44 Time limits for filing claims.

(a) * * *

(3) Within 30 calendar days of the effective date of a revocation of Medicare billing privileges as defined in § 424.535 for physician or nonphysician practitioner organizations, physicians, nonphysician practitioners or independent diagnostic testing facilities.

* * * * *

Subpart D—To Whom Payment Is Ordinarily Made

31. Section 424.57 is amended by—

A. Amending paragraph (a) by adding the definitions of ''Continuous positive airway pressure (CPAP)'' and ''Sleep test'' in alphabetical order.

B. Adding new paragraph (f).

The revisions and additions read as follows:

§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

(a) * * *

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 clinical test 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 the sleep test and/or provides the sleep test device used to administer the sleep test.

* * * * *

(f) *Payment prohibition.* A supplier cannot receive Medicare payment for a CPAP device if that supplier, or its affiliate, is directly or indirectly the provider of the sleep test used to diagnose a beneficiary with obstructive sleep apnea.

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

32. Section 424.502 is amended by adding the definition ''Physician or nonphysician practitioner organization'' in alphabetical order to read as follows:

§ 424.502 Definitions.

* * * * *

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 such as clinic or group practice.

* * * * *

§ 424.510 [Amended]

33. In § 424.510, paragraph (d)(8) is removed.

34. 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 part.

(c) *Reporting requirements DMEPOS suppliers.* DMEPOS reporting requirements are specified in § 424.57(c)(2).

(d) *Reporting requirements for physician and nonphysician practitioner organizations (NPP), physicians and nonphysician practitioners.* Physician groups/organizations, physicians and nonphysician practitioners must report to CMS the following information within the specified timeframes:

(1) Within 30 days—

(i) A change of ownership;

(ii) Any adverse legal action; or

(iii) 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.* Provider 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 10 years from the date of service. Physicians and nonphysician practitioners are required to maintain written ordering and referring documentation for 10 years from the date of service.

35. 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]

36. 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 part.

(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.

37. 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.

* * * * *

38. Section 424.535 is amended by—

A. Reserving paragraph (a)(8).

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) * * *

(8) [Reserved]

(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.

* * * * *

(f) *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.

(g) *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 30 calendar days of the effective date of revocation.

39. Section 424.565 is added to read as follows:

§ 424.565 Overpayment.

Failure to report. 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 adverse legal 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

40. 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

41. 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.

These services must be furnished by personnel that meet the qualifications set forth in § 485.70 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.

* * * * *

42. Section 485.70 is amended by—

A. Revising paragraphs (c), (e), and (j).

B. Removing paragraph (k).

C. Redesignating paragraphs (l) and (m) as paragraphs (k) and (l), respectively.

The revision reads 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 registered respiratory therapist must—

(1) Be licensed by the State in which practicing, if applicable; and

(2) Must meet one of the following requirements:

(i) Has successfully completed the requirements of the Commission on the Accreditation of Allied Health Education Programs (CAAHEP) for the Advanced Level Therapist and the registry examinations administered by the National Board for Respiratory Care.

(ii) Has successfully completed the requirements of the Commission on the Accreditation of Allied Health Education Programs (CAAHEP) for the Advanced Level Therapist and is eligible to take the registry examination for registered respiratory therapists administered by the National Board for Respiratory Therapy, Inc.

(iii) Has equivalent training and experience as determined by the National Board for Respiratory Therapy, Inc. and be eligible to take the registry examination for registered respiratory therapists administered by the National Board for Respiratory Therapy, Inc.

* * * * *

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

43. Section 485.703 is amended by—

A. Adding the definition, ''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 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.

* * * * *

Rehabilitation agency. An agency that—

* * * * *

(2) Provides at least physical therapy or speech-language pathology services.

* * * * *

44. Section 485.711 is amended by revising paragraphs (b)(3) and (c) to read as follows:

§ 485.711 Condition of participation: Plan of care and physician involvement.

* * * * *

(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. (For Medicare patients, the plan must be reviewed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant at least every 30 days.)

* * * * *

(c) *Standard: Emergency care.* The established procedures to be followed by personnel in an emergency cover immediate care of the patient, persons to be notified, and reports to be prepared.

45. 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 whom 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 services provided under contract.

(b) *Standard: Arrangements for services.* If services are provided under contract, the contract must specify all of the following:

(1) Term of the contract.

(2) The manner of termination or renewal.

(3) Provisions stating that the agency retains responsibility for the control and supervision of the services.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

46. 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

47. 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 paragraph (a)(1) 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.

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

Dated: June 9, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 23, 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 alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B—2009 Relative Value Units and Related Information Used in Determining Medicare Payments for 2009

This addendum contains the following information for each CPT code and alpha-numeric HCPCS code, except for: Alpha-numeric 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 alpha-numeric HCPCS number for the service. Alpha-numeric 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 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. Note: The separate BN adjustor is *not* reflected in these physician work RVUs.

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 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
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	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
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	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
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	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
0049T		C	External circulation assist	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
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	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
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	13.04	14.30	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

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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
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
0088T		C	Rf tongue base vol reduxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0089T		C	Actigraphy testing, 3-day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0090T		C	Cervical artific disc	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
0093T		C	Cervical artific diskectomy	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
0096T		C	Rev cervical artific disc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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
0137T		C	Prostate saturation sampling	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
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

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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
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
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
0162T		C	Anal program gast neurostim	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

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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
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
10021		A	Fna w/o image	1.27	2.17	2.17	0.37	0.41	0.10	XXX
10022		A	Fna w/image	1.27	2.18	2.28	0.41	0.41	0.08	XXX
10040		A	Acne surgery	1.19	1.33	1.25	0.97	0.93	0.05	010
10060		A	Drainage of skin abscess	1.19	1.51	1.44	1.09	1.05	0.12	010
10061		A	Drainage of skin abscess	2.42	2.07	2.01	1.51	1.51	0.26	010
10080		A	Drainage of pilonidal cyst	1.19	2.68	2.79	1.10	1.11	0.11	010
10081		A	Drainage of pilonidal cyst	2.47	3.56	3.69	1.47	1.48	0.24	010
10120		A	Remove foreign body	1.23	1.96	2.01	0.95	0.95	0.12	010
10121		A	Remove foreign body	2.71	3.50	3.51	1.65	1.68	0.33	010
10140		A	Drainage of hematoma/fluid	1.55	2.26	2.14	1.29	1.29	0.19	010
10160		A	Puncture drainage of lesion	1.22	1.85	1.79	1.08	1.08	0.14	010
10180		A	Complex drainage, wound	2.27	3.26	3.19	1.80	1.85	0.35	010
11000		A	Debride infected skin	0.60	0.73	0.69	0.16	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	3.20	3.38	0.67	000
11005		A	Debride abdom wall	14.24	NA	NA	3.77	4.22	0.96	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	3.88	4.12	1.28	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	1.30	1.49	0.61	ZZZ
11010		A	Debride skin, fx	4.19	6.89	6.89	2.36	2.43	0.66	010
11011		A	Debride skin/muscle, fx	4.94	7.13	7.39	2.06	2.13	0.74	000
11012		A	Debride skin/muscle/bone, fx	6.87	9.03	9.82	3.13	3.31	1.16	000
11040		A	Debride skin, partial	0.50	0.68	0.64	0.16	0.17	0.06	000
11041		A	Debride skin, full	0.60	0.72	0.71	0.19	0.22	0.10	000
11042		A	Debride skin/tissue	0.80	0.95	0.96	0.24	0.29	0.13	000
11043		A	Debride tissue/muscle	3.04	3.51	3.48	2.60	2.60	0.32	010
11044		A	Debride tissue/muscle/bone	4.11	4.90	4.79	3.62	3.66	0.43	010
11055		R	Trim skin lesion	0.43	0.81	0.75	0.11	0.13	0.05	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.88	0.82	0.16	0.18	0.07	000
11057		R	Trim skin lesions, over 4	0.79	0.99	0.93	0.20	0.23	0.10	000
11100		A	Biopsy, skin lesion	0.81	1.87	1.72	0.38	0.38	0.03	000
11101		A	Biopsy, skin add-on	0.41	0.41	0.39	0.20	0.19	0.02	ZZZ
11200		A	Removal of skin tags	0.79	1.23	1.18	0.90	0.87	0.04	010

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11201		A	Remove skin tags add-on	0.29	0.16	0.16	0.11	0.11	0.02	ZZZ
11300		A	Shave skin lesion	0.51	1.20	1.15	0.21	0.21	0.03	000
11301		A	Shave skin lesion	0.85	1.50	1.40	0.38	0.38	0.04	000
11302		A	Shave skin lesion	1.05	1.76	1.64	0.48	0.47	0.05	000
11303		A	Shave skin lesion	1.24	2.03	1.91	0.55	0.54	0.07	000
11305		A	Shave skin lesion	0.67	1.06	1.01	0.20	0.22	0.07	000
11306		A	Shave skin lesion	0.99	1.41	1.33	0.37	0.39	0.07	000
11307		A	Shave skin lesion	1.14	1.71	1.61	0.48	0.48	0.07	000
11308		A	Shave skin lesion	1.41	1.71	1.64	0.49	0.52	0.13	000
11310		A	Shave skin lesion	0.73	1.38	1.31	0.31	0.31	0.04	000
11311		A	Shave skin lesion	1.05	1.63	1.53	0.48	0.48	0.05	000
11312		A	Shave skin lesion	1.20	1.91	1.79	0.56	0.55	0.06	000
11313		A	Shave skin lesion	1.62	2.18	2.09	0.72	0.72	0.10	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.87	1.91	1.93	0.95	0.93	0.06	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.25	2.21	2.17	1.16	1.13	0.10	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.42	2.42	2.37	1.22	1.19	0.13	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.81	2.57	2.53	1.57	1.51	0.17	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.08	2.90	2.85	1.66	1.59	0.21	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.47	3.57	3.44	2.12	2.00	0.32	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.00	1.84	1.82	0.94	0.94	0.09	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.44	2.23	2.19	1.17	1.16	0.13	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.65	2.43	2.39	1.53	1.48	0.16	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.03	2.68	2.66	1.66	1.61	0.20	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.45	2.97	2.93	1.77	1.73	0.25	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.04	3.61	3.58	2.32	2.27	0.44	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.02	2.01	2.06	1.32	1.32	0.08	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.50	2.39	2.38	1.56	1.54	0.13	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.74	2.65	2.62	1.66	1.64	0.16	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.31	2.88	2.89	1.84	1.84	0.22	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.16	3.34	3.37	2.12	2.14	0.30	010
11446		A	Exc face-mm b9+marg > 4 cm	4.75	4.11	4.10	2.70	2.72	0.43	010
11450		A	Removal, sweat gland lesion	3.14	5.16	5.13	2.43	2.33	0.34	090
11451		A	Removal, sweat gland lesion	4.35	6.31	6.39	2.88	2.80	0.53	090
11462		A	Removal, sweat gland lesion	2.92	5.32	5.27	2.46	2.35	0.32	090
11463		A	Removal, sweat gland lesion	4.35	6.68	6.73	3.04	2.96	0.54	090
11470		A	Removal, sweat gland lesion	3.66	5.51	5.40	2.64	2.55	0.40	090
11471		A	Removal, sweat gland lesion	4.81	6.44	6.51	3.00	2.94	0.58	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.58	2.74	2.72	1.14	1.10	0.10	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.02	3.46	3.27	1.51	1.44	0.12	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.22	3.85	3.59	1.69	1.58	0.12	010

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11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.77	4.05	3.81	1.88	1.74	0.16	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.12	4.38	4.13	1.96	1.81	0.20	010
11606		A	Exc tr-ext mlg+marg > 4 cm	4.97	5.52	5.16	2.47	2.29	0.36	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	2.86	2.80	1.20	1.14	0.09	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.03	3.51	3.31	1.54	1.47	0.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.36	3.91	3.68	1.75	1.66	0.14	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.06	4.14	3.95	1.97	1.87	0.20	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.57	4.45	4.28	2.09	2.02	0.27	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	4.98	4.90	2.34	2.35	0.45	010
11640		A	Exc face-mm malig+marg 0.5 <	1.62	3.06	2.96	1.29	1.25	0.11	010
11641		A	Exc face-mm malig+marg 0.6-1	2.12	3.63	3.49	1.61	1.59	0.16	010
11642		A	Exc face-mm malig+marg 1.1-2	2.57	4.03	3.87	1.83	1.80	0.19	010
11643		A	Exc face-mm malig+marg 2.1-3	3.37	4.28	4.16	2.11	2.07	0.26	010
11644		A	Exc face-mm malig+marg 3.1-4	4.29	5.05	4.97	2.45	2.46	0.37	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.21	5.90	5.87	3.13	3.22	0.61	010
11719		R	Trim nail(s)	0.17	0.38	0.35	0.04	0.05	0.02	000
11720		A	Debride nail, 1-5	0.32	0.47	0.43	0.08	0.09	0.04	000
11721		A	Debride nail, 6 or more	0.54	0.55	0.52	0.14	0.16	0.07	000
11730		A	Removal of nail plate	1.10	1.33	1.26	0.28	0.32	0.14	000
11732		A	Remove nail plate, add-on	0.57	0.54	0.52	0.15	0.17	0.07	ZZZ
11740		A	Drain blood from under nail	0.37	0.80	0.74	0.43	0.41	0.04	000
11750		A	Removal of nail bed	2.40	2.96	2.76	1.88	1.85	0.22	010
11752		A	Remove nail bed/finger tip	3.48	4.08	3.81	2.79	2.84	0.35	010
11755		A	Biopsy, nail unit	1.31	2.01	1.90	0.75	0.76	0.14	000
11760		A	Repair of nail bed	1.60	3.45	3.25	1.45	1.54	0.21	010
11762		A	Reconstruction of nail bed	2.91	3.71	3.51	1.69	1.85	0.36	010
11765		A	Excision of nail fold, toe	0.71	2.67	2.45	1.01	0.95	0.08	010
11770		A	Removal of pilonidal lesion	2.63	3.47	3.48	1.52	1.52	0.33	010
11771		A	Removal of pilonidal lesion	5.98	6.74	6.48	3.75	3.64	0.74	090
11772		A	Removal of pilonidal lesion	7.23	8.01	7.89	5.55	5.43	0.89	090
11900		A	Injection into skin lesions	0.52	0.91	0.85	0.25	0.24	0.02	000
11901		A	Added skin lesions injection	0.80	1.00	0.92	0.39	0.38	0.03	000
11920		R	Correct skin color defects	1.61	2.39	2.72	1.12	1.11	0.24	000
11921		R	Correct skin color defects	1.93	2.66	2.99	1.26	1.26	0.29	000
11922		R	Correct skin color defects	0.49	0.92	0.97	0.22	0.23	0.07	ZZZ
11950		R	Therapy for contour defects	0.84	0.93	0.99	0.39	0.39	0.06	000
11951		R	Therapy for contour defects	1.19	1.13	1.22	0.50	0.50	0.11	000
11952		R	Therapy for contour defects	1.69	1.33	1.46	0.57	0.60	0.16	000
11954		R	Therapy for contour defects	1.85	1.79	1.96	0.83	0.85	0.25	000
11960		A	Insert tissue expander(s)	11.01	NA	NA	10.73	10.65	1.31	090
11970		A	Replace tissue expander	7.86	NA	NA	6.19	6.18	1.05	090
11971		A	Remove tissue expander(s)	3.21	7.38	7.83	4.00	3.95	0.32	090
11975		N	Insert contraceptive cap	1.48	1.83	1.73	0.47	0.50	0.17	XXX
11976		R	Removal of contraceptive cap	1.78	1.83	1.80	0.47	0.53	0.21	000

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11977		N	Removal/reinsert contra cap	3.30	2.44	2.40	1.05	1.11	0.37	XXX
11980		A	Implant hormone pellet(s)	1.48	1.05	1.06	0.47	0.49	0.13	000
11981		A	Insert drug implant device	1.48	1.88	1.84	0.57	0.59	0.12	XXX
11982		A	Remove drug implant device	1.78	2.03	2.01	0.70	0.73	0.17	XXX
11983		A	Remove/insert drug implant	3.30	2.63	2.54	1.31	1.35	0.23	XXX
12001		A	Repair superficial wound(s)	1.72	1.75	1.81	0.73	0.74	0.15	010
12002		A	Repair superficial wound(s)	1.88	1.82	1.88	0.85	0.86	0.17	010
12004		A	Repair superficial wound(s)	2.26	2.10	2.16	0.93	0.95	0.21	010
12005		A	Repair superficial wound(s)	2.88	2.53	2.61	1.07	1.10	0.27	010
12006		A	Repair superficial wound(s)	3.68	3.02	3.11	1.28	1.34	0.35	010
12007		A	Repair superficial wound(s)	4.13	3.42	3.52	1.48	1.56	0.45	010
12011		A	Repair superficial wound(s)	1.78	1.92	1.98	0.76	0.77	0.16	010
12013		A	Repair superficial wound(s)	2.01	2.09	2.14	0.90	0.91	0.18	010
12014		A	Repair superficial wound(s)	2.48	2.32	2.38	0.98	1.00	0.23	010
12015		A	Repair superficial wound(s)	3.21	2.82	2.90	1.13	1.16	0.29	010
12016		A	Repair superficial wound(s)	3.94	3.24	3.32	1.32	1.37	0.37	010
12017		A	Repair superficial wound(s)	4.72	NA	NA	1.46	1.57	0.47	010
12018		A	Repair superficial wound(s)	5.54	NA	NA	2.13	2.16	0.64	010
12020		A	Closure of split wound	2.64	3.67	3.71	1.74	1.79	0.30	010
12021		A	Closure of split wound	1.86	1.85	1.85	1.33	1.35	0.24	010
12031		A	Layer closure of wound(s)	2.17	3.91	3.51	1.78	1.58	0.17	010
12032		A	Layer closure of wound(s)	2.49	5.22	4.88	2.28	2.16	0.16	010
12034		A	Layer closure of wound(s)	2.94	4.60	4.25	1.99	1.85	0.25	010
12035		A	Layer closure of wound(s)	3.44	5.34	5.31	2.13	2.14	0.39	010
12036		A	Layer closure of wound(s)	4.06	5.36	5.42	2.21	2.30	0.55	010
12037		A	Layer closure of wound(s)	4.68	5.93	5.98	2.62	2.71	0.66	010
12041		A	Layer closure of wound(s)	2.39	3.89	3.56	1.79	1.63	0.19	010
12042		A	Layer closure of wound(s)	2.76	4.49	4.19	2.12	1.96	0.17	010
12044		A	Layer closure of wound(s)	3.16	5.40	4.86	1.96	1.87	0.27	010
12045		A	Layer closure of wound(s)	3.65	5.11	5.15	2.09	2.14	0.41	010
12046		A	Layer closure of wound(s)	4.26	6.04	6.16	2.46	2.54	0.54	010
12047		A	Layer closure of wound(s)	4.66	6.49	6.46	2.65	2.76	0.58	010
12051		A	Layer closure of wound(s)	2.49	4.11	3.90	1.92	1.80	0.20	010
12052		A	Layer closure of wound(s)	2.81	4.87	4.46	2.57	2.29	0.17	010
12053		A	Layer closure of wound(s)	3.14	5.39	4.86	2.13	1.98	0.23	010
12054		A	Layer closure of wound(s)	3.47	5.43	4.97	2.05	1.95	0.30	010
12055		A	Layer closure of wound(s)	4.44	6.07	5.68	2.10	2.11	0.45	010
12056		A	Layer closure of wound(s)	5.25	6.49	6.56	2.55	2.68	0.59	010
12057		A	Layer closure of wound(s)	5.97	7.69	7.31	3.02	3.21	0.56	010
13100		A	Repair of wound or lesion	3.14	4.51	4.40	2.52	2.47	0.26	010
13101		A	Repair of wound or lesion	3.93	5.95	5.63	2.97	2.90	0.26	010
13102		A	Repair wound/lesion add-on	1.24	1.35	1.30	0.53	0.54	0.13	ZZZ
13120		A	Repair of wound or lesion	3.32	4.63	4.51	2.61	2.54	0.26	010
13121		A	Repair of wound or lesion	4.36	6.70	6.25	3.64	3.43	0.25	010

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13122		A	Repair wound/lesion add-on	1.44	1.36	1.40	0.58	0.59	0.15	ZZZ
13131		A	Repair of wound or lesion	3.80	5.01	4.85	2.87	2.83	0.26	010
13132		A	Repair of wound or lesion	6.48	7.87	7.38	4.94	4.75	0.32	010
13133		A	Repair wound/lesion add-on	2.19	1.88	1.83	0.98	0.99	0.18	ZZZ
13150		A	Repair of wound or lesion	3.82	4.70	4.75	2.71	2.73	0.34	010
13151		A	Repair of wound or lesion	4.46	5.51	5.34	3.22	3.20	0.31	010
13152		A	Repair of wound or lesion	6.34	7.52	7.16	3.90	3.94	0.40	010
13153		A	Repair wound/lesion add-on	2.38	2.03	2.01	1.02	1.05	0.24	ZZZ
13160		A	Late closure of wound	11.84	NA	NA	7.04	7.08	1.54	090
14000		A	Skin tissue rearrangement	6.83	8.90	8.65	6.01	5.88	0.59	090
14001		A	Skin tissue rearrangement	9.60	11.10	10.69	7.56	7.44	0.82	090
14020		A	Skin tissue rearrangement	7.66	10.02	9.67	6.87	6.80	0.64	090
14021		A	Skin tissue rearrangement	11.18	12.48	11.86	8.66	8.58	0.81	090
14040		A	Skin tissue rearrangement	8.44	10.20	9.86	6.99	7.05	0.62	090
14041		A	Skin tissue rearrangement	12.67	13.58	12.84	9.34	9.18	0.73	090
14060		A	Skin tissue rearrangement	9.07	9.68	9.47	7.17	7.24	0.68	090
14061		A	Skin tissue rearrangement	13.67	14.80	14.01	10.14	9.99	0.76	090
14300		A	Skin tissue rearrangement	13.26	13.49	12.91	9.42	9.37	1.16	090
14350		A	Skin tissue rearrangement	10.82	NA	NA	6.82	6.91	1.34	090
15002		A	Wnd prep, ch/inf, trk/arm/lg	3.65	4.23	4.23	1.67	1.67	0.49	000
15003		A	Wnd prep, ch/inf addl 100 cm	0.80	0.91	0.91	0.26	0.26	0.11	ZZZ
15004		A	Wnd prep ch/inf, f/n/hf/g	4.58	4.94	4.94	2.07	2.07	0.62	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.24	1.24	0.53	0.53	0.22	ZZZ
15040		A	Harvest cultured skin graft	2.00	3.94	4.10	1.00	1.03	0.24	000
15050		A	Skin pinch graft	5.37	7.64	7.46	5.02	5.05	0.57	090
15100		A	Skin splt grft, trnk/arm/leg	9.74	9.82	10.52	6.71	7.00	1.28	090
15101		A	Skin splt grft t/a/l, add-on	1.72	2.48	2.79	0.85	0.93	0.24	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.88	8.47	9.03	6.08	6.32	1.31	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	0.89	0.99	0.63	0.67	0.26	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.19	8.95	9.03	6.49	6.72	1.15	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.30	1.37	0.96	1.00	0.33	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	10.96	11.32	11.18	7.42	7.52	1.16	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.42	3.69	1.25	1.40	0.36	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.41	7.89	8.40	5.52	5.73	0.97	090
15131		A	Derm autograft t/a/l add-on	1.50	0.73	0.81	0.55	0.57	0.21	ZZZ
15135		A	Derm autograft face/nck/hf/g	10.91	9.18	9.37	6.78	7.13	1.23	090
15136		A	Derm autograft, f/n/hf/g add	1.50	0.53	0.62	0.39	0.46	0.20	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.30	6.64	7.10	5.42	5.69	1.14	090
15151		A	Cult epiderm grft t/a/l addl	2.00	0.90	1.00	0.71	0.74	0.28	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.34	1.40	1.13	1.11	0.35	ZZZ
15155		A	Cult epiderm graft, f/n/hf/g	10.05	7.06	7.26	5.76	6.07	1.05	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.36	1.41	1.16	1.18	0.36	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.51	1.58	1.21	1.24	0.39	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	4.16	4.08	2.73	2.64	0.55	090

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15171		A	Acell graft t/arm/leg add-on	1.55	0.64	0.65	0.50	0.53	0.19	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	4.51	4.75	3.18	3.39	0.82	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.09	1.09	0.83	0.87	0.29	ZZZ
15200		A	Skin full graft, trunk	8.97	10.17	9.99	6.55	6.47	0.98	090
15201		A	Skin full graft trunk add-on	1.32	2.07	2.20	0.52	0.54	0.19	ZZZ
15220		A	Skin full graft sclp/arm/leg	7.95	10.47	10.16	6.71	6.71	0.84	090
15221		A	Skin full graft add-on	1.19	2.02	2.10	0.52	0.53	0.16	ZZZ
15240		A	Skin full grft face/genit/hf	10.15	12.06	11.61	8.92	8.68	0.92	090
15241		A	Skin full graft add-on	1.86	2.54	2.51	0.81	0.83	0.23	ZZZ
15260		A	Skin full graft een & lips	11.39	13.01	12.32	9.33	9.15	0.69	090
15261		A	Skin full graft add-on	2.23	2.96	2.89	1.15	1.21	0.21	ZZZ
15300		A	Apply skinallogrft, t/arm/lg	4.65	3.49	3.42	2.18	2.20	0.49	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0.49	0.48	0.35	0.36	0.14	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	3.77	3.74	2.34	2.39	0.58	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.70	0.70	0.52	0.54	0.21	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	3.55	3.46	2.18	2.20	0.49	090
15331		A	Aply acell grft t/a/l add-on	1.00	0.48	0.48	0.36	0.37	0.14	ZZZ
15335		A	Apply acell graft, f/n/hf/g	4.50	3.28	3.33	1.98	2.10	0.55	090
15336		A	Aply acell grft f/n/hf/g add	1.43	0.62	0.64	0.41	0.45	0.20	ZZZ
15340		A	Apply cult skin substitute	3.76	3.72	3.79	2.66	2.69	0.41	010
15341		A	Apply cult skin sub add-on	0.50	0.64	0.63	0.14	0.15	0.06	ZZZ
15360		A	Apply cult derm sub, t/a/l	3.93	4.73	4.67	3.45	3.36	0.43	090
15361		A	Aply cult derm sub t/a/l add	1.15	0.51	0.52	0.33	0.36	0.14	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.21	4.12	4.23	3.02	3.06	0.46	090
15366		A	Apply cult derm f/hf/g add	1.45	0.57	0.61	0.38	0.43	0.17	ZZZ
15400		A	Apply skin xenograft, t/a/l	4.38	5.32	5.00	4.02	4.03	0.47	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.00	1.22	0.32	0.35	0.14	ZZZ
15420		A	Apply skin xgraft, f/n/hf/g	4.89	5.94	5.66	4.59	4.40	0.52	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.16	1.20	0.48	0.51	0.21	ZZZ
15430		A	Apply acellular xenograft	5.93	6.37	6.51	5.83	6.03	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	10.29	10.55	6.41	6.50	1.34	090
15572		A	Form skin pedicle flap	9.94	9.87	9.79	6.72	6.66	1.20	090
15574		A	Form skin pedicle flap	10.52	10.61	10.64	7.08	7.27	1.20	090
15576		A	Form skin pedicle flap	9.24	9.70	9.73	6.55	6.64	0.87	090
15600		A	Skin graft	1.95	5.36	5.93	2.77	2.85	0.27	090
15610		A	Skin graft	2.46	5.62	5.39	3.09	3.17	0.35	090
15620		A	Skin graft	3.62	6.47	6.81	3.90	3.90	0.35	090
15630		A	Skin graft	3.95	7.08	7.08	4.31	4.28	0.34	090
15650		A	Transfer skin pedicle flap	4.64	7.75	7.61	4.71	4.59	0.42	090
15731		A	Forehead flap w/vasc pedicle	14.12	12.67	12.67	9.95	9.95	1.28	090
15732		A	Muscle-skin graft, head/neck	19.70	14.61	15.48	11.06	11.36	2.00	090
15734		A	Muscle-skin graft, trunk	19.62	15.65	16.28	11.79	11.95	2.62	090
15736		A	Muscle-skin graft, arm	16.92	13.62	14.79	9.83	10.19	2.46	090

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15738		A	Muscle-skin graft, leg	18.92	13.82	14.88	10.24	10.62	2.66	090
15740		A	Island pedicle flap graft	11.57	13.57	12.72	9.41	9.13	0.63	090
15750		A	Neurovascular pedicle graft	12.73	NA	NA	8.69	8.79	1.42	090
15756		A	Free myo/skin flap microvasc	36.74	NA	NA	18.67	19.17	4.62	090
15757		A	Free skin flap, microvasc	36.95	NA	NA	17.80	18.77	3.90	090
15758		A	Free fascial flap, microvasc	36.70	NA	NA	17.95	18.88	4.24	090
15760		A	Composite skin graft	9.68	10.42	10.33	7.04	7.11	0.85	090
15770		A	Derma-fat-fascia graft	8.73	NA	NA	6.68	6.68	1.05	090
15775		R	Hair transplant punch grafts	3.95	3.50	3.69	1.63	1.55	0.52	000
15776		R	Hair transplant punch grafts	5.53	4.91	5.03	2.16	2.32	0.72	000
15780		A	Abrasion treatment of skin	8.50	11.43	11.47	6.60	7.02	0.67	090
15781		A	Abrasion treatment of skin	4.91	8.28	7.94	5.38	5.38	0.34	090
15782		A	Abrasion treatment of skin	4.36	9.18	9.36	5.24	5.58	0.34	090
15783		A	Abrasion treatment of skin	4.33	7.50	7.35	4.67	4.55	0.28	090
15786		A	Abrasion, lesion, single	2.05	3.88	3.75	1.27	1.28	0.11	010
15787		A	Abrasion, lesions, add-on	0.33	0.78	0.86	0.10	0.11	0.04	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	8.93	8.38	3.89	3.69	0.11	090
15789		R	Chemical peel, face, dermal	4.91	9.05	8.82	5.60	5.41	0.20	090
15792		R	Chemical peel, nonfacial	1.86	8.91	8.46	4.55	4.53	0.13	090
15793		A	Chemical peel, nonfacial	3.82	8.08	7.64	4.88	4.76	0.19	090
15819		A	Plastic surgery, neck	10.45	NA	NA	6.92	6.99	0.97	090
15820		A	Revision of lower eyelid	6.09	6.47	6.60	5.26	5.34	0.40	090
15821		A	Revision of lower eyelid	6.66	6.62	6.81	5.32	5.43	0.45	090
15822		A	Revision of upper eyelid	4.51	5.27	5.42	4.12	4.22	0.37	090
15823		A	Revision of upper eyelid	8.12	7.45	7.56	6.17	6.24	0.50	090
15830		R	Exc skin abd	16.90	NA	NA	9.95	9.95	2.93	090
15832		A	Excise excessive skin tissue	12.65	NA	NA	8.03	8.12	1.66	090
15833		A	Excise excessive skin tissue	11.70	NA	NA	7.82	7.92	1.49	090
15834		A	Excise excessive skin tissue	11.97	NA	NA	7.49	7.55	1.61	090
15835		A	Excise excessive skin tissue	12.79	NA	NA	7.97	7.87	1.60	090
15836		A	Excise excessive skin tissue	10.41	NA	NA	6.84	6.83	1.34	090
15837		A	Excise excessive skin tissue	9.37	8.68	8.66	5.82	6.22	1.18	090
15838		A	Excise excessive skin tissue	8.07	NA	NA	5.55	5.68	0.58	090
15839		A	Excise excessive skin tissue	10.32	10.06	9.76	6.71	6.64	1.22	090
15840		A	Graft for face nerve palsy	14.76	NA	NA	8.97	9.23	1.32	090
15841		A	Graft for face nerve palsy	25.69	NA	NA	13.94	14.22	2.55	090
15842		A	Flap for face nerve palsy	40.68	NA	NA	20.75	21.32	4.94	090
15845		A	Skin and muscle repair, face	14.04	NA	NA	8.46	8.68	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	1.41	1.45	0.25	0.26	0.05	XXX
15851		A	Removal of sutures	0.86	1.32	1.41	0.24	0.25	0.06	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.26	0.28	0.09	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.66	0.69	0.27	000
15920		A	Removal of tail bone ulcer	8.15	NA	NA	5.57	5.57	1.04	090

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15922		A	Removal of tail bone ulcer	10.23	NA	NA	7.06	7.10	1.42	090
15931		A	Remove sacrum pressure sore	9.96	NA	NA	5.53	5.58	1.25	090
15933		A	Remove sacrum pressure sore	11.60	NA	NA	7.45	7.56	1.52	090
15934		A	Remove sacrum pressure sore	13.54	NA	NA	7.63	7.74	1.79	090
15935		A	Remove sacrum pressure sore	15.58	NA	NA	9.49	9.71	2.10	090
15936		A	Remove sacrum pressure sore	13.04	NA	NA	7.31	7.55	1.77	090
15937		A	Remove sacrum pressure sore	15.00	NA	NA	8.82	9.08	2.07	090
15940		A	Remove hip pressure sore	10.11	NA	NA	5.74	5.85	1.31	090
15941		A	Remove hip pressure sore	12.24	NA	NA	8.29	8.59	1.66	090
15944		A	Remove hip pressure sore	12.27	NA	NA	8.03	8.18	1.65	090
15945		A	Remove hip pressure sore	13.57	NA	NA	8.95	9.14	1.85	090
15946		A	Remove hip pressure sore	23.80	NA	NA	13.93	14.06	3.17	090
15950		A	Remove thigh pressure sore	7.91	NA	NA	5.37	5.39	1.04	090
15951		A	Remove thigh pressure sore	11.41	NA	NA	7.38	7.50	1.49	090
15952		A	Remove thigh pressure sore	12.14	NA	NA	7.66	7.69	1.60	090
15953		A	Remove thigh pressure sore	13.39	NA	NA	8.59	8.70	1.80	090
15956		A	Remove thigh pressure sore	16.59	NA	NA	9.68	9.96	2.22	090
15958		A	Remove thigh pressure sore	16.55	NA	NA	10.38	10.56	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	0.72	0.76	0.23	0.24	0.08	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.10	1.15	0.55	0.56	0.08	000
16025		A	Dress/debrid p-thick burn, m	1.85	1.60	1.64	0.87	0.90	0.19	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.04	2.08	0.99	1.02	0.24	000
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.23	1.32	0.46	000
16036		A	Escharotomy; add ╞l incision	1.50	NA	NA	0.46	0.50	0.20	ZZZ
17000		A	Destruct premalg lesion	0.62	1.41	1.30	0.74	0.69	0.03	010
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.10	0.03	0.04	0.01	ZZZ
17004		A	Destroy premlg lesions 15+	1.82	2.43	2.40	1.37	1.42	0.11	010
17106		A	Destruction of skin lesions	4.62	4.67	4.66	3.26	3.28	0.35	090
17107		A	Destruction of skin lesions	9.19	6.71	6.84	4.76	4.94	0.63	090
17108		A	Destruction of skin lesions	13.22	8.17	8.46	5.85	6.31	0.54	090
17110		A	Destruct b9 lesion, 1-14	0.67	2.14	2.01	1.06	0.97	0.05	010
17111		A	Destruct lesion, 15 or more	0.94	2.42	2.24	1.20	1.10	0.05	010
17250		A	Chemical cautery, tissue	0.50	1.33	1.30	0.38	0.37	0.06	000
17260		A	Destruction of skin lesions	0.93	1.40	1.37	0.70	0.69	0.04	010
17261		A	Destruction of skin lesions	1.19	2.48	2.26	1.06	1.00	0.05	010
17262		A	Destruction of skin lesions	1.60	2.82	2.59	1.26	1.20	0.06	010
17263		A	Destruction of skin lesions	1.81	3.04	2.80	1.36	1.29	0.07	010
17264		A	Destruction of skin lesions	1.96	3.23	2.98	1.42	1.34	0.08	010
17266		A	Destruction of skin lesions	2.36	3.47	3.23	1.58	1.49	0.09	010
17270		A	Destruction of skin lesions	1.34	2.41	2.24	1.08	1.03	0.05	010
17271		A	Destruction of skin lesions	1.51	2.65	2.43	1.21	1.15	0.06	010
17272		A	Destruction of skin lesions	1.79	2.95	2.72	1.35	1.29	0.07	010
17273		A	Destruction of skin lesions	2.07	3.19	2.95	1.48	1.41	0.08	010

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17274		A	Destruction of skin lesions	2.61	3.57	3.32	1.72	1.65	0.10	010
17276		A	Destruction of skin lesions	3.22	3.83	3.61	1.95	1.89	0.16	010
17280		A	Destruction of skin lesions	1.19	2.35	2.16	1.02	0.97	0.05	010
17281		A	Destruction of skin lesions	1.74	2.72	2.52	1.32	1.26	0.07	010
17282		A	Destruction of skin lesions	2.06	3.11	2.88	1.47	1.42	0.08	010
17283		A	Destruction of skin lesions	2.66	3.52	3.28	1.75	1.68	0.11	010
17284		A	Destruction of skin lesions	3.23	3.92	3.67	2.00	1.94	0.13	010
17286		A	Destruction of skin lesions	4.45	4.41	4.23	2.48	2.48	0.23	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.64	10.64	3.02	3.02	0.24	000
17312		A	Mohs addl stage	3.30	6.84	6.84	1.61	1.61	0.13	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	9.82	9.82	2.71	2.71	0.22	000
17314		A	Mohs, addl stage, t/a/l	3.06	6.33	6.33	1.48	1.48	0.12	ZZZ
17315		A	Mohs surg, addl block	0.87	1.13	1.13	0.43	0.43	0.03	ZZZ
17340		A	Cryotherapy of skin	0.76	0.42	0.41	0.37	0.37	0.05	010
17360		A	Skin peel therapy	1.44	1.85	1.75	1.00	0.97	0.06	010
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	1.93	1.94	0.27	0.28	0.08	000
19001		A	Drain breast lesion add-on	0.42	0.26	0.26	0.14	0.14	0.04	ZZZ
19020		A	Incision of breast lesion	3.74	6.66	6.59	3.05	2.96	0.45	090
19030		A	Injection for breast x-ray	1.53	2.71	2.75	0.56	0.54	0.09	000
19100		A	Bx breast percut w/o image	1.27	2.09	2.09	0.33	0.35	0.16	000
19101		A	Biopsy of breast, open	3.20	4.39	4.42	1.78	1.82	0.39	010
19102		A	Bx breast percut w/image	2.00	3.51	3.59	0.70	0.69	0.14	000
19103		A	Bx breast percut w/device	3.69	10.19	10.53	1.22	1.22	0.30	000
19105		A	Cryosurg ablate fa, each	3.69	52.72	52.72	1.24	1.24	0.30	000
19110		A	Nipple exploration	4.35	6.39	6.25	3.25	3.16	0.57	090
19112		A	Excise breast duct fistula	3.72	6.31	6.25	3.17	3.05	0.48	090
19120		A	Removal of breast lesion	5.84	5.10	4.97	3.38	3.30	0.73	090
19125		A	Excision, breast lesion	6.59	5.56	5.37	3.65	3.56	0.80	090
19126		A	Excision, addl breast lesion	2.93	NA	NA	0.75	0.81	0.38	ZZZ
19260		A	Removal of chest wall lesion	17.60	NA	NA	10.08	10.36	2.14	090
19271		A	Revision of chest wall	21.86	NA	NA	15.76	16.33	2.63	090
19272		A	Extensive chest wall surgery	24.82	NA	NA	16.81	17.36	3.00	090
19290		A	Place needle wire, breast	1.27	2.93	2.91	0.46	0.45	0.07	000
19291		A	Place needle wire, breast	0.63	1.15	1.17	0.22	0.22	0.04	ZZZ
19295		A	Place breast clip, percut	0.00	2.29	2.40	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	86.21	96.15	1.19	1.27	0.36	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.44	0.49	0.17	ZZZ
19298		A	Place breast rad tube/caths	6.00	22.08	27.15	2.04	2.14	0.43	000
19300		A	Removal of breast tissue	5.20	8.02	7.81	3.84	3.73	0.69	090
19301		A	Partical mastectomy	10.00	NA	NA	4.63	4.33	0.79	090
19302		A	P-mastectomy w/ln removal	13.88	NA	NA	6.16	6.21	1.80	090
19303		A	Mast, simple, complete	15.67	NA	NA	7.00	6.51	1.18	090
19304		A	Mast, subq	7.81	NA	NA	4.92	4.88	1.04	090

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19305		A	Mast, radical	17.23	NA	NA	8.06	8.04	1.93	090
19306		A	Mast, rad, urban type	17.85	NA	NA	8.75	8.63	2.08	090
19307		A	Mast, mod rad	17.95	NA	NA	8.78	8.65	2.13	090
19316		A	Suspension of breast	10.98	NA	NA	6.86	7.03	1.64	090
19318		A	Reduction of large breast	15.91	NA	NA	9.94	10.26	2.93	090
19324		A	Enlarge breast	6.65	NA	NA	4.34	4.48	0.84	090
19325		A	Enlarge breast with implant	8.52	NA	NA	6.44	6.47	1.33	090
19328		A	Removal of breast implant	6.35	NA	NA	5.02	5.03	0.91	090
19330		A	Removal of implant material	8.39	NA	NA	6.21	6.17	1.26	090
19340		A	Immediate breast prosthesis	6.32	NA	NA	2.82	2.90	1.06	ZZZ
19342		A	Delayed breast prosthesis	12.40	NA	NA	9.00	8.99	1.84	090
19350		A	Breast reconstruction	8.99	9.91	10.91	6.60	6.75	1.41	090
19355		A	Correct inverted nipple(s)	8.37	7.59	8.27	4.79	4.77	0.92	090
19357		A	Breast reconstruction	20.57	NA	NA	15.45	15.51	2.94	090
19361		A	Breast reconstr w/lat flap	23.17	NA	NA	16.78	15.71	2.93	090
19364		A	Breast reconstruction	42.40	NA	NA	22.52	22.80	6.24	090
19366		A	Breast reconstruction	21.70	NA	NA	9.92	10.34	3.25	090
19367		A	Breast reconstruction	26.59	NA	NA	15.31	15.68	4.04	090
19368		A	Breast reconstruction	33.61	NA	NA	18.09	18.32	5.54	090
19369		A	Breast reconstruction	31.02	NA	NA	16.07	16.68	4.51	090
19370		A	Surgery of breast capsule	8.99	NA	NA	6.81	6.84	1.29	090
19371		A	Removal of breast capsule	10.42	NA	NA	7.72	7.76	1.62	090
19380		A	Revise breast reconstruction	10.21	NA	NA	7.65	7.67	1.44	090
19396		A	Design custom breast implant	2.17	3.73	3.07	0.95	0.96	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	2.79	2.77	1.53	1.58	0.25	010
20005		A	Incision of deep abscess	3.55	3.69	3.64	2.03	2.09	0.46	010
20100		A	Explore wound, neck	10.33	NA	NA	3.31	3.60	1.21	010
20101		A	Explore wound, chest	3.22	6.32	6.23	1.50	1.53	0.44	010
20102		A	Explore wound, abdomen	3.95	6.96	7.09	1.85	1.86	0.49	010
20103		A	Explore wound, extremity	5.31	7.84	8.04	2.80	2.95	0.75	010
20150		A	Excise epiphyseal bar	14.60	NA	NA	8.19	7.91	2.04	090
20200		A	Muscle biopsy	1.46	3.16	3.13	0.71	0.72	0.23	000
20205		A	Deep muscle biopsy	2.35	3.86	3.87	1.11	1.13	0.33	000
20206		A	Needle biopsy, muscle	0.99	5.28	5.59	0.58	0.60	0.07	000
20220		A	Bone biopsy, trocar/needle	1.27	2.74	3.20	0.69	0.72	0.08	000
20225		A	Bone biopsy, trocar/needle	1.87	12.18	15.28	1.05	1.07	0.22	000
20240		A	Bone biopsy, excisional	3.25	NA	NA	2.03	2.17	0.44	010
20245		A	Bone biopsy, excisional	8.77	NA	NA	5.69	5.92	1.31	010
20250		A	Open bone biopsy	5.16	NA	NA	3.51	3.51	1.02	010
20251		A	Open bone biopsy	5.69	NA	NA	3.84	3.92	1.15	010
20500		A	Injection of sinus tract	1.25	1.36	1.59	0.90	1.06	0.12	010
20501		A	Inject sinus tract for x-ray	0.76	2.41	2.54	0.28	0.27	0.04	000
20520		A	Removal of foreign body	1.87	2.60	2.68	1.45	1.53	0.21	010

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20525		A	Removal of foreign body	3.51	7.15	7.66	2.22	2.32	0.51	010
20526		A	Ther injection, carp tunnel	0.94	0.81	0.85	0.41	0.44	0.13	000
20550		A	Inj tendon sheath/ligament	0.75	0.63	0.65	0.28	0.27	0.09	000
20551		A	Inj tendon origin/insertion	0.75	0.63	0.64	0.28	0.29	0.08	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.58	0.62	0.25	0.23	0.05	000
20553		A	Inject trigger points, =/> 3	0.75	0.65	0.69	0.27	0.26	0.04	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.20	2.20	0.43	000
20600		A	Drain/inject, joint/bursa	0.66	0.66	0.66	0.31	0.32	0.08	000
20605		A	Drain/inject, joint/bursa	0.68	0.74	0.74	0.32	0.33	0.08	000
20610		A	Drain/inject, joint/bursa	0.79	1.07	1.04	0.40	0.41	0.11	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.70	0.71	0.32	0.33	0.10	000
20615		A	Treatment of bone cyst	2.30	2.76	2.95	1.45	1.55	0.20	010
20650		A	Insert and remove bone pin	2.25	2.47	2.45	1.45	1.48	0.31	010
20660		A	Apply, rem fixation device	4.00	1.50	1.89	1.50	1.53	0.59	000
20661		A	Application of head brace	5.14	NA	NA	5.94	5.69	1.14	090
20662		A	Application of pelvis brace	6.26	NA	NA	5.08	5.20	0.56	090
20663		A	Application of thigh brace	5.62	NA	NA	4.67	4.72	0.94	090
20664		A	Halo brace application	9.86	NA	NA	8.06	7.81	1.75	090
20665		A	Removal of fixation device	1.33	1.34	1.55	0.96	1.05	0.19	010
20670		A	Removal of support implant	1.76	6.62	7.87	1.67	1.78	0.28	010
20680		A	Removal of support implant	5.90	8.12	8.30	4.06	3.98	0.56	090
20690		A	Apply bone fixation device	8.65	NA	NA	4.99	4.37	0.59	090
20692		A	Apply bone fixation device	16.00	NA	NA	10.00	8.44	1.05	090
20693		A	Adjust bone fixation device	5.97	NA	NA	4.53	4.77	0.98	090
20694		A	Remove bone fixation device	4.20	5.32	5.79	3.54	3.67	0.71	090
20802		A	Replantation, arm, complete	42.30	NA	NA	15.25	16.70	3.82	090
20805		A	Replant forearm, complete	51.14	NA	NA	16.85	21.26	4.85	090
20808		A	Replantation hand, complete	62.77	NA	NA	32.21	34.77	6.88	090
20816		A	Replantation digit, complete	31.74	NA	NA	16.48	21.85	4.53	090
20822		A	Replantation digit, complete	26.42	NA	NA	13.65	18.93	4.19	090
20824		A	Replantation thumb, complete	31.74	NA	NA	16.65	21.67	4.62	090
20827		A	Replantation thumb, complete	27.24	NA	NA	14.87	20.31	3.67	090
20838		A	Replantation foot, complete	42.56	NA	NA	17.82	18.96	1.12	090
20900		A	Removal of bone for graft	5.77	9.30	9.09	4.93	5.13	0.94	090
20902		A	Removal of bone for graft	7.98	NA	NA	5.99	6.22	1.30	090
20910		A	Remove cartilage for graft	5.41	NA	NA	4.74	4.86	0.71	090
20912		A	Remove cartilage for graft	6.42	NA	NA	4.91	5.14	0.69	090
20920		A	Removal of fascia for graft	5.42	NA	NA	4.27	4.26	0.66	090
20922		A	Removal of fascia for graft	6.84	7.81	7.75	5.12	5.06	0.70	090
20924		A	Removal of tendon for graft	6.59	NA	NA	5.00	5.23	1.04	090
20926		A	Removal of tissue for graft	5.70	NA	NA	4.48	4.55	0.87	090
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	0.68	0.74	0.43	ZZZ
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.08	1.17	0.54	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.15	1.25	0.64	ZZZ

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20950		A	Fluid pressure, muscle	1.26	4.03	4.74	0.85	0.88	0.20	000
20955		A	Fibula bone graft, microvasc	40.02	NA	NA	19.35	20.61	4.90	090
20956		A	Iliac bone graft, microvasc	40.93	NA	NA	19.79	21.06	7.03	090
20957		A	Mt bone graft, microvasc	42.33	NA	NA	16.29	16.97	7.07	090
20962		A	Other bone graft, microvasc	39.21	NA	NA	20.33	21.91	6.57	090
20969		A	Bone/skin graft, microvasc	45.11	NA	NA	20.96	22.41	4.80	090
20970		A	Bone/skin graft, iliac crest	44.26	NA	NA	21.41	22.43	6.62	090
20972		A	Bone/skin graft, metatarsal	44.19	NA	NA	16.45	17.51	5.32	090
20973		A	Bone/skin graft, great toe	46.95	NA	NA	15.60	18.02	5.56	090
20974		A	Electrical bone stimulation	0.62	1.02	0.94	0.50	0.51	0.11	000
20975		A	Electrical bone stimulation	2.60	NA	NA	1.47	1.53	0.51	000
20979		A	Us bone stimulation	0.62	0.61	0.66	0.20	0.24	0.09	000
20982		A	Ablate, bone tumor(s) perq	7.27	80.49	87.88	2.73	2.79	0.69	000
20985		A	Cptr-asst dir ms px	2.50	0.99	0.99	0.99	0.99	0.48	ZZZ
20986		C	Cptr-asst dir ms px io img	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
20987		C	Cptr-asst dir ms px pre img	0.00	0.00	0.00	0.00	0.00	0.00	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	6.17	6.41	1.11	090
21015		A	Resection of facial tumor	5.59	NA	NA	4.37	4.53	0.70	090
21025		A	Excision of bone, lower jaw	11.07	12.63	12.55	8.81	8.95	1.32	090
21026		A	Excision of facial bone(s)	5.54	8.82	8.59	5.93	6.03	0.60	090
21029		A	Contour of face bone lesion	8.26	9.61	9.56	6.54	6.67	0.94	090
21030		A	Excise max/zygoma b9 tumor	4.80	7.20	6.99	4.69	4.78	0.54	090
21031		A	Remove exostosis, mandible	3.26	5.99	5.79	3.52	3.55	0.48	090
21032		A	Remove exostosis, maxilla	3.28	6.09	5.91	3.39	3.43	0.47	090
21034		A	Excise max/zygoma mlg tumor	17.17	13.95	14.46	10.12	10.77	1.72	090
21040		A	Excise mandible lesion	4.80	7.29	7.08	4.71	4.72	0.54	090
21044		A	Removal of jaw bone lesion	12.61	NA	NA	8.11	8.43	1.12	090
21045		A	Extensive jaw surgery	18.13	NA	NA	10.79	11.20	1.52	090
21046		A	Remove mandible cyst complex	13.97	NA	NA	11.72	11.78	1.86	090
21047		A	Excise lwr jaw cyst w/repair	19.83	NA	NA	10.38	11.16	2.13	090
21048		A	Remove maxilla cyst complex	14.47	NA	NA	11.47	11.65	1.77	090
21049		A	Excis uppr jaw cyst w/repair	19.08	NA	NA	10.55	11.18	1.59	090
21050		A	Removal of jaw joint	11.54	NA	NA	8.78	8.95	1.47	090
21060		A	Remove jaw joint cartilage	10.91	NA	NA	7.49	7.78	1.38	090
21070		A	Remove coronoid process	8.50	NA	NA	6.41	6.59	1.27	090
21073		A	Mnpj of tmj w/anesth	3.33	5.46	5.46	2.29	2.29	0.43	090
21076		A	Prepare face/oral prosthesis	13.40	8.13	9.20	4.77	6.09	2.00	010
21077		A	Prepare face/oral prosthesis	33.70	19.02	22.13	12.42	15.85	4.56	090
21079		A	Prepare face/oral prosthesis	22.31	14.09	15.96	8.19	10.45	3.16	090
21080		A	Prepare face/oral prosthesis	25.06	16.22	18.31	9.06	11.66	3.75	090
21081		A	Prepare face/oral prosthesis	22.85	15.07	16.90	8.45	10.73	3.21	090
21082		A	Prepare face/oral prosthesis	20.84	15.00	16.11	8.32	10.19	3.12	090

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21083		A	Prepare face/oral prosthesis	19.27	14.92	15.91	7.80	9.47	2.89	090
21084		A	Prepare face/oral prosthesis	22.48	16.87	18.28	8.96	11.16	2.19	090
21085		A	Prepare face/oral prosthesis	8.99	6.92	7.27	3.51	4.34	1.27	010
21086		A	Prepare face/oral prosthesis	24.88	12.90	15.64	8.44	11.21	3.72	090
21087		A	Prepare face/oral prosthesis	24.88	13.08	15.65	8.58	11.25	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	13.10	12.72	5.11	5.02	0.34	090
21110		A	Interdental fixation	5.80	13.05	12.19	9.73	9.39	0.72	090
21116		A	Injection, jaw joint x-ray	0.81	2.40	2.89	0.22	0.24	0.06	000
21120		A	Reconstruction of chin	4.99	9.73	9.95	6.68	6.89	0.60	090
21121		A	Reconstruction of chin	7.70	11.16	10.81	7.99	7.96	0.90	090
21122		A	Reconstruction of chin	8.59	NA	NA	8.45	8.50	1.07	090
21123		A	Reconstruction of chin	11.22	NA	NA	8.63	9.18	1.40	090
21125		A	Augmentation, lower jaw bone	10.68	67.21	64.28	6.84	7.22	0.79	090
21127		A	Augmentation, lower jaw bone	12.24	88.80	77.35	8.00	8.37	1.52	090
21137		A	Reduction of forehead	10.12	NA	NA	6.53	6.84	1.32	090
21138		A	Reduction of forehead	12.73	NA	NA	7.91	8.33	1.75	090
21139		A	Reduction of forehead	14.90	NA	NA	8.79	9.37	1.18	090
21141		A	Reconstruct midface, lefort	19.27	NA	NA	12.31	12.66	2.36	090
21142		A	Reconstruct midface, lefort	19.98	NA	NA	10.99	11.47	2.39	090
21143		A	Reconstruct midface, lefort	20.75	NA	NA	11.77	12.42	1.66	090
21145		A	Reconstruct midface, lefort	23.64	NA	NA	12.55	12.90	2.85	090
21146		A	Reconstruct midface, lefort	24.54	NA	NA	14.25	14.54	3.10	090
21147		A	Reconstruct midface, lefort	26.14	NA	NA	14.72	14.82	1.85	090
21150		A	Reconstruct midface, lefort	25.78	NA	NA	13.70	14.48	2.56	090
21151		A	Reconstruct midface, lefort	28.84	NA	NA	19.75	20.58	2.31	090
21154		A	Reconstruct midface, lefort	31.05	NA	NA	16.86	18.45	2.49	090
21155		A	Reconstruct midface, lefort	34.98	NA	NA	17.13	18.84	6.66	090
21159		A	Reconstruct midface, lefort	42.90	NA	NA	19.65	22.04	8.20	090
21160		A	Reconstruct midface, lefort	46.95	NA	NA	20.94	22.61	4.14	090
21172		A	Reconstruct orbit/forehead	28.07	NA	NA	13.81	13.81	3.56	090
21175		A	Reconstruct orbit/forehead	33.43	NA	NA	16.57	16.89	4.84	090
21179		A	Reconstruct entire forehead	22.53	NA	NA	11.78	12.39	2.81	090
21180		A	Reconstruct entire forehead	25.46	NA	NA	13.76	14.18	3.49	090
21181		A	Contour cranial bone lesion	10.18	NA	NA	6.18	6.51	1.32	090
21182		A	Reconstruct cranial bone	32.45	NA	NA	15.55	16.46	2.81	090
21183		A	Reconstruct cranial bone	35.57	NA	NA	17.42	18.30	4.48	090
21184		A	Reconstruct cranial bone	38.49	NA	NA	17.30	18.48	5.72	090
21188		A	Reconstruction of midface	22.97	NA	NA	15.72	16.53	1.70	090
21193		A	Reconst lwr jaw w/o graft	18.65	NA	NA	10.08	10.74	2.24	090
21194		A	Reconst lwr jaw w/graft	21.54	NA	NA	11.93	12.40	2.03	090
21195		A	Reconst lwr jaw w/o fixation	18.88	NA	NA	12.76	13.29	1.64	090
21196		A	Reconst lwr jaw w/fixation	20.55	NA	NA	13.81	14.30	2.08	090

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21198		A	Reconstr lwr jaw segment	15.48	NA	NA	11.95	12.15	1.44	090
21199		A	Reconstr lwr jaw w/advance	16.62	NA	NA	7.68	8.05	1.39	090
21206		A	Reconstruct upper jaw bone	15.36	NA	NA	11.60	11.88	1.33	090
21208		A	Augmentation of facial bones	11.15	33.96	31.08	8.26	8.60	1.09	090
21209		A	Reduction of facial bones	7.58	12.24	11.90	7.43	7.60	0.90	090
21210		A	Face bone graft	11.40	43.89	39.16	7.76	8.17	1.30	090
21215		A	Lower jaw bone graft	11.94	86.14	75.12	7.97	8.33	1.53	090
21230		A	Rib cartilage graft	11.06	NA	NA	6.77	7.09	1.29	090
21235		A	Ear cartilage graft	7.31	10.16	10.09	6.20	6.26	0.61	090
21240		A	Reconstruction of jaw joint	15.77	NA	NA	9.65	10.26	2.25	090
21242		A	Reconstruction of jaw joint	14.32	NA	NA	9.08	9.70	1.79	090
21243		A	Reconstruction of jaw joint	24.03	NA	NA	14.48	15.24	3.26	090
21244		A	Reconstruction of lower jaw	13.35	NA	NA	11.57	11.72	1.25	090
21245		A	Reconstruction of jaw	12.88	14.39	14.41	8.79	9.07	1.19	090
21246		A	Reconstruction of jaw	12.78	NA	NA	6.91	7.46	1.35	090
21247		A	Reconstruct lower jaw bone	24.05	NA	NA	13.12	14.20	2.84	090
21248		A	Reconstruction of jaw	12.54	13.00	12.80	7.78	8.20	1.55	090
21249		A	Reconstruction of jaw	18.57	16.19	16.34	9.98	10.67	2.49	090
21255		A	Reconstruct lower jaw bone	18.14	NA	NA	16.15	16.16	2.39	090
21256		A	Reconstruction of orbit	17.42	NA	NA	10.13	10.56	1.50	090
21260		A	Revise eye sockets	17.74	NA	NA	15.20	14.61	0.97	090
21261		A	Revise eye sockets	33.78	NA	NA	18.69	20.11	3.43	090
21263		A	Revise eye sockets	30.72	NA	NA	17.72	18.08	2.63	090
21267		A	Revise eye sockets	20.45	NA	NA	15.66	16.71	1.71	090
21268		A	Revise eye sockets	26.78	NA	NA	17.63	18.30	3.66	090
21270		A	Augmentation, cheek bone	10.52	11.20	11.32	5.92	6.26	0.72	090
21275		A	Revision, orbitofacial bones	11.65	NA	NA	7.29	7.51	1.29	090
21280		A	Revision of eyelid	6.92	NA	NA	5.64	5.72	0.42	090
21282		A	Revision of eyelid	4.11	NA	NA	4.22	4.29	0.26	090
21295		A	Revision of jaw muscle/bone	1.82	NA	NA	2.35	2.40	0.16	090
21296		A	Revision of jaw muscle/bone	4.67	NA	NA	5.82	5.60	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	2.01	2.08	0.11	0.12	0.05	000
21315		A	Treatment of nose fracture	1.78	4.71	4.59	1.77	1.80	0.14	010
21320		A	Treatment of nose fracture	1.86	4.29	4.20	1.35	1.42	0.18	010
21325		A	Treatment of nose fracture	4.07	NA	NA	6.97	7.39	0.31	090
21330		A	Treatment of nose fracture	5.68	NA	NA	7.63	8.16	0.56	090
21335		A	Treatment of nose fracture	8.91	NA	NA	8.53	8.82	0.74	090
21336		A	Treat nasal septal fracture	6.56	NA	NA	8.65	8.90	0.55	090
21337		A	Treat nasal septal fracture	3.26	6.16	6.16	3.58	3.58	0.28	090
21338		A	Treat nasoethmoid fracture	6.76	NA	NA	9.79	10.86	0.82	090
21339		A	Treat nasoethmoid fracture	8.39	NA	NA	10.25	11.18	0.96	090
21340		A	Treatment of nose fracture	11.33	NA	NA	7.66	7.85	1.15	090
21343		A	Treatment of sinus fracture	14.11	NA	NA	12.58	13.32	1.47	090

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21344		A	Treatment of sinus fracture	21.36	NA	NA	13.48	14.25	2.44	090
21345		A	Treat nose/jaw fracture	8.87	10.34	10.22	6.50	6.67	0.92	090
21346		A	Treat nose/jaw fracture	11.29	NA	NA	11.31	11.55	1.21	090
21347		A	Treat nose/jaw fracture	13.37	NA	NA	12.05	13.11	1.47	090
21348		A	Treat nose/jaw fracture	17.36	NA	NA	9.46	9.89	2.49	090
21355		A	Treat cheek bone fracture	4.32	6.16	6.19	3.43	3.45	0.34	010
21356		A	Treat cheek bone fracture	4.70	7.01	7.05	4.09	4.21	0.46	010
21360		A	Treat cheek bone fracture	7.03	NA	NA	5.40	5.54	0.74	090
21365		A	Treat cheek bone fracture	16.52	NA	NA	9.21	9.62	1.70	090
21366		A	Treat cheek bone fracture	18.44	NA	NA	9.77	10.17	2.50	090
21385		A	Treat eye socket fracture	9.46	NA	NA	7.26	7.52	0.97	090
21386		A	Treat eye socket fracture	9.46	NA	NA	6.02	6.29	0.97	090
21387		A	Treat eye socket fracture	10.00	NA	NA	7.22	7.66	1.08	090
21390		A	Treat eye socket fracture	11.07	NA	NA	7.14	7.31	0.90	090
21395		A	Treat eye socket fracture	14.62	NA	NA	8.05	8.31	1.44	090
21400		A	Treat eye socket fracture	1.44	2.92	2.85	2.11	2.06	0.15	090
21401		A	Treat eye socket fracture	3.57	7.75	7.82	3.44	3.45	0.38	090
21406		A	Treat eye socket fracture	7.31	NA	NA	5.34	5.53	0.73	090
21407		A	Treat eye socket fracture	8.91	NA	NA	5.98	6.21	0.94	090
21408		A	Treat eye socket fracture	12.67	NA	NA	7.71	8.01	1.44	090
21421		A	Treat mouth roof fracture	5.80	12.44	11.68	9.22	9.00	0.73	090
21422		A	Treat mouth roof fracture	8.62	NA	NA	7.06	7.32	0.99	090
21423		A	Treat mouth roof fracture	10.71	NA	NA	7.72	8.13	1.27	090
21431		A	Treat craniofacial fracture	7.74	NA	NA	10.22	10.05	0.70	090
21432		A	Treat craniofacial fracture	8.76	NA	NA	6.96	7.25	0.81	090
21433		A	Treat craniofacial fracture	26.13	NA	NA	13.41	14.18	2.79	090
21435		A	Treat craniofacial fracture	20.02	NA	NA	11.62	11.90	1.99	090
21436		A	Treat craniofacial fracture	30.01	NA	NA	16.37	16.85	3.10	090
21440		A	Treat dental ridge fracture	3.28	10.40	9.58	7.71	7.33	0.38	090
21445		A	Treat dental ridge fracture	6.04	12.66	11.94	8.75	8.66	0.78	090
21450		A	Treat lower jaw fracture	3.55	10.74	9.91	7.86	7.62	0.33	090
21451		A	Treat lower jaw fracture	5.46	12.96	12.07	9.66	9.35	0.63	090
21452		A	Treat lower jaw fracture	2.29	12.20	12.42	6.15	5.77	0.27	090
21453		A	Treat lower jaw fracture	6.40	14.91	13.88	11.74	11.50	0.74	090
21454		A	Treat lower jaw fracture	7.17	NA	NA	5.78	5.91	0.82	090
21461		A	Treat lower jaw fracture	9.07	42.17	37.77	12.99	12.92	0.98	090
21462		A	Treat lower jaw fracture	10.77	43.66	39.68	13.66	13.44	1.27	090
21465		A	Treat lower jaw fracture	12.88	NA	NA	8.22	8.63	1.50	090
21470		A	Treat lower jaw fracture	17.24	NA	NA	10.38	10.80	1.97	090
21480		A	Reset dislocated jaw	0.61	1.56	1.62	0.17	0.18	0.06	000
21485		A	Reset dislocated jaw	4.58	12.07	11.12	9.08	8.74	0.51	090
21490		A	Repair dislocated jaw	12.71	NA	NA	8.49	8.80	1.97	090
21495		A	Treat hyoid bone fracture	6.55	NA	NA	10.47	9.97	0.46	090
21497		A	Interdental wiring	4.45	12.44	11.45	9.53	9.06	0.50	090

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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	6.58	6.55	3.53	3.61	0.43	090
21502		A	Drain chest lesion	7.43	NA	NA	4.52	4.81	0.97	090
21510		A	Drainage of bone lesion	6.06	NA	NA	4.50	4.80	0.80	090
21550		A	Biopsy of neck/chest	2.08	4.28	4.11	1.76	1.75	0.16	010
21555		A	Remove lesion, neck/chest	4.40	5.84	5.76	3.47	3.40	0.56	090
21556		A	Remove lesion, neck/chest	5.63	NA	NA	4.15	4.15	0.65	090
21557		A	Remove tumor, neck/chest	8.91	NA	NA	4.53	4.74	1.08	090
21600		A	Partial removal of rib	7.14	NA	NA	5.88	5.85	0.99	090
21610		A	Partial removal of rib	15.76	NA	NA	8.53	8.63	3.08	090
21615		A	Removal of rib	10.31	NA	NA	4.95	5.39	1.45	090
21616		A	Removal of rib and nerves	12.54	NA	NA	7.50	7.64	1.87	090
21620		A	Partial removal of sternum	7.16	NA	NA	4.85	5.14	0.98	090
21627		A	Sternal debridement	7.18	NA	NA	5.55	5.74	1.02	090
21630		A	Extensive sternum surgery	19.01	NA	NA	10.47	10.82	2.59	090
21632		A	Extensive sternum surgery	19.51	NA	NA	9.40	9.84	2.66	090
21685		A	Hyoid myotomy & suspension	14.89	NA	NA	8.72	9.05	1.06	090
21700		A	Revision of neck muscle	6.23	NA	NA	3.85	4.00	0.32	090
21705		A	Revision of neck muscle/rib	9.83	NA	NA	5.26	5.35	1.43	090
21720		A	Revision of neck muscle	5.72	NA	NA	4.28	3.83	0.91	090
21725		A	Revision of neck muscle	7.10	NA	NA	5.15	5.23	1.21	090
21740		A	Reconstruction of sternum	17.47	NA	NA	7.93	8.09	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	5.30	5.51	1.63	090
21800		A	Treatment of rib fracture	0.98	1.38	1.37	1.44	1.42	0.09	090
21805		A	Treatment of rib fracture	2.80	NA	NA	3.29	3.27	0.38	090
21810		A	Treatment of rib fracture(s)	6.92	NA	NA	4.74	4.80	0.94	090
21820		A	Treat sternum fracture	1.31	1.77	1.78	1.83	1.82	0.16	090
21825		A	Treat sternum fracture	7.65	NA	NA	5.35	5.62	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	4.37	4.10	1.85	1.75	0.14	010
21925		A	Biopsy soft tissue of back	4.54	5.42	5.36	3.40	3.36	0.60	090
21930		A	Remove lesion, back or flank	5.06	6.06	5.98	3.79	3.69	0.66	090
21935		A	Remove tumor, back	18.38	NA	NA	8.51	8.80	2.48	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.57	NA	NA	8.42	8.55	1.74	090
22015		A	I&d, p-spine, l/s/ls	12.46	NA	NA	8.42	8.53	1.72	090
22100		A	Remove part of neck vertebra	10.80	NA	NA	8.14	8.00	2.14	090
22101		A	Remove part, thorax vertebra	10.88	NA	NA	8.03	7.97	1.91	090
22102		A	Remove part, lumbar vertebra	10.88	NA	NA	7.78	7.87	1.88	090
22103		A	Remove extra spine segment	2.34	NA	NA	0.91	0.99	0.44	ZZZ
22110		A	Remove part of neck vertebra	13.80	NA	NA	9.42	9.36	2.77	090
22112		A	Remove part, thorax vertebra	13.87	NA	NA	9.17	9.21	2.53	090
22114		A	Remove part, lumbar vertebra	13.87	NA	NA	9.14	9.18	2.64	090

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22116		A	Remove extra spine segment	2.32	NA	NA	0.88	0.95	0.50	ZZZ
22206		A	Cut spine 3 col, thor	37.00	NA	NA	17.83	17.83	6.23	090
22207		A	Cut spine 3 col, lumb	36.50	NA	NA	17.69	17.69	6.07	090
22208		A	Cut spine 3 col, addl seg	9.66	3.74	3.74	3.74	3.74	2.07	ZZZ
22210		A	Revision of neck spine	25.13	NA	NA	14.65	14.86	5.46	090
22212		A	Revision of thorax spine	20.74	NA	NA	12.50	12.71	3.91	090
22214		A	Revision of lumbar spine	20.77	NA	NA	12.60	12.92	3.92	090
22216		A	Revise, extra spine segment	6.03	NA	NA	2.33	2.54	1.29	ZZZ
22220		A	Revision of neck spine	22.69	NA	NA	13.06	13.22	5.08	090
22222		A	Revision of thorax spine	22.84	NA	NA	9.95	10.26	4.13	090
22224		A	Revision of lumbar spine	22.84	NA	NA	12.82	13.18	4.19	090
22226		A	Revise, extra spine segment	6.03	NA	NA	2.31	2.51	1.29	ZZZ
22305		A	Treat spine process fracture	2.08	2.15	2.19	1.80	1.83	0.39	090
22310		A	Treat spine fracture	3.69	3.00	2.95	2.51	2.47	0.50	090
22315		A	Treat spine fracture	9.91	9.75	9.74	7.36	7.36	1.86	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	NA	13.17	13.24	5.30	090
22319		A	Treat odontoid fx w/graft	25.15	NA	NA	13.62	13.91	6.05	090
22325		A	Treat spine fracture	19.62	NA	NA	12.21	12.19	3.88	090
22326		A	Treat neck spine fracture	20.64	NA	NA	12.10	12.26	4.43	090
22327		A	Treat thorax spine fracture	20.52	NA	NA	12.34	12.36	3.99	090
22328		A	Treat each add spine fx	4.60	NA	NA	1.76	1.89	0.94	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	0.96	0.95	0.36	010
22520		A	Percut vertebroplasty thor	9.17	44.43	48.81	4.69	4.80	1.72	010
22521		A	Percut vertebroplasty lumb	8.60	45.70	48.33	4.47	4.60	1.60	010
22522		A	Percut vertebroplasty add ╞I	4.30	NA	NA	1.56	1.59	0.82	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	NA	4.68	5.00	1.72	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	NA	4.54	4.83	1.60	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.69	1.84	0.82	ZZZ
22526		A	Idet, single level	6.07	42.39	42.39	1.85	1.85	1.16	010
22527		A	Idet, 1 or more levels	3.03	35.19	35.19	0.56	0.56	0.58	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	NA	13.77	14.05	4.35	090
22533		A	Lat lumbar spine fusion	24.61	NA	NA	13.50	13.53	3.16	090
22534		A	Lat thor/lumb, add ╞I seg	5.99	NA	NA	2.29	2.48	1.25	ZZZ
22548		A	Neck spine fusion	26.86	NA	NA	14.69	14.99	5.61	090
22554		A	Neck spine fusion	17.54	NA	NA	10.63	11.07	4.46	090
22556		A	Thorax spine fusion	24.50	NA	NA	12.90	13.37	4.35	090
22558		A	Lumbar spine fusion	23.33	NA	NA	11.59	12.03	3.16	090
22585		A	Additional spinal fusion	5.52	NA	NA	2.06	2.25	1.25	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	NA	13.10	13.17	4.79	090
22595		A	Neck spinal fusion	20.44	NA	NA	12.55	12.64	4.41	090
22600		A	Neck spine fusion	17.20	NA	NA	11.21	11.22	3.73	090
22610		A	Thorax spine fusion	17.08	NA	NA	10.88	11.03	3.53	090
22612		A	Lumbar spine fusion	23.38	NA	NA	12.53	12.96	4.47	090
22614		A	Spine fusion, extra segment	6.43	NA	NA	2.46	2.68	1.38	ZZZ

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22630		A	Lumbar spine fusion	21.89	NA	NA	12.56	12.83	4.73	090
22632		A	Spine fusion, extra segment	5.22	NA	NA	1.99	2.16	1.16	ZZZ
22800		A	Fusion of spine	19.30	NA	NA	11.24	11.64	3.76	090
22802		A	Fusion of spine	31.91	NA	NA	16.11	17.01	6.17	090
22804		A	Fusion of spine	37.30	NA	NA	18.07	19.25	7.00	090
22808		A	Fusion of spine	27.31	NA	NA	14.05	14.63	4.93	090
22810		A	Fusion of spine	31.30	NA	NA	14.75	15.68	5.15	090
22812		A	Fusion of spine	34.00	NA	NA	16.72	17.58	5.30	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	NA	16.37	17.01	6.47	090
22819		A	Kyphectomy, 3 or more	39.18	NA	NA	19.57	19.72	7.67	090
22830		A	Exploration of spinal fusion	11.13	NA	NA	7.08	7.31	2.30	090
22840		A	Insert spine fixation device	12.52	NA	NA	4.78	5.21	2.79	ZZZ
22842		A	Insert spine fixation device	12.56	NA	NA	4.80	5.23	2.75	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	5.18	5.54	2.86	ZZZ
22844		A	Insert spine fixation device	16.42	NA	NA	6.44	7.03	3.19	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	4.50	4.90	2.86	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	4.67	5.09	2.96	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	5.23	5.69	3.00	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	2.34	2.56	1.15	ZZZ
22849		A	Reinsert spinal fixation	19.08	NA	NA	10.23	10.62	3.90	090
22850		A	Remove spine fixation device	9.74	NA	NA	6.42	6.57	2.05	090
22851		A	Apply spine prosth device	6.70	NA	NA	2.54	2.75	1.49	ZZZ
22852		A	Remove spine fixation device	9.29	NA	NA	6.19	6.35	1.90	090
22855		A	Remove spine fixation device	15.77	NA	NA	9.16	9.30	3.52	090
22857		R	Lumbar artif diskectomy	26.93	NA	NA	13.39	13.39	3.56	090
22862		R	Revise lumbar artif disc	32.43	NA	NA	13.31	13.31	5.36	090
22865		R	Remove lumb artif disc	31.55	NA	NA	17.85	17.85	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	3.56	3.48	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	7.97	8.12	3.77	3.94	0.68	090
23020		A	Release shoulder joint	9.24	NA	NA	6.49	6.76	1.54	090
23030		A	Drain shoulder lesion	3.44	6.26	6.55	2.38	2.51	0.57	010
23031		A	Drain shoulder bursa	2.76	5.92	6.41	2.00	2.19	0.46	010
23035		A	Drain shoulder bone lesion	9.04	NA	NA	6.41	6.88	1.47	090
23040		A	Exploratory shoulder surgery	9.63	NA	NA	6.75	7.04	1.60	090
23044		A	Exploratory shoulder surgery	7.48	NA	NA	5.53	5.76	1.24	090
23065		A	Biopsy shoulder tissues	2.28	2.92	2.81	1.71	1.69	0.20	010
23066		A	Biopsy shoulder tissues	4.21	7.76	7.75	3.61	3.71	0.63	090
23075		A	Removal of shoulder lesion	2.41	3.71	3.70	1.72	1.74	0.34	010
23076		A	Removal of shoulder lesion	7.77	NA	NA	5.29	5.36	1.13	090
23077		A	Remove tumor of shoulder	18.08	NA	NA	9.60	9.76	2.34	090
23100		A	Biopsy of shoulder joint	6.09	NA	NA	5.06	5.21	1.04	090
23101		A	Shoulder joint surgery	5.63	NA	NA	4.54	4.74	0.96	090

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23105		A	Remove shoulder joint lining	8.36	NA	NA	6.12	6.38	1.42	090
23106		A	Incision of collarbone joint	6.02	NA	NA	4.78	5.02	0.99	090
23107		A	Explore treat shoulder joint	8.75	NA	NA	6.26	6.55	1.49	090
23120		A	Partial removal, collar bone	7.23	NA	NA	5.48	5.73	1.23	090
23125		A	Removal of collar bone	9.52	NA	NA	6.43	6.72	1.62	090
23130		A	Remove shoulder bone, part	7.63	NA	NA	6.08	6.35	1.30	090
23140		A	Removal of bone lesion	7.01	NA	NA	4.81	4.92	1.08	090
23145		A	Removal of bone lesion	9.28	NA	NA	6.50	6.74	1.49	090
23146		A	Removal of bone lesion	7.96	NA	NA	5.55	5.95	1.35	090
23150		A	Removal of humerus lesion	8.79	NA	NA	6.26	6.43	1.32	090
23155		A	Removal of humerus lesion	10.72	NA	NA	7.31	7.58	1.81	090
23156		A	Removal of humerus lesion	8.99	NA	NA	6.31	6.59	1.50	090
23170		A	Remove collar bone lesion	7.10	NA	NA	4.92	5.20	1.12	090
23172		A	Remove shoulder blade lesion	7.20	NA	NA	5.23	5.50	1.01	090
23174		A	Remove humerus lesion	9.90	NA	NA	7.26	7.54	1.65	090
23180		A	Remove collar bone lesion	8.85	NA	NA	6.38	7.05	1.47	090
23182		A	Remove shoulder blade lesion	8.47	NA	NA	6.36	6.92	1.37	090
23184		A	Remove humerus lesion	9.76	NA	NA	6.93	7.54	1.63	090
23190		A	Partial removal of scapula	7.36	NA	NA	5.34	5.55	1.17	090
23195		A	Removal of head of humerus	10.24	NA	NA	6.97	7.17	1.71	090
23200		A	Removal of collar bone	12.69	NA	NA	7.65	7.93	1.94	090
23210		A	Removal of shoulder blade	13.16	NA	NA	8.16	8.38	2.03	090
23220		A	Partial removal of humerus	15.36	NA	NA	9.01	9.47	2.49	090
23221		A	Partial removal of humerus	18.41	NA	NA	10.03	10.47	3.06	090
23222		A	Partial removal of humerus	25.44	NA	NA	13.31	13.95	3.95	090
23330		A	Remove shoulder foreign body	1.87	3.38	3.46	1.54	1.63	0.24	010
23331		A	Remove shoulder foreign body	7.51	NA	NA	5.86	6.10	1.27	090
23332		A	Remove shoulder foreign body	12.23	NA	NA	7.98	8.33	2.03	090
23350		A	Injection for shoulder x-ray	1.00	2.76	2.94	0.36	0.35	0.06	000
23395		A	Muscle transfer,shoulder/arm	18.29	NA	NA	11.21	11.64	2.94	090
23397		A	Muscle transfers	16.62	NA	NA	9.65	10.09	2.74	090
23400		A	Fixation of shoulder blade	13.73	NA	NA	8.56	8.95	2.30	090
23405		A	Incision of tendon & muscle	8.43	NA	NA	5.93	6.19	1.45	090
23406		A	Incise tendon(s) & muscle(s)	10.90	NA	NA	6.95	7.31	1.88	090
23410		A	Repair rotator cuff, acute	12.63	NA	NA	7.79	8.21	2.17	090
23412		A	Repair rotator cuff, chronic	13.55	NA	NA	8.18	8.62	2.32	090
23415		A	Release of shoulder ligament	10.09	NA	NA	6.62	6.97	1.74	090
23420		A	Repair of shoulder	14.75	NA	NA	9.72	10.01	2.32	090
23430		A	Repair biceps tendon	10.05	NA	NA	6.78	7.12	1.74	090
23440		A	Remove/transplant tendon	10.53	NA	NA	6.76	7.14	1.83	090
23450		A	Repair shoulder capsule	13.58	NA	NA	8.11	8.55	2.33	090
23455		A	Repair shoulder capsule	14.55	NA	NA	8.55	9.03	2.50	090
23460		A	Repair shoulder capsule	15.68	NA	NA	9.36	9.87	2.67	090
23462		A	Repair shoulder capsule	15.60	NA	NA	9.02	9.47	2.60	090

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23465		A	Repair shoulder capsule	16.16	NA	NA	9.54	9.96	2.77	090
23466		A	Repair shoulder capsule	15.55	NA	NA	10.06	10.40	2.47	090
23470		A	Reconstruct shoulder joint	17.75	NA	NA	10.13	10.68	2.99	090
23472		A	Reconstruct shoulder joint	22.47	NA	NA	12.15	12.73	3.67	090
23480		A	Revision of collar bone	11.42	NA	NA	7.26	7.65	1.95	090
23485		A	Revision of collar bone	13.79	NA	NA	8.27	8.69	2.34	090
23490		A	Reinforce clavicle	12.04	NA	NA	7.41	7.74	1.47	090
23491		A	Reinforce shoulder bones	14.40	NA	NA	8.77	9.27	2.47	090
23500		A	Treat clavicle fracture	2.13	2.65	2.71	2.72	2.67	0.30	090
23505		A	Treat clavicle fracture	3.74	4.02	4.12	3.62	3.68	0.61	090
23515		A	Treat clavicle fracture	9.53	NA	NA	7.04	6.92	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	3.98	4.12	3.48	3.60	0.46	090
23530		A	Treat clavicle dislocation	7.37	NA	NA	4.81	5.10	1.20	090
23532		A	Treat clavicle dislocation	8.08	NA	NA	6.03	6.27	1.38	090
23540		A	Treat clavicle dislocation	2.28	2.63	2.69	2.70	2.62	0.29	090
23545		A	Treat clavicle dislocation	3.32	3.82	3.91	3.31	3.33	0.35	090
23550		A	Treat clavicle dislocation	7.48	NA	NA	5.55	5.76	1.25	090
23552		A	Treat clavicle dislocation	8.70	NA	NA	6.26	6.54	1.46	090
23570		A	Treat shoulder blade fx	2.28	2.79	2.85	2.93	2.93	0.36	090
23575		A	Treat shoulder blade fx	4.12	4.58	4.66	4.05	4.12	0.59	090
23585		A	Treat scapula fracture	14.07	NA	NA	8.52	8.31	1.54	090
23600		A	Treat humerus fracture	3.00	4.07	4.20	3.65	3.63	0.48	090
23605		A	Treat humerus fracture	4.94	5.38	5.58	4.59	4.73	0.84	090
23615		A	Treat humerus fracture	12.12	NA	NA	8.07	8.27	1.62	090
23616		A	Treat humerus fracture	18.19	NA	NA	10.46	11.40	3.70	090
23620		A	Treat humerus fracture	2.46	3.42	3.47	3.15	3.11	0.40	090
23625		A	Treat humerus fracture	3.99	4.42	4.56	3.89	3.99	0.67	090
23630		A	Treat humerus fracture	10.39	NA	NA	7.40	7.21	1.27	090
23650		A	Treat shoulder dislocation	3.44	3.32	3.44	2.85	2.83	0.30	090
23655		A	Treat shoulder dislocation	4.64	NA	NA	4.19	4.19	0.69	090
23660		A	Treat shoulder dislocation	7.55	NA	NA	5.69	5.87	1.29	090
23665		A	Treat dislocation/fracture	4.54	4.87	4.99	4.29	4.40	0.71	090
23670		A	Treat dislocation/fracture	12.12	NA	NA	7.95	7.68	1.36	090
23675		A	Treat dislocation/fracture	6.13	6.05	6.25	5.07	5.27	1.01	090
23680		A	Treat dislocation/fracture	12.99	NA	NA	8.31	8.27	1.76	090
23700		A	Fixation of shoulder	2.54	NA	NA	1.89	1.97	0.44	010
23800		A	Fusion of shoulder joint	14.59	NA	NA	8.93	9.31	2.36	090
23802		A	Fusion of shoulder joint	18.17	NA	NA	11.19	10.94	2.71	090
23900		A	Amputation of arm & girdle	20.57	NA	NA	9.83	10.31	3.19	090
23920		A	Amputation at shoulder joint	16.03	NA	NA	8.79	9.08	2.47	090
23921		A	Amputation follow-up surgery	5.61	NA	NA	3.21	3.69	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	5.03	5.36	2.01	2.08	0.43	010

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23931		A	Drainage of arm bursa	1.81	4.36	4.75	1.76	1.86	0.28	010
23935		A	Drain arm/elbow bone lesion	6.27	NA	NA	4.98	5.22	1.05	090
24000		A	Exploratory elbow surgery	5.99	NA	NA	4.77	4.94	0.97	090
24006		A	Release elbow joint	9.62	NA	NA	6.58	6.88	1.50	090
24065		A	Biopsy arm/elbow soft tissue	2.10	4.16	3.93	1.92	1.88	0.17	010
24066		A	Biopsy arm/elbow soft tissue	5.26	8.30	8.47	3.93	3.98	0.80	090
24075		A	Remove arm/elbow lesion	3.96	7.23	7.27	3.29	3.32	0.56	090
24076		A	Remove arm/elbow lesion	6.36	NA	NA	4.59	4.66	0.95	090
24077		A	Remove tumor of arm/elbow	11.95	NA	NA	6.80	7.04	1.73	090
24100		A	Biopsy elbow joint lining	4.98	NA	NA	4.28	4.35	0.85	090
24101		A	Explore/treat elbow joint	6.19	NA	NA	5.09	5.30	1.03	090
24102		A	Remove elbow joint lining	8.15	NA	NA	5.78	6.06	1.33	090
24105		A	Removal of elbow bursa	3.67	NA	NA	4.03	4.13	0.61	090
24110		A	Remove humerus lesion	7.46	NA	NA	5.76	5.99	1.28	090
24115		A	Remove/graft bone lesion	10.00	NA	NA	6.79	6.90	1.68	090
24116		A	Remove/graft bone lesion	12.11	NA	NA	7.51	7.91	2.06	090
24120		A	Remove elbow lesion	6.71	NA	NA	5.15	5.35	1.10	090
24125		A	Remove/graft bone lesion	8.02	NA	NA	6.00	6.05	1.06	090
24126		A	Remove/graft bone lesion	8.50	NA	NA	6.19	6.41	1.16	090
24130		A	Removal of head of radius	6.31	NA	NA	5.13	5.36	1.04	090
24134		A	Removal of arm bone lesion	10.10	NA	NA	6.85	7.36	1.64	090
24136		A	Remove radius bone lesion	8.29	NA	NA	4.90	5.49	1.38	090
24138		A	Remove elbow bone lesion	8.33	NA	NA	6.77	7.03	1.34	090
24140		A	Partial removal of arm bone	9.43	NA	NA	6.61	7.25	1.51	090
24145		A	Partial removal of radius	7.70	NA	NA	5.70	6.30	1.25	090
24147		A	Partial removal of elbow	7.69	NA	NA	6.29	6.87	1.30	090
24149		A	Radical resection of elbow	15.92	NA	NA	10.77	11.00	2.35	090
24150		A	Extensive humerus surgery	13.70	NA	NA	8.47	8.86	2.33	090
24151		A	Extensive humerus surgery	16.08	NA	NA	9.36	9.91	2.60	090
24152		A	Extensive radius surgery	10.24	NA	NA	6.65	6.93	1.48	090
24153		A	Extensive radius surgery	11.73	NA	NA	7.71	7.18	0.74	090
24155		A	Removal of elbow joint	11.97	NA	NA	7.50	7.74	1.93	090
24160		A	Remove elbow joint implant	7.89	NA	NA	5.84	6.11	1.30	090
24164		A	Remove radius head implant	6.34	NA	NA	4.90	5.13	1.03	090
24200		A	Removal of arm foreign body	1.78	2.71	2.89	1.34	1.42	0.20	010
24201		A	Removal of arm foreign body	4.61	7.81	8.32	3.70	3.84	0.72	090
24220		A	Injection for elbow x-ray	1.31	2.79	3.00	0.49	0.48	0.08	000
24300		A	Manipulate elbow w/anesth	3.86	NA	NA	5.13	5.28	0.65	090
24301		A	Muscle/tendon transfer	10.26	NA	NA	6.89	7.22	1.66	090
24305		A	Arm tendon lengthening	7.51	NA	NA	5.66	5.93	1.15	090
24310		A	Revision of arm tendon	6.03	NA	NA	4.75	4.96	0.96	090
24320		A	Repair of arm tendon	10.74	NA	NA	7.14	7.24	1.74	090
24330		A	Revision of arm muscles	9.67	NA	NA	6.61	6.94	1.60	090
24331		A	Revision of arm muscles	10.83	NA	NA	7.11	7.51	1.78	090

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24332		A	Tenolysis, triceps	7.77	NA	NA	6.05	6.24	1.23	090
24340		A	Repair of biceps tendon	7.96	NA	NA	5.94	6.21	1.36	090
24341		A	Repair arm tendon/muscle	9.24	NA	NA	7.51	7.62	1.36	090
24342		A	Repair of ruptured tendon	10.74	NA	NA	7.06	7.44	1.86	090
24343		A	Repr elbow lat ligmnt w/tiss	8.99	NA	NA	7.02	7.31	1.43	090
24344		A	Reconstruct elbow lat ligmnt	14.97	NA	NA	9.90	10.32	2.37	090
24345		A	Repr elbw med ligmnt w/tissu	8.99	NA	NA	6.90	7.19	1.44	090
24346		A	Reconstruct elbow med ligmnt	14.97	NA	NA	10.07	10.40	2.34	090
24357		A	Repair elbow, perc	5.32	NA	NA	4.70	4.92	0.87	090
24358		A	Repair elbow w/deb, open	6.54	NA	NA	5.28	5.51	1.07	090
24359		A	Repair elbow deb/attch open	8.86	NA	NA	6.20	6.20	1.41	090
24360		A	Reconstruct elbow joint	12.53	NA	NA	8.05	8.41	2.06	090
24361		A	Reconstruct elbow joint	14.27	NA	NA	8.83	9.28	2.19	090
24362		A	Reconstruct elbow joint	15.18	NA	NA	9.36	9.54	2.61	090
24363		A	Replace elbow joint	22.47	NA	NA	12.18	12.58	3.02	090
24365		A	Reconstruct head of radius	8.51	NA	NA	6.00	6.31	1.41	090
24366		A	Reconstruct head of radius	9.25	NA	NA	6.30	6.62	1.52	090
24400		A	Revision of humerus	11.19	NA	NA	7.58	7.91	1.93	090
24410		A	Revision of humerus	14.96	NA	NA	9.01	9.35	2.58	090
24420		A	Revision of humerus	13.58	NA	NA	9.04	9.43	2.18	090
24430		A	Repair of humerus	15.07	NA	NA	9.26	9.39	2.22	090
24435		A	Repair humerus with graft	14.74	NA	NA	9.81	10.09	2.28	090
24470		A	Revision of elbow joint	8.81	NA	NA	5.16	5.81	1.48	090
24495		A	Decompression of forearm	8.30	NA	NA	6.60	7.15	1.18	090
24498		A	Reinforce humerus	12.16	NA	NA	7.70	8.10	2.07	090
24500		A	Treat humerus fracture	3.29	4.46	4.56	3.82	3.79	0.50	090
24505		A	Treat humerus fracture	5.25	5.82	6.02	4.85	5.00	0.89	090
24515		A	Treat humerus fracture	11.97	NA	NA	8.03	8.38	2.03	090
24516		A	Treat humerus fracture	12.07	NA	NA	7.66	8.03	2.03	090
24530		A	Treat humerus fracture	3.57	4.74	4.86	4.00	4.02	0.57	090
24535		A	Treat humerus fracture	6.96	6.81	7.08	5.85	6.05	1.18	090
24538		A	Treat humerus fracture	9.63	NA	NA	7.23	7.61	1.64	090
24545		A	Treat humerus fracture	12.99	NA	NA	8.30	8.35	1.83	090
24546		A	Treat humerus fracture	14.73	NA	NA	9.10	9.67	2.74	090
24560		A	Treat humerus fracture	2.87	4.10	4.20	3.42	3.37	0.44	090
24565		A	Treat humerus fracture	5.64	5.72	5.95	4.86	5.03	0.93	090
24566		A	Treat humerus fracture	8.86	NA	NA	7.20	7.45	1.30	090
24575		A	Treat humerus fracture	9.53	NA	NA	7.08	7.42	1.87	090
24576		A	Treat humerus fracture	2.94	4.42	4.51	3.71	3.72	0.46	090
24577		A	Treat humerus fracture	5.87	5.98	6.23	5.03	5.24	0.95	090
24579		A	Treat humerus fracture	11.26	NA	NA	7.76	8.04	2.03	090
24582		A	Treat humerus fracture	9.89	NA	NA	7.99	8.28	1.48	090
24586		A	Treat elbow fracture	15.64	NA	NA	9.36	9.84	2.65	090
24587		A	Treat elbow fracture	15.65	NA	NA	9.36	9.79	2.53	090

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24600		A	Treat elbow dislocation	4.28	3.81	4.07	3.23	3.30	0.50	090
24605		A	Treat elbow dislocation	5.50	NA	NA	4.94	5.05	0.89	090
24615		A	Treat elbow dislocation	9.72	NA	NA	6.56	6.89	1.60	090
24620		A	Treat elbow fracture	7.07	NA	NA	5.46	5.67	1.07	090
24635		A	Treat elbow fracture	8.64	NA	NA	6.58	8.46	2.29	090
24640		A	Treat elbow dislocation	1.22	1.49	1.58	0.81	0.80	0.12	010
24650		A	Treat radius fracture	2.22	3.44	3.53	3.00	2.94	0.35	090
24655		A	Treat radius fracture	4.48	5.18	5.38	4.40	4.50	0.70	090
24665		A	Treat radius fracture	8.22	NA	NA	6.51	6.77	1.41	090
24666		A	Treat radius fracture	9.74	NA	NA	6.98	7.26	1.62	090
24670		A	Treat ulnar fracture	2.60	3.74	3.84	3.17	3.15	0.41	090
24675		A	Treat ulnar fracture	4.79	5.38	5.54	4.58	4.68	0.81	090
24685		A	Treat ulnar fracture	8.21	NA	NA	6.53	6.78	1.52	090
24800		A	Fusion of elbow joint	11.27	NA	NA	6.98	7.43	1.63	090
24802		A	Fusion/graft of elbow joint	14.18	NA	NA	8.61	9.06	2.38	090
24900		A	Amputation of upper arm	10.04	NA	NA	6.54	6.68	1.53	090
24920		A	Amputation of upper arm	10.02	NA	NA	6.39	6.54	1.61	090
24925		A	Amputation follow-up surgery	7.19	NA	NA	5.61	5.74	1.14	090
24930		A	Amputation follow-up surgery	10.72	NA	NA	6.70	6.84	1.68	090
24931		A	Amputate upper arm & implant	13.32	NA	NA	6.54	6.34	1.90	090
24935		A	Revision of amputation	16.30	NA	NA	7.50	7.64	2.14	090
24940		C	Revision of upper arm	0.00	NA	NA	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	4.00	4.73	0.55	090
25001		A	Incise flexor carpi radialis	3.68	NA	NA	3.94	4.02	0.55	090
25020		A	Decompress forearm 1 space	5.97	NA	NA	6.87	7.56	0.93	090
25023		A	Decompress forearm 1 space	13.69	NA	NA	11.04	12.03	2.04	090
25024		A	Decompress forearm 2 spaces	10.62	NA	NA	7.33	7.37	1.36	090
25025		A	Decompress forearm 2 spaces	17.77	NA	NA	10.11	10.09	1.83	090
25028		A	Drainage of forearm lesion	5.30	NA	NA	6.30	6.78	0.81	090
25031		A	Drainage of forearm bursa	4.18	NA	NA	3.54	4.64	0.63	090
25035		A	Treat forearm bone lesion	7.54	NA	NA	5.54	7.57	1.24	090
25040		A	Explore/treat wrist joint	7.41	NA	NA	5.43	5.91	1.15	090
25065		A	Biopsy forearm soft tissues	2.01	4.26	4.01	1.94	1.93	0.15	010
25066		A	Biopsy forearm soft tissues	4.18	NA	NA	3.85	4.66	0.64	090
25075		A	Removal forearm lesion subcu	3.78	NA	NA	3.31	3.96	0.55	090
25076		A	Removal forearm lesion deep	4.97	NA	NA	4.11	5.48	0.74	090
25077		A	Remove tumor, forearm/wrist	9.90	NA	NA	6.18	7.67	1.42	090
25085		A	Incision of wrist capsule	5.55	NA	NA	4.62	5.25	0.85	090
25100		A	Biopsy of wrist joint	3.94	NA	NA	3.72	4.12	0.59	090
25101		A	Explore/treat wrist joint	4.74	NA	NA	4.32	4.72	0.75	090
25105		A	Remove wrist joint lining	5.91	NA	NA	4.98	5.57	0.92	090
25107		A	Remove wrist joint cartilage	7.50	NA	NA	6.36	6.86	0.99	090
25109		A	Excise tendon forearm/wrist	6.81	NA	NA	5.35	5.35	0.96	090

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25110		A	Remove wrist tendon lesion	3.96	NA	NA	3.63	4.50	0.62	090
25111		A	Remove wrist tendon lesion	3.44	NA	NA	3.64	3.91	0.53	090
25112		A	Reremove wrist tendon lesion	4.58	NA	NA	4.03	4.34	0.70	090
25115		A	Remove wrist/forearm lesion	9.89	NA	NA	7.35	9.03	1.31	090
25116		A	Remove wrist/forearm lesion	7.38	NA	NA	6.20	7.95	1.11	090
25118		A	Excise wrist tendon sheath	4.42	NA	NA	4.14	4.55	0.68	090
25119		A	Partial removal of ulna	6.10	NA	NA	5.08	5.71	0.96	090
25120		A	Removal of forearm lesion	6.16	NA	NA	5.10	6.86	1.00	090
25125		A	Remove/graft forearm lesion	7.55	NA	NA	5.90	7.65	1.06	090
25126		A	Remove/graft forearm lesion	7.62	NA	NA	5.78	7.60	1.27	090
25130		A	Removal of wrist lesion	5.32	NA	NA	4.76	5.18	0.80	090
25135		A	Remove & graft wrist lesion	6.96	NA	NA	5.66	6.13	1.02	090
25136		A	Remove & graft wrist lesion	6.03	NA	NA	5.07	5.46	1.03	090
25145		A	Remove forearm bone lesion	6.43	NA	NA	5.24	6.95	1.01	090
25150		A	Partial removal of ulna	7.27	NA	NA	5.57	6.24	1.14	090
25151		A	Partial removal of radius	7.57	NA	NA	5.65	7.43	1.18	090
25170		A	Extensive forearm surgery	11.34	NA	NA	7.47	9.41	1.78	090
25210		A	Removal of wrist bone	6.01	NA	NA	5.05	5.49	0.88	090
25215		A	Removal of wrist bones	8.02	NA	NA	6.05	6.74	1.19	090
25230		A	Partial removal of radius	5.28	NA	NA	4.47	4.90	0.79	090
25240		A	Partial removal of ulna	5.22	NA	NA	4.47	5.10	0.81	090
25246		A	Injection for wrist x-ray	1.45	2.72	2.90	0.53	0.52	0.09	000
25248		A	Remove forearm foreign body	5.20	NA	NA	4.03	5.16	0.72	090
25250		A	Removal of wrist prosthesis	6.66	NA	NA	5.30	5.50	1.01	090
25251		A	Removal of wrist prosthesis	9.70	NA	NA	6.64	6.97	1.26	090
25259		A	Manipulate wrist w/anesthes	3.86	NA	NA	5.20	5.33	0.62	090
25260		A	Repair forearm tendon/muscle	7.89	NA	NA	6.34	8.10	1.19	090
25263		A	Repair forearm tendon/muscle	7.90	NA	NA	6.31	8.07	1.18	090
25265		A	Repair forearm tendon/muscle	9.96	NA	NA	7.06	8.89	1.47	090
25270		A	Repair forearm tendon/muscle	6.06	NA	NA	5.03	6.79	0.95	090
25272		A	Repair forearm tendon/muscle	7.10	NA	NA	5.45	7.30	1.11	090
25274		A	Repair forearm tendon/muscle	8.82	NA	NA	6.40	8.22	1.36	090
25275		A	Repair forearm tendon sheath	8.82	NA	NA	6.54	6.81	1.31	090
25280		A	Revise wrist/forearm tendon	7.28	NA	NA	5.56	7.34	1.08	090
25290		A	Incise wrist/forearm tendon	5.34	NA	NA	4.52	7.15	0.82	090
25295		A	Release wrist/forearm tendon	6.61	NA	NA	5.30	7.02	1.00	090
25300		A	Fusion of tendons at wrist	8.88	NA	NA	6.66	7.11	1.26	090
25301		A	Fusion of tendons at wrist	8.47	NA	NA	6.20	6.68	1.29	090
25310		A	Transplant forearm tendon	8.26	NA	NA	5.95	7.73	1.21	090
25312		A	Transplant forearm tendon	9.70	NA	NA	6.75	8.56	1.41	090
25315		A	Revise palsy hand tendon(s)	10.56	NA	NA	7.17	8.99	1.58	090
25316		A	Revise palsy hand tendon(s)	12.76	NA	NA	7.73	9.87	1.75	090
25320		A	Repair/revise wrist joint	12.38	NA	NA	9.86	10.25	1.61	090
25332		A	Revise wrist joint	11.60	NA	NA	7.68	8.06	1.84	090

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25335		A	Realignment of hand	13.25	NA	NA	8.31	9.14	1.93	090
25337		A	Reconstruct ulna/radioulnar	11.44	NA	NA	8.68	9.29	1.61	090
25350		A	Revision of radius	8.97	NA	NA	6.43	8.33	1.46	090
25355		A	Revision of radius	10.41	NA	NA	7.05	8.96	1.74	090
25360		A	Revision of ulna	8.62	NA	NA	6.26	8.18	1.41	090
25365		A	Revise radius & ulna	12.77	NA	NA	7.96	9.90	2.16	090
25370		A	Revise radius or ulna	13.93	NA	NA	9.02	10.80	2.29	090
25375		A	Revise radius & ulna	13.41	NA	NA	8.38	10.41	2.27	090
25390		A	Shorten radius or ulna	10.58	NA	NA	7.07	8.96	1.65	090
25391		A	Lengthen radius or ulna	14.14	NA	NA	8.54	10.57	2.22	090
25392		A	Shorten radius & ulna	14.44	NA	NA	8.99	10.75	2.11	090
25393		A	Lengthen radius & ulna	16.42	NA	NA	9.57	11.59	2.77	090
25394		A	Repair carpal bone, shorten	10.71	NA	NA	7.19	7.41	1.59	090
25400		A	Repair radius or ulna	11.16	NA	NA	7.28	9.27	1.83	090
25405		A	Repair/graft radius or ulna	14.87	NA	NA	8.97	11.06	2.33	090
25415		A	Repair radius & ulna	13.66	NA	NA	8.79	10.74	2.18	090
25420		A	Repair/graft radius & ulna	16.89	NA	NA	10.01	12.10	2.62	090
25425		A	Repair/graft radius or ulna	13.58	NA	NA	8.56	11.79	2.09	090
25426		A	Repair/graft radius & ulna	16.31	NA	NA	7.69	9.93	2.55	090
25430		A	Vasc graft into carpal bone	9.57	NA	NA	6.98	7.08	1.27	090
25431		A	Repair nonunion carpal bone	10.75	NA	NA	6.97	7.34	1.91	090
25440		A	Repair/graft wrist bone	10.56	NA	NA	6.99	7.60	1.63	090
25441		A	Reconstruct wrist joint	13.15	NA	NA	8.36	8.78	2.08	090
25442		A	Reconstruct wrist joint	10.98	NA	NA	7.54	7.88	1.53	090
25443		A	Reconstruct wrist joint	10.52	NA	NA	7.23	7.63	1.37	090
25444		A	Reconstruct wrist joint	11.28	NA	NA	7.52	7.91	1.72	090
25445		A	Reconstruct wrist joint	9.76	NA	NA	6.70	7.03	1.55	090
25446		A	Wrist replacement	17.16	NA	NA	9.95	10.46	2.48	090
25447		A	Repair wrist joint(s)	10.95	NA	NA	7.89	8.09	1.61	090
25449		A	Remove wrist joint implant	14.80	NA	NA	8.94	9.38	2.22	090
25450		A	Revision of wrist joint	7.94	NA	NA	4.82	6.17	1.36	090
25455		A	Revision of wrist joint	9.57	NA	NA	5.54	6.88	0.96	090
25490		A	Reinforce radius	9.61	NA	NA	6.31	8.18	1.43	090
25491		A	Reinforce ulna	10.03	NA	NA	6.79	8.73	1.60	090
25492		A	Reinforce radius and ulna	12.52	NA	NA	8.11	9.93	2.15	090
25500		A	Treat fracture of radius	2.51	3.32	3.39	2.87	2.84	0.35	090
25505		A	Treat fracture of radius	5.30	5.86	6.04	5.00	5.11	0.90	090
25515		A	Treat fracture of radius	8.64	NA	NA	6.50	6.75	1.59	090
25520		A	Treat fracture of radius	6.35	5.79	6.07	5.22	5.44	1.08	090
25525		A	Treat fracture of radius	10.37	NA	NA	7.43	8.08	2.13	090
25526		A	Treat fracture of radius	12.96	NA	NA	8.75	9.95	2.20	090
25530		A	Treat fracture of ulna	2.15	3.49	3.56	2.98	2.96	0.34	090
25535		A	Treat fracture of ulna	5.22	5.63	5.73	4.89	5.00	0.89	090
25545		A	Treat fracture of ulna	7.78	NA	NA	6.24	6.61	1.53	090

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25560		A	Treat fracture radius & ulna	2.50	3.40	3.48	2.88	2.81	0.35	090
25565		A	Treat fracture radius & ulna	5.71	5.95	6.15	4.96	5.08	0.93	090
25574		A	Treat fracture radius & ulna	8.64	NA	NA	6.57	6.73	1.21	090
25575		A	Treat fracture radius/ulna	12.10	NA	NA	8.38	8.68	1.82	090
25600		A	Treat fracture radius/ulna	2.69	3.69	3.79	3.18	3.13	0.42	090
25605		A	Treat fracture radius/ulna	7.02	6.86	6.96	6.12	6.16	1.00	090
25606		A	Treat fx distal radial	8.10	NA	NA	6.70	7.28	1.26	090
25607		A	Treat fx rad extra-articul	9.35	NA	NA	7.22	7.22	1.36	090
25608		A	Treat fx rad intra-articul	10.86	NA	NA	7.82	7.82	1.84	090
25609		A	Treat fx radial 3+ frag	14.12	NA	NA	9.68	9.68	2.38	090
25622		A	Treat wrist bone fracture	2.68	3.89	3.99	3.34	3.29	0.41	090
25624		A	Treat wrist bone fracture	4.62	5.63	5.81	4.77	4.85	0.76	090
25628		A	Treat wrist bone fracture	9.51	NA	NA	6.90	7.14	1.37	090
25630		A	Treat wrist bone fracture	2.94	3.75	3.86	3.24	3.17	0.45	090
25635		A	Treat wrist bone fracture	4.47	5.24	5.42	4.43	4.30	0.74	090
25645		A	Treat wrist bone fracture	7.31	NA	NA	5.47	5.77	1.20	090
25650		A	Treat wrist bone fracture	3.12	3.87	3.99	3.47	3.40	0.45	090
25651		A	Pin ulnar styloid fracture	5.68	NA	NA	5.17	5.25	0.86	090
25652		A	Treat fracture ulnar styloid	7.92	NA	NA	6.18	6.39	1.21	090
25660		A	Treat wrist dislocation	4.84	NA	NA	4.33	4.43	0.58	090
25670		A	Treat wrist dislocation	7.98	NA	NA	5.83	6.12	1.28	090
25671		A	Pin radioulnar dislocation	6.32	NA	NA	5.50	5.67	1.00	090
25675		A	Treat wrist dislocation	4.75	4.88	5.08	4.14	4.27	0.62	090
25676		A	Treat wrist dislocation	8.17	NA	NA	6.13	6.43	1.34	090
25680		A	Treat wrist fracture	6.08	NA	NA	4.45	4.53	0.78	090
25685		A	Treat wrist fracture	9.97	NA	NA	6.68	6.97	1.60	090
25690		A	Treat wrist dislocation	5.58	NA	NA	4.90	5.06	0.88	090
25695		A	Treat wrist dislocation	8.40	NA	NA	5.98	6.27	1.32	090
25800		A	Fusion of wrist joint	9.95	NA	NA	6.80	7.38	1.57	090
25805		A	Fusion/graft of wrist joint	11.59	NA	NA	7.74	8.38	1.81	090
25810		A	Fusion/graft of wrist joint	11.75	NA	NA	8.04	8.51	1.68	090
25820		A	Fusion of hand bones	7.52	NA	NA	6.35	6.73	1.22	090
25825		A	Fuse hand bones with graft	9.54	NA	NA	7.68	8.08	1.41	090
25830		A	Fusion, radioulnar jnt/ulna	10.69	NA	NA	10.57	11.55	1.55	090
25900		A	Amputation of forearm	9.46	NA	NA	6.70	8.18	1.30	090
25905		A	Amputation of forearm	9.48	NA	NA	6.44	7.92	1.40	090
25907		A	Amputation follow-up surgery	7.98	NA	NA	5.79	7.30	1.10	090
25909		A	Amputation follow-up surgery	9.20	NA	NA	6.32	7.83	1.44	090
25915		A	Amputation of forearm	17.38	NA	NA	9.65	11.98	2.94	090
25920		A	Amputate hand at wrist	8.92	NA	NA	6.81	7.08	1.35	090
25922		A	Amputate hand at wrist	7.54	NA	NA	5.56	5.94	1.12	090
25924		A	Amputation follow-up surgery	8.70	NA	NA	6.52	6.92	1.32	090
25927		A	Amputation of hand	8.98	NA	NA	8.71	9.46	1.27	090
25929		A	Amputation follow-up surgery	7.71	NA	NA	5.16	5.35	1.14	090

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25931		A	Amputation follow-up surgery	7.93	NA	NA	8.05	8.92	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	4.12	4.49	1.54	1.56	0.18	010
26011		A	Drainage of finger abscess	2.21	6.32	6.95	1.99	2.07	0.33	010
26020		A	Drain hand tendon sheath	4.97	NA	NA	4.76	4.91	0.73	090
26025		A	Drainage of palm bursa	4.99	NA	NA	4.46	4.63	0.76	090
26030		A	Drainage of palm bursa(s)	6.16	NA	NA	4.98	5.18	0.92	090
26034		A	Treat hand bone lesion	6.49	NA	NA	5.60	5.80	1.01	090
26035		A	Decompress fingers/hand	11.14	NA	NA	8.05	8.01	1.47	090
26037		A	Decompress fingers/hand	7.48	NA	NA	5.49	5.70	1.13	090
26040		A	Release palm contracture	3.38	NA	NA	3.61	3.72	0.53	090
26045		A	Release palm contracture	5.62	NA	NA	4.89	5.09	0.93	090
26055		A	Incise finger tendon sheath	3.00	9.06	10.40	3.83	3.86	0.43	090
26060		A	Incision of finger tendon	2.85	NA	NA	3.14	3.23	0.45	090
26070		A	Explore/treat hand joint	3.73	NA	NA	3.15	3.21	0.48	090
26075		A	Explore/treat finger joint	3.83	NA	NA	3.40	3.50	0.53	090
26080		A	Explore/treat finger joint	4.36	NA	NA	4.35	4.48	0.66	090
26100		A	Biopsy hand joint lining	3.71	NA	NA	3.57	3.72	0.54	090
26105		A	Biopsy finger joint lining	3.75	NA	NA	3.68	3.82	0.59	090
26110		A	Biopsy finger joint lining	3.57	NA	NA	3.62	3.73	0.53	090
26115		A	Removal hand lesion subcut	3.92	9.87	10.69	4.24	4.38	0.59	090
26116		A	Removal hand lesion, deep	5.61	NA	NA	5.32	5.50	0.84	090
26117		A	Remove tumor, hand/finger	8.62	NA	NA	6.20	6.42	1.26	090
26121		A	Release palm contracture	7.61	NA	NA	5.94	6.20	1.17	090
26123		A	Release palm contracture	10.63	NA	NA	8.23	8.39	1.43	090
26125		A	Release palm contracture	4.60	NA	NA	1.88	2.02	0.70	ZZZ
26130		A	Remove wrist joint lining	5.48	NA	NA	4.85	4.98	0.94	090
26135		A	Revise finger joint, each	7.02	NA	NA	5.47	5.72	1.07	090
26140		A	Revise finger joint, each	6.23	NA	NA	5.19	5.41	0.92	090
26145		A	Tendon excision, palm/finger	6.38	NA	NA	5.20	5.42	0.97	090
26160		A	Remove tendon sheath lesion	3.46	9.06	9.90	3.95	4.00	0.49	090
26170		A	Removal of palm tendon, each	4.82	NA	NA	4.37	4.52	0.69	090
26180		A	Removal of finger tendon	5.24	NA	NA	4.78	4.95	0.78	090
26185		A	Remove finger bone	6.32	NA	NA	5.91	5.95	0.81	090
26200		A	Remove hand bone lesion	5.56	NA	NA	4.65	4.83	0.88	090
26205		A	Remove/graft bone lesion	7.82	NA	NA	5.83	6.11	1.20	090
26210		A	Removal of finger lesion	5.21	NA	NA	4.75	4.92	0.79	090
26215		A	Remove/graft finger lesion	7.16	NA	NA	5.49	5.70	0.98	090
26230		A	Partial removal of hand bone	6.38	NA	NA	5.00	5.24	1.01	090
26235		A	Partial removal, finger bone	6.24	NA	NA	4.98	5.20	0.95	090
26236		A	Partial removal, finger bone	5.37	NA	NA	4.62	4.80	0.81	090
26250		A	Extensive hand surgery	7.61	NA	NA	5.74	5.92	1.07	090
26255		A	Extensive hand surgery	12.80	NA	NA	7.17	7.73	1.69	090
26260		A	Extensive finger surgery	7.09	NA	NA	5.37	5.58	1.01	090

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26261		A	Extensive finger surgery	9.28	NA	NA	6.54	6.46	1.14	090
26262		A	Partial removal of finger	5.72	NA	NA	4.68	4.85	0.88	090
26320		A	Removal of implant from hand	4.02	NA	NA	3.79	3.92	0.59	090
26340		A	Manipulate finger w/anesth	2.62	NA	NA	4.62	4.69	0.39	090
26350		A	Repair finger/hand tendon	6.07	NA	NA	9.53	10.82	0.93	090
26352		A	Repair/graft hand tendon	7.75	NA	NA	9.96	11.33	1.13	090
26356		A	Repair finger/hand tendon	10.22	NA	NA	13.75	14.93	1.21	090
26357		A	Repair finger/hand tendon	8.65	NA	NA	10.43	11.75	1.33	090
26358		A	Repair/graft hand tendon	9.22	NA	NA	10.92	12.37	1.38	090
26370		A	Repair finger/hand tendon	7.17	NA	NA	9.61	11.00	1.12	090
26372		A	Repair/graft hand tendon	8.89	NA	NA	10.54	12.06	1.40	090
26373		A	Repair finger/hand tendon	8.29	NA	NA	10.21	11.69	1.23	090
26390		A	Revise hand/finger tendon	9.31	NA	NA	9.03	10.11	1.40	090
26392		A	Repair/graft hand tendon	10.38	NA	NA	10.94	12.40	1.57	090
26410		A	Repair hand tendon	4.68	NA	NA	7.68	8.76	0.73	090
26412		A	Repair/graft hand tendon	6.37	NA	NA	8.72	9.87	0.97	090
26415		A	Excision, hand/finger tendon	8.40	NA	NA	7.47	8.56	0.98	090
26416		A	Graft hand or finger tendon	9.44	NA	NA	7.06	8.96	0.79	090
26418		A	Repair finger tendon	4.33	NA	NA	8.19	9.24	0.67	090
26420		A	Repair/graft finger tendon	6.83	NA	NA	8.71	9.96	1.07	090
26426		A	Repair finger/hand tendon	6.21	NA	NA	5.15	7.17	0.95	090
26428		A	Repair/graft finger tendon	7.28	NA	NA	9.22	10.40	1.09	090
26432		A	Repair finger tendon	4.07	NA	NA	6.80	7.68	0.64	090
26433		A	Repair finger tendon	4.61	NA	NA	7.02	7.97	0.72	090
26434		A	Repair/graft finger tendon	6.15	NA	NA	7.95	8.86	0.93	090
26437		A	Realignment of tendons	5.88	NA	NA	7.81	8.76	0.89	090
26440		A	Release palm/finger tendon	5.07	NA	NA	8.55	9.78	0.75	090
26442		A	Release palm & finger tendon	9.50	NA	NA	11.82	12.87	1.20	090
26445		A	Release hand/finger tendon	4.36	NA	NA	8.25	9.49	0.65	090
26449		A	Release forearm/hand tendon	8.34	NA	NA	7.34	9.46	1.06	090
26450		A	Incision of palm tendon	3.71	NA	NA	5.20	5.74	0.59	090
26455		A	Incision of finger tendon	3.68	NA	NA	5.16	5.70	0.58	090
26460		A	Incise hand/finger tendon	3.50	NA	NA	5.12	5.63	0.55	090
26471		A	Fusion of finger tendons	5.79	NA	NA	7.73	8.62	0.88	090
26474		A	Fusion of finger tendons	5.38	NA	NA	7.54	8.51	0.76	090
26476		A	Tendon lengthening	5.24	NA	NA	7.36	8.27	0.79	090
26477		A	Tendon shortening	5.21	NA	NA	7.51	8.41	0.81	090
26478		A	Lengthening of hand tendon	5.86	NA	NA	7.87	8.88	0.90	090
26479		A	Shortening of hand tendon	5.80	NA	NA	7.82	8.77	0.92	090
26480		A	Transplant hand tendon	6.76	NA	NA	9.68	11.04	1.02	090
26483		A	Transplant/graft hand tendon	8.36	NA	NA	10.30	11.62	1.26	090
26485		A	Transplant palm tendon	7.77	NA	NA	10.10	11.43	1.15	090
26489		A	Transplant/graft palm tendon	9.74	NA	NA	10.57	10.96	1.26	090
26490		A	Revise thumb tendon	8.48	NA	NA	8.98	9.96	1.21	090

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26492		A	Tendon transfer with graft	9.70	NA	NA	9.86	10.81	1.40	090
26494		A	Hand tendon/muscle transfer	8.54	NA	NA	9.08	10.07	1.28	090
26496		A	Revise thumb tendon	9.66	NA	NA	9.55	10.49	1.45	090
26497		A	Finger tendon transfer	9.64	NA	NA	9.52	10.55	1.41	090
26498		A	Finger tendon transfer	14.07	NA	NA	11.48	12.67	2.11	090
26499		A	Revision of finger	9.05	NA	NA	9.31	10.26	1.35	090
26500		A	Hand tendon reconstruction	6.02	NA	NA	7.80	8.72	0.90	090
26502		A	Hand tendon reconstruction	7.20	NA	NA	8.40	9.32	1.13	090
26508		A	Release thumb contracture	6.07	NA	NA	7.65	8.67	0.98	090
26510		A	Thumb tendon transfer	5.49	NA	NA	7.67	8.60	0.79	090
26516		A	Fusion of knuckle joint	7.21	NA	NA	8.27	9.28	1.10	090
26517		A	Fusion of knuckle joints	8.96	NA	NA	9.27	10.34	1.41	090
26518		A	Fusion of knuckle joints	9.15	NA	NA	9.34	10.37	1.35	090
26520		A	Release knuckle contracture	5.36	NA	NA	8.91	10.17	0.80	090
26525		A	Release finger contracture	5.39	NA	NA	8.92	10.20	0.81	090
26530		A	Revise knuckle joint	6.76	NA	NA	5.41	5.60	1.04	090
26531		A	Revise knuckle with implant	7.99	NA	NA	6.19	6.43	1.17	090
26535		A	Revise finger joint	5.30	NA	NA	4.16	4.06	0.71	090
26536		A	Revise/implant finger joint	6.44	NA	NA	9.26	9.37	0.96	090
26540		A	Repair hand joint	6.49	NA	NA	8.06	9.03	0.99	090
26541		A	Repair hand joint with graft	8.69	NA	NA	9.15	10.23	1.28	090
26542		A	Repair hand joint with graft	6.84	NA	NA	8.22	9.19	1.02	090
26545		A	Reconstruct finger joint	6.99	NA	NA	8.41	9.35	1.05	090
26546		A	Repair nonunion hand	10.53	NA	NA	11.46	12.37	1.44	090
26548		A	Reconstruct finger joint	8.10	NA	NA	8.80	9.83	1.20	090
26550		A	Construct thumb replacement	21.54	NA	NA	12.32	13.66	2.46	090
26551		A	Great toe-hand transfer	48.23	NA	NA	23.86	26.05	7.98	090
26553		A	Single transfer, toe-hand	47.92	NA	NA	19.44	20.27	2.42	090
26554		A	Double transfer, toe-hand	56.73	NA	NA	25.27	28.38	9.44	090
26555		A	Positional change of finger	16.94	NA	NA	14.14	15.17	2.49	090
26556		A	Toe joint transfer	49.43	NA	NA	17.15	21.24	2.58	090
26560		A	Repair of web finger	5.43	NA	NA	7.31	7.94	0.85	090
26561		A	Repair of web finger	10.98	NA	NA	9.59	10.30	1.45	090
26562		A	Repair of web finger	16.40	NA	NA	13.48	14.42	2.24	090
26565		A	Correct metacarpal flaw	6.80	NA	NA	8.10	9.09	1.00	090
26567		A	Correct finger deformity	6.88	NA	NA	8.22	9.16	1.04	090
26568		A	Lengthen metacarpal/finger	9.15	NA	NA	10.69	11.89	1.49	090
26580		A	Repair hand deformity	19.50	NA	NA	13.15	13.29	2.29	090
26587		A	Reconstruct extra finger	14.36	NA	NA	7.79	8.16	1.53	090
26590		A	Repair finger deformity	18.51	NA	NA	8.95	10.21	2.78	090
26591		A	Repair muscles of hand	3.30	NA	NA	6.30	7.14	0.48	090
26593		A	Release muscles of hand	5.38	NA	NA	7.84	8.68	0.78	090
26596		A	Excision constricting tissue	9.02	NA	NA	7.69	7.99	1.43	090
26600		A	Treat metacarpal fracture	2.48	3.85	3.79	3.50	3.29	0.30	090

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26605		A	Treat metacarpal fracture	2.92	4.09	4.22	3.51	3.55	0.49	090
26607		A	Treat metacarpal fracture	5.40	NA	NA	4.11	4.66	0.87	090
26608		A	Treat metacarpal fracture	5.43	NA	NA	5.25	5.51	0.88	090
26615		A	Treat metacarpal fracture	6.91	NA	NA	6.04	5.86	0.86	090
26641		A	Treat thumb dislocation	4.01	4.26	4.34	3.60	3.59	0.39	090
26645		A	Treat thumb fracture	4.47	4.72	4.84	4.03	4.08	0.67	090
26650		A	Treat thumb fracture	5.19	NA	NA	5.40	5.73	0.94	090
26665		A	Treat thumb fracture	7.78	NA	NA	6.35	6.42	0.90	090
26670		A	Treat hand dislocation	3.74	3.60	3.77	3.01	2.99	0.39	090
26675		A	Treat hand dislocation	4.71	5.10	5.20	4.37	4.40	0.77	090
26676		A	Pin hand dislocation	5.60	NA	NA	5.59	5.87	0.91	090
26685		A	Treat hand dislocation	6.91	NA	NA	6.05	6.08	1.09	090
26686		A	Treat hand dislocation	8.06	NA	NA	6.03	6.25	1.24	090
26700		A	Treat knuckle dislocation	3.74	3.33	3.44	2.96	2.94	0.35	090
26705		A	Treat knuckle dislocation	4.26	4.69	4.86	3.98	4.07	0.66	090
26706		A	Pin knuckle dislocation	5.19	NA	NA	4.61	4.73	0.81	090
26715		A	Treat knuckle dislocation	6.87	NA	NA	6.03	5.90	0.91	090
26720		A	Treat finger fracture, each	1.70	2.59	2.64	2.31	2.25	0.24	090
26725		A	Treat finger fracture, each	3.39	4.08	4.26	3.41	3.44	0.53	090
26727		A	Treat finger fracture, each	5.30	NA	NA	5.21	5.47	0.84	090
26735		A	Treat finger fracture, each	7.26	NA	NA	6.18	6.03	0.95	090
26740		A	Treat finger fracture, each	1.99	2.98	3.02	2.69	2.70	0.31	090
26742		A	Treat finger fracture, each	3.90	4.29	4.47	3.58	3.66	0.58	090
26746		A	Treat finger fracture, each	9.59	NA	NA	7.21	6.80	0.91	090
26750		A	Treat finger fracture, each	1.74	2.25	2.31	2.26	2.20	0.22	090
26755		A	Treat finger fracture, each	3.15	3.77	3.94	2.96	2.97	0.42	090
26756		A	Pin finger fracture, each	4.46	NA	NA	4.85	5.08	0.71	090
26765		A	Treat finger fracture, each	5.70	NA	NA	5.47	5.20	0.66	090
26770		A	Treat finger dislocation	3.07	2.93	3.06	2.55	2.52	0.27	090
26775		A	Treat finger dislocation	3.78	4.66	4.80	3.90	3.88	0.54	090
26776		A	Pin finger dislocation	4.87	NA	NA	4.99	5.25	0.77	090
26785		A	Treat finger dislocation	6.44	NA	NA	5.78	5.47	0.68	090
26820		A	Thumb fusion with graft	8.33	NA	NA	9.00	10.08	1.30	090
26841		A	Fusion of thumb	7.21	NA	NA	8.76	9.89	1.18	090
26842		A	Thumb fusion with graft	8.37	NA	NA	9.05	10.15	1.32	090
26843		A	Fusion of hand joint	7.67	NA	NA	8.55	9.52	1.15	090
26844		A	Fusion/graft of hand joint	8.86	NA	NA	9.22	10.27	1.33	090
26850		A	Fusion of knuckle	7.03	NA	NA	8.31	9.30	1.06	090
26852		A	Fusion of knuckle with graft	8.59	NA	NA	9.14	10.09	1.22	090
26860		A	Fusion of finger joint	4.76	NA	NA	7.55	8.47	0.73	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	NA	0.70	0.76	0.27	ZZZ
26862		A	Fusion/graft of finger joint	7.44	NA	NA	8.65	9.59	1.10	090
26863		A	Fuse/graft added joint	3.89	NA	NA	1.55	1.70	0.56	ZZZ
26910		A	Amputate metacarpal bone	7.67	NA	NA	8.30	9.04	1.16	090

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26951		A	Amputation of finger/thumb	5.85	NA	NA	8.40	8.85	0.71	090
26952		A	Amputation of finger/thumb	6.37	NA	NA	7.93	8.88	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	6.25	6.50	1.22	090
26991		A	Drainage of pelvis bursa	6.97	8.70	9.33	4.92	5.06	1.11	090
26992		A	Drainage of bone lesion	13.37	NA	NA	8.52	8.99	2.17	090
27000		A	Incision of hip tendon	5.66	NA	NA	4.46	4.68	0.98	090
27001		A	Incision of hip tendon	7.05	NA	NA	5.22	5.44	1.24	090
27003		A	Incision of hip tendon	7.70	NA	NA	5.62	5.85	1.12	090
27005		A	Incision of hip tendon	9.96	NA	NA	6.62	6.93	1.73	090
27006		A	Incision of hip tendons	9.99	NA	NA	6.80	7.10	1.70	090
27025		A	Incision of hip/thigh fascia	12.66	NA	NA	8.08	8.21	1.85	090
27030		A	Drainage of hip joint	13.54	NA	NA	8.06	8.46	2.27	090
27033		A	Exploration of hip joint	13.99	NA	NA	8.43	8.81	2.33	090
27035		A	Denervation of hip joint	17.23	NA	NA	7.84	8.70	2.16	090
27036		A	Excision of hip joint/muscle	14.18	NA	NA	8.94	9.22	2.27	090
27040		A	Biopsy of soft tissues	2.89	5.31	5.30	1.93	1.95	0.27	010
27041		A	Biopsy of soft tissues	10.07	NA	NA	5.89	6.09	1.35	090
27047		A	Remove hip/pelvis lesion	7.51	7.01	7.04	4.48	4.56	1.03	090
27048		A	Remove hip/pelvis lesion	6.44	NA	NA	4.64	4.68	0.92	090
27049		A	Remove tumor, hip/pelvis	15.20	NA	NA	8.13	8.20	2.07	090
27050		A	Biopsy of sacroiliac joint	4.65	NA	NA	3.28	3.57	0.60	090
27052		A	Biopsy of hip joint	7.27	NA	NA	5.60	5.68	1.08	090
27054		A	Removal of hip joint lining	9.09	NA	NA	6.47	6.70	1.47	090
27060		A	Removal of ischial bursa	5.78	NA	NA	4.24	4.28	0.80	090
27062		A	Remove femur lesion/bursa	5.66	NA	NA	4.61	4.76	0.93	090
27065		A	Removal of hip bone lesion	6.44	NA	NA	5.12	5.20	1.01	090
27066		A	Removal of hip bone lesion	11.06	NA	NA	7.47	7.72	1.80	090
27067		A	Remove/graft hip bone lesion	14.57	NA	NA	9.09	9.49	1.85	090
27070		A	Partial removal of hip bone	11.44	NA	NA	8.08	8.35	1.75	090
27071		A	Partial removal of hip bone	12.25	NA	NA	8.58	8.97	1.93	090
27075		A	Extensive hip surgery	36.77	NA	NA	16.37	17.10	5.66	090
27076		A	Extensive hip surgery	24.25	NA	NA	12.60	13.09	3.71	090
27077		A	Extensive hip surgery	42.54	NA	NA	19.05	19.98	6.14	090
27078		A	Extensive hip surgery	14.54	NA	NA	8.94	9.20	2.23	090
27079		A	Extensive hip surgery	14.91	NA	NA	7.85	8.29	1.95	090
27080		A	Removal of tail bone	6.80	NA	NA	4.72	4.75	0.93	090
27086		A	Remove hip foreign body	1.89	3.74	3.94	1.51	1.59	0.25	010
27087		A	Remove hip foreign body	8.72	NA	NA	5.76	6.00	1.35	090
27090		A	Removal of hip prosthesis	11.57	NA	NA	7.43	7.78	1.95	090
27091		A	Removal of hip prosthesis	24.15	NA	NA	12.90	13.19	3.85	090
27093		A	Injection for hip x-ray	1.30	3.18	3.50	0.48	0.48	0.13	000
27095		A	Injection for hip x-ray	1.50	3.84	4.32	0.53	0.53	0.14	000
27096		A	Inject sacroiliac joint	1.40	2.59	3.03	0.34	0.34	0.08	000

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27097		A	Revision of hip tendon	9.16	NA	NA	6.20	6.26	1.57	090
27098		A	Transfer tendon to pelvis	9.20	NA	NA	5.07	5.57	0.95	090
27100		A	Transfer of abdominal muscle	11.21	NA	NA	7.57	7.86	1.86	090
27105		A	Transfer of spinal muscle	11.90	NA	NA	7.86	8.20	1.73	090
27110		A	Transfer of iliopsoas muscle	13.63	NA	NA	8.45	8.62	2.19	090
27111		A	Transfer of iliopsoas muscle	12.46	NA	NA	6.84	7.43	1.95	090
27120		A	Reconstruction of hip socket	19.10	NA	NA	10.68	10.98	3.09	090
27122		A	Reconstruction of hip socket	15.95	NA	NA	9.43	9.84	2.62	090
27125		A	Partial hip replacement	16.46	NA	NA	9.60	9.87	2.55	090
27130		A	Total hip arthroplasty	21.61	NA	NA	11.79	12.18	3.51	090
27132		A	Total hip arthroplasty	25.49	NA	NA	13.45	14.01	4.05	090
27134		A	Revise hip joint replacement	30.13	NA	NA	14.71	15.50	4.95	090
27137		A	Revise hip joint replacement	22.55	NA	NA	11.75	12.31	3.68	090
27138		A	Revise hip joint replacement	23.55	NA	NA	12.14	12.72	3.85	090
27140		A	Transplant femur ridge	12.66	NA	NA	7.92	8.30	2.12	090
27146		A	Incision of hip bone	18.72	NA	NA	10.36	10.82	2.97	090
27147		A	Revision of hip bone	21.87	NA	NA	12.18	12.47	3.58	090
27151		A	Incision of hip bones	23.92	NA	NA	12.89	11.67	3.92	090
27156		A	Revision of hip bones	26.03	NA	NA	13.25	13.97	4.22	090
27158		A	Revision of pelvis	20.89	NA	NA	11.53	11.40	3.17	090
27161		A	Incision of neck of femur	17.74	NA	NA	10.31	10.77	2.95	090
27165		A	Incision/fixation of femur	20.06	NA	NA	11.59	11.94	3.11	090
27170		A	Repair/graft femur head/neck	17.46	NA	NA	9.74	10.14	2.82	090
27175		A	Treat slipped epiphysis	9.29	NA	NA	5.96	6.15	1.46	090
27176		A	Treat slipped epiphysis	12.78	NA	NA	8.20	8.42	2.23	090
27177		A	Treat slipped epiphysis	15.94	NA	NA	9.65	9.97	2.62	090
27178		A	Treat slipped epiphysis	12.78	NA	NA	8.20	8.27	2.09	090
27179		A	Revise head/neck of femur	13.83	NA	NA	8.44	8.84	2.26	090
27181		A	Treat slipped epiphysis	15.98	NA	NA	9.75	9.87	1.57	090
27185		A	Revision of femur epiphysis	9.67	NA	NA	5.37	5.92	2.40	090
27187		A	Reinforce hip bones	14.09	NA	NA	8.69	9.11	2.38	090
27193		A	Treat pelvic ring fracture	5.98	4.64	4.75	4.77	4.85	0.96	090
27194		A	Treat pelvic ring fracture	10.08	NA	NA	6.30	6.65	1.65	090
27200		A	Treat tail bone fracture	1.87	2.06	2.10	2.20	2.19	0.28	090
27202		A	Treat tail bone fracture	7.25	NA	NA	4.87	7.88	1.06	090
27215		A	Treat pelvic fracture(s)	10.45	NA	NA	6.61	6.73	1.98	090
27216		A	Treat pelvic ring fracture	15.73	NA	NA	9.12	9.25	2.64	090
27217		A	Treat pelvic ring fracture	14.65	NA	NA	8.66	9.04	2.42	090
27218		A	Treat pelvic ring fracture	20.93	NA	NA	11.32	11.35	3.49	090
27220		A	Treat hip socket fracture	6.72	5.27	5.39	5.17	5.29	1.07	090
27222		A	Treat hip socket fracture	13.97	NA	NA	8.48	8.86	2.20	090
27226		A	Treat hip wall fracture	15.45	NA	NA	9.01	8.71	2.49	090
27227		A	Treat hip fracture(s)	25.21	NA	NA	13.38	13.90	4.06	090
27228		A	Treat hip fracture(s)	29.13	NA	NA	14.92	15.62	4.67	090

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27230		A	Treat thigh fracture	5.69	4.96	5.11	4.90	4.95	0.95	090
27232		A	Treat thigh fracture	11.66	NA	NA	6.12	6.39	1.86	090
27235		A	Treat thigh fracture	12.88	NA	NA	7.99	8.37	2.12	090
27236		A	Treat thigh fracture	17.43	NA	NA	10.15	10.39	2.72	090
27238		A	Treat thigh fracture	5.64	NA	NA	4.70	4.81	0.89	090
27240		A	Treat thigh fracture	13.66	NA	NA	8.31	8.61	2.17	090
27244		A	Treat thigh fracture	17.08	NA	NA	9.63	10.06	2.78	090
27245		A	Treat thigh fracture	21.09	NA	NA	11.36	11.97	3.53	090
27246		A	Treat thigh fracture	4.75	3.92	4.06	3.95	4.07	0.81	090
27248		A	Treat thigh fracture	10.64	NA	NA	6.41	6.87	1.82	090
27250		A	Treat hip dislocation	7.21	NA	NA	4.30	4.38	0.62	090
27252		A	Treat hip dislocation	10.92	NA	NA	6.49	6.73	1.66	090
27253		A	Treat hip dislocation	13.46	NA	NA	8.18	8.59	2.25	090
27254		A	Treat hip dislocation	18.80	NA	NA	10.49	10.89	3.18	090
27256		A	Treat hip dislocation	4.25	2.49	2.75	1.41	1.58	0.46	010
27257		A	Treat hip dislocation	5.35	NA	NA	2.50	2.58	0.69	010
27258		A	Treat hip dislocation	16.04	NA	NA	9.42	9.80	2.65	090
27259		A	Treat hip dislocation	23.03	NA	NA	12.84	13.17	3.75	090
27265		A	Treat hip dislocation	5.12	NA	NA	3.90	4.13	0.63	090
27266		A	Treat hip dislocation	7.67	NA	NA	5.51	5.73	1.29	090
27267		A	Cltx thigh fx	5.38	NA	NA	4.20	4.20	0.89	090
27268		A	Cltx thigh fx w/mnpj	7.00	NA	NA	4.80	4.80	1.16	090
27269		A	Optx thigh fx	18.75	NA	NA	9.45	9.45	2.93	090
27275		A	Manipulation of hip joint	2.29	NA	NA	1.81	1.89	0.39	010
27280		A	Fusion of sacroiliac joint	14.49	NA	NA	9.09	9.39	2.54	090
27282		A	Fusion of pubic bones	11.71	NA	NA	6.80	7.11	1.87	090
27284		A	Fusion of hip joint	24.91	NA	NA	10.19	11.35	3.93	090
27286		A	Fusion of hip joint	24.97	NA	NA	13.31	13.95	3.13	090
27290		A	Amputation of leg at hip	24.38	NA	NA	11.97	12.51	3.44	090
27295		A	Amputation of leg at hip	19.54	NA	NA	9.78	10.17	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	8.25	8.72	4.68	4.80	1.04	090
27303		A	Drainage of bone lesion	8.52	NA	NA	6.02	6.27	1.43	090
27305		A	Incise thigh tendon & fascia	6.09	NA	NA	4.56	4.72	1.01	090
27306		A	Incision of thigh tendon	4.66	NA	NA	3.86	4.08	0.85	090
27307		A	Incision of thigh tendons	5.97	NA	NA	4.59	4.80	1.04	090
27310		A	Exploration of knee joint	9.88	NA	NA	6.79	6.99	1.61	090
27323		A	Biopsy, thigh soft tissues	2.30	4.21	4.04	1.93	1.92	0.24	010
27324		A	Biopsy, thigh soft tissues	4.95	NA	NA	3.85	3.94	0.75	090
27325		A	Neurectomy, hamstring	7.09	NA	NA	5.21	5.15	1.09	090
27326		A	Neurectomy, popliteal	6.36	NA	NA	4.80	4.91	1.06	090
27327		A	Removal of thigh lesion	4.52	6.07	6.05	3.60	3.63	0.64	090
27328		A	Removal of thigh lesion	5.62	NA	NA	4.08	4.16	0.84	090
27329		A	Remove tumor, thigh/knee	15.68	NA	NA	8.50	8.64	2.15	090

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27330		A	Biopsy, knee joint lining	5.02	NA	NA	4.12	4.24	0.86	090
27331		A	Explore/treat knee joint	5.93	NA	NA	4.79	4.98	1.02	090
27332		A	Removal of knee cartilage	8.34	NA	NA	6.19	6.43	1.43	090
27333		A	Removal of knee cartilage	7.43	NA	NA	5.74	5.98	1.26	090
27334		A	Remove knee joint lining	9.07	NA	NA	6.40	6.66	1.51	090
27335		A	Remove knee joint lining	10.43	NA	NA	7.02	7.33	1.75	090
27340		A	Removal of kneecap bursa	4.23	NA	NA	4.04	4.18	0.72	090
27345		A	Removal of knee cyst	5.98	NA	NA	4.92	5.10	1.00	090
27347		A	Remove knee cyst	6.58	NA	NA	5.33	5.36	0.98	090
27350		A	Removal of kneecap	8.54	NA	NA	6.26	6.52	1.41	090
27355		A	Remove femur lesion	7.89	NA	NA	5.82	6.07	1.32	090
27356		A	Remove femur lesion/graft	9.97	NA	NA	6.85	7.11	1.65	090
27357		A	Remove femur lesion/graft	11.02	NA	NA	7.51	7.82	1.96	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	1.88	2.04	0.82	ZZZ
27360		A	Partial removal, leg bone(s)	11.34	NA	NA	8.04	8.43	1.84	090
27365		A	Extensive leg surgery	17.93	NA	NA	10.41	10.74	2.80	090
27370		A	Injection for knee x-ray	0.96	2.99	3.18	0.35	0.35	0.08	000
27372		A	Removal of foreign body	5.12	8.39	8.82	4.08	4.24	0.84	090
27380		A	Repair of kneecap tendon	7.34	NA	NA	6.05	6.36	1.24	090
27381		A	Repair/graft kneecap tendon	10.64	NA	NA	7.57	7.96	1.80	090
27385		A	Repair of thigh muscle	8.00	NA	NA	6.32	6.66	1.36	090
27386		A	Repair/graft of thigh muscle	10.99	NA	NA	7.89	8.30	1.86	090
27390		A	Incision of thigh tendon	5.44	NA	NA	4.59	4.73	0.92	090
27391		A	Incision of thigh tendons	7.38	NA	NA	5.59	5.84	1.23	090
27392		A	Incision of thigh tendons	9.51	NA	NA	6.45	6.74	1.57	090
27393		A	Lengthening of thigh tendon	6.50	NA	NA	5.00	5.21	1.10	090
27394		A	Lengthening of thigh tendons	8.68	NA	NA	6.14	6.42	1.47	090
27395		A	Lengthening of thigh tendons	12.10	NA	NA	7.95	8.31	2.05	090
27396		A	Transplant of thigh tendon	8.04	NA	NA	5.90	6.18	1.34	090
27397		A	Transplants of thigh tendons	12.46	NA	NA	8.41	8.58	1.83	090
27400		A	Revise thigh muscles/tendons	9.21	NA	NA	6.59	6.76	1.31	090
27403		A	Repair of knee cartilage	8.51	NA	NA	6.07	6.35	1.44	090
27405		A	Repair of knee ligament	8.96	NA	NA	6.43	6.71	1.51	090
27407		A	Repair of knee ligament	10.71	NA	NA	6.83	7.21	1.79	090
27409		A	Repair of knee ligaments	13.57	NA	NA	8.47	8.85	2.25	090
27412		A	Autochondrocyte implant knee	24.53	NA	NA	13.67	13.97	4.36	090
27415		A	Osteochondral knee allograft	19.79	NA	NA	11.79	12.00	4.36	090
27416		A	Osteochondral knee autograft	14.00	NA	NA	8.37	8.37	2.32	090
27418		A	Repair degenerated kneecap	11.46	NA	NA	7.59	7.93	1.89	090
27420		A	Revision of unstable kneecap	10.14	NA	NA	6.90	7.21	1.72	090
27422		A	Revision of unstable kneecap	10.09	NA	NA	6.87	7.19	1.71	090
27424		A	Revision/removal of kneecap	10.12	NA	NA	6.90	7.21	1.71	090
27425		A	Lat retinacular release open	5.28	NA	NA	4.71	4.92	0.90	090
27427		A	Reconstruction, knee	9.67	NA	NA	6.70	6.98	1.63	090

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27428		A	Reconstruction, knee	15.33	NA	NA	10.05	10.36	2.43	090
27429		A	Reconstruction, knee	17.24	NA	NA	11.22	11.53	2.71	090
27430		A	Revision of thigh muscles	10.04	NA	NA	6.83	7.13	1.70	090
27435		A	Incision of knee joint	10.68	NA	NA	7.61	7.83	1.70	090
27437		A	Revise kneecap	8.82	NA	NA	6.20	6.46	1.49	090
27438		A	Revise kneecap with implant	11.77	NA	NA	7.51	7.77	1.96	090
27440		A	Revision of knee joint	10.97	NA	NA	7.16	6.88	1.82	090
27441		A	Revision of knee joint	11.42	NA	NA	7.07	6.99	1.89	090
27442		A	Revision of knee joint	12.25	NA	NA	7.62	7.95	2.10	090
27443		A	Revision of knee joint	11.29	NA	NA	7.29	7.66	1.91	090
27445		A	Revision of knee joint	18.52	NA	NA	10.41	10.91	3.09	090
27446		A	Revision of knee joint	16.26	NA	NA	9.29	9.80	2.81	090
27447		A	Total knee arthroplasty	23.04	NA	NA	12.59	13.11	3.80	090
27448		A	Incision of thigh	11.48	NA	NA	7.27	7.61	1.95	090
27450		A	Incision of thigh	14.47	NA	NA	8.84	9.29	2.43	090
27454		A	Realignment of thigh bone	18.97	NA	NA	10.72	11.18	3.13	090
27455		A	Realignment of knee	13.24	NA	NA	8.32	8.72	2.25	090
27457		A	Realignment of knee	13.92	NA	NA	8.22	8.66	2.35	090
27465		A	Shortening of thigh bone	18.44	NA	NA	10.32	10.31	2.48	090
27466		A	Lengthening of thigh bone	17.13	NA	NA	10.07	10.52	2.78	090
27468		A	Shorten/lengthen thighs	19.82	NA	NA	.	3.10	3.31	090
27470		A	Repair of thigh	16.97	NA	NA	10.17	10.59	2.80	090
27472		A	Repair/graft of thigh	18.57	NA	NA	10.66	11.18	3.08	090
27475		A	Surgery to stop leg growth	8.82	NA	NA	6.21	6.47	1.36	090
27477		A	Surgery to stop leg growth	10.03	NA	NA	6.68	6.95	1.74	090
27479		A	Surgery to stop leg growth	13.04	NA	NA	8.06	8.47	2.79	090
27485		A	Surgery to stop leg growth	9.02	NA	NA	6.23	6.53	1.53	090
27486		A	Revise/replace knee joint	20.92	NA	NA	11.65	12.13	3.37	090
27487		A	Revise/replace knee joint	26.91	NA	NA	14.01	14.66	4.40	090
27488		A	Removal of knee prosthesis	17.40	NA	NA	10.26	10.63	2.75	090
27495		A	Reinforce thigh	16.40	NA	NA	9.61	10.07	2.72	090
27496		A	Decompression of thigh/knee	6.66	NA	NA	4.89	5.07	0.99	090
27497		A	Decompression of thigh/knee	7.70	NA	NA	4.81	4.97	1.15	090
27498		A	Decompression of thigh/knee	8.54	NA	NA	5.06	5.29	1.24	090
27499		A	Decompression of thigh/knee	9.31	NA	NA	5.66	5.96	1.47	090
27500		A	Treatment of thigh fracture	6.21	5.41	5.59	4.62	4.72	1.02	090
27501		A	Treatment of thigh fracture	6.34	5.01	5.22	4.93	5.05	1.03	090
27502		A	Treatment of thigh fracture	11.24	NA	NA	6.77	7.11	1.79	090
27503		A	Treatment of thigh fracture	11.13	NA	NA	7.22	7.50	1.85	090
27506		A	Treatment of thigh fracture	19.42	NA	NA	11.38	11.75	3.04	090
27507		A	Treatment of thigh fracture	14.39	NA	NA	8.14	8.57	2.43	090
27508		A	Treatment of thigh fracture	6.08	5.66	5.87	5.03	5.15	0.97	090
27509		A	Treatment of thigh fracture	8.02	NA	NA	6.56	6.92	1.34	090
27510		A	Treatment of thigh fracture	9.68	NA	NA	6.31	6.57	1.53	090

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27511		A	Treatment of thigh fracture	14.97	NA	NA	8.11	8.90	2.38	090
27513		A	Treatment of thigh fracture	19.11	NA	NA	9.76	10.81	3.13	090
27514		A	Treatment of thigh fracture	14.46	NA	NA	7.91	9.28	3.01	090
27516		A	Treat thigh fx growth plate	5.45	5.61	5.80	4.99	5.13	0.81	090
27517		A	Treat thigh fx growth plate	8.98	NA	NA	6.54	6.77	1.22	090
27519		A	Treat thigh fx growth plate	13.11	NA	NA	7.42	8.47	2.56	090
27520		A	Treat kneecap fracture	2.93	4.10	4.22	3.53	3.51	0.47	090
27524		A	Treat kneecap fracture	10.25	NA	NA	6.94	7.27	1.75	090
27530		A	Treat knee fracture	3.97	4.82	4.95	4.26	4.30	0.65	090
27532		A	Treat knee fracture	7.43	6.40	6.65	5.63	5.84	1.26	090
27535		A	Treat knee fracture	13.27	NA	NA	7.44	8.12	2.01	090
27536		A	Treat knee fracture	17.19	NA	NA	10.20	10.57	2.74	090
27538		A	Treat knee fracture(s)	4.95	5.52	5.68	4.90	4.98	0.84	090
27540		A	Treat knee fracture	11.16	NA	NA	7.45	7.98	2.28	090
27550		A	Treat knee dislocation	5.84	5.39	5.55	4.65	4.73	0.76	090
27552		A	Treat knee dislocation	8.04	NA	NA	6.09	6.32	1.36	090
27556		A	Treat knee dislocation	12.86	NA	NA	7.26	8.37	2.51	090
27557		A	Treat knee dislocation	15.76	NA	NA	8.46	9.64	2.98	090
27558		A	Treat knee dislocation	18.25	NA	NA	9.52	10.42	3.09	090
27560		A	Treat kneecap dislocation	3.88	4.42	4.53	3.89	3.71	0.40	090
27562		A	Treat kneecap dislocation	5.86	NA	NA	4.79	4.79	0.94	090
27566		A	Treat kneecap dislocation	12.59	NA	NA	7.85	8.23	2.13	090
27570		A	Fixation of knee joint	1.76	NA	NA	1.62	1.66	0.30	010
27580		A	Fusion of knee	20.90	NA	NA	12.24	12.90	3.38	090
27590		A	Amputate leg at thigh	13.35	NA	NA	5.98	6.16	1.75	090
27591		A	Amputate leg at thigh	13.82	NA	NA	7.37	7.70	2.03	090
27592		A	Amputate leg at thigh	10.86	NA	NA	5.56	5.72	1.45	090
27594		A	Amputation follow-up surgery	7.17	NA	NA	4.73	4.84	1.02	090
27596		A	Amputation follow-up surgery	11.15	NA	NA	5.98	6.19	1.57	090
27598		A	Amputate lower leg at knee	11.08	NA	NA	6.31	6.50	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	3.87	4.04	0.86	090
27601		A	Decompression of lower leg	5.94	NA	NA	4.35	4.48	0.80	090
27602		A	Decompression of lower leg	7.71	NA	NA	4.27	4.49	1.10	090
27603		A	Drain lower leg lesion	5.12	7.06	7.17	3.90	3.97	0.74	090
27604		A	Drain lower leg bursa	4.51	6.31	6.26	3.31	3.48	0.69	090
27605		A	Incision of achilles tendon	2.89	5.24	5.85	1.77	1.91	0.41	010
27606		A	Incision of achilles tendon	4.15	NA	NA	2.62	2.81	0.69	010
27607		A	Treat lower leg bone lesion	8.51	NA	NA	5.77	5.88	1.31	090
27610		A	Explore/treat ankle joint	9.01	NA	NA	6.13	6.35	1.40	090
27612		A	Exploration of ankle joint	8.01	NA	NA	5.32	5.52	1.13	090
27613		A	Biopsy lower leg soft tissue	2.19	3.97	3.79	1.80	1.80	0.20	010
27614		A	Biopsy lower leg soft tissue	5.71	7.65	7.53	3.87	4.02	0.78	090
27615		A	Remove tumor, lower leg	12.93	NA	NA	7.26	7.80	1.84	090

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27618		A	Remove lower leg lesion	5.14	6.47	6.36	3.83	3.87	0.72	090
27619		A	Remove lower leg lesion	8.47	9.92	9.83	5.22	5.41	1.25	090
27620		A	Explore/treat ankle joint	6.04	NA	NA	4.58	4.81	0.97	090
27625		A	Remove ankle joint lining	8.37	NA	NA	5.36	5.64	1.28	090
27626		A	Remove ankle joint lining	8.98	NA	NA	5.80	6.09	1.48	090
27630		A	Removal of tendon lesion	4.85	7.91	7.83	3.78	3.93	0.74	090
27635		A	Remove lower leg bone lesion	7.91	NA	NA	5.71	5.98	1.31	090
27637		A	Remove/graft leg bone lesion	10.17	NA	NA	7.09	7.40	1.66	090
27638		A	Remove/graft leg bone lesion	10.87	NA	NA	7.02	7.35	1.85	090
27640		A	Partial removal of tibia	12.10	NA	NA	7.50	8.22	1.89	090
27641		A	Partial removal of fibula	9.73	NA	NA	6.05	6.63	1.46	090
27645		A	Extensive lower leg surgery	14.78	NA	NA	8.94	9.73	2.42	090
27646		A	Extensive lower leg surgery	13.21	NA	NA	7.72	8.56	2.06	090
27647		A	Extensive ankle/heel surgery	12.85	NA	NA	6.24	6.59	1.76	090
27648		A	Injection for ankle x-ray	0.96	2.88	3.04	0.34	0.34	0.08	000
27650		A	Repair achilles tendon	9.94	NA	NA	6.18	6.52	1.59	090
27652		A	Repair/graft achilles tendon	10.64	NA	NA	6.40	6.82	1.72	090
27654		A	Repair of achilles tendon	10.32	NA	NA	5.96	6.26	1.58	090
27656		A	Repair leg fascia defect	4.62	8.03	8.16	3.64	3.68	0.69	090
27658		A	Repair of leg tendon, each	5.03	NA	NA	3.87	4.05	0.79	090
27659		A	Repair of leg tendon, each	6.99	NA	NA	4.64	4.90	1.09	090
27664		A	Repair of leg tendon, each	4.64	NA	NA	3.80	4.00	0.76	090
27665		A	Repair of leg tendon, each	5.46	NA	NA	4.24	4.43	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	5.85	6.08	1.37	090
27680		A	Release of lower leg tendon	5.79	NA	NA	4.23	4.45	0.93	090
27681		A	Release of lower leg tendons	6.94	NA	NA	4.97	5.21	1.15	090
27685		A	Revision of lower leg tendon	6.57	8.78	8.42	4.57	4.80	0.97	090
27686		A	Revise lower leg tendons	7.64	NA	NA	5.35	5.64	1.24	090
27687		A	Revision of calf tendon	6.30	NA	NA	4.46	4.68	1.00	090
27690		A	Revise lower leg tendon	8.96	NA	NA	5.41	5.65	1.33	090
27691		A	Revise lower leg tendon	10.28	NA	NA	6.69	6.97	1.64	090
27692		A	Revise additional leg tendon	1.87	NA	NA	0.70	0.76	0.32	ZZZ
27695		A	Repair of ankle ligament	6.58	NA	NA	4.83	5.10	1.05	090
27696		A	Repair of ankle ligaments	8.46	NA	NA	5.17	5.49	1.28	090
27698		A	Repair of ankle ligament	9.49	NA	NA	5.82	6.11	1.47	090
27700		A	Revision of ankle joint	9.54	NA	NA	5.21	5.33	1.30	090
27702		A	Reconstruct ankle joint	14.28	NA	NA	8.61	9.08	2.38	090
27703		A	Reconstruction, ankle joint	16.79	NA	NA	9.86	10.21	2.77	090
27704		A	Removal of ankle implant	7.69	NA	NA	5.64	5.63	1.27	090
27705		A	Incision of tibia	10.74	NA	NA	6.89	7.22	1.81	090
27707		A	Incision of fibula	4.67	NA	NA	4.47	4.59	0.76	090
27709		A	Incision of tibia & fibula	17.32	NA	NA	9.84	9.42	1.74	090
27712		A	Realignment of lower leg	15.67	NA	NA	9.67	9.95	2.48	090

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27715		A	Revision of lower leg	15.36	NA	NA	9.20	9.61	2.50	090
27720		A	Repair of tibia	12.22	NA	NA	7.96	8.33	2.05	090
27722		A	Repair/graft of tibia	12.31	NA	NA	7.91	8.22	2.06	090
27724		A	Repair/graft of tibia	19.18	NA	NA	10.30	10.83	3.17	090
27725		A	Repair of lower leg	17.15	NA	NA	10.63	10.96	2.72	090
27726		A	Repair fibula nonunion	14.20	NA	NA	7.60	7.60	1.43	090
27727		A	Repair of lower leg	14.69	NA	NA	7.33	8.09	2.44	090
27730		A	Repair of tibia epiphysis	7.59	NA	NA	5.66	5.86	1.73	090
27732		A	Repair of fibula epiphysis	5.37	NA	NA	3.82	4.10	0.77	090
27734		A	Repair lower leg epiphyses	8.72	NA	NA	4.99	5.32	1.35	090
27740		A	Repair of leg epiphyses	9.49	NA	NA	5.34	6.01	1.62	090
27742		A	Repair of leg epiphyses	10.49	NA	NA	5.83	5.77	1.80	090
27745		A	Reinforce tibia	10.37	NA	NA	6.94	7.26	1.76	090
27750		A	Treatment of tibia fracture	3.26	4.32	4.43	3.73	3.77	0.55	090
27752		A	Treatment of tibia fracture	6.15	5.94	6.12	5.10	5.25	1.01	090
27756		A	Treatment of tibia fracture	7.33	NA	NA	5.70	5.90	1.17	090
27758		A	Treatment of tibia fracture	12.40	NA	NA	8.02	8.32	2.04	090
27759		A	Treatment of tibia fracture	14.31	NA	NA	8.68	9.10	2.39	090
27760		A	Cltx medial ankle fx	3.09	4.27	4.37	3.66	3.65	0.48	090
27762		A	Cltx med ankle fx w/mnpj	5.33	5.53	5.74	4.69	4.84	0.85	090
27766		A	Optx medial ankle fx	7.73	NA	NA	6.12	6.40	1.44	090
27767		A	Cltx post ankle fx	2.50	3.46	3.46	3.50	3.50	0.30	090
27768		A	Cltx post ankle fx w/mnpj	5.00	NA	NA	4.37	4.37	0.79	090
27769		A	Optx post ankle fx	10.00	NA	NA	6.18	6.18	1.45	090
27780		A	Treatment of fibula fracture	2.72	3.89	3.97	3.34	3.31	0.41	090
27781		A	Treatment of fibula fracture	4.47	4.97	5.11	4.35	4.43	0.73	090
27784		A	Treatment of fibula fracture	9.51	NA	NA	6.84	6.75	1.23	090
27786		A	Treatment of ankle fracture	2.91	4.05	4.16	3.43	3.41	0.46	090
27788		A	Treatment of ankle fracture	4.52	4.97	5.15	4.24	4.34	0.74	090
27792		A	Treatment of ankle fracture	9.55	NA	NA	6.80	6.85	1.32	090
27808		A	Treatment of ankle fracture	2.91	4.40	4.50	3.70	3.70	0.46	090
27810		A	Treatment of ankle fracture	5.20	5.42	5.63	4.56	4.72	0.82	090
27814		A	Treatment of ankle fracture	10.46	NA	NA	7.24	7.58	1.86	090
27816		A	Treatment of ankle fracture	2.96	3.97	4.08	3.31	3.34	0.43	090
27818		A	Treatment of ankle fracture	5.57	5.38	5.63	4.41	4.60	0.82	090
27822		A	Treatment of ankle fracture	11.03	NA	NA	8.21	8.83	1.92	090
27823		A	Treatment of ankle fracture	12.98	NA	NA	8.93	9.58	2.26	090
27824		A	Treat lower leg fracture	3.20	3.73	3.82	3.54	3.55	0.45	090
27825		A	Treat lower leg fracture	6.60	5.82	6.02	4.78	4.94	1.02	090
27826		A	Treat lower leg fracture	10.92	NA	NA	8.20	8.37	1.47	090
27827		A	Treat lower leg fracture	14.56	NA	NA	10.17	10.84	2.44	090
27828		A	Treat lower leg fracture	18.20	NA	NA	11.60	12.20	2.82	090
27829		A	Treat lower leg joint	8.64	NA	NA	6.99	6.94	0.95	090
27830		A	Treat lower leg dislocation	3.85	4.31	4.33	3.76	3.79	0.54	090

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27831		A	Treat lower leg dislocation	4.62	NA	NA	4.08	4.18	0.73	090
27832		A	Treat lower leg dislocation	10.01	NA	NA	6.90	6.72	1.03	090
27840		A	Treat ankle dislocation	4.65	NA	NA	3.65	3.68	0.46	090
27842		A	Treat ankle dislocation	6.34	NA	NA	4.87	4.94	1.00	090
27846		A	Treat ankle dislocation	10.16	NA	NA	6.81	7.10	1.71	090
27848		A	Treat ankle dislocation	11.56	NA	NA	7.38	7.97	1.95	090
27860		A	Fixation of ankle joint	2.36	NA	NA	1.78	1.84	0.39	010
27870		A	Fusion of ankle joint, open	15.21	NA	NA	9.10	9.47	2.37	090
27871		A	Fusion of tibiofibular joint	9.42	NA	NA	6.50	6.78	1.59	090
27880		A	Amputation of lower leg	15.24	NA	NA	6.65	6.78	1.76	090
27881		A	Amputation of lower leg	13.32	NA	NA	7.36	7.74	1.99	090
27882		A	Amputation of lower leg	9.67	NA	NA	4.87	5.28	1.29	090
27884		A	Amputation follow-up surgery	8.64	NA	NA	5.05	5.23	1.22	090
27886		A	Amputation follow-up surgery	9.88	NA	NA	5.74	5.94	1.40	090
27888		A	Amputation of foot at ankle	10.23	NA	NA	6.14	6.49	1.51	090
27889		A	Amputation of foot at ankle	10.72	NA	NA	5.31	5.60	1.46	090
27892		A	Decompression of leg	7.82	NA	NA	4.88	5.07	1.10	090
27893		A	Decompression of leg	7.78	NA	NA	5.20	5.27	1.10	090
27894		A	Decompression of leg	12.42	NA	NA	7.54	7.61	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	4.00	3.75	1.61	1.70	0.33	010
28002		A	Treatment of foot infection	5.78	6.69	6.27	3.58	3.63	0.61	010
28003		A	Treatment of foot infection	8.95	7.78	7.40	4.56	4.73	1.12	090
28005		A	Treat foot bone lesion	9.30	NA	NA	5.55	5.68	1.16	090
28008		A	Incision of foot fascia	4.50	6.10	5.72	2.96	3.02	0.57	090
28010		A	Incision of toe tendon	2.89	2.85	2.73	2.34	2.35	0.36	090
28011		A	Incision of toe tendons	4.19	3.84	3.71	3.07	3.13	0.59	090
28020		A	Exploration of foot joint	5.06	7.32	7.00	3.56	3.70	0.72	090
28022		A	Exploration of foot joint	4.72	6.87	6.46	3.30	3.44	0.62	090
28024		A	Exploration of toe joint	4.43	6.55	6.22	3.11	3.32	0.58	090
28035		A	Decompression of tibia nerve	5.14	7.40	7.02	3.61	3.74	0.70	090
28043		A	Excision of foot lesion	3.58	4.78	4.54	2.73	2.84	0.46	090
28045		A	Excision of foot lesion	4.77	7.05	6.64	3.26	3.35	0.63	090
28046		A	Resection of tumor, foot	10.55	10.31	9.93	5.73	5.92	1.36	090
28050		A	Biopsy of foot joint lining	4.30	6.94	6.43	3.29	3.37	0.60	090
28052		A	Biopsy of foot joint lining	3.98	6.27	5.93	2.86	3.00	0.53	090
28054		A	Biopsy of toe joint lining	3.49	6.23	5.86	2.79	2.90	0.46	090
28055		A	Neurectomy, foot	6.20	NA	NA	3.51	3.55	0.74	090
28060		A	Partial removal, foot fascia	5.29	7.10	6.70	3.56	3.64	0.70	090
28062		A	Removal of foot fascia	6.58	7.83	7.51	3.82	3.87	0.83	090
28070		A	Removal of foot joint lining	5.15	7.21	6.72	3.45	3.55	0.73	090
28072		A	Removal of foot joint lining	4.63	7.59	7.08	3.62	3.79	0.68	090
28080		A	Removal of foot lesion	4.65	7.64	7.02	4.18	4.06	0.47	090
28086		A	Excise foot tendon sheath	4.83	7.59	7.69	3.67	3.92	0.76	090

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28088		A	Excise foot tendon sheath	3.90	7.08	6.76	3.24	3.41	0.61	090
28090		A	Removal of foot lesion	4.46	6.76	6.36	3.17	3.25	0.59	090
28092		A	Removal of toe lesions	3.69	6.42	6.12	2.96	3.11	0.49	090
28100		A	Removal of ankle/heel lesion	5.72	8.18	8.14	4.04	4.21	0.82	090
28102		A	Remove/graft foot lesion	7.80	NA	NA	5.57	5.67	1.14	090
28103		A	Remove/graft foot lesion	6.56	NA	NA	4.30	4.38	0.91	090
28104		A	Removal of foot lesion	5.17	7.16	6.75	3.43	3.56	0.70	090
28106		A	Remove/graft foot lesion	7.23	NA	NA	4.33	4.36	0.97	090
28107		A	Remove/graft foot lesion	5.62	8.00	7.64	3.82	3.92	0.74	090
28108		A	Removal of toe lesions	4.21	6.34	5.91	2.98	3.05	0.53	090
28110		A	Part removal of metatarsal	4.13	6.92	6.50	3.06	3.10	0.54	090
28111		A	Part removal of metatarsal	5.06	7.19	6.97	3.24	3.35	0.67	090
28112		A	Part removal of metatarsal	4.54	7.21	6.86	3.25	3.34	0.61	090
28113		A	Part removal of metatarsal	5.88	8.40	7.82	4.63	4.56	0.63	090
28114		A	Removal of metatarsal heads	11.61	13.39	12.96	8.30	8.33	1.42	090
28116		A	Revision of foot	8.94	9.27	8.66	5.22	5.21	1.03	090
28118		A	Removal of heel bone	6.02	8.03	7.59	4.08	4.15	0.84	090
28119		A	Removal of heel spur	5.45	7.19	6.75	3.56	3.60	0.70	090
28120		A	Part removal of ankle/heel	5.64	8.06	7.87	3.95	4.07	0.77	090
28122		A	Partial removal of foot bone	7.56	8.49	8.08	4.79	4.91	0.98	090
28124		A	Partial removal of toe	4.88	6.78	6.34	3.46	3.51	0.60	090
28126		A	Partial removal of toe	3.56	5.97	5.54	2.67	2.75	0.45	090
28130		A	Removal of ankle bone	9.30	NA	NA	5.93	6.13	1.26	090
28140		A	Removal of metatarsal	7.03	7.82	7.68	4.12	4.28	0.92	090
28150		A	Removal of toe	4.14	6.34	5.97	2.97	3.05	0.53	090
28153		A	Partial removal of toe	3.71	6.23	5.75	2.90	2.85	0.47	090
28160		A	Partial removal of toe	3.79	6.35	5.91	2.94	3.05	0.49	090
28171		A	Extensive foot surgery	9.85	NA	NA	5.19	5.25	1.33	090
28173		A	Extensive foot surgery	9.05	8.75	8.47	4.63	4.77	1.12	090
28175		A	Extensive foot surgery	6.17	7.14	6.79	3.63	3.65	0.73	090
28190		A	Removal of foot foreign body	1.98	4.03	3.87	1.34	1.38	0.22	010
28192		A	Removal of foot foreign body	4.69	6.67	6.37	3.16	3.29	0.61	090
28193		A	Removal of foot foreign body	5.79	7.30	6.88	3.61	3.69	0.73	090
28200		A	Repair of foot tendon	4.65	6.86	6.42	3.22	3.31	0.61	090
28202		A	Repair/graft of foot tendon	6.96	7.81	7.67	3.96	4.10	0.91	090
28208		A	Repair of foot tendon	4.42	6.72	6.25	3.20	3.23	0.58	090
28210		A	Repair/graft of foot tendon	6.41	7.57	7.24	3.90	3.94	0.81	090
28220		A	Release of foot tendon	4.58	6.39	5.97	3.06	3.16	0.57	090
28222		A	Release of foot tendons	5.67	6.90	6.49	3.32	3.53	0.69	090
28225		A	Release of foot tendon	3.70	5.91	5.51	2.66	2.72	0.46	090
28226		A	Release of foot tendons	4.58	6.91	6.39	3.27	3.39	0.58	090
28230		A	Incision of foot tendon(s)	4.28	6.24	5.85	2.86	3.07	0.55	090
28232		A	Incision of toe tendon	3.43	5.94	5.59	2.68	2.84	0.44	090
28234		A	Incision of foot tendon	3.43	6.36	5.94	3.09	3.16	0.44	090

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28238		A	Revision of foot tendon	7.85	8.39	8.11	4.37	4.52	1.06	090
28240		A	Release of big toe	4.40	6.45	6.00	3.00	3.13	0.58	090
28250		A	Revision of foot fascia	5.97	7.64	7.14	3.87	3.94	0.82	090
28260		A	Release of midfoot joint	8.08	8.34	7.84	4.54	4.66	1.14	090
28261		A	Revision of foot tendon	12.91	10.65	10.15	6.31	6.57	1.57	090
28262		A	Revision of foot and ankle	17.01	15.20	14.81	9.52	9.88	2.60	090
28264		A	Release of midfoot joint	10.53	10.77	10.02	6.24	6.51	1.54	090
28270		A	Release of foot contracture	4.82	6.94	6.43	3.45	3.53	0.62	090
28272		A	Release of toe joint, each	3.84	5.82	5.42	2.64	2.70	0.46	090
28280		A	Fusion of toes	5.24	7.31	7.05	3.55	3.78	0.73	090
28285		A	Repair of hammertoe	4.65	6.73	6.26	3.36	3.38	0.59	090
28286		A	Repair of hammertoe	4.61	6.50	6.08	3.04	3.10	0.57	090
28288		A	Partial removal of foot bone	5.81	8.56	7.91	4.67	4.72	0.65	090
28289		A	Repair hallux rigidus	8.11	9.35	9.02	5.29	5.42	1.02	090
28290		A	Correction of bunion	5.72	8.12	7.66	3.93	4.13	0.82	090
28292		A	Correction of bunion	8.72	10.38	9.66	6.18	6.02	0.91	090
28293		A	Correction of bunion	11.10	14.47	13.55	6.92	6.72	1.13	090
28294		A	Correction of bunion	8.63	9.43	8.94	4.75	4.75	1.09	090
28296		A	Correction of bunion	9.31	9.57	9.23	4.79	4.95	1.19	090
28297		A	Correction of bunion	9.31	10.41	10.06	5.30	5.55	1.32	090
28298		A	Correction of bunion	8.01	9.35	8.82	4.62	4.72	1.05	090
28299		A	Correction of bunion	11.39	10.62	10.17	5.78	5.85	1.37	090
28300		A	Incision of heel bone	9.61	NA	NA	6.03	6.29	1.54	090
28302		A	Incision of ankle bone	9.62	NA	NA	6.03	6.25	1.42	090
28304		A	Incision of midfoot bones	9.29	9.71	9.28	5.18	5.32	1.27	090
28305		A	Incise/graft midfoot bones	10.63	NA	NA	6.13	6.28	1.27	090
28306		A	Incision of metatarsal	5.91	8.53	8.11	3.95	4.01	0.84	090
28307		A	Incision of metatarsal	6.39	9.85	10.16	4.62	4.79	0.90	090
28308		A	Incision of metatarsal	5.36	7.98	7.43	3.86	3.82	0.70	090
28309		A	Incision of metatarsals	13.96	NA	NA	7.38	7.53	2.05	090
28310		A	Revision of big toe	5.48	7.55	7.10	3.42	3.46	0.70	090
28312		A	Revision of toe	4.60	7.44	6.94	3.27	3.36	0.63	090
28313		A	Repair deformity of toe	5.06	7.52	6.97	3.75	4.02	0.73	090
28315		A	Removal of sesamoid bone	4.91	6.64	6.21	3.20	3.24	0.63	090
28320		A	Repair of foot bones	9.25	NA	NA	5.54	5.84	1.43	090
28322		A	Repair of metatarsals	8.41	9.72	9.60	5.30	5.57	1.27	090
28340		A	Resect enlarged toe tissue	7.04	7.87	7.52	3.94	4.02	0.84	090
28341		A	Resect enlarged toe	8.60	8.50	8.12	4.35	4.47	1.01	090
28344		A	Repair extra toe(s)	4.31	7.32	6.93	3.42	3.48	0.51	090
28345		A	Repair webbed toe(s)	5.98	7.91	7.49	3.95	4.14	0.80	090
28360		A	Reconstruct cleft foot	14.67	NA	NA	7.86	8.53	2.29	090
28400		A	Treatment of heel fracture	2.22	3.34	3.41	2.89	2.94	0.35	090
28405		A	Treatment of heel fracture	4.63	4.35	4.47	3.60	3.86	0.73	090
28406		A	Treatment of heel fracture	6.44	NA	NA	5.57	5.88	1.11	090

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28415		A	Treat heel fracture	15.96	NA	NA	10.09	10.91	2.67	090
28420		A	Treat/graft heel fracture	17.29	NA	NA	10.41	11.05	2.81	090
28430		A	Treatment of ankle fracture	2.14	3.07	3.15	2.53	2.54	0.31	090
28435		A	Treatment of ankle fracture	3.45	3.96	3.95	3.23	3.36	0.55	090
28436		A	Treatment of ankle fracture	4.78	NA	NA	4.92	5.18	0.81	090
28445		A	Treat ankle fracture	15.53	NA	NA	9.32	9.76	2.59	090
28446		A	Osteochondral talus autogrft	17.50	NA	NA	10.30	10.30	2.45	090
28450		A	Treat midfoot fracture, each	1.95	2.89	2.95	2.40	2.42	0.28	090
28455		A	Treat midfoot fracture, each	3.15	3.68	3.62	3.05	3.14	0.44	090
28456		A	Treat midfoot fracture	2.75	NA	NA	3.60	3.74	0.44	090
28465		A	Treat midfoot fracture, each	8.64	NA	NA	5.95	6.05	1.10	090
28470		A	Treat metatarsal fracture	1.99	2.80	2.88	2.36	2.38	0.30	090
28475		A	Treat metatarsal fracture	2.97	3.12	3.18	2.51	2.69	0.44	090
28476		A	Treat metatarsal fracture	3.46	NA	NA	4.40	4.55	0.54	090
28485		A	Treat metatarsal fracture	7.28	NA	NA	5.53	5.52	0.83	090
28490		A	Treat big toe fracture	1.12	2.09	2.08	1.67	1.67	0.14	090
28495		A	Treat big toe fracture	1.62	2.49	2.41	1.89	1.93	0.20	090
28496		A	Treat big toe fracture	2.39	7.24	7.50	2.92	2.99	0.36	090
28505		A	Treat big toe fracture	7.28	8.47	8.39	4.83	4.60	0.56	090
28510		A	Treatment of toe fracture	1.12	1.68	1.64	1.61	1.59	0.14	090
28515		A	Treatment of toe fracture	1.50	2.22	2.14	1.82	1.84	0.18	090
28525		A	Treat toe fracture	5.46	7.81	7.75	4.15	3.97	0.49	090
28530		A	Treat sesamoid bone fracture	1.08	1.63	1.59	1.35	1.37	0.14	090
28531		A	Treat sesamoid bone fracture	2.51	5.89	6.24	2.15	2.13	0.34	090
28540		A	Treat foot dislocation	2.10	2.69	2.62	2.25	2.29	0.26	090
28545		A	Treat foot dislocation	2.51	3.50	3.21	2.87	2.74	0.37	090
28546		A	Treat foot dislocation	3.28	7.98	7.72	3.61	3.81	0.52	090
28555		A	Repair foot dislocation	9.49	10.90	10.66	6.35	6.19	1.04	090
28570		A	Treat foot dislocation	1.70	2.36	2.38	1.82	1.95	0.23	090
28575		A	Treat foot dislocation	3.38	4.41	4.24	3.71	3.72	0.56	090
28576		A	Treat foot dislocation	4.48	NA	NA	3.76	3.87	0.69	090
28585		A	Repair foot dislocation	10.92	11.57	10.52	6.97	6.70	1.25	090
28600		A	Treat foot dislocation	1.94	3.01	2.96	2.36	2.44	0.27	090
28605		A	Treat foot dislocation	2.78	3.64	3.52	3.06	3.08	0.40	090
28606		A	Treat foot dislocation	4.97	NA	NA	3.99	4.17	0.82	090
28615		A	Repair foot dislocation	10.46	NA	NA	8.07	8.07	1.30	090
28630		A	Treat toe dislocation	1.72	1.85	1.78	0.91	0.93	0.20	010
28635		A	Treat toe dislocation	1.93	2.28	2.22	1.34	1.38	0.26	010
28636		A	Treat toe dislocation	2.77	4.15	4.08	1.93	2.11	0.43	010
28645		A	Repair toe dislocation	7.28	8.40	7.54	4.66	4.31	0.57	090
28660		A	Treat toe dislocation	1.25	1.33	1.31	0.80	0.80	0.13	010
28665		A	Treat toe dislocation	1.94	1.83	1.73	1.33	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	8.36	8.06	4.50	4.22	0.45	090

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28705		A	Fusion of foot bones	20.12	NA	NA	10.59	11.07	3.09	090
28715		A	Fusion of foot bones	14.40	NA	NA	8.46	8.80	2.17	090
28725		A	Fusion of foot bones	11.97	NA	NA	6.72	7.11	1.87	090
28730		A	Fusion of foot bones	12.21	NA	NA	7.74	7.93	1.71	090
28735		A	Fusion of foot bones	12.03	NA	NA	6.98	7.20	1.69	090
28737		A	Revision of foot bones	10.83	NA	NA	6.11	6.29	1.47	090
28740		A	Fusion of foot bones	9.09	10.82	10.84	5.96	6.09	1.22	090
28750		A	Fusion of big toe joint	8.37	10.77	11.07	5.88	6.09	1.13	090
28755		A	Fusion of big toe joint	4.79	7.30	7.01	3.38	3.47	0.65	090
28760		A	Fusion of big toe joint	8.94	10.01	9.51	5.35	5.40	1.05	090
28800		A	Amputation of midfoot	8.65	NA	NA	4.98	5.19	1.15	090
28805		A	Amputation thru metatarsal	12.55	NA	NA	5.89	5.84	1.18	090
28810		A	Amputation toe & metatarsal	6.52	NA	NA	4.05	4.16	0.86	090
28820		A	Amputation of toe	4.89	7.63	7.62	3.54	3.60	0.61	090
28825		A	Partial amputation of toe	3.71	7.15	7.12	3.14	3.23	0.50	090
28890		A	High energy eswt, plantar f	3.36	4.60	4.89	2.22	2.19	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	4.41	4.05	1.76	1.75	0.41	000
29010		A	Application of body cast	2.06	3.71	3.61	1.50	1.57	0.45	000
29015		A	Application of body cast	2.41	3.25	3.19	1.38	1.44	0.28	000
29020		A	Application of body cast	2.11	3.27	3.25	1.31	1.33	0.28	000
29025		A	Application of body cast	2.40	3.59	3.48	1.61	1.67	0.44	000
29035		A	Application of body cast	1.77	3.97	3.89	1.53	1.54	0.28	000
29040		A	Application of body cast	2.22	3.40	3.17	1.43	1.45	0.36	000
29044		A	Application of body cast	2.12	3.94	3.95	1.64	1.71	0.35	000
29046		A	Application of body cast	2.41	4.49	4.18	1.91	1.96	0.42	000
29049		A	Application of figure eight	0.89	1.04	1.11	0.55	0.55	0.13	000
29055		A	Application of shoulder cast	1.78	3.01	3.01	1.33	1.37	0.30	000
29058		A	Application of shoulder cast	1.31	1.20	1.29	0.64	0.66	0.17	000
29065		A	Application of long arm cast	0.87	1.28	1.29	0.70	0.72	0.15	000
29075		A	Application of forearm cast	0.77	1.24	1.24	0.66	0.67	0.13	000
29085		A	Apply hand/wrist cast	0.87	1.27	1.27	0.69	0.68	0.14	000
29086		A	Apply finger cast	0.62	1.08	1.05	0.55	0.54	0.07	000
29105		A	Apply long arm splint	0.87	1.09	1.13	0.53	0.53	0.12	000
29125		A	Apply forearm splint	0.59	0.97	0.98	0.43	0.42	0.07	000
29126		A	Apply forearm splint	0.77	0.99	1.04	0.47	0.47	0.07	000
29130		A	Application of finger splint	0.50	0.43	0.44	0.18	0.18	0.06	000
29131		A	Application of finger splint	0.55	0.62	0.65	0.25	0.25	0.03	000
29200		A	Strapping of chest	0.65	0.58	0.62	0.33	0.33	0.04	000
29220		A	Strapping of low back	0.64	0.66	0.67	0.38	0.38	0.04	000
29240		A	Strapping of shoulder	0.71	0.65	0.70	0.37	0.37	0.06	000
29260		A	Strapping of elbow or wrist	0.55	0.65	0.67	0.36	0.35	0.05	000
29280		A	Strapping of hand or finger	0.51	0.65	0.69	0.36	0.35	0.03	000
29305		A	Application of hip cast	2.03	3.37	3.36	1.60	1.64	0.35	000

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29325		A	Application of hip casts	2.32	3.72	3.68	1.78	1.82	0.40	000
29345		A	Application of long leg cast	1.40	1.66	1.69	0.94	0.97	0.24	000
29355		A	Application of long leg cast	1.53	1.64	1.66	0.95	0.99	0.26	000
29358		A	Apply long leg cast brace	1.43	2.07	2.07	0.94	0.98	0.25	000
29365		A	Application of long leg cast	1.18	1.58	1.60	0.86	0.88	0.20	000
29405		A	Apply short leg cast	0.86	1.19	1.20	0.65	0.66	0.14	000
29425		A	Apply short leg cast	1.01	1.22	1.22	0.65	0.67	0.15	000
29435		A	Apply short leg cast	1.18	1.51	1.53	0.80	0.83	0.20	000
29440		A	Addition of walker to cast	0.57	0.64	0.65	0.25	0.26	0.08	000
29445		A	Apply rigid leg cast	1.78	1.55	1.62	0.88	0.90	0.27	000
29450		A	Application of leg cast	2.08	1.54	1.53	0.87	0.93	0.27	000
29505		A	Application, long leg splint	0.69	1.08	1.11	0.46	0.46	0.08	000
29515		A	Application lower leg splint	0.73	0.96	0.94	0.46	0.46	0.09	000
29520		A	Strapping of hip	0.54	0.61	0.67	0.33	0.37	0.03	000
29530		A	Strapping of knee	0.57	0.63	0.67	0.34	0.34	0.05	000
29540		A	Strapping of ankle and/or ft	0.51	0.55	0.52	0.31	0.31	0.06	000
29550		A	Strapping of toes	0.47	0.56	0.53	0.30	0.29	0.06	000
29580		A	Application of paste boot	0.55	0.71	0.70	0.33	0.34	0.07	000
29590		A	Application of foot splint	0.76	0.59	0.57	0.26	0.27	0.09	000
29700		A	Removal/revision of cast	0.57	0.96	0.94	0.25	0.26	0.08	000
29705		A	Removal/revision of cast	0.76	0.78	0.79	0.37	0.37	0.13	000
29710		A	Removal/revision of cast	1.34	1.34	1.39	0.58	0.61	0.20	000
29715		A	Removal/revision of cast	0.94	1.19	1.19	0.44	0.43	0.09	000
29720		A	Repair of body cast	0.68	1.17	1.16	0.35	0.36	0.12	000
29730		A	Windowing of cast	0.75	0.74	0.76	0.34	0.34	0.12	000
29740		A	Wedging of cast	1.12	1.00	1.04	0.46	0.47	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.09	1.08	0.54	0.55	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	4.88	5.41	0.99	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	NA	5.80	6.26	1.38	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	NA	4.73	4.97	1.02	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	NA	9.38	9.84	2.50	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	NA	9.22	9.67	2.42	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.66	5.95	1.32	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	NA	5.19	5.45	1.22	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	NA	5.67	5.96	1.33	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	NA	5.58	5.87	1.28	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	NA	6.06	6.36	1.41	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	NA	6.54	6.80	1.42	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.64	5.93	1.32	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	NA	6.19	6.53	1.55	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	NA	9.33	9.89	2.67	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	NA	8.20	8.20	2.17	090
29830		A	Elbow arthroscopy	5.80	NA	NA	4.49	4.71	0.99	090

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29834		A	Elbow arthroscopy/surgery	6.33	NA	NA	4.88	5.13	1.08	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	NA	4.98	5.21	1.13	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	NA	5.63	5.93	1.22	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	NA	5.12	5.38	1.19	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	NA	5.68	5.99	1.30	090
29840		A	Wrist arthroscopy	5.59	NA	NA	4.64	4.82	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	NA	4.93	5.11	0.92	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	NA	4.87	5.11	1.04	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	NA	5.45	5.72	0.99	090
29846		A	Wrist arthroscopy/surgery	6.80	NA	NA	5.11	5.35	1.07	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	NA	5.25	5.50	1.08	090
29848		A	Wrist endoscopy/surgery	6.24	NA	NA	5.29	5.37	0.86	090
29850		A	Knee arthroscopy/surgery	8.18	NA	NA	5.24	5.19	1.25	090
29851		A	Knee arthroscopy/surgery	13.08	NA	NA	8.23	8.63	2.35	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	NA	7.33	7.70	1.85	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	NA	8.72	9.22	2.40	090
29860		A	Hip arthroscopy, dx	8.85	NA	NA	6.08	6.31	1.36	090
29861		A	Hip arthroscopy/surgery	9.95	NA	NA	6.61	6.80	1.59	090
29862		A	Hip arthroscopy/surgery	10.97	NA	NA	7.62	7.86	1.62	090
29863		A	Hip arthroscopy/surgery	10.97	NA	NA	7.53	7.79	1.42	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	NA	9.45	9.94	2.40	090
29867		A	Allgrft implnt, knee w/scope	18.18	NA	NA	10.76	11.39	2.79	090
29868		A	Meniscal trnspl, knee w/scpe	24.89	NA	NA	13.35	14.23	4.36	090
29870		A	Knee arthroscopy, dx	5.11	NA	NA	4.20	4.38	0.85	090
29871		A	Knee arthroscopy/drainage	6.60	NA	NA	5.06	5.27	1.14	090
29873		A	Knee arthroscopy/surgery	6.09	NA	NA	5.61	5.86	1.04	090
29874		A	Knee arthroscopy/surgery	7.10	NA	NA	5.15	5.39	1.11	090
29875		A	Knee arthroscopy/surgery	6.36	NA	NA	4.89	5.14	1.09	090
29876		A	Knee arthroscopy/surgery	8.72	NA	NA	6.20	6.41	1.37	090
29877		A	Knee arthroscopy/surgery	8.15	NA	NA	5.99	6.18	1.28	090
29879		A	Knee arthroscopy/surgery	8.84	NA	NA	6.25	6.47	1.39	090
29880		A	Knee arthroscopy/surgery	9.30	NA	NA	6.44	6.67	1.47	090
29881		A	Knee arthroscopy/surgery	8.56	NA	NA	6.15	6.36	1.34	090
29882		A	Knee arthroscopy/surgery	9.45	NA	NA	6.46	6.66	1.50	090
29883		A	Knee arthroscopy/surgery	11.61	NA	NA	7.62	7.99	1.93	090
29884		A	Knee arthroscopy/surgery	8.13	NA	NA	5.97	6.16	1.27	090
29885		A	Knee arthroscopy/surgery	10.03	NA	NA	7.04	7.28	1.58	090
29886		A	Knee arthroscopy/surgery	8.34	NA	NA	6.07	6.27	1.30	090
29887		A	Knee arthroscopy/surgery	9.98	NA	NA	6.99	7.23	1.57	090
29888		A	Knee arthroscopy/surgery	14.14	NA	NA	8.31	8.80	2.42	090
29889		A	Knee arthroscopy/surgery	17.15	NA	NA	10.79	11.22	2.79	090
29891		A	Ankle arthroscopy/surgery	9.47	NA	NA	6.63	6.86	1.39	090
29892		A	Ankle arthroscopy/surgery	10.07	NA	NA	6.29	6.66	1.41	090
29893		A	Scope, plantar fasciotomy	6.08	8.81	8.18	4.65	4.49	0.63	090

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29894		A	Ankle arthroscopy/surgery	7.26	NA	NA	4.76	4.95	1.15	090
29895		A	Ankle arthroscopy/surgery	7.04	NA	NA	4.53	4.77	1.11	090
29897		A	Ankle arthroscopy/surgery	7.23	NA	NA	4.86	5.12	1.17	090
29898		A	Ankle arthroscopy/surgery	8.38	NA	NA	5.21	5.46	1.28	090
29899		A	Ankle arthroscopy/surgery	15.21	NA	NA	9.11	9.48	2.41	090
29900		A	Mcp joint arthroscopy, dx	5.74	NA	NA	4.61	4.93	0.94	090
29901		A	Mcp joint arthroscopy, surg	6.45	NA	NA	4.81	5.18	1.06	090
29902		A	Mcp joint arthroscopy, surg	7.02	NA	NA	5.07	5.44	1.12	090
29904		A	Subtalar arthro w/fb rmvl	8.50	NA	NA	5.93	5.93	1.25	090
29905		A	Subtalar arthro w/exc	9.00	NA	NA	6.56	6.56	1.32	090
29906		A	Subtalar arthro w/deb	9.47	NA	NA	6.93	6.93	1.39	090
29907		A	Subtalar arthro w/fusion	12.00	NA	NA	7.92	7.92	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	4.09	4.09	1.37	1.38	0.12	010
30020		A	Drainage of nose lesion	1.45	4.12	3.91	1.38	1.40	0.12	010
30100		A	Intranasal biopsy	0.94	2.58	2.43	0.75	0.77	0.07	000
30110		A	Removal of nose polyp(s)	1.65	3.91	3.74	1.45	1.48	0.14	010
30115		A	Removal of nose polyp(s)	4.38	NA	NA	5.98	5.93	0.41	090
30117		A	Removal of intranasal lesion	3.20	18.18	16.93	4.91	4.85	0.26	090
30118		A	Removal of intranasal lesion	9.81	NA	NA	8.52	8.70	0.78	090
30120		A	Revision of nose	5.31	7.26	7.08	5.23	5.43	0.52	090
30124		A	Removal of nose lesion	3.14	NA	NA	3.32	3.40	0.25	090
30125		A	Removal of nose lesion	7.21	NA	NA	7.33	7.58	0.63	090
30130		A	Excise inferior turbinate	3.41	NA	NA	5.64	5.64	0.31	090
30140		A	Resect inferior turbinate	3.48	NA	NA	7.11	6.89	0.35	090
30150		A	Partial removal of nose	9.44	NA	NA	8.91	9.45	0.93	090
30160		A	Removal of nose	9.88	NA	NA	8.75	9.12	0.88	090
30200		A	Injection treatment of nose	0.78	2.01	1.91	0.67	0.69	0.06	000
30210		A	Nasal sinus therapy	1.10	2.52	2.42	1.28	1.29	0.09	010
30220		A	Insert nasal septal button	1.56	5.84	5.44	1.43	1.45	0.12	010
30300		A	Remove nasal foreign body	1.06	4.31	4.40	1.87	1.89	0.08	010
30310		A	Remove nasal foreign body	1.98	NA	NA	2.90	2.96	0.16	010
30320		A	Remove nasal foreign body	4.56	NA	NA	6.06	6.31	0.39	090
30400		R	Reconstruction of nose	10.58	NA	NA	13.96	14.36	1.04	090
30410		R	Reconstruction of nose	13.72	NA	NA	14.62	15.58	1.42	090
30420		R	Reconstruction of nose	16.62	NA	NA	15.91	16.43	1.46	090
30430		R	Revision of nose	7.96	NA	NA	13.35	14.03	0.77	090
30435		R	Revision of nose	12.45	NA	NA	15.39	16.40	1.22	090
30450		R	Revision of nose	19.38	NA	NA	17.25	18.44	1.97	090
30460		A	Revision of nose	10.24	NA	NA	7.29	7.96	1.03	090
30462		A	Revision of nose	20.12	NA	NA	14.85	16.22	2.54	090
30465		A	Repair nasal stenosis	12.20	NA	NA	11.09	11.32	1.06	090
30520		A	Repair of nasal septum	6.85	NA	NA	8.04	7.70	0.46	090
30540		A	Repair nasal defect	7.81	NA	NA	8.00	8.33	0.67	090

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30545		A	Repair nasal defect	11.50	NA	NA	11.08	11.30	1.71	090
30560		A	Release of nasal adhesions	1.28	5.30	5.17	2.03	2.06	0.10	010
30580		A	Repair upper jaw fistula	6.76	8.26	8.15	4.77	5.03	0.89	090
30600		A	Repair mouth/nose fistula	6.07	7.80	7.74	4.26	4.45	0.70	090
30620		A	Intranasal reconstruction	6.04	NA	NA	8.77	8.79	0.57	090
30630		A	Repair nasal septum defect	7.18	NA	NA	7.74	7.80	0.61	090
30801		A	Ablate inf turbinate, superf	1.11	4.37	4.31	2.15	2.10	0.09	010
30802		A	Cauterization, inner nose	2.05	4.98	4.89	2.52	2.48	0.16	010
30901		A	Control of nosebleed	1.21	1.28	1.30	0.31	0.31	0.11	000
30903		A	Control of nosebleed	1.54	3.28	3.14	0.42	0.44	0.13	000
30905		A	Control of nosebleed	1.97	3.96	3.85	0.51	0.57	0.17	000
30906		A	Repeat control of nosebleed	2.45	4.30	4.20	0.76	0.87	0.20	000
30915		A	Ligation, nasal sinus artery	7.36	NA	NA	6.44	6.51	0.58	090
30920		A	Ligation, upper jaw artery	11.03	NA	NA	8.93	8.95	0.80	090
30930		A	Ther fx, nasal inf turbinate	1.28	NA	NA	1.64	1.63	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	3.21	3.12	1.34	1.35	0.09	010
31002		A	Irrigation, sphenoid sinus	1.93	NA	NA	2.81	2.92	0.15	010
31020		A	Exploration, maxillary sinus	2.99	8.63	8.61	5.55	5.47	0.29	090
31030		A	Exploration, maxillary sinus	5.95	10.51	10.77	6.51	6.56	0.60	090
31032		A	Explore sinus, remove polyps	6.61	NA	NA	7.02	7.08	0.59	090
31040		A	Exploration behind upper jaw	9.66	NA	NA	7.79	8.31	0.87	090
31050		A	Exploration, sphenoid sinus	5.31	NA	NA	6.61	6.56	0.49	090
31051		A	Sphenoid sinus surgery	7.16	NA	NA	8.35	8.33	0.62	090
31070		A	Exploration of frontal sinus	4.32	NA	NA	6.20	6.14	0.38	090
31075		A	Exploration of frontal sinus	9.40	NA	NA	9.39	9.49	0.75	090
31080		A	Removal of frontal sinus	12.54	NA	NA	11.10	11.72	1.23	090
31081		A	Removal of frontal sinus	13.99	NA	NA	15.48	15.13	2.47	090
31084		A	Removal of frontal sinus	14.75	NA	NA	13.74	13.70	1.19	090
31085		A	Removal of frontal sinus	15.44	NA	NA	14.42	14.32	1.73	090
31086		A	Removal of frontal sinus	14.16	NA	NA	12.57	12.76	1.07	090
31087		A	Removal of frontal sinus	14.39	NA	NA	11.85	12.03	1.44	090
31090		A	Exploration of sinuses	10.88	NA	NA	13.42	13.22	0.94	090
31200		A	Removal of ethmoid sinus	5.03	NA	NA	7.48	7.93	0.29	090
31201		A	Removal of ethmoid sinus	8.49	NA	NA	8.97	9.03	0.82	090
31205		A	Removal of ethmoid sinus	10.47	NA	NA	9.63	10.21	0.67	090
31225		A	Removal of upper jaw	26.44	NA	NA	17.96	17.94	1.59	090
31230		A	Removal of upper jaw	30.56	NA	NA	19.03	19.14	1.78	090
31231		A	Nasal endoscopy, dx	1.10	3.60	3.55	0.77	0.80	0.09	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.27	4.28	1.12	1.21	0.20	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.69	4.75	1.27	1.38	0.26	000
31237		A	Nasal/sinus endoscopy, surg	2.98	4.90	4.98	1.39	1.51	0.28	000
31238		A	Nasal/sinus endoscopy, surg	3.26	4.83	4.94	1.48	1.63	0.27	000
31239		A	Nasal/sinus endoscopy, surg	9.23	NA	NA	6.48	6.87	0.62	010

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31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.27	1.39	0.24	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	1.94	2.17	0.45	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	2.69	3.05	0.73	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	1.49	1.65	0.33	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	2.20	2.48	0.55	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	3.31	3.77	0.92	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	1.69	1.88	0.39	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	1.91	2.14	0.46	000
31290		A	Nasal/sinus endoscopy, surg	18.50	NA	NA	9.06	9.82	1.40	010
31291		A	Nasal/sinus endoscopy, surg	19.45	NA	NA	9.49	10.25	1.69	010
31292		A	Nasal/sinus endoscopy, surg	15.79	NA	NA	8.08	8.73	1.21	010
31293		A	Nasal/sinus endoscopy, surg	17.36	NA	NA	8.68	9.37	1.28	010
31294		A	Nasal/sinus endoscopy, surg	20.20	NA	NA	9.60	10.44	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	14.68	14.77	1.17	090
31320		A	Diagnostic incision, larynx	5.62	NA	NA	10.00	10.08	0.46	090
31360		A	Removal of larynx	29.57	NA	NA	20.04	19.23	1.38	090
31365		A	Removal of larynx	38.47	NA	NA	23.00	22.36	1.98	090
31367		A	Partial removal of larynx	30.23	NA	NA	22.51	22.38	1.79	090
31368		A	Partial removal of larynx	33.85	NA	NA	24.53	24.80	2.21	090
31370		A	Partial removal of larynx	27.23	NA	NA	22.24	22.27	1.75	090
31375		A	Partial removal of larynx	25.73	NA	NA	21.32	21.11	1.63	090
31380		A	Partial removal of larynx	25.23	NA	NA	20.97	20.90	1.71	090
31382		A	Partial removal of larynx	28.23	NA	NA	22.59	22.37	1.68	090
31390		A	Removal of larynx & pharynx	42.17	NA	NA	25.94	25.58	2.24	090
31395		A	Reconstruct larynx & pharynx	43.46	NA	NA	28.53	28.51	2.49	090
31400		A	Revision of larynx	11.48	NA	NA	12.55	12.87	0.83	090
31420		A	Removal of epiglottis	11.32	NA	NA	8.71	8.93	0.83	090
31500		A	Insert emergency airway	2.33	NA	NA	0.42	0.45	0.17	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.21	0.23	0.05	000
31505		A	Diagnostic laryngoscopy	0.61	1.42	1.43	0.59	0.59	0.05	000
31510		A	Laryngoscopy with biopsy	1.92	3.23	3.25	1.01	1.07	0.16	000
31511		A	Remove foreign body, larynx	2.16	2.97	3.01	1.04	1.05	0.19	000
31512		A	Removal of larynx lesion	2.07	2.96	3.02	1.07	1.14	0.18	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.10	1.19	0.17	000
31515		A	Laryngoscopy for aspiration	1.80	3.28	3.35	0.91	0.94	0.14	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.17	1.27	0.20	000
31525		A	Dx laryngoscopy excl nb	2.63	3.44	3.50	1.23	1.34	0.21	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.25	1.37	0.21	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	1.44	1.55	0.26	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.14	1.22	0.19	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.25	1.37	0.22	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	1.43	1.56	0.29	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	1.58	1.75	0.29	000

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31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	1.44	1.58	0.26	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	1.57	1.75	0.29	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	1.76	1.96	0.33	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	1.89	2.12	0.37	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	2.52	2.76	0.37	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	3.59	3.94	0.78	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	2.16	2.41	0.43	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	2.35	2.61	0.49	000
31570		A	Laryngoscope w/vc inj	3.86	4.28	4.64	1.65	1.84	0.31	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	1.81	2.01	0.35	000
31575		A	Diagnostic laryngoscopy	1.10	1.69	1.75	0.76	0.79	0.09	000
31576		A	Laryngoscopy with biopsy	1.97	3.55	3.58	1.05	1.11	0.14	000
31577		A	Remove foreign body, larynx	2.47	3.40	3.49	1.16	1.25	0.21	000
31578		A	Removal of larynx lesion	2.84	4.00	4.07	1.34	1.38	0.23	000
31579		A	Diagnostic laryngoscopy	2.26	2.87	3.10	1.15	1.23	0.18	000
31580		A	Revision of larynx	14.46	NA	NA	14.32	14.73	1.00	090
31582		A	Revision of larynx	22.87	NA	NA	22.61	23.44	1.76	090
31584		A	Treat larynx fracture	20.35	NA	NA	15.81	16.41	1.72	090
31587		A	Revision of larynx	15.12	NA	NA	8.78	8.91	0.97	090
31588		A	Revision of larynx	14.62	NA	NA	12.50	12.79	1.06	090
31590		A	Reinnervate larynx	7.63	NA	NA	13.51	14.04	0.84	090
31595		A	Larynx nerve surgery	8.75	NA	NA	9.63	9.87	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	2.28	2.51	0.80	000
31601		A	Incision of windpipe	4.44	NA	NA	1.94	2.06	0.40	000
31603		A	Incision of windpipe	4.14	NA	NA	1.20	1.33	0.44	000
31605		A	Incision of windpipe	3.57	NA	NA	0.83	0.92	0.40	000
31610		A	Incision of windpipe	9.29	NA	NA	7.72	7.86	0.79	090
31611		A	Surgery/speech prosthesis	5.92	NA	NA	7.07	7.08	0.46	090
31612		A	Puncture/clear windpipe	0.91	1.07	1.08	0.25	0.28	0.08	000
31613		A	Repair windpipe opening	4.63	NA	NA	6.15	6.12	0.42	090
31614		A	Repair windpipe opening	8.47	NA	NA	9.60	9.39	0.58	090
31615		A	Visualization of windpipe	2.09	2.38	2.43	1.04	1.08	0.16	000
31620		A	Endobronchial us add-on	1.40	6.02	5.93	0.33	0.38	0.11	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.23	5.34	0.89	0.94	0.18	000
31623		A	Dx bronchoscope/brush	2.88	5.96	6.09	0.89	0.93	0.13	000
31624		A	Dx bronchoscope/lavage	2.88	5.32	5.44	0.89	0.93	0.13	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.46	5.56	1.01	1.06	0.18	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.94	6.97	1.10	1.15	0.18	000
31629		A	Bronchoscopy/needle bx, each	4.09	11.97	12.56	1.17	1.23	0.16	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.26	1.37	0.32	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.41	1.50	0.34	000
31632		A	Bronchoscopy/lung bx, add ╞	1.03	0.85	0.84	0.24	0.26	0.18	ZZZ
31633		A	Bronchoscopy/needle bx add ╞	1.32	0.98	0.97	0.30	0.33	0.16	ZZZ

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31635		A	Bronchoscopy w/fb removal	3.67	5.18	5.42	1.12	1.20	0.24	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.34	1.45	0.31	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.41	0.45	0.13	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	1.53	1.64	0.22	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	1.54	1.67	0.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	1.48	1.58	0.35	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.03	1.08	0.20	000
31645		A	Bronchoscopy, clear airways	3.16	4.71	4.83	0.96	1.00	0.16	000
31646		A	Bronchoscopy, reclear airway	2.72	4.43	4.55	0.85	0.89	0.14	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.75	6.14	0.69	0.73	0.15	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.31	0.32	0.07	000
31717		A	Bronchial brush biopsy	2.12	5.87	6.48	0.72	0.73	0.14	000
31720		A	Clearance of airways	1.06	NA	NA	0.26	0.28	0.07	000
31725		A	Clearance of airways	1.96	NA	NA	0.40	0.45	0.14	000
31730		A	Intro, windpipe wire/tube	2.85	25.66	19.80	0.76	0.82	0.21	000
31750		A	Repair of windpipe	15.19	NA	NA	17.49	17.53	1.05	090
31755		A	Repair of windpipe	17.19	NA	NA	24.31	24.39	1.29	090
31760		A	Repair of windpipe	23.36	NA	NA	10.17	10.31	2.95	090
31766		A	Reconstruction of windpipe	31.58	NA	NA	11.27	11.88	4.53	090
31770		A	Repair/graft of bronchus	23.48	NA	NA	8.71	9.10	2.84	090
31775		A	Reconstruct bronchus	24.51	NA	NA	8.51	9.34	3.02	090
31780		A	Reconstruct windpipe	19.70	NA	NA	8.78	9.36	1.65	090
31781		A	Reconstruct windpipe	24.77	NA	NA	9.59	10.24	2.25	090
31785		A	Remove windpipe lesion	18.29	NA	NA	7.66	8.30	1.59	090
31786		A	Remove windpipe lesion	25.34	NA	NA	10.06	10.84	3.30	090
31800		A	Repair of windpipe injury	8.10	NA	NA	8.72	8.86	0.79	090
31805		A	Repair of windpipe injury	13.34	NA	NA	6.45	6.65	1.83	090
31820		A	Closure of windpipe lesion	4.58	5.87	5.82	3.26	3.36	0.38	090
31825		A	Repair of windpipe defect	6.98	7.48	7.53	4.50	4.73	0.53	090
31830		A	Revise windpipe scar	4.54	5.94	5.90	3.56	3.67	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	6.04	6.00	1.26	090
32036		A	Exploration of chest	12.21	NA	NA	6.39	6.41	1.43	090
32095		A	Biopsy through chest wall	10.06	NA	NA	5.11	5.18	1.22	090
32100		A	Exploration/biopsy of chest	16.08	NA	NA	7.01	7.22	2.24	090
32110		A	Explore/repair chest	25.15	NA	NA	9.86	10.09	3.22	090
32120		A	Re-exploration of chest	14.27	NA	NA	6.79	6.86	1.63	090
32124		A	Explore chest free adhesions	15.33	NA	NA	6.94	7.01	1.90	090
32140		A	Removal of lung lesion(s)	16.54	NA	NA	7.33	7.43	1.97	090
32141		A	Remove/treat lung lesions	27.10	NA	NA	10.30	9.62	2.01	090
32150		A	Removal of lung lesion(s)	16.70	NA	NA	7.36	7.43	2.01	090
32151		A	Remove lung foreign body	16.82	NA	NA	7.86	7.90	2.04	090
32160		A	Open chest heart massage	13.02	NA	NA	5.85	5.71	1.31	090
32200		A	Drain, open, lung lesion	18.48	NA	NA	8.71	8.69	2.14	090

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32201		A	Drain, percut, lung lesion	3.99	20.16	20.32	1.47	1.42	0.24	000
32215		A	Treat chest lining	12.93	NA	NA	6.34	6.49	1.69	090
32220		A	Release of lung	26.41	NA	NA	11.91	12.19	3.57	090
32225		A	Partial release of lung	16.63	NA	NA	7.41	7.48	2.07	090
32310		A	Removal of chest lining	15.16	NA	NA	6.90	7.03	2.00	090
32320		A	Free/remove chest lining	27.04	NA	NA	11.48	11.66	3.52	090
32400		A	Needle biopsy chest lining	1.76	2.19	2.17	0.59	0.58	0.10	000
32402		A	Open biopsy chest lining	8.89	NA	NA	4.78	4.87	1.07	090
32405		A	Biopsy, lung or mediastinum	1.93	0.72	0.71	0.72	0.70	0.11	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.75	0.73	0.12	000
32421		A	Thoracentesis for aspiration	1.54	2.43	2.59	0.48	0.48	0.08	000
32422		A	Thoracentesis w/tube insert	2.19	2.92	3.00	1.06	1.06	0.12	000
32440		A	Removal of lung	27.17	NA	NA	10.89	11.41	3.69	090
32442		A	Sleeve pneumonectomy	56.37	NA	NA	17.77	17.04	3.85	090
32445		A	Removal of lung	63.60	NA	NA	22.38	20.32	3.72	090
32480		A	Partial removal of lung	25.71	NA	NA	10.19	10.67	3.50	090
32482		A	Bilobectomy	27.28	NA	NA	11.13	11.59	3.67	090
32484		A	Segmentectomy	25.30	NA	NA	9.51	9.99	3.04	090
32486		A	Sleeve lobectomy	42.80	NA	NA	14.63	14.30	3.52	090
32488		A	Completion pneumonectomy	42.83	NA	NA	15.23	14.89	3.81	090
32491		R	Lung volume reduction	25.09	NA	NA	11.00	11.42	2.99	090
32500		A	Partial removal of lung	24.48	NA	NA	10.25	10.79	3.26	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.35	1.40	0.65	ZZZ
32503		A	Resect apical lung tumor	31.61	NA	NA	11.89	12.70	4.38	090
32504		A	Resect apical lung tum/chest	36.41	NA	NA	13.69	14.45	5.09	090
32540		A	Removal of lung lesion	30.22	NA	NA	11.86	11.32	2.08	090
32550		A	Insert pleural cath	4.17	15.05	16.30	1.54	1.57	0.42	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.00	1.09	0.43	000
32560		A	Treat lung lining chemically	2.19	5.07	5.42	0.59	0.62	0.23	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.07	2.14	0.80	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.21	2.29	0.87	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	2.77	2.84	1.14	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.12	3.20	1.25	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	2.42	2.55	1.00	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	2.95	3.05	1.22	000
32650		A	Thoracoscopy, surgical	10.77	NA	NA	5.23	5.62	1.58	090
32651		A	Thoracoscopy, surgical	18.70	NA	NA	7.63	7.54	1.87	090
32652		A	Thoracoscopy, surgical	29.00	NA	NA	11.10	10.87	2.73	090
32653		A	Thoracoscopy, surgical	18.09	NA	NA	7.37	7.28	1.89	090
32654		A	Thoracoscopy, surgical	20.44	NA	NA	8.01	7.90	1.63	090
32655		A	Thoracoscopy, surgical	16.09	NA	NA	6.87	6.97	1.90	090
32656		A	Thoracoscopy, surgical	13.18	NA	NA	5.92	6.44	1.90	090
32657		A	Thoracoscopy, surgical	12.85	NA	NA	5.98	6.41	2.00	090
32658		A	Thoracoscopy, surgical	11.65	NA	NA	5.61	6.06	1.70	090

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32659		A	Thoracoscopy, surgical	11.86	NA	NA	5.74	6.18	1.62	090
32660		A	Thoracoscopy, surgical	17.69	NA	NA	7.31	7.87	2.09	090
32661		A	Thoracoscopy, surgical	13.27	NA	NA	5.98	6.44	1.93	090
32662		A	Thoracoscopy, surgical	14.91	NA	NA	6.60	7.16	2.18	090
32663		A	Thoracoscopy, surgical	24.56	NA	NA	9.39	9.74	2.73	090
32664		A	Thoracoscopy, surgical	14.22	NA	NA	6.18	6.55	2.33	090
32665		A	Thoracoscopy, surgical	21.45	NA	NA	8.56	8.46	2.16	090
32800		A	Repair lung hernia	15.59	NA	NA	7.09	7.18	1.99	090
32810		A	Close chest after drainage	14.83	NA	NA	6.96	7.11	1.94	090
32815		A	Close bronchial fistula	49.79	NA	NA	18.32	16.49	3.28	090
32820		A	Reconstruct injured chest	22.33	NA	NA	10.02	10.57	2.53	090
32851		A	Lung transplant, single	40.94	NA	NA	20.52	22.34	5.58	090
32852		A	Lung transplant with bypass	44.65	NA	NA	22.80	25.43	6.02	090
32853		A	Lung transplant, double	50.11	NA	NA	22.92	25.16	7.07	090
32854		A	Lung transplant with bypass	53.88	NA	NA	26.40	28.52	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	9.50	9.61	2.94	090
32905		A	Revise & repair chest wall	23.17	NA	NA	9.18	9.43	3.16	090
32906		A	Revise & repair chest wall	29.18	NA	NA	11.08	11.34	3.98	090
32940		A	Revision of lung	21.22	NA	NA	8.46	8.73	2.89	090
32960		A	Therapeutic pneumothorax	1.84	1.68	1.69	0.74	0.69	0.16	000
32997		A	Total lung lavage	7.31	NA	NA	1.74	1.79	0.55	000
32998		A	Perq rf ablate tx, pul tumor	5.68	69.90	69.90	2.22	2.22	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	1.06	0.99	0.14	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.93	0.90	0.15	000
33015		A	Incision of heart sac	8.44	NA	NA	5.33	5.24	0.65	090
33020		A	Incision of heart sac	14.87	NA	NA	6.42	6.52	1.80	090
33025		A	Incision of heart sac	13.65	NA	NA	5.85	5.98	1.81	090
33030		A	Partial removal of heart sac	22.27	NA	NA	9.02	9.16	2.84	090
33031		A	Partial removal of heart sac	25.30	NA	NA	9.70	9.79	3.14	090
33050		A	Removal of heart sac lesion	16.85	NA	NA	7.37	7.49	2.15	090
33120		A	Removal of heart lesion	27.33	NA	NA	10.60	10.86	3.70	090
33130		A	Removal of heart lesion	24.05	NA	NA	9.69	9.80	3.01	090
33140		A	Heart revascularize (tmr)	28.26	NA	NA	10.61	10.69	2.86	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.77	0.97	0.69	ZZZ
33202		A	Insert epicard eltrd, open	13.15	NA	NA	5.99	5.99	1.71	090
33203		A	Insert epicard eltrd, endo	13.92	NA	NA	6.59	6.59	1.39	090
33206		A	Insertion of heart pacemaker	7.31	NA	NA	5.15	4.98	0.52	090
33207		A	Insertion of heart pacemaker	8.00	NA	NA	5.26	5.11	0.59	090
33208		A	Insertion of heart pacemaker	8.72	NA	NA	5.70	5.47	0.56	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.67	1.57	0.18	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.52	1.46	0.21	000

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33212		A	Insertion of pulse generator	5.51	NA	NA	3.73	3.64	0.43	090
33213		A	Insertion of pulse generator	6.36	NA	NA	4.24	4.11	0.45	090
33214		A	Upgrade of pacemaker system	7.78	NA	NA	5.29	5.19	0.58	090
33215		A	Reposition pacing-defib lead	4.89	NA	NA	3.49	3.41	0.37	090
33216		A	Insert lead pace-defib, one	5.81	NA	NA	4.59	4.50	0.36	090
33217		A	Insert lead pace-defib, dual	5.78	NA	NA	4.47	4.41	0.39	090
33218		A	Repair lead pace-defib, one	5.97	NA	NA	4.83	4.70	0.37	090
33220		A	Repair lead pace-defib, dual	6.05	NA	NA	4.84	4.70	0.37	090
33222		A	Revise pocket, pacemaker	5.01	NA	NA	4.32	4.31	0.42	090
33223		A	Revise pocket, pacing-defib	6.49	NA	NA	4.90	4.83	0.45	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	4.92	4.69	0.54	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	4.35	4.08	0.45	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	4.78	4.54	0.59	000
33233		A	Removal of pacemaker system	3.33	NA	NA	3.27	3.27	0.22	090
33234		A	Removal of pacemaker system	7.85	NA	NA	5.48	5.34	0.56	090
33235		A	Removal pacemaker electrode	9.93	NA	NA	7.23	7.13	0.73	090
33236		A	Remove electrode/thoracotomy	12.64	NA	NA	6.42	6.68	1.69	090
33237		A	Remove electrode/thoracotomy	13.75	NA	NA	8.00	7.95	1.59	090
33238		A	Remove electrode/thoracotomy	15.28	NA	NA	7.60	7.76	2.03	090
33240		A	Insert pulse generator	7.61	NA	NA	5.26	5.09	0.41	090
33241		A	Remove pulse generator	3.26	NA	NA	3.00	2.99	0.18	090
33243		A	Remove eltrd/thoracotomy	23.42	NA	NA	10.86	11.02	2.10	090
33244		A	Remove eltrd, transven	13.84	NA	NA	9.47	9.33	0.99	090
33249		A	Eltrd/insert pace-defib	15.02	NA	NA	10.14	9.71	0.77	090
33250		A	Ablate heart dysrhythm focus	25.78	NA	NA	10.18	10.41	3.19	090
33251		A	Ablate heart dysrhythm focus	28.80	NA	NA	11.00	11.18	3.60	090
33254		A	Ablate atria, lmtd	23.58	NA	NA	9.72	9.72	3.35	090
33255		A	Ablate atria w/o bypass, ext	28.91	NA	NA	12.12	12.12	3.94	090
33256		A	Ablate atria w/bypass, exten	34.77	NA	NA	13.93	13.93	4.95	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	4.82	4.82	0.89	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.26	5.26	1.09	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	6.85	6.85	1.78	ZZZ
33261		A	Ablate heart dysrhythm focus	28.80	NA	NA	10.86	11.10	3.46	090
33265		A	Ablate atria, lmtd, endo	23.58	NA	NA	9.66	9.66	3.35	090
33266		A	Ablate atria, x10sv, endo	32.91	NA	NA	12.52	12.52	4.80	090
33282		A	Implant pat-active ht record	4.70	NA	NA	4.26	4.20	0.23	090
33284		A	Remove pat-active ht record	3.04	NA	NA	3.38	3.42	0.14	090
33300		A	Repair of heart wound	44.89	NA	NA	15.18	13.71	2.66	090
33305		A	Repair of heart wound	76.85	NA	NA	25.23	21.59	3.13	090
33310		A	Exploratory heart surgery	20.22	NA	NA	8.38	8.70	2.59	090
33315		A	Exploratory heart surgery	26.05	NA	NA	10.44	10.56	3.28	090
33320		A	Repair major blood vessel(s)	18.46	NA	NA	7.84	7.94	2.08	090
33321		A	Repair major vessel	20.71	NA	NA	8.22	8.62	2.91	090
33322		A	Repair major blood vessel(s)	24.30	NA	NA	9.91	10.04	2.86	090

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33330		A	Insert major vessel graft	25.17	NA	NA	9.37	9.60	2.82	090
33332		A	Insert major vessel graft	24.46	NA	NA	10.23	10.32	3.03	090
33335		A	Insert major vessel graft	33.79	NA	NA	12.46	12.69	4.28	090
33400		A	Repair of aortic valve	41.37	NA	NA	15.18	15.32	4.11	090
33401		A	Valvuloplasty, open	24.41	NA	NA	12.49	12.76	3.57	090
33403		A	Valvuloplasty, w/cp bypass	25.39	NA	NA	11.02	11.85	3.55	090
33404		A	Prepare heart-aorta conduit	31.25	NA	NA	11.98	12.64	4.33	090
33405		A	Replacement of aortic valve	41.19	NA	NA	15.04	15.87	5.33	090
33406		A	Replacement of aortic valve	52.55	NA	NA	18.34	18.56	5.45	090
33410		A	Replacement of aortic valve	46.28	NA	NA	16.49	16.54	4.69	090
33411		A	Replacement of aortic valve	61.94	NA	NA	20.95	20.42	5.48	090
33412		A	Replacement of aortic valve	43.77	NA	NA	16.40	17.43	6.39	090
33413		A	Replacement of aortic valve	59.74	NA	NA	20.84	20.86	6.53	090
33414		A	Repair of aortic valve	39.29	NA	NA	14.62	14.51	4.57	090
33415		A	Revision, subvalvular tissue	37.19	NA	NA	12.98	12.75	4.14	090
33416		A	Revise ventricle muscle	36.43	NA	NA	13.34	13.40	4.57	090
33417		A	Repair of aortic valve	29.17	NA	NA	11.78	12.25	4.10	090
33420		A	Revision of mitral valve	25.67	NA	NA	9.06	9.20	1.82	090
33422		A	Revision of mitral valve	29.61	NA	NA	11.54	12.08	3.94	090
33425		A	Repair of mitral valve	49.83	NA	NA	17.46	16.37	4.07	090
33426		A	Repair of mitral valve	43.15	NA	NA	15.72	16.09	5.03	090
33427		A	Repair of mitral valve	44.70	NA	NA	15.59	16.56	6.09	090
33430		A	Replacement of mitral valve	50.75	NA	NA	18.51	18.22	5.10	090
33460		A	Revision of tricuspid valve	44.62	NA	NA	15.29	14.30	3.45	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	NA	19.46	17.84	3.87	090
33464		A	Valvuloplasty, tricuspid	44.49	NA	NA	15.72	15.19	4.15	090
33465		A	Replace tricuspid valve	50.59	NA	NA	17.37	16.29	4.39	090
33468		A	Revision of tricuspid valve	32.82	NA	NA	14.00	13.93	4.07	090
33470		A	Revision of pulmonary valve	21.32	NA	NA	8.56	9.11	1.03	090
33471		A	Valvotomy, pulmonary valve	22.83	NA	NA	10.01	9.95	3.39	090
33472		A	Revision of pulmonary valve	22.90	NA	NA	9.51	10.11	3.55	090
33474		A	Revision of pulmonary valve	39.27	NA	NA	12.94	12.44	3.22	090
33475		A	Replacement, pulmonary valve	42.27	NA	NA	14.87	15.01	4.93	090
33476		A	Revision of heart chamber	26.41	NA	NA	10.02	10.52	2.42	090
33478		A	Revision of heart chamber	27.38	NA	NA	10.73	11.33	3.89	090
33496		A	Repair, prosth valve clot	29.71	NA	NA	11.34	11.70	4.13	090
33500		A	Repair heart vessel fistula	27.82	NA	NA	10.90	11.05	3.87	090
33501		A	Repair heart vessel fistula	19.43	NA	NA	7.93	8.02	1.91	090
33502		A	Coronary artery correction	21.69	NA	NA	9.08	9.59	3.00	090
33503		A	Coronary artery graft	22.29	NA	NA	13.80	12.80	1.78	090
33504		A	Coronary artery graft	25.30	NA	NA	9.99	10.45	3.36	090
33505		A	Repair artery w/tunnel	38.35	NA	NA	12.06	12.28	2.19	090
33506		A	Repair artery, translocation	37.80	NA	NA	12.58	13.09	4.66	090
33507		A	Repair art, intramural	31.35	NA	NA	10.91	11.61	4.06	090

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33508		A	Endoscopic vein harvest	0.31	NA	NA	0.09	0.09	0.04	ZZZ
33510		A	CABG, vein, single	34.87	NA	NA	12.87	13.76	4.41	090
33511		A	CABG, vein, two	38.34	NA	NA	14.14	14.89	4.56	090
33512		A	CABG, vein, three	43.87	NA	NA	15.92	16.36	4.67	090
33513		A	CABG, vein, four	45.26	NA	NA	15.71	16.25	4.88	090
33514		A	CABG, vein, five	47.97	NA	NA	17.16	17.40	4.77	090
33516		A	Cabg, vein, six or more	49.65	NA	NA	18.00	18.22	5.13	090
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.08	1.02	0.39	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.36	2.17	0.73	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.14	2.94	1.04	ZZZ
33521		A	CABG, artery-vein, four	12.59	NA	NA	3.76	3.59	1.37	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	4.22	4.12	1.78	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	4.76	4.70	2.13	ZZZ
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	3.00	2.73	0.88	ZZZ
33533		A	CABG, arterial, single	33.64	NA	NA	12.54	13.54	4.56	090
33534		A	CABG, arterial, two	39.77	NA	NA	14.70	15.47	4.70	090
33535		A	CABG, arterial, three	44.64	NA	NA	16.33	16.80	5.03	090
33536		A	Cabg, arterial, four or more	48.32	NA	NA	17.06	17.39	5.44	090
33542		A	Removal of heart lesion	48.08	NA	NA	16.68	15.77	4.38	090
33545		A	Repair of heart damage	56.93	NA	NA	19.26	18.37	5.21	090
33548		A	Restore/remodel, ventricle	53.96	NA	NA	19.83	19.72	5.53	090
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.31	1.35	0.65	ZZZ
33600		A	Closure of valve	30.15	NA	NA	11.63	11.87	4.42	090
33602		A	Closure of valve	29.18	NA	NA	10.76	11.20	3.82	090
33606		A	Anastomosis/artery-aorta	31.37	NA	NA	11.90	12.36	4.41	090
33608		A	Repair anomaly w/conduit	31.72	NA	NA	12.82	13.16	4.74	090
33610		A	Repair by enlargement	31.24	NA	NA	11.94	12.37	4.56	090
33611		A	Repair double ventricle	35.49	NA	NA	12.34	12.81	4.37	090
33612		A	Repair double ventricle	36.49	NA	NA	12.30	13.03	5.30	090
33615		A	Repair, modified fontan	35.76	NA	NA	14.70	14.33	4.32	090
33617		A	Repair single ventricle	38.96	NA	NA	13.35	14.03	5.66	090
33619		A	Repair single ventricle	48.60	NA	NA	15.79	17.07	6.46	090
33641		A	Repair heart septum defect	29.50	NA	NA	10.81	10.51	3.23	090
33645		A	Revision of heart veins	27.98	NA	NA	10.86	11.10	3.79	090
33647		A	Repair heart septum defects	29.37	NA	NA	12.42	12.77	3.32	090
33660		A	Repair of heart defects	31.75	NA	NA	11.00	11.63	4.49	090
33665		A	Repair of heart defects	34.77	NA	NA	12.14	12.58	4.00	090
33670		A	Repair of heart chambers	36.58	NA	NA	11.96	12.28	4.65	090
33675		A	Close mult vsd	35.87	NA	NA	12.49	12.49	4.95	090
33676		A	Close mult vsd w/resection	36.87	NA	NA	13.93	13.93	5.44	090
33677		A	Cl mult vsd w/rem pul band	38.37	NA	NA	14.41	14.41	5.68	090
33681		A	Repair heart septum defect	32.16	NA	NA	12.44	13.01	4.45	090
33684		A	Repair heart septum defect	34.29	NA	NA	12.00	12.42	3.39	090
33688		A	Repair heart septum defect	34.67	NA	NA	11.59	11.33	4.73	090

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33690		A	Reinforce pulmonary artery	20.20	NA	NA	8.45	8.89	1.97	090
33692		A	Repair of heart defects	31.38	NA	NA	11.25	11.94	4.58	090
33694		A	Repair of heart defects	35.49	NA	NA	13.46	13.66	5.28	090
33697		A	Repair of heart defects	37.49	NA	NA	17.11	16.57	4.09	090
33702		A	Repair of heart defects	27.11	NA	NA	10.14	10.76	3.68	090
33710		A	Repair of heart defects	30.28	NA	NA	16.79	16.10	4.43	090
33720		A	Repair of heart defect	27.13	NA	NA	10.84	11.22	3.84	090
33722		A	Repair of heart defect	29.05	NA	NA	9.92	10.92	1.30	090
33724		A	Repair venous anomaly	27.55	NA	NA	11.14	11.14	4.00	090
33726		A	Repair pul venous stenosis	37.04	NA	NA	13.98	13.98	5.03	090
33730		A	Repair heart-vein defect(s)	36.01	NA	NA	11.70	12.32	5.03	090
33732		A	Repair heart-vein defect	28.80	NA	NA	11.24	11.79	3.68	090
33735		A	Revision of heart chamber	22.04	NA	NA	10.02	9.76	1.92	090
33736		A	Revision of heart chamber	24.16	NA	NA	9.82	10.34	3.09	090
33737		A	Revision of heart chamber	22.34	NA	NA	9.11	9.58	3.25	090
33750		A	Major vessel shunt	22.06	NA	NA	12.50	11.94	1.16	090
33755		A	Major vessel shunt	22.44	NA	NA	9.40	9.26	3.26	090
33762		A	Major vessel shunt	22.44	NA	NA	9.40	9.60	3.14	090
33764		A	Major vessel shunt & graft	22.44	NA	NA	8.67	9.07	3.01	090
33766		A	Major vessel shunt	23.41	NA	NA	11.04	11.21	3.70	090
33767		A	Major vessel shunt	25.14	NA	NA	8.74	9.50	3.82	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	2.55	2.58	1.19	ZZZ
33770		A	Repair great vessels defect	39.02	NA	NA	13.02	13.45	5.74	090
33771		A	Repair great vessels defect	40.58	NA	NA	14.30	13.83	5.68	090
33774		A	Repair great vessels defect	31.54	NA	NA	12.18	12.81	4.81	090
33775		A	Repair great vessels defect	32.83	NA	NA	13.37	13.79	4.99	090
33776		A	Repair great vessels defect	34.53	NA	NA	14.22	14.63	5.09	090
33777		A	Repair great vessels defect	33.95	NA	NA	13.23	13.84	5.49	090
33778		A	Repair great vessels defect	42.62	NA	NA	16.23	16.41	6.20	090
33779		A	Repair great vessels defect	43.15	NA	NA	15.38	15.39	2.92	090
33780		A	Repair great vessels defect	43.85	NA	NA	15.77	16.62	3.68	090
33781		A	Repair great vessels defect	43.16	NA	NA	15.12	14.69	5.97	090
33786		A	Repair arterial trunk	41.74	NA	NA	14.07	14.75	5.71	090
33788		A	Revision of pulmonary artery	27.26	NA	NA	10.94	11.20	4.03	090
33800		A	Aortic suspension	17.23	NA	NA	6.39	6.83	2.46	090
33802		A	Repair vessel defect	18.24	NA	NA	7.38	7.85	2.27	090
33803		A	Repair vessel defect	20.18	NA	NA	7.01	7.71	3.20	090
33813		A	Repair septal defect	21.23	NA	NA	10.97	10.97	3.13	090
33814		A	Repair septal defect	26.41	NA	NA	10.55	11.09	3.85	090
33820		A	Revise major vessel	16.61	NA	NA	7.31	7.58	2.35	090
33822		A	Revise major vessel	17.63	NA	NA	7.76	8.07	2.68	090
33824		A	Revise major vessel	20.10	NA	NA	8.61	8.96	2.89	090
33840		A	Remove aorta constriction	21.21	NA	NA	7.97	8.56	2.16	090
33845		A	Remove aorta constriction	22.77	NA	NA	11.14	11.21	3.22	090

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33851		A	Remove aorta constriction	21.85	NA	NA	8.72	9.23	3.18	090
33852		A	Repair septal defect	24.28	NA	NA	9.67	10.11	2.16	090
33853		A	Repair septal defect	32.35	NA	NA	14.15	14.34	4.48	090
33860		A	Ascending aortic graft	59.33	NA	NA	20.18	19.27	5.76	090
33861		A	Ascending aortic graft	43.94	NA	NA	15.57	16.13	6.37	090
33863		A	Ascending aortic graft	58.71	NA	NA	19.43	19.26	6.59	090
33864		A	Ascending aortic graft	60.00	NA	NA	20.37	20.37	6.73	090
33870		A	Transverse aortic arch graft	45.93	NA	NA	16.27	16.82	6.62	090
33875		A	Thoracic aortic graft	35.68	NA	NA	12.92	13.23	4.89	090
33877		A	Thoracoabdominal graft	68.85	NA	NA	21.17	19.98	5.94	090
33880		A	Endovasc taa repr incl subcl	34.48	NA	NA	11.20	11.78	2.75	090
33881		A	Endovasc taa repr w/o subcl	29.48	NA	NA	9.72	10.30	2.33	090
33883		A	Insert endovasc prosth, taa	20.99	NA	NA	7.36	7.83	2.11	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.14	2.25	0.86	ZZZ
33886		A	Endovasc prosth, delayed	17.99	NA	NA	6.29	6.78	1.80	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	3.96	4.27	2.18	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	4.85	5.39	2.73	000
33910		A	Remove lung artery emboli	29.59	NA	NA	11.71	11.65	3.70	090
33915		A	Remove lung artery emboli	24.83	NA	NA	8.89	9.09	1.44	090
33916		A	Surgery of great vessel	28.30	NA	NA	13.92	13.29	3.67	090
33917		A	Repair pulmonary artery	25.14	NA	NA	12.31	12.29	3.70	090
33920		A	Repair pulmonary atresia	32.58	NA	NA	11.60	12.17	4.38	090
33922		A	Transect pulmonary artery	24.09	NA	NA	9.62	9.95	3.10	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.51	1.60	0.82	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.25	NA	NA	11.40	12.23	4.61	090
33926		A	Repr pul art, unifocal w/cpb	44.68	NA	NA	11.98	13.43	6.22	090
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	22.03	23.75	9.06	090
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	30.20	28.02	6.26	090
33960		A	External circulation assist	19.33	NA	NA	5.53	5.38	2.67	000
33961		A	External circulation assist	10.91	NA	NA	3.13	3.25	0.88	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	2.42	2.28	0.35	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.26	0.25	0.07	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.60	2.52	0.82	000
33971		A	Aortic circulation assist	11.91	NA	NA	6.20	6.16	1.25	090
33973		A	Insert balloon device	9.75	NA	NA	3.85	3.72	1.26	000
33974		A	Remove intra-aortic balloon	14.93	NA	NA	8.09	8.04	1.74	090
33975		A	Implant ventricular device	20.97	NA	NA	6.45	6.42	3.07	XXX
33976		A	Implant ventricular device	22.97	NA	NA	7.64	7.63	3.26	XXX
33977		A	Remove ventricular device	20.07	NA	NA	9.39	9.82	2.81	090
33978		A	Remove ventricular device	22.51	NA	NA	9.69	10.22	3.31	090
33979		A	Insert intracorporeal device	45.93	NA	NA	13.55	13.91	6.97	XXX
33980		A	Remove intracorporeal device	64.86	NA	NA	24.02	24.35	8.59	090

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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	6.56	6.61	1.85	090
34051		A	Removal of artery clot	16.91	NA	NA	7.01	7.21	2.21	090
34101		A	Removal of artery clot	10.85	NA	NA	4.27	4.55	1.41	090
34111		A	Removal of arm artery clot	10.85	NA	NA	4.28	4.55	1.40	090
34151		A	Removal of artery clot	26.41	NA	NA	8.51	8.99	3.56	090
34201		A	Removal of artery clot	19.38	NA	NA	6.50	6.23	1.45	090
34203		A	Removal of leg artery clot	17.73	NA	NA	6.38	6.81	2.36	090
34401		A	Removal of vein clot	26.41	NA	NA	10.34	10.44	3.10	090
34421		A	Removal of vein clot	13.29	NA	NA	5.15	5.44	1.55	090
34451		A	Removal of vein clot	28.41	NA	NA	9.18	9.76	3.84	090
34471		A	Removal of vein clot	21.00	NA	NA	7.30	6.81	1.18	090
34490		A	Removal of vein clot	10.83	NA	NA	4.38	4.65	1.41	090
34501		A	Repair valve, femoral vein	16.74	NA	NA	6.66	7.13	2.35	090
34502		A	Reconstruct vena cava	27.86	NA	NA	10.36	10.86	3.63	090
34510		A	Transposition of vein valve	19.80	NA	NA	6.93	7.56	2.33	090
34520		A	Cross-over vein graft	19.05	NA	NA	6.71	7.16	2.29	090
34530		A	Leg vein fusion	17.77	NA	NA	6.45	7.00	1.74	090
34800		A	Endovas aaa repr w/sm tube	21.46	NA	NA	7.50	7.93	2.46	090
34802		A	Endovas aaa repr w/2-p part	23.71	NA	NA	8.19	8.60	2.33	090
34803		A	Endovas aaa repr w/3-p part	24.74	NA	NA	8.01	8.57	2.01	090
34804		A	Endovas aaa repr w/1-p part	23.71	NA	NA	8.16	8.58	2.30	090
34805		A	Endovas aaa repr w/long tube	22.59	NA	NA	7.24	7.85	2.01	090
34806		A	Aneurysm press sensor add-on	2.06	0.63	0.63	0.63	0.63	0.30	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.06	1.14	0.59	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	1.67	1.81	1.18	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.14	1.25	0.67	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	2.47	2.66	1.50	000
34825		A	Endovasc extend prosth, init	12.72	NA	NA	5.17	5.42	1.28	090
34826		A	Endovasc exten prosth, add ╪l	4.12	NA	NA	1.13	1.19	0.44	ZZZ
34830		A	Open aortic tube prosth repr	35.10	NA	NA	10.58	11.37	4.55	090
34831		A	Open aortoiliac prosth repr	37.85	NA	NA	11.14	11.30	4.89	090
34832		A	Open aortofemor prosth repr	37.85	NA	NA	11.26	12.11	4.85	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	3.27	3.56	1.70	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	1.57	1.73	0.76	000
34900		A	Endovasc iliac repr w/graft	16.77	NA	NA	6.20	6.55	2.00	090
35001		A	Repair defect of artery	20.70	NA	NA	7.64	8.13	2.81	090
35002		A	Repair artery rupture, neck	22.12	NA	NA	7.84	8.32	3.00	090
35005		A	Repair defect of artery	19.18	NA	NA	7.64	7.95	1.77	090
35011		A	Repair defect of artery	18.50	NA	NA	6.34	6.76	2.55	090
35013		A	Repair artery rupture, arm	23.10	NA	NA	7.80	8.28	3.10	090
35021		A	Repair defect of artery	22.09	NA	NA	8.46	8.71	2.87	090
35022		A	Repair artery rupture, chest	25.62	NA	NA	9.04	9.26	3.17	090
35045		A	Repair defect of arm artery	17.94	NA	NA	6.35	6.65	2.45	090

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35081		A	Repair defect of artery	33.37	NA	NA	10.66	10.87	4.01	090
35082		A	Repair artery rupture, aorta	41.93	NA	NA	12.71	13.38	5.44	090
35091		A	Repair defect of artery	35.35	NA	NA	9.96	10.88	5.14	090
35092		A	Repair artery rupture, aorta	50.81	NA	NA	14.54	15.33	6.40	090
35102		A	Repair defect of artery	36.37	NA	NA	11.27	11.56	4.48	090
35103		A	Repair artery rupture, groin	43.49	NA	NA	12.82	13.60	5.76	090
35111		A	Repair defect of artery	26.17	NA	NA	8.62	9.09	3.47	090
35112		A	Repair artery rupture,spleen	32.44	NA	NA	10.52	10.89	4.08	090
35121		A	Repair defect of artery	31.41	NA	NA	9.58	10.29	4.30	090
35122		A	Repair artery rupture, belly	37.76	NA	NA	12.07	12.52	4.75	090
35131		A	Repair defect of artery	26.29	NA	NA	8.66	9.19	3.80	090
35132		A	Repair artery rupture, groin	32.44	NA	NA	10.04	10.64	4.30	090
35141		A	Repair defect of artery	20.83	NA	NA	6.85	7.38	2.90	090
35142		A	Repair artery rupture, thigh	25.03	NA	NA	8.29	8.82	3.36	090
35151		A	Repair defect of artery	23.61	NA	NA	7.67	8.26	3.24	090
35152		A	Repair artery rupture, knee	27.53	NA	NA	8.97	9.58	3.61	090
35180		A	Repair blood vessel lesion	15.01	NA	NA	6.99	6.98	1.00	090
35182		A	Repair blood vessel lesion	31.58	NA	NA	11.41	11.77	4.36	090
35184		A	Repair blood vessel lesion	18.72	NA	NA	6.48	6.94	2.53	090
35188		A	Repair blood vessel lesion	15.05	NA	NA	6.12	6.51	2.16	090
35189		A	Repair blood vessel lesion	29.85	NA	NA	9.70	10.28	4.01	090
35190		A	Repair blood vessel lesion	13.33	NA	NA	5.22	5.54	1.80	090
35201		A	Repair blood vessel lesion	16.84	NA	NA	6.32	6.75	2.34	090
35206		A	Repair blood vessel lesion	13.76	NA	NA	5.23	5.57	1.87	090
35207		A	Repair blood vessel lesion	10.85	NA	NA	6.61	6.80	1.48	090
35211		A	Repair blood vessel lesion	24.50	NA	NA	9.41	9.72	3.20	090
35216		A	Repair blood vessel lesion	36.47	NA	NA	13.45	12.34	2.65	090
35221		A	Repair blood vessel lesion	26.54	NA	NA	8.39	8.79	3.37	090
35226		A	Repair blood vessel lesion	15.22	NA	NA	5.69	6.13	2.02	090
35231		A	Repair blood vessel lesion	21.08	NA	NA	8.12	8.54	2.89	090
35236		A	Repair blood vessel lesion	17.94	NA	NA	6.34	6.73	2.43	090
35241		A	Repair blood vessel lesion	25.50	NA	NA	9.71	10.08	3.53	090
35246		A	Repair blood vessel lesion	28.15	NA	NA	10.36	10.64	3.86	090
35251		A	Repair blood vessel lesion	31.83	NA	NA	9.51	10.09	4.13	090
35256		A	Repair blood vessel lesion	18.98	NA	NA	6.41	6.90	2.63	090
35261		A	Repair blood vessel lesion	18.88	NA	NA	7.08	7.32	2.61	090
35266		A	Repair blood vessel lesion	15.75	NA	NA	5.65	6.00	2.10	090
35271		A	Repair blood vessel lesion	24.50	NA	NA	9.39	9.68	3.16	090
35276		A	Repair blood vessel lesion	25.72	NA	NA	9.76	10.13	3.49	090
35281		A	Repair blood vessel lesion	29.93	NA	NA	9.56	10.11	3.97	090
35286		A	Repair blood vessel lesion	17.06	NA	NA	6.29	6.74	2.35	090
35301		A	Rechanneling of artery	19.53	NA	NA	6.67	7.12	2.68	090
35302		A	Rechanneling of artery	21.27	NA	NA	6.91	6.91	2.98	090
35303		A	Rechanneling of artery	23.52	NA	NA	7.49	7.49	3.26	090

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35304		A	Rechanneling of artery	24.52	NA	NA	7.71	7.71	3.41	090
35305		A	Rechanneling of artery	23.52	NA	NA	7.44	7.44	3.26	090
35306		A	Rechanneling of artery	9.25	NA	NA	2.22	2.22	1.34	ZZZ
35311		A	Rechanneling of artery	28.52	NA	NA	9.29	9.92	3.42	090
35321		A	Rechanneling of artery	16.51	NA	NA	5.78	6.19	2.25	090
35331		A	Rechanneling of artery	27.61	NA	NA	9.27	9.77	3.83	090
35341		A	Rechanneling of artery	26.10	NA	NA	8.32	8.97	3.78	090
35351		A	Rechanneling of artery	24.53	NA	NA	7.66	8.16	3.35	090
35355		A	Rechanneling of artery	19.78	NA	NA	6.39	6.82	2.67	090
35361		A	Rechanneling of artery	30.11	NA	NA	9.56	10.11	4.15	090
35363		A	Rechanneling of artery	32.22	NA	NA	11.20	11.56	4.33	090
35371		A	Rechanneling of artery	15.23	NA	NA	5.31	5.73	2.14	090
35372		A	Rechanneling of artery	18.50	NA	NA	6.10	6.59	2.63	090
35390		A	Reoperation, carotid add-on	3.19	NA	NA	0.81	0.87	0.46	ZZZ
35400		A	Angioscopy	3.00	NA	NA	0.78	0.86	0.43	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.03	3.17	1.25	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.09	2.22	0.94	000
35454		A	Repair arterial blockage	6.03	NA	NA	1.82	1.95	0.87	000
35456		A	Repair arterial blockage	7.34	NA	NA	2.15	2.31	1.04	000
35458		A	Repair arterial blockage	9.48	NA	NA	2.78	2.96	1.26	000
35459		A	Repair arterial blockage	8.62	NA	NA	2.62	2.76	1.21	000
35460		A	Repair venous blockage	6.03	NA	NA	1.75	1.88	0.83	000
35470		A	Repair arterial blockage	8.62	61.42	68.39	3.47	3.45	0.69	000
35471		A	Repair arterial blockage	10.05	66.26	74.88	4.68	4.50	0.67	000
35472		A	Repair arterial blockage	6.90	47.38	51.70	2.70	2.72	0.58	000
35473		A	Repair arterial blockage	6.03	46.73	50.08	2.51	2.49	0.51	000
35474		A	Repair arterial blockage	7.35	60.67	67.54	3.00	2.98	0.57	000
35475		R	Repair arterial blockage	9.48	48.73	50.64	3.45	3.48	0.62	000
35476		A	Repair venous blockage	6.03	37.55	39.39	2.24	2.27	0.34	000
35480		A	Atherectomy, open	11.06	NA	NA	3.13	3.36	1.28	000
35481		A	Atherectomy, open	7.60	NA	NA	2.48	2.58	1.13	000
35482		A	Atherectomy, open	6.64	NA	NA	2.30	2.37	0.89	000
35483		A	Atherectomy, open	8.09	NA	NA	2.62	2.73	1.15	000
35484		A	Atherectomy, open	10.42	NA	NA	2.97	3.18	1.27	000
35485		A	Atherectomy, open	9.48	NA	NA	2.89	3.05	1.35	000
35490		A	Atherectomy, percutaneous	11.06	NA	NA	5.37	5.20	0.71	000
35491		A	Atherectomy, percutaneous	7.60	NA	NA	3.01	3.08	0.74	000
35492		A	Atherectomy, percutaneous	6.64	NA	NA	3.30	3.27	0.43	000
35493		A	Atherectomy, percutaneous	8.09	NA	NA	4.00	3.96	0.56	000
35494		A	Atherectomy, percutaneous	10.42	NA	NA	5.09	4.94	0.59	000
35495		A	Atherectomy, percutaneous	9.48	NA	NA	4.45	4.44	0.69	000
35500		A	Harvest vein for bypass	6.44	NA	NA	1.60	1.71	0.93	ZZZ
35501		A	Artery bypass graft	28.99	NA	NA	11.45	10.71	4.10	090
35506		A	Artery bypass graft	25.23	NA	NA	8.60	8.83	2.87	090

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35508		A	Artery bypass graft	25.99	NA	NA	9.41	9.43	2.78	090
35509		A	Artery bypass graft	27.99	NA	NA	10.60	10.15	3.92	090
35510		A	Artery bypass graft	24.29	NA	NA	7.81	8.41	2.12	090
35511		A	Artery bypass graft	22.12	NA	NA	7.69	8.11	2.91	090
35512		A	Artery bypass graft	23.79	NA	NA	7.44	8.09	2.12	090
35515		A	Artery bypass graft	25.99	NA	NA	7.75	8.14	2.78	090
35516		A	Artery bypass graft	24.11	NA	NA	7.35	7.22	2.34	090
35518		A	Artery bypass graft	22.57	NA	NA	7.86	8.15	3.03	090
35521		A	Artery bypass graft	24.00	NA	NA	7.86	8.36	3.13	090
35522		A	Artery bypass graft	23.05	NA	NA	7.53	8.10	2.12	090
35523		A	Artery bypass graft	24.00	NA	NA	9.01	9.01	2.14	090
35525		A	Artery bypass graft	21.59	NA	NA	6.93	7.55	2.12	090
35526		A	Artery bypass graft	31.47	NA	NA	10.84	11.27	3.63	090
35531		A	Artery bypass graft	38.98	NA	NA	11.80	12.49	5.18	090
35533		A	Artery bypass graft	29.79	NA	NA	9.68	10.20	3.85	090
35536		A	Artery bypass graft	33.60	NA	NA	9.92	10.69	4.62	090
35537		A	Artery bypass graft	41.75	NA	NA	12.78	12.78	5.72	090
35538		A	Artery bypass graft	46.82	NA	NA	14.61	14.61	6.39	090
35539		A	Artery bypass graft	43.98	NA	NA	12.97	12.97	6.02	090
35540		A	Artery bypass graft	49.20	NA	NA	14.49	14.49	6.76	090
35548		A	Artery bypass graft	22.57	NA	NA	7.63	8.09	2.98	090
35549		A	Artery bypass graft	24.34	NA	NA	8.41	8.91	3.30	090
35551		A	Artery bypass graft	27.72	NA	NA	9.64	10.11	3.75	090
35556		A	Artery bypass graft	26.62	NA	NA	8.56	8.86	3.10	090
35558		A	Artery bypass graft	23.00	NA	NA	7.82	8.26	3.00	090
35560		A	Artery bypass graft	33.90	NA	NA	10.54	11.25	4.75	090
35563		A	Artery bypass graft	25.99	NA	NA	8.26	8.84	3.52	090
35565		A	Artery bypass graft	25.00	NA	NA	8.26	8.74	3.30	090
35566		A	Artery bypass graft	32.22	NA	NA	9.90	10.28	3.83	090
35571		A	Artery bypass graft	25.39	NA	NA	8.09	8.79	3.43	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	1.93	2.01	0.99	ZZZ
35583		A	Vein bypass graft	27.62	NA	NA	8.68	9.06	3.17	090
35585		A	Vein bypass graft	32.22	NA	NA	9.95	10.53	4.02	090
35587		A	Vein bypass graft	26.08	NA	NA	8.43	9.20	3.52	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.50	1.53	0.73	ZZZ
35601		A	Artery bypass graft	26.99	NA	NA	10.16	9.78	3.72	090
35606		A	Artery bypass graft	22.36	NA	NA	7.24	7.69	2.70	090
35612		A	Artery bypass graft	16.71	NA	NA	6.52	6.87	2.09	090
35616		A	Artery bypass graft	21.74	NA	NA	7.04	7.32	2.20	090
35621		A	Artery bypass graft	20.95	NA	NA	6.73	7.23	2.92	090
35623		A	Bypass graft, not vein	25.79	NA	NA	8.31	8.87	3.46	090
35626		A	Artery bypass graft	29.06	NA	NA	10.07	10.56	4.08	090
35631		A	Artery bypass graft	35.90	NA	NA	10.51	11.35	4.96	090
35636		A	Artery bypass graft	31.62	NA	NA	9.95	10.55	4.10	090

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35637		A	Artery bypass graft	32.92	NA	NA	10.40	10.40	4.44	090
35638		A	Artery bypass graft	33.47	NA	NA	10.76	10.76	4.52	090
35642		A	Artery bypass graft	18.85	NA	NA	7.43	7.75	2.28	090
35645		A	Artery bypass graft	18.34	NA	NA	6.17	6.70	2.50	090
35646		A	Artery bypass graft	32.84	NA	NA	10.32	11.03	4.44	090
35647		A	Artery bypass graft	29.62	NA	NA	9.54	10.11	3.99	090
35650		A	Artery bypass graft	20.08	NA	NA	6.72	7.14	2.72	090
35651		A	Artery bypass graft	25.97	NA	NA	8.85	9.33	3.36	090
35654		A	Artery bypass graft	26.17	NA	NA	8.34	8.93	3.53	090
35656		A	Artery bypass graft	20.39	NA	NA	6.79	7.25	2.80	090
35661		A	Artery bypass graft	20.22	NA	NA	7.05	7.53	2.72	090
35663		A	Artery bypass graft	23.80	NA	NA	7.84	8.38	3.11	090
35665		A	Artery bypass graft	22.22	NA	NA	7.35	7.88	3.01	090
35666		A	Artery bypass graft	23.53	NA	NA	8.44	9.00	3.16	090
35671		A	Artery bypass graft	20.64	NA	NA	7.55	8.01	2.78	090
35681		A	Composite bypass graft	1.60	NA	NA	0.40	0.44	0.23	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	1.73	1.89	1.03	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.04	2.24	1.20	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	0.97	1.06	0.58	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	0.89	0.95	0.47	ZZZ
35691		A	Arterial transposition	18.32	NA	NA	6.35	6.87	2.59	090
35693		A	Arterial transposition	15.64	NA	NA	6.41	6.74	2.22	090
35694		A	Arterial transposition	19.19	NA	NA	6.23	6.83	2.70	090
35695		A	Arterial transposition	19.97	NA	NA	6.65	7.14	2.74	090
35697		A	Reimplant artery each	3.00	NA	NA	0.74	0.81	0.41	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	0.77	0.83	0.44	ZZZ
35701		A	Exploration, carotid artery	9.11	NA	NA	4.38	4.58	1.12	090
35721		A	Exploration, femoral artery	7.66	NA	NA	3.77	3.94	1.03	090
35741		A	Exploration popliteal artery	8.61	NA	NA	3.88	4.08	1.12	090
35761		A	Exploration of artery/vein	5.84	NA	NA	3.47	3.61	0.75	090
35800		A	Explore neck vessels	7.99	NA	NA	3.96	4.14	0.95	090
35820		A	Explore chest vessels	36.81	NA	NA	12.80	11.41	1.95	090
35840		A	Explore abdominal vessels	10.87	NA	NA	4.77	4.90	1.34	090
35860		A	Explore limb vessels	6.72	NA	NA	3.40	3.56	0.78	090
35870		A	Repair vessel graft defect	24.39	NA	NA	7.94	8.41	3.01	090
35875		A	Removal of clot in graft	10.64	NA	NA	4.25	4.49	1.41	090
35876		A	Removal of clot in graft	17.74	NA	NA	5.97	6.36	2.40	090
35879		A	Revise graft w/vein	17.28	NA	NA	5.91	6.36	2.28	090
35881		A	Revise graft w/vein	19.22	NA	NA	6.49	7.05	2.56	090
35883		A	Revise graft w/nonauto graft	23.07	NA	NA	7.30	7.30	3.19	090
35884		A	Revise graft w/vein	24.57	NA	NA	7.42	7.42	3.41	090
35901		A	Excision, graft, neck	8.26	NA	NA	4.21	4.49	1.15	090
35903		A	Excision, graft, extremity	9.44	NA	NA	4.58	4.98	1.30	090
35905		A	Excision, graft, thorax	33.39	NA	NA	10.17	10.94	4.44	090

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35907		A	Excision, graft, abdomen	37.14	NA	NA	10.90	11.73	4.92	090
36000		A	Place needle in vein	0.18	0.46	0.49	0.07	0.06	0.01	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.28	2.43	0.88	0.90	0.17	000
36005		A	Injection ext venography	0.95	8.44	8.25	0.38	0.36	0.05	000
36010		A	Place catheter in vein	2.43	11.18	13.23	0.81	0.80	0.20	XXX
36011		A	Place catheter in vein	3.14	19.70	21.76	1.03	1.04	0.27	XXX
36012		A	Place catheter in vein	3.51	20.23	19.93	1.27	1.25	0.23	XXX
36013		A	Place catheter in artery	2.52	18.50	19.24	0.91	0.86	0.25	XXX
36014		A	Place catheter in artery	3.02	19.39	19.59	1.15	1.12	0.19	XXX
36015		A	Place catheter in artery	3.51	20.44	21.28	1.32	1.29	0.21	XXX
36100		A	Establish access to artery	3.02	11.04	11.32	1.16	1.15	0.26	XXX
36120		A	Establish access to artery	2.01	9.53	9.84	0.62	0.63	0.14	XXX
36140		A	Establish access to artery	2.01	10.57	11.14	0.72	0.70	0.16	XXX
36145		A	Artery to vein shunt	2.01	10.42	10.97	0.66	0.66	0.11	XXX
36160		A	Establish access to aorta	2.52	11.29	11.86	1.01	0.97	0.26	XXX
36200		A	Place catheter in aorta	3.02	13.76	14.47	1.02	1.02	0.24	XXX
36215		A	Place catheter in artery	4.67	26.18	26.43	1.89	1.82	0.27	XXX
36216		A	Place catheter in artery	5.27	28.47	28.65	2.13	2.05	0.31	XXX
36217		A	Place catheter in artery	6.29	46.77	49.00	2.48	2.40	0.44	XXX
36218		A	Place catheter in artery	1.01	3.84	4.15	0.39	0.38	0.07	ZZZ
36245		A	Place catheter in artery	4.67	28.92	29.75	2.14	2.02	0.31	XXX
36246		A	Place catheter in artery	5.27	27.69	28.29	2.02	1.98	0.38	XXX
36247		A	Place catheter in artery	6.29	45.56	46.61	2.38	2.32	0.47	XXX
36248		A	Place catheter in artery	1.01	3.21	3.42	0.39	0.38	0.07	ZZZ
36260		A	Insertion of infusion pump	9.82	NA	NA	4.60	4.68	1.29	090
36261		A	Revision of infusion pump	5.55	NA	NA	3.27	3.37	0.70	090
36262		A	Removal of infusion pump	4.05	NA	NA	2.75	2.76	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	0.29	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	0.26	0.27	0.06	0.05	0.01	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.32	0.31	0.05	0.05	0.01	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.22	0.24	0.07	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.22	0.22	0.06	XXX
36430		A	Blood transfusion service	0.00	0.94	0.96	NA	NA	0.06	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.27	0.27	0.10	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	0.73	0.73	0.21	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.85	0.89	0.15	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	1.70	1.84	0.79	XXX
36470		A	Injection therapy of vein	1.09	2.38	2.46	0.64	0.66	0.12	010
36471		A	Injection therapy of veins	1.60	2.61	2.73	0.81	0.85	0.19	010
36475		A	Endovenous rf, 1st vein	6.72	36.95	40.62	1.97	2.11	0.37	000
36476		A	Endovenous rf, vein add-on	3.38	6.20	6.63	0.86	0.93	0.18	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	27.21	32.15	2.09	2.20	0.37	000

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36479		A	Endovenous laser vein addon	3.38	6.89	7.17	0.91	0.96	0.18	ZZZ
36481		A	Insertion of catheter, vein	6.98	3.07	3.75	NA	NA	0.55	000
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.23	1.27	0.20	000
36510		A	Insertion of catheter, vein	1.09	1.01	1.73	0.28	0.37	0.10	000
36511		A	Apheresis wbc	1.74	NA	NA	0.55	0.60	0.08	000
36512		A	Apheresis rbc	1.74	NA	NA	0.59	0.63	0.08	000
36513		A	Apheresis platelets	1.74	NA	NA	0.61	0.64	0.17	000
36514		A	Apheresis plasma	1.74	10.45	12.10	0.52	0.57	0.08	000
36515		A	Apheresis, adsorp/reinfuse	1.74	45.14	50.51	0.48	0.52	0.08	000
36516		A	Apheresis, selective	1.22	49.10	57.93	0.37	0.39	0.08	000
36522		A	Photopheresis	1.67	35.92	35.07	0.93	0.94	0.13	000
36555		A	Insert non-tunnel cv cath	2.68	4.15	4.55	0.60	0.65	0.11	000
36556		A	Insert non-tunnel cv cath	2.50	2.88	3.57	0.56	0.61	0.19	000
36557		A	Insert tunneled cv cath	5.11	15.53	16.96	2.45	2.50	0.57	010
36558		A	Insert tunneled cv cath	4.81	15.00	16.53	2.41	2.45	0.57	010
36560		A	Insert tunneled cv cath	6.26	22.54	24.36	2.69	2.78	0.57	010
36561		A	Insert tunneled cv cath	6.01	22.34	24.18	2.67	2.75	0.57	010
36563		A	Insert tunneled cv cath	6.21	23.27	24.17	2.64	2.73	0.84	010
36565		A	Insert tunneled cv cath	6.01	17.57	19.38	2.49	2.61	0.57	010
36566		A	Insert tunneled cv cath	6.51	112.20	90.56	2.61	2.74	0.57	010
36568		A	Insert picc cath	1.92	5.94	6.34	0.62	0.61	0.11	000
36569		A	Insert picc cath	1.82	4.55	5.25	0.69	0.66	0.19	000
36570		A	Insert picvad cath	5.33	23.20	25.74	2.73	2.73	0.57	010
36571		A	Insert picvad cath	5.31	24.79	26.94	2.46	2.52	0.57	010
36575		A	Repair tunneled cv cath	0.67	3.33	3.51	0.24	0.24	0.20	000
36576		A	Repair tunneled cv cath	3.21	5.94	6.20	1.58	1.65	0.19	010
36578		A	Replace tunneled cv cath	3.51	9.28	9.75	1.99	2.07	0.19	010
36580		A	Replace cvad cath	1.31	4.03	4.76	0.45	0.44	0.19	000
36581		A	Replace tunneled cv cath	3.45	15.75	16.71	1.77	1.81	0.19	010
36582		A	Replace tunneled cv cath	5.21	21.91	22.97	2.48	2.58	0.19	010
36583		A	Replace tunneled cv cath	5.26	21.88	22.95	2.42	2.54	0.19	010
36584		A	Replace picc cath	1.20	4.04	4.78	0.63	0.61	0.19	000
36585		A	Replace picvad cath	4.81	22.87	24.14	2.42	2.50	0.19	010
36589		A	Removal tunneled cv cath	2.27	1.88	1.98	1.25	1.28	0.24	010
36590		A	Removal tunneled cv cath	3.32	3.65	3.58	1.61	1.64	0.44	010
36591		T	Draw blood off venous device	0.00	0.62	0.62	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.68	0.68	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.83	0.72	NA	NA	0.37	XXX
36595		A	Mech remov tunneled cv cath	3.59	11.01	12.59	1.45	1.45	0.21	000
36596		A	Mech remov tunneled cv cath	0.75	2.61	2.88	0.44	0.46	0.05	000
36597		A	Reposition venous catheter	1.21	2.08	2.16	0.48	0.47	0.07	000
36598		T	Inj w/fluor, eval cv device	0.74	2.20	2.32	0.28	0.87	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.49	0.49	0.07	0.08	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.15	0.17	0.07	000

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36625		A	Insertion catheter, artery	2.11	NA	NA	0.52	0.52	0.26	000
36640		A	Insertion catheter, artery	2.10	NA	NA	0.90	0.94	0.21	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.26	0.30	0.14	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.26	0.32	0.11	000
36800		A	Insertion of cannula	2.43	NA	NA	1.54	1.61	0.25	000
36810		A	Insertion of cannula	3.96	NA	NA	1.20	1.32	0.45	000
36815		A	Insertion of cannula	2.62	NA	NA	1.08	1.10	0.35	000
36818		A	Av fuse, uppr arm, cephalic	11.81	NA	NA	4.51	4.90	1.90	090
36819		A	Av fuse, uppr arm, basilic	14.39	NA	NA	5.13	5.45	1.96	090
36820		A	Av fusion/forearm vein	14.39	NA	NA	5.23	5.52	1.95	090
36821		A	Av fusion direct any site	9.15	NA	NA	3.94	4.12	1.23	090
36822		A	Insertion of cannula(s)	5.51	NA	NA	3.74	3.91	0.79	090
36823		A	Insertion of cannula(s)	22.82	NA	NA	8.83	8.98	2.89	090
36825		A	Artery-vein autograft	10.00	NA	NA	4.24	4.45	1.35	090
36830		A	Artery-vein nonautograft	12.00	NA	NA	4.13	4.41	1.66	090
36831		A	Open thrombect av fistula	8.01	NA	NA	3.18	3.38	1.09	090
36832		A	Av fistula revision, open	10.50	NA	NA	3.74	3.99	1.44	090
36833		A	Av fistula revision	11.95	NA	NA	4.12	4.40	1.65	090
36834		A	Repair A-V aneurysm	11.11	NA	NA	4.22	4.36	1.37	090
36835		A	Artery to vein shunt	7.43	NA	NA	3.92	4.02	0.98	090
36838		A	Dist revas ligation, hemo	21.59	NA	NA	6.94	7.56	3.02	090
36860		A	External cannula declotting	2.01	3.40	3.00	0.63	0.65	0.11	000
36861		A	Cannula declotting	2.52	NA	NA	1.24	1.30	0.27	000
36870		A	Percut thrombect av fistula	5.17	41.35	44.33	2.79	2.88	0.29	090
37140		A	Revision of circulation	25.12	NA	NA	8.76	9.20	2.02	090
37145		A	Revision of circulation	26.13	NA	NA	9.84	10.11	3.26	090
37160		A	Revision of circulation	23.13	NA	NA	8.19	8.46	2.82	090
37180		A	Revision of circulation	26.13	NA	NA	8.71	9.12	3.35	090
37181		A	Splice spleen/kidney veins	28.26	NA	NA	9.62	9.98	3.41	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	6.65	6.51	1.00	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	NA	3.24	3.18	0.47	000
37184		A	Prim art mech thrombectomy	8.66	51.18	56.39	3.37	3.37	0.55	000
37185		A	Prim art m-thrombect add-on	3.28	16.64	18.23	1.15	1.14	0.21	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	35.71	39.19	1.96	1.89	0.32	ZZZ
37187		A	Venous mech thrombectomy	8.03	48.70	54.15	3.12	3.13	0.51	000
37188		A	Venous m-thrombectomy add-on	5.71	42.17	47.19	2.37	2.37	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	1.74	1.68	0.27	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.37	2.42	0.33	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	3.32	3.25	0.43	000
37203		A	Transcatheter retrieval	5.02	30.37	31.03	2.12	2.10	0.29	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.52	6.37	1.48	000
37205		A	Transcath iv stent, percut	8.27	109.10	82.77	3.23	3.37	0.60	000

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37206		A	Transcath iv stent/perc addl	4.12	66.71	50.39	1.57	1.53	0.31	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	2.39	2.59	1.17	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.02	1.11	0.59	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.79	0.78	0.15	000
37210		A	Embolization uterine fibroid	10.60	85.04	85.04	4.12	4.12	0.60	000
37215		R	Transcath stent, cca w/eps	19.58	NA	NA	9.97	9.76	1.09	090
37216		N	Transcath stent, cca w/o eps	18.85	NA	NA	7.62	7.93	1.04	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.76	0.76	0.21	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.48	0.50	0.19	ZZZ
37500		A	Endoscopy ligate perf veins	11.54	NA	NA	5.32	5.71	1.54	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	11.97	NA	NA	5.16	5.28	1.33	090
37600		A	Ligation of neck artery	12.34	NA	NA	4.82	5.28	1.41	090
37605		A	Ligation of neck artery	14.20	NA	NA	5.28	5.70	1.99	090
37606		A	Ligation of neck artery	8.72	NA	NA	4.26	4.34	1.23	090
37607		A	Ligation of a-v fistula	6.19	NA	NA	3.03	3.16	0.85	090
37609		A	Temporal artery procedure	3.02	4.20	4.28	1.83	1.86	0.36	010
37615		A	Ligation of neck artery	7.72	NA	NA	4.08	4.09	0.68	090
37616		A	Ligation of chest artery	18.89	NA	NA	7.95	7.99	2.33	090
37617		A	Ligation of abdomen artery	23.71	NA	NA	7.85	8.19	2.98	090
37618		A	Ligation of extremity artery	5.95	NA	NA	3.36	3.43	0.67	090
37620		A	Revision of major vein	11.49	NA	NA	5.59	5.63	0.91	090
37650		A	Revision of major vein	8.41	NA	NA	4.21	4.33	1.01	090
37660		A	Revision of major vein	22.20	NA	NA	7.57	7.95	2.49	090
37700		A	Revise leg vein	3.76	NA	NA	2.38	2.49	0.53	090
37718		A	Ligate/strip short leg vein	7.05	NA	NA	3.56	3.69	0.14	090
37722		A	Ligate/strip long leg vein	8.08	NA	NA	3.70	3.88	0.86	090
37735		A	Removal of leg veins/lesion	10.81	NA	NA	4.62	4.85	1.48	090
37760		A	Ligation, leg veins, open	10.69	NA	NA	4.53	4.74	1.44	090
37765		A	Phleb veins extrem 10-20	7.63	NA	NA	3.58	3.85	0.48	090
37766		A	Phleb veins extrem 20+	9.58	NA	NA	4.13	4.43	0.48	090
37780		A	Revision of leg vein	3.87	NA	NA	2.51	2.60	0.53	090
37785		A	Ligate/divide/excise vein	3.87	4.89	4.97	2.56	2.60	0.54	090
37788		A	Revascularization, penis	23.21	NA	NA	12.02	11.29	2.26	090
37790		A	Penile venous occlusion	8.37	NA	NA	4.47	4.45	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	6.86	6.69	1.92	090
38101		A	Removal of spleen, partial	19.47	NA	NA	6.84	6.77	2.05	090
38102		A	Removal of spleen, total	4.79	NA	NA	1.24	1.34	0.63	ZZZ
38115		A	Repair of ruptured spleen	21.80	NA	NA	7.53	7.31	2.09	090
38120		A	Laparoscopy, splenectomy	16.97	NA	NA	6.90	7.03	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	0.96	0.94	0.14	000
38204		B	Bl donor search management	2.00	0.64	0.64	0.64	0.64	0.06	XXX

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38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.54	0.57	0.07	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.53	0.57	0.07	000
38207		I	Cryopreserve stem cells	0.89	0.40	0.40	0.40	0.40	0.01	XXX
38208		I	Thaw preserved stem cells	0.56	0.25	0.25	0.25	0.25	0.02	XXX
38209		I	Wash harvest stem cells	0.24	0.11	0.11	0.11	0.11	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	0.72	0.72	0.72	0.72	0.03	XXX
38211		I	Tumor cell deplete of harvst	1.42	0.65	0.65	0.65	0.65	0.02	XXX
38212		I	Rbc depletion of harvest	0.94	0.43	0.43	0.43	0.43	0.02	XXX
38213		I	Platelet deplete of harvest	0.24	0.11	0.11	0.11	0.11	0.01	XXX
38214		I	Volume deplete of harvest	0.81	0.37	0.37	0.37	0.37	0.01	XXX
38215		I	Harvest stem cell concentrte	0.94	0.43	0.43	0.43	0.43	0.02	XXX
38220		A	Bone marrow aspiration	1.08	2.70	2.96	0.45	0.47	0.05	XXX
38221		A	Bone marrow biopsy	1.37	2.80	3.09	0.58	0.60	0.07	XXX
38230		R	Bone marrow collection	4.80	NA	NA	3.03	3.08	0.48	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	0.93	0.95	0.11	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	0.95	0.97	0.11	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	0.71	0.73	0.08	000
38300		A	Drainage, lymph node lesion	2.28	4.27	4.28	2.05	2.06	0.25	010
38305		A	Drainage, lymph node lesion	6.55	NA	NA	4.14	4.22	0.88	090
38308		A	Incision of lymph channels	6.73	NA	NA	3.53	3.59	0.85	090
38380		A	Thoracic duct procedure	8.34	NA	NA	4.99	5.17	0.74	090
38381		A	Thoracic duct procedure	13.32	NA	NA	5.97	6.20	1.85	090
38382		A	Thoracic duct procedure	10.51	NA	NA	5.29	5.41	1.37	090
38500		A	Biopsy/removal, lymph nodes	3.76	3.75	3.74	2.03	2.04	0.49	010
38505		A	Needle biopsy, lymph nodes	1.14	2.13	2.11	0.75	0.76	0.09	000
38510		A	Biopsy/removal, lymph nodes	6.69	5.40	5.44	3.10	3.20	0.72	010
38520		A	Biopsy/removal, lymph nodes	6.95	NA	NA	3.78	3.85	0.84	090
38525		A	Biopsy/removal, lymph nodes	6.35	NA	NA	3.47	3.43	0.80	090
38530		A	Biopsy/removal, lymph nodes	8.26	NA	NA	4.16	4.22	1.12	090
38542		A	Explore deep node(s), neck	6.08	NA	NA	3.97	4.10	0.60	090
38550		A	Removal, neck/armpit lesion	6.99	NA	NA	4.26	4.17	0.88	090
38555		A	Removal, neck/armpit lesion	15.42	NA	NA	7.47	7.74	1.76	090
38562		A	Removal, pelvic lymph nodes	10.92	NA	NA	5.79	5.79	1.20	090
38564		A	Removal, abdomen lymph nodes	11.29	NA	NA	5.17	5.19	1.32	090
38570		A	Laparoscopy, lymph node biop	9.28	NA	NA	4.10	4.07	1.13	010
38571		A	Laparoscopy, lymphadenectomy	14.70	NA	NA	6.89	6.59	1.15	010
38572		A	Laparoscopy, lymphadenectomy	16.86	NA	NA	5.94	6.23	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	6.50	6.44	0.72	090
38720		A	Removal of lymph nodes, neck	21.72	NA	NA	10.20	10.00	1.20	090
38724		A	Removal of lymph nodes, neck	23.72	NA	NA	10.93	10.67	1.28	090

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38740		A	Remove armpit lymph nodes	10.57	NA	NA	5.03	5.02	1.32	090
38745		A	Remove armpit lymph nodes	13.71	NA	NA	6.05	6.06	1.74	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.42	1.47	0.72	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	1.27	1.37	0.64	ZZZ
38760		A	Remove groin lymph nodes	13.49	NA	NA	5.95	6.00	1.72	090
38765		A	Remove groin lymph nodes	21.78	NA	NA	8.48	8.57	2.48	090
38770		A	Remove pelvis lymph nodes	13.98	NA	NA	6.76	6.51	1.40	090
38780		A	Remove abdomen lymph nodes	17.56	NA	NA	8.21	8.22	1.89	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.75	0.75	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	3.32	3.36	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	4.34	4.42	0.89	090
39010		A	Exploration of chest	13.11	NA	NA	5.99	6.39	1.76	090
39200		A	Removal chest lesion	15.04	NA	NA	6.15	6.50	2.03	090
39220		A	Removal chest lesion	19.47	NA	NA	8.02	8.37	2.46	090
39400		A	Visualization of chest	8.00	NA	NA	4.14	4.32	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	5.82	5.99	1.78	090
39502		A	Repair paraesophageal hernia	17.09	NA	NA	6.58	6.73	2.17	090
39503		A	Repair of diaphragm hernia	108.67	NA	NA	29.35	30.40	10.98	090
39520		A	Repair of diaphragm hernia	16.63	NA	NA	6.78	7.10	2.24	090
39530		A	Repair of diaphragm hernia	16.22	NA	NA	6.29	6.51	2.11	090
39531		A	Repair of diaphragm hernia	17.23	NA	NA	6.19	6.50	2.22	090
39540		A	Repair of diaphragm hernia	14.51	NA	NA	5.63	5.79	1.80	090
39541		A	Repair of diaphragm hernia	15.67	NA	NA	6.13	6.25	1.93	090
39545		A	Revision of diaphragm	14.58	NA	NA	6.84	7.03	1.84	090
39560		A	Resect diaphragm, simple	12.97	NA	NA	5.52	5.71	1.59	090
39561		A	Resect diaphragm, complex	19.75	NA	NA	9.33	9.34	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	2.07	1.96	0.57	0.58	0.05	000
40500		A	Partial excision of lip	4.35	7.86	7.63	4.33	4.33	0.38	090
40510		A	Partial excision of lip	4.74	6.80	6.76	3.66	3.75	0.49	090
40520		A	Partial excision of lip	4.71	6.96	7.11	3.80	3.88	0.52	090
40525		A	Reconstruct lip with flap	7.61	NA	NA	5.46	5.68	0.85	090
40527		A	Reconstruct lip with flap	9.20	NA	NA	6.20	6.50	0.97	090
40530		A	Partial removal of lip	5.45	7.51	7.59	4.21	4.30	0.55	090
40650		A	Repair lip	3.69	6.11	6.29	3.25	3.26	0.38	090
40652		A	Repair lip	4.32	7.14	7.30	4.00	4.07	0.52	090
40654		A	Repair lip	5.37	8.16	8.28	4.73	4.78	0.60	090
40700		A	Repair cleft lip/nasal	13.97	NA	NA	8.38	8.56	0.95	090
40701		A	Repair cleft lip/nasal	17.03	NA	NA	10.33	10.59	1.65	090

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40702		A	Repair cleft lip/nasal	14.09	NA	NA	7.10	7.40	1.23	090
40720		A	Repair cleft lip/nasal	14.54	NA	NA	8.41	8.79	1.80	090
40761		A	Repair cleft lip/nasal	15.69	NA	NA	9.30	9.56	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	3.88	3.66	1.90	1.87	0.13	010
40801		A	Drainage of mouth lesion	2.57	4.97	4.74	2.63	2.66	0.31	010
40804		A	Removal, foreign body, mouth	1.26	3.81	3.71	1.85	1.86	0.11	010
40805		A	Removal, foreign body, mouth	2.73	5.11	4.96	2.65	2.70	0.32	010
40806		A	Incision of lip fold	0.31	2.47	2.32	0.51	0.51	0.04	000
40808		A	Biopsy of mouth lesion	0.98	3.63	3.39	1.63	1.60	0.10	010
40810		A	Excision of mouth lesion	1.33	3.71	3.50	1.73	1.71	0.13	010
40812		A	Excise/repair mouth lesion	2.33	4.59	4.37	2.31	2.33	0.28	010
40814		A	Excise/repair mouth lesion	3.45	5.73	5.54	3.72	3.77	0.41	090
40816		A	Excision of mouth lesion	3.70	5.98	5.78	3.82	3.87	0.40	090
40818		A	Excise oral mucosa for graft	2.72	5.92	5.73	3.81	3.86	0.21	090
40819		A	Excise lip or cheek fold	2.45	4.95	4.74	3.12	3.12	0.29	090
40820		A	Treatment of mouth lesion	1.30	5.43	5.06	3.01	2.87	0.11	010
40830		A	Repair mouth laceration	1.78	4.17	4.06	2.05	2.06	0.19	010
40831		A	Repair mouth laceration	2.50	5.33	5.17	2.77	2.84	0.30	010
40840		R	Reconstruction of mouth	9.03	10.24	10.14	5.72	6.04	1.08	090
40842		R	Reconstruction of mouth	9.03	9.90	9.95	5.49	5.82	1.08	090
40843		R	Reconstruction of mouth	12.62	11.87	11.90	5.97	6.44	1.39	090
40844		R	Reconstruction of mouth	16.57	16.18	16.09	9.81	10.26	2.00	090
40845		R	Reconstruction of mouth	19.13	15.81	16.15	10.00	10.82	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	2.56	2.50	1.34	1.36	0.12	010
41005		A	Drainage of mouth lesion	1.28	4.42	4.15	1.82	1.79	0.12	010
41006		A	Drainage of mouth lesion	3.28	5.40	5.25	2.80	2.90	0.35	090
41007		A	Drainage of mouth lesion	3.14	5.55	5.45	2.85	2.90	0.31	090
41008		A	Drainage of mouth lesion	3.40	5.61	5.38	2.90	2.98	0.42	090
41009		A	Drainage of mouth lesion	3.63	5.90	5.67	3.19	3.29	0.47	090
41010		A	Incision of tongue fold	1.08	3.94	3.82	1.58	1.58	0.07	010
41015		A	Drainage of mouth lesion	4.00	6.26	6.05	3.97	4.01	0.46	090
41016		A	Drainage of mouth lesion	4.11	6.33	6.16	4.15	4.17	0.53	090
41017		A	Drainage of mouth lesion	4.11	6.43	6.24	4.17	4.21	0.53	090
41018		A	Drainage of mouth lesion	5.14	6.82	6.65	4.52	4.54	0.68	090
41019		A	Place needles h&n for rt	8.84	NA	NA	3.31	3.31	0.59	000
41100		A	Biopsy of tongue	1.39	2.69	2.63	1.17	1.24	0.15	010
41105		A	Biopsy of tongue	1.44	2.69	2.59	1.21	1.24	0.13	010
41108		A	Biopsy of floor of mouth	1.07	2.53	2.42	1.09	1.10	0.10	010
41110		A	Excision of tongue lesion	1.53	3.66	3.50	1.65	1.65	0.13	010
41112		A	Excision of tongue lesion	2.77	5.28	5.08	3.26	3.25	0.28	090
41113		A	Excision of tongue lesion	3.23	5.54	5.35	3.41	3.43	0.34	090
41114		A	Excision of tongue lesion	8.71	NA	NA	6.38	6.59	0.83	090

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41115		A	Excision of tongue fold	1.76	4.34	4.08	1.78	1.80	0.18	010
41116		A	Excision of mouth lesion	2.47	5.58	5.28	2.81	2.81	0.23	090
41120		A	Partial removal of tongue	10.91	NA	NA	14.43	14.66	0.79	090
41130		A	Partial removal of tongue	15.51	NA	NA	15.87	15.97	0.93	090
41135		A	Tongue and neck surgery	29.83	NA	NA	21.87	22.24	1.89	090
41140		A	Removal of tongue	28.81	NA	NA	23.83	24.58	2.27	090
41145		A	Tongue removal, neck surgery	37.59	NA	NA	28.97	29.40	2.55	090
41150		A	Tongue, mouth, jaw surgery	29.52	NA	NA	23.12	23.55	1.95	090
41153		A	Tongue, mouth, neck surgery	33.28	NA	NA	23.94	24.24	2.01	090
41155		A	Tongue, jaw, & neck surgery	43.96	NA	NA	27.76	27.55	2.34	090
41250		A	Repair tongue laceration	1.93	3.85	3.58	1.61	1.50	0.18	010
41251		A	Repair tongue laceration	2.29	3.34	3.33	1.71	1.67	0.22	010
41252		A	Repair tongue laceration	2.99	4.51	4.36	2.06	2.11	0.29	010
41500		A	Fixation of tongue	3.74	NA	NA	7.11	7.20	0.30	090
41510		A	Tongue to lip surgery	3.45	NA	NA	6.23	6.66	0.20	090
41520		A	Reconstruction, tongue fold	2.77	5.75	5.48	3.23	3.33	0.27	090
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	4.90	4.32	2.15	1.93	0.12	010
41805		A	Removal foreign body, gum	1.28	4.98	4.40	2.90	2.73	0.13	010
41806		A	Removal foreign body,jawbone	2.73	5.94	5.36	3.41	3.32	0.37	010
41822		R	Excision of gum lesion	2.35	4.60	4.42	1.75	1.79	0.31	010
41823		R	Excision of gum lesion	3.63	6.66	6.39	3.86	3.90	0.47	090
41825		A	Excision of gum lesion	1.35	3.72	3.56	1.48	1.67	0.15	010
41826		A	Excision of gum lesion	2.35	5.16	4.48	2.61	2.49	0.30	010
41827		A	Excision of gum lesion	3.72	6.74	6.44	3.44	3.50	0.35	090
41828		R	Excision of gum lesion	3.11	4.07	4.01	1.63	1.97	0.44	010
41830		R	Removal of gum tissue	3.38	5.96	5.72	3.10	3.23	0.44	010
41872		R	Repair gum	2.90	5.99	5.75	3.31	3.35	0.30	090
41874		R	Repair tooth socket	3.13	5.73	5.51	2.76	2.86	0.45	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.25	2.51	2.53	1.22	1.23	0.12	010
42100		A	Biopsy roof of mouth	1.33	2.28	2.23	1.27	1.29	0.13	010
42104		A	Excision lesion, mouth roof	1.66	3.59	3.33	1.68	1.64	0.16	010
42106		A	Excision lesion, mouth roof	2.12	4.50	4.18	2.09	2.18	0.25	010
42107		A	Excision lesion, mouth roof	4.48	6.62	6.40	3.75	3.80	0.44	090
42120		A	Remove palate/lesion	11.70	NA	NA	12.25	12.14	0.52	090
42140		A	Excision of uvula	1.65	4.58	4.37	2.11	2.11	0.13	090
42145		A	Repair palate, pharynx/uvula	9.63	NA	NA	7.49	7.50	0.65	090
42160		A	Treatment mouth roof lesion	1.82	3.84	3.95	1.72	1.87	0.17	010
42180		A	Repair palate	2.52	3.37	3.30	1.88	1.94	0.21	010
42182		A	Repair palate	3.84	4.04	4.00	2.42	2.58	0.40	010
42200		A	Reconstruct cleft palate	12.41	NA	NA	8.52	8.95	1.27	090
42205		A	Reconstruct cleft palate	13.57	NA	NA	8.20	8.68	1.58	090
42210		A	Reconstruct cleft palate	14.91	NA	NA	9.94	10.34	2.17	090

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42215		A	Reconstruct cleft palate	8.88	NA	NA	7.39	7.82	1.31	090
42220		A	Reconstruct cleft palate	7.07	NA	NA	5.83	6.08	0.73	090
42225		A	Reconstruct cleft palate	9.66	NA	NA	12.11	13.37	0.86	090
42226		A	Lengthening of palate	10.24	NA	NA	11.71	12.48	1.01	090
42227		A	Lengthening of palate	9.81	NA	NA	11.18	12.29	0.98	090
42235		A	Repair palate	7.92	NA	NA	9.62	10.20	0.72	090
42260		A	Repair nose to lip fistula	10.10	9.57	9.74	5.87	6.17	1.26	090
42280		A	Preparation, palate mold	1.56	2.24	2.17	0.83	0.91	0.19	010
42281		A	Insertion, palate prosthesis	1.95	3.01	2.92	1.69	1.74	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	3.11	3.04	1.73	1.75	0.16	010
42305		A	Drainage of salivary gland	6.23	NA	NA	4.07	4.24	0.51	090
42310		A	Drainage of salivary gland	1.58	2.31	2.30	1.40	1.44	0.13	010
42320		A	Drainage of salivary gland	2.37	3.73	3.62	1.88	1.94	0.21	010
42330		A	Removal of salivary stone	2.23	3.41	3.35	1.73	1.76	0.19	010
42335		A	Removal of salivary stone	3.35	5.78	5.57	2.86	2.93	0.29	090
42340		A	Removal of salivary stone	4.64	6.65	6.51	3.46	3.58	0.42	090
42400		A	Biopsy of salivary gland	0.78	1.99	1.90	0.65	0.67	0.06	000
42405		A	Biopsy of salivary gland	3.31	3.98	3.99	2.16	2.24	0.28	010
42408		A	Excision of salivary cyst	4.58	6.41	6.30	3.27	3.36	0.45	090
42409		A	Drainage of salivary cyst	2.85	5.28	5.09	2.51	2.58	0.27	090
42410		A	Excise parotid gland/lesion	9.46	NA	NA	5.35	5.57	0.91	090
42415		A	Excise parotid gland/lesion	17.99	NA	NA	8.64	9.21	1.43	090
42420		A	Excise parotid gland/lesion	20.87	NA	NA	9.58	10.29	1.65	090
42425		A	Excise parotid gland/lesion	13.31	NA	NA	6.78	7.25	1.05	090
42426		A	Excise parotid gland/lesion	22.54	NA	NA	9.99	10.76	1.81	090
42440		A	Excise submaxillary gland	7.05	NA	NA	3.86	4.10	0.59	090
42450		A	Excise sublingual gland	4.66	6.32	6.22	3.99	4.06	0.42	090
42500		A	Repair salivary duct	4.34	6.15	6.04	3.88	3.96	0.41	090
42505		A	Repair salivary duct	6.23	7.23	7.21	4.67	4.85	0.55	090
42507		A	Parotid duct diversion	6.16	NA	NA	6.40	6.44	0.49	090
42508		A	Parotid duct diversion	9.22	NA	NA	8.59	8.53	1.04	090
42509		A	Parotid duct diversion	11.65	NA	NA	8.28	8.77	0.93	090
42510		A	Parotid duct diversion	8.26	NA	NA	6.97	7.18	0.66	090
42550		A	Injection for salivary x-ray	1.25	2.30	2.53	0.46	0.45	0.07	000
42600		A	Closure of salivary fistula	4.86	6.92	6.84	3.64	3.76	0.43	090
42650		A	Dilation of salivary duct	0.77	1.29	1.24	0.66	0.67	0.07	000
42660		A	Dilation of salivary duct	1.13	1.47	1.44	0.76	0.79	0.09	000
42665		A	Ligation of salivary duct	2.57	5.12	4.89	2.43	2.48	0.23	090
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42700		A	Drainage of tonsil abscess	1.64	2.97	2.90	1.66	1.67	0.13	010
42720		A	Drainage of throat abscess	6.31	4.76	4.78	3.22	3.37	0.44	010
42725		A	Drainage of throat abscess	12.28	NA	NA	7.22	7.48	0.91	090
42800		A	Biopsy of throat	1.41	2.46	2.40	1.30	1.32	0.11	010

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42802		A	Biopsy of throat	1.56	4.15	4.30	1.68	1.78	0.12	010
42804		A	Biopsy of upper nose/throat	1.26	3.60	3.64	1.50	1.56	0.10	010
42806		A	Biopsy of upper nose/throat	1.60	3.84	3.90	1.61	1.70	0.13	010
42808		A	Excise pharynx lesion	2.32	3.23	3.20	1.60	1.69	0.19	010
42809		A	Remove pharynx foreign body	1.83	2.27	2.29	1.33	1.33	0.16	010
42810		A	Excision of neck cyst	3.30	6.17	6.06	3.70	3.67	0.29	090
42815		A	Excision of neck cyst	7.23	NA	NA	6.25	6.30	0.61	090
42820		A	Remove tonsils and adenoids	4.17	NA	NA	2.86	2.97	0.31	090
42821		A	Remove tonsils and adenoids	4.31	NA	NA	2.99	3.12	0.35	090
42825		A	Removal of tonsils	3.45	NA	NA	2.90	2.97	0.25	090
42826		A	Removal of tonsils	3.40	NA	NA	2.68	2.77	0.27	090
42830		A	Removal of adenoids	2.60	NA	NA	2.43	2.47	0.20	090
42831		A	Removal of adenoids	2.75	NA	NA	2.67	2.71	0.22	090
42835		A	Removal of adenoids	2.33	NA	NA	2.16	2.23	0.21	090
42836		A	Removal of adenoids	3.21	NA	NA	2.63	2.72	0.26	090
42842		A	Extensive surgery of throat	12.02	NA	NA	12.03	11.79	0.71	090
42844		A	Extensive surgery of throat	17.57	NA	NA	15.55	15.74	1.16	090
42845		A	Extensive surgery of throat	32.35	NA	NA	21.35	21.84	1.99	090
42860		A	Excision of tonsil tags	2.25	NA	NA	2.31	2.34	0.18	090
42870		A	Excision of lingual tonsil	5.44	NA	NA	8.73	8.70	0.44	090
42890		A	Partial removal of pharynx	18.92	NA	NA	15.27	15.01	1.05	090
42892		A	Revision of pharyngeal walls	25.77	NA	NA	19.20	18.72	1.28	090
42894		A	Revision of pharyngeal walls	33.61	NA	NA	23.50	23.15	1.87	090
42900		A	Repair throat wound	5.26	NA	NA	2.94	3.12	0.50	010
42950		A	Reconstruction of throat	8.16	NA	NA	11.09	11.30	0.72	090
42953		A	Repair throat, esophagus	9.33	NA	NA	13.73	14.65	0.88	090
42955		A	Surgical opening of throat	7.92	NA	NA	10.14	10.28	0.80	090
42960		A	Control throat bleeding	2.35	NA	NA	1.72	1.79	0.19	010
42961		A	Control throat bleeding	5.69	NA	NA	4.47	4.60	0.45	090
42962		A	Control throat bleeding	7.31	NA	NA	5.22	5.40	0.58	090
42970		A	Control nose/throat bleeding	5.76	NA	NA	3.69	3.82	0.39	090
42971		A	Control nose/throat bleeding	6.54	NA	NA	4.62	4.75	0.51	090
42972		A	Control nose/throat bleeding	7.53	NA	NA	4.77	5.01	0.62	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43020		A	Incision of esophagus	8.14	NA	NA	4.27	4.56	0.87	090
43030		A	Throat muscle surgery	7.91	NA	NA	4.55	4.79	0.70	090
43045		A	Incision of esophagus	21.70	NA	NA	9.57	9.86	2.59	090
43100		A	Excision of esophagus lesion	9.55	NA	NA	5.32	5.55	0.93	090
43101		A	Excision of esophagus lesion	16.99	NA	NA	7.37	7.51	2.32	090
43107		A	Removal of esophagus	43.97	NA	NA	16.31	16.82	5.24	090
43108		A	Removal of esophagus	82.66	NA	NA	25.31	22.55	4.08	090
43112		A	Removal of esophagus	47.27	NA	NA	16.90	17.54	5.81	090
43113		A	Removal of esophagus	79.85	NA	NA	28.43	25.11	4.43	090
43116		A	Partial removal of esophagus	92.78	NA	NA	31.63	27.91	3.06	090

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43117		A	Partial removal of esophagus	43.52	NA	NA	15.28	15.80	5.19	090
43118		A	Partial removal of esophagus	66.86	NA	NA	21.10	19.28	4.11	090
43121		A	Partial removal of esophagus	51.22	NA	NA	17.86	16.83	3.91	090
43122		A	Partial removal of esophagus	43.97	NA	NA	15.57	16.04	5.42	090
43123		A	Partial removal of esophagus	82.91	NA	NA	25.79	22.88	4.16	090
43124		A	Removal of esophagus	68.83	NA	NA	24.24	21.47	3.74	090
43130		A	Removal of esophagus pouch	12.41	NA	NA	6.43	6.72	1.16	090
43135		A	Removal of esophagus pouch	26.09	NA	NA	9.85	9.42	2.34	090
43200		A	Esophagus endoscopy	1.59	3.71	3.82	0.98	1.00	0.13	000
43201		A	Esoph scope w/submucous inj	2.09	5.69	5.43	1.21	1.18	0.15	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.17	5.27	0.99	0.97	0.15	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.01	1.89	0.30	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	2.03	1.90	0.28	000
43215		A	Esophagus endoscopy	2.60	NA	NA	1.28	1.26	0.22	000
43216		A	Esophagus endoscopy/lesion	2.40	3.07	2.57	1.25	1.21	0.20	000
43217		A	Esophagus endoscopy	2.90	6.52	6.63	1.37	1.33	0.26	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.56	1.51	0.24	000
43220		A	Esoph endoscopy, dilation	2.10	NA	NA	1.13	1.09	0.17	000
43226		A	Esoph endoscopy, dilation	2.34	NA	NA	1.28	1.22	0.19	000
43227		A	Esoph endoscopy, repair	3.59	NA	NA	1.79	1.71	0.28	000
43228		A	Esoph endoscopy, ablation	3.76	NA	NA	1.96	1.86	0.34	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	1.75	1.64	0.23	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.29	2.17	0.34	000
43234		A	Upper GI endoscopy, exam	2.01	4.99	5.08	1.02	0.98	0.17	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.32	5.28	1.36	1.28	0.19	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.74	6.66	1.66	1.55	0.21	000
43237		A	Endoscopic us exam, esoph	3.98	NA	NA	2.14	2.00	0.43	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.63	2.46	0.43	000
43239		A	Upper GI endoscopy, biopsy	2.87	6.09	6.00	1.57	1.48	0.22	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.39	3.20	0.56	000
43241		A	Upper GI endoscopy with tube	2.59	NA	NA	1.43	1.35	0.21	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	3.71	3.47	0.53	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.38	2.23	0.33	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	NA	2.66	2.49	0.37	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	1.63	1.55	0.26	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.12	2.01	0.34	000
43247		A	Operative upper GI endoscopy	3.38	NA	NA	1.79	1.69	0.27	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	1.78	1.66	0.23	000
43249		A	Esoph endoscopy, dilation	2.90	NA	NA	1.63	1.52	0.22	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	NA	1.61	1.53	0.26	000
43251		A	Operative upper GI endoscopy	3.69	NA	NA	1.94	1.83	0.29	000
43255		A	Operative upper GI endoscopy	4.81	NA	NA	2.54	2.38	0.35	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.24	2.11	0.32	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	2.55	2.46	0.36	000

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43258		A	Operative upper GI endoscopy	4.54	NA	NA	2.38	2.23	0.33	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	2.72	2.54	0.35	000
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	3.08	2.89	0.43	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.23	3.02	0.46	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	3.76	3.52	0.54	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	3.74	3.50	0.54	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	4.48	4.19	0.65	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	5.00	4.67	0.73	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	3.68	3.46	0.54	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	3.91	3.66	0.54	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	4.14	3.88	0.60	000
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	3.75	3.51	0.54	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	3.71	3.48	0.54	000
43280		A	Laparoscopy, fundoplasty	18.00	NA	NA	6.66	6.82	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	5.43	5.67	1.12	090
43305		A	Repair esophagus and fistula	17.98	NA	NA	8.28	8.89	1.54	090
43310		A	Repair of esophagus	26.18	NA	NA	9.98	10.27	3.61	090
43312		A	Repair esophagus and fistula	29.23	NA	NA	10.65	10.97	4.01	090
43313		A	Esophagoplasty congenital	48.17	NA	NA	16.01	16.73	5.47	090
43314		A	Tracheo-esophagoplasty cong	53.15	NA	NA	21.12	20.66	6.65	090
43320		A	Fuse esophagus & stomach	23.18	NA	NA	9.16	9.18	2.74	090
43324		A	Revise esophagus & stomach	22.86	NA	NA	8.37	8.48	2.76	090
43325		A	Revise esophagus & stomach	22.47	NA	NA	8.34	8.46	2.60	090
43326		A	Revise esophagus & stomach	22.15	NA	NA	9.16	9.21	2.85	090
43330		A	Repair of esophagus	22.06	NA	NA	8.11	8.22	2.63	090
43331		A	Repair of esophagus	22.93	NA	NA	9.76	9.78	2.94	090
43340		A	Fuse esophagus & intestine	22.86	NA	NA	8.73	8.80	2.46	090
43341		A	Fuse esophagus & intestine	24.10	NA	NA	10.67	10.52	2.92	090
43350		A	Surgical opening, esophagus	19.31	NA	NA	8.07	8.17	1.42	090
43351		A	Surgical opening, esophagus	21.87	NA	NA	9.68	9.72	2.47	090
43352		A	Surgical opening, esophagus	17.68	NA	NA	8.11	8.19	2.06	090
43360		A	Gastrointestinal repair	39.90	NA	NA	15.07	15.09	4.97	090
43361		A	Gastrointestinal repair	45.50	NA	NA	16.47	16.60	4.50	090
43400		A	Ligate esophagus veins	25.47	NA	NA	15.17	13.75	1.96	090
43401		A	Esophagus surgery for veins	26.36	NA	NA	9.46	9.48	3.05	090
43405		A	Ligate/staple esophagus	24.55	NA	NA	10.58	10.34	2.84	090
43410		A	Repair esophagus wound	16.28	NA	NA	7.78	7.75	1.72	090
43415		A	Repair esophagus wound	28.70	NA	NA	11.76	11.76	3.53	090
43420		A	Repair esophagus opening	16.65	NA	NA	7.63	7.58	1.43	090
43425		A	Repair esophagus opening	24.91	NA	NA	11.06	10.80	3.03	090
43450		A	Dilate esophagus	1.38	2.69	2.68	0.93	0.87	0.11	000
43453		A	Dilate esophagus	1.51	6.33	6.27	1.01	0.94	0.11	000
43456		A	Dilate esophagus	2.57	13.00	13.20	1.44	1.36	0.20	000

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43458		A	Dilate esophagus	3.06	6.96	6.89	1.60	1.52	0.24	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	1.84	1.76	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	5.25	5.18	1.45	090
43501		A	Surgical repair of stomach	22.47	NA	NA	8.10	8.16	2.65	090
43502		A	Surgical repair of stomach	25.56	NA	NA	8.89	9.04	3.10	090
43510		A	Surgical opening of stomach	15.01	NA	NA	7.65	7.39	1.48	090
43520		A	Incision of pyloric muscle	11.21	NA	NA	4.80	4.92	1.36	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.81	0.77	0.14	000
43605		A	Biopsy of stomach	13.64	NA	NA	5.32	5.32	1.58	090
43610		A	Excision of stomach lesion	16.26	NA	NA	6.04	6.08	1.94	090
43611		A	Excision of stomach lesion	20.25	NA	NA	7.56	7.57	2.36	090
43620		A	Removal of stomach	33.91	NA	NA	11.10	11.29	3.96	090
43621		A	Removal of stomach	39.40	NA	NA	12.44	12.33	4.04	090
43622		A	Removal of stomach	39.90	NA	NA	12.40	12.46	4.30	090
43631		A	Removal of stomach, partial	24.38	NA	NA	8.60	8.75	2.99	090
43632		A	Removal of stomach, partial	35.01	NA	NA	11.27	10.75	2.99	090
43633		A	Removal of stomach, partial	33.01	NA	NA	10.76	10.41	3.06	090
43634		A	Removal of stomach, partial	36.51	NA	NA	11.92	11.47	3.33	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.52	0.57	0.27	ZZZ
43640		A	Vagotomy & pylorus repair	19.43	NA	NA	7.33	7.32	2.26	090
43641		A	Vagotomy & pylorus repair	19.68	NA	NA	7.28	7.31	2.25	090
43644		A	Lap gastric bypass/roux-en-y	29.24	NA	NA	10.17	10.44	3.16	090
43645		A	Lap gastr bypass incl smll i	31.37	NA	NA	10.60	10.97	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	4.71	4.72	1.33	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	5.07	5.24	1.55	090
43653		A	Laparoscopy, gastrostomy	8.38	NA	NA	4.48	4.41	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	0.27	0.27	0.02	000
43760		A	Change gastrostomy tube	0.90	9.91	7.96	0.33	0.36	0.09	000
43761		A	Reposition gastrostomy tube	2.01	1.08	1.10	0.74	0.72	0.13	000
43770		A	Lap place gastr adj device	17.85	NA	NA	7.46	7.53	2.19	090
43771		A	Lap revise gastr adj device	20.64	NA	NA	8.12	8.25	2.55	090
43772		A	Lap rmvl gastr adj device	15.62	NA	NA	6.16	6.23	1.93	090
43773		A	Lap replace gastr adj device	20.64	NA	NA	8.16	8.28	2.56	090
43774		A	Lap rmvl gastr adj all parts	15.66	NA	NA	6.16	6.27	1.85	090
43800		A	Reconstruction of pylorus	15.35	NA	NA	5.84	5.86	1.82	090
43810		A	Fusion of stomach and bowel	16.80	NA	NA	6.20	6.20	1.94	090
43820		A	Fusion of stomach and bowel	22.40	NA	NA	8.11	7.69	2.04	090
43825		A	Fusion of stomach and bowel	21.63	NA	NA	7.92	7.95	2.54	090
43830		A	Place gastrostomy tube	10.75	NA	NA	5.19	5.11	1.25	090

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43831		A	Place gastrostomy tube	8.38	NA	NA	5.09	4.95	1.03	090
43832		A	Place gastrostomy tube	17.26	NA	NA	7.14	7.07	1.98	090
43840		A	Repair of stomach lesion	22.70	NA	NA	8.18	7.83	2.06	090
43842		N	V-band gastroplasty	20.90	NA	NA	8.87	8.61	2.45	090
43843		A	Gastroplasty w/o v-band	21.08	NA	NA	7.79	7.79	2.46	090
43845		A	Gastroplasty duodenal switch	33.12	NA	NA	11.49	11.32	4.06	090
43846		A	Gastric bypass for obesity	27.23	NA	NA	9.90	9.95	3.19	090
43847		A	Gastric bypass incl small i	30.10	NA	NA	10.33	10.48	3.56	090
43848		A	Revision gastroplasty	32.57	NA	NA	11.27	11.42	3.88	090
43850		A	Revise stomach-bowel fusion	27.45	NA	NA	9.22	9.38	3.28	090
43855		A	Revise stomach-bowel fusion	28.56	NA	NA	9.72	9.88	3.47	090
43860		A	Revise stomach-bowel fusion	27.76	NA	NA	9.53	9.65	3.31	090
43865		A	Revise stomach-bowel fusion	28.92	NA	NA	9.70	9.92	3.51	090
43870		A	Repair stomach opening	11.36	NA	NA	4.89	4.80	1.27	090
43880		A	Repair stomach-bowel fistula	27.05	NA	NA	9.31	9.47	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	3.47	3.39	0.25	090
43887		A	Remove gastric port, open	4.24	NA	NA	3.09	3.02	0.51	090
43888		A	Change gastric port, open	6.34	NA	NA	3.92	3.88	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	6.60	6.64	2.15	090
44010		A	Incision of small bowel	14.18	NA	NA	5.57	5.55	1.64	090
44015		A	Insert needle cath bowel	2.62	NA	NA	0.69	0.74	0.35	ZZZ
44020		A	Explore small intestine	16.14	NA	NA	6.02	6.01	1.86	090
44021		A	Decompress small bowel	16.23	NA	NA	6.25	6.19	1.87	090
44025		A	Incision of large bowel	16.43	NA	NA	6.12	6.11	1.90	090
44050		A	Reduce bowel obstruction	15.44	NA	NA	5.83	5.87	1.86	090
44055		A	Correct malrotation of bowel	25.53	NA	NA	8.54	8.59	2.91	090
44100		A	Biopsy of bowel	2.01	NA	NA	0.93	0.88	0.17	000
44110		A	Excise intestine lesion(s)	13.96	NA	NA	5.47	5.41	1.55	090
44111		A	Excision of bowel lesion(s)	16.44	NA	NA	6.04	6.06	1.87	090
44120		A	Removal of small intestine	20.74	NA	NA	7.16	7.14	2.25	090
44121		A	Removal of small intestine	4.44	NA	NA	1.12	1.22	0.58	ZZZ
44125		A	Removal of small intestine	19.93	NA	NA	7.04	7.10	2.27	090
44126		A	Enterectomy w/o taper, cong	42.02	NA	NA	13.61	13.75	4.69	090
44127		A	Enterectomy w/taper, cong	49.09	NA	NA	15.56	15.62	5.77	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.13	1.23	0.61	ZZZ
44130		A	Bowel to bowel fusion	21.98	NA	NA	7.98	7.54	1.88	090
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	0.56	0.61	0.28	ZZZ
44140		A	Partial removal of colon	22.46	NA	NA	8.09	8.24	2.71	090
44141		A	Partial removal of colon	29.75	NA	NA	11.83	11.39	2.53	090
44143		A	Partial removal of colon	27.63	NA	NA	10.29	10.40	3.05	090

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44144		A	Partial removal of colon	29.75	NA	NA	10.63	10.39	2.86	090
44145		A	Partial removal of colon	28.45	NA	NA	9.49	9.83	3.29	090
44146		A	Partial removal of colon	35.14	NA	NA	13.35	13.24	3.41	090
44147		A	Partial removal of colon	33.56	NA	NA	10.81	10.29	2.56	090
44150		A	Removal of colon	29.99	NA	NA	12.60	12.47	3.04	090
44151		A	Removal of colon/ileostomy	34.73	NA	NA	13.89	13.78	3.49	090
44155		A	Removal of colon/ileostomy	34.23	NA	NA	13.37	13.37	3.28	090
44156		A	Removal of colon/ileostomy	37.23	NA	NA	14.81	14.88	3.95	090
44157		A	Colectomy w/ileoanal anast	35.49	NA	NA	13.79	13.79	3.93	090
44158		A	Colectomy w/neo-rectum pouch	36.49	NA	NA	13.94	13.94	4.06	090
44160		A	Removal of colon	20.78	NA	NA	7.53	7.59	2.37	090
44180		A	Lap, enterolysis	15.19	NA	NA	5.81	5.93	1.86	090
44186		A	Lap, jejunostomy	10.30	NA	NA	4.58	4.63	1.27	090
44187		A	Lap, ileo/jejuno-stomy	17.27	NA	NA	7.95	8.04	1.96	090
44188		A	Lap, colostomy	19.20	NA	NA	8.71	8.76	2.24	090
44202		A	Lap, enterectomy	23.26	NA	NA	8.31	8.48	2.85	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.10	1.20	0.57	ZZZ
44204		A	Laparo partial colectomy	26.29	NA	NA	8.90	9.17	3.11	090
44205		A	Lap colectomy part w/ileum	22.86	NA	NA	7.82	8.08	2.75	090
44206		A	Lap part colectomy w/stoma	29.63	NA	NA	10.45	10.66	3.46	090
44207		A	L colectomy/coloproctostomy	31.79	NA	NA	10.11	10.46	3.67	090
44208		A	L colectomy/coloproctostomy	33.86	NA	NA	11.89	12.22	3.88	090
44210		A	Laparo total proctocolectomy	29.88	NA	NA	11.17	11.36	3.42	090
44211		A	Lap colectomy w/proctectomy	36.87	NA	NA	13.41	13.74	4.17	090
44212		A	Laparo total proctocolectomy	34.37	NA	NA	13.04	13.22	3.78	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	0.86	0.95	0.44	ZZZ
44227		A	Lap, close enterostomy	28.49	NA	NA	9.63	9.89	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	5.56	5.55	1.60	090
44310		A	Ileostomy/jejunostomy	17.49	NA	NA	6.42	6.49	1.99	090
44312		A	Revision of ileostomy	9.33	NA	NA	4.64	4.48	0.92	090
44314		A	Revision of ileostomy	16.61	NA	NA	6.79	6.74	1.75	090
44316		A	Devise bowel pouch	23.46	NA	NA	8.42	8.46	2.38	090
44320		A	Colostomy	19.75	NA	NA	7.61	7.63	2.26	090
44322		A	Colostomy with biopsies	13.15	NA	NA	9.11	8.98	1.54	090
44340		A	Revision of colostomy	9.12	NA	NA	4.95	4.78	0.99	090
44345		A	Revision of colostomy	17.06	NA	NA	6.93	6.93	1.97	090
44346		A	Revision of colostomy	19.47	NA	NA	7.51	7.49	2.13	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.52	1.41	0.19	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.65	1.54	0.21	000
44363		A	Small bowel endoscopy	3.49	NA	NA	1.81	1.70	0.27	000
44364		A	Small bowel endoscopy	3.73	NA	NA	2.03	1.89	0.27	000
44365		A	Small bowel endoscopy	3.31	NA	NA	1.81	1.70	0.24	000

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44366		A	Small bowel endoscopy	4.40	NA	NA	2.39	2.22	0.32	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.43	2.26	0.33	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	2.66	2.49	0.37	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.11	2.02	0.35	000
44373		A	Small bowel endoscopy	3.49	NA	NA	1.81	1.71	0.27	000
44376		A	Small bowel endoscopy	5.25	NA	NA	2.55	2.42	0.42	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	2.82	2.65	0.40	000
44378		A	Small bowel endoscopy	7.12	NA	NA	3.57	3.36	0.52	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	3.82	3.59	0.62	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.75	0.70	0.08	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.88	0.82	0.12	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.61	1.52	0.21	000
44385		A	Endoscopy of bowel pouch	1.82	4.83	4.46	0.86	0.83	0.15	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.69	6.69	1.03	0.99	0.20	000
44388		A	Colonoscopy	2.82	6.16	5.89	1.36	1.31	0.26	000
44389		A	Colonoscopy with biopsy	3.13	7.15	7.02	1.58	1.50	0.27	000
44390		A	Colonoscopy for foreign body	3.82	8.06	7.83	1.79	1.71	0.32	000
44391		A	Colonoscopy for bleeding	4.31	8.84	8.82	2.16	2.04	0.34	000
44392		A	Colonoscopy & polypectomy	3.81	7.28	7.12	1.67	1.62	0.34	000
44393		A	Colonoscopy, lesion removal	4.83	8.15	7.84	2.18	2.10	0.42	000
44394		A	Colonoscopy w/snare	4.42	8.56	8.38	2.10	2.01	0.38	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.41	2.26	0.39	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.18	0.17	0.03	000
44602		A	Suture, small intestine	24.64	NA	NA	7.54	7.26	2.12	090
44603		A	Suture, small intestine	28.03	NA	NA	8.95	8.54	2.42	090
44604		A	Suture, large intestine	18.06	NA	NA	6.07	6.17	2.12	090
44605		A	Repair of bowel lesion	22.00	NA	NA	7.82	7.97	2.52	090
44615		A	Intestinal stricturoplasty	18.08	NA	NA	6.58	6.61	2.07	090
44620		A	Repair bowel opening	14.35	NA	NA	5.50	5.46	1.51	090
44625		A	Repair bowel opening	17.20	NA	NA	6.16	6.21	1.86	090
44626		A	Repair bowel opening	27.82	NA	NA	8.92	9.15	3.27	090
44640		A	Repair bowel-skin fistula	24.12	NA	NA	8.05	8.19	2.78	090
44650		A	Repair bowel fistula	25.04	NA	NA	8.39	8.52	2.93	090
44660		A	Repair bowel-bladder fistula	23.83	NA	NA	9.32	9.09	2.14	090
44661		A	Repair bowel-bladder fistula	27.27	NA	NA	9.36	9.42	2.81	090
44680		A	Surgical revision, intestine	17.88	NA	NA	6.55	6.53	2.00	090
44700		A	Suspend bowel w/prosthesis	17.40	NA	NA	6.14	6.28	1.84	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	0.76	0.84	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	1.59	1.62	0.37	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	.	0.60	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	5.48	5.46	1.47	090
44820		A	Excision of mesentery lesion	13.63	NA	NA	5.59	5.57	1.59	090

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44850		A	Repair of mesentery	12.03	NA	NA	4.90	4.93	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	5.08	4.99	1.33	090
44901		A	Drain app abscess, percut	3.37	20.20	22.16	1.21	1.19	0.22	000
44950		A	Appendectomy	10.52	NA	NA	4.05	4.12	1.31	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.40	0.44	0.20	ZZZ
44960		A	Appendectomy	14.39	NA	NA	5.42	5.41	1.63	090
44970		A	Laparoscopy, appendectomy	9.35	NA	NA	4.20	4.18	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	3.62	3.46	0.52	090
45005		A	Drainage of rectal abscess	2.00	3.99	4.01	1.59	1.59	0.25	010
45020		A	Drainage of rectal abscess	8.43	NA	NA	4.58	4.25	0.55	090
45100		A	Biopsy of rectum	3.96	NA	NA	2.83	2.72	0.44	090
45108		A	Removal of anorectal lesion	5.04	NA	NA	3.12	3.03	0.59	090
45110		A	Removal of rectum	30.57	NA	NA	11.84	11.99	3.36	090
45111		A	Partial removal of rectum	17.89	NA	NA	7.00	7.05	2.07	090
45112		A	Removal of rectum	33.05	NA	NA	10.39	10.74	3.43	090
45113		A	Partial proctectomy	33.09	NA	NA	11.62	11.88	3.49	090
45114		A	Partial removal of rectum	30.63	NA	NA	10.18	10.36	3.36	090
45116		A	Partial removal of rectum	27.56	NA	NA	9.05	9.31	2.88	090
45119		A	Remove rectum w/reservoir	33.35	NA	NA	11.52	11.77	3.36	090
45120		A	Removal of rectum	26.25	NA	NA	9.54	9.70	2.90	090
45121		A	Removal of rectum and colon	28.93	NA	NA	10.07	10.34	3.25	090
45123		A	Partial proctectomy	18.70	NA	NA	6.94	6.93	1.86	090
45126		A	Pelvic exenteration	48.89	NA	NA	17.71	18.11	4.33	090
45130		A	Excision of rectal prolapse	18.37	NA	NA	6.66	6.69	1.80	090
45135		A	Excision of rectal prolapse	22.15	NA	NA	8.47	8.47	2.36	090
45136		A	Excise ileoanal reservior	30.63	NA	NA	11.86	12.04	2.82	090
45150		A	Excision of rectal stricture	5.77	NA	NA	3.58	3.43	0.61	090
45160		A	Excision of rectal lesion	16.17	NA	NA	6.64	6.65	1.68	090
45170		A	Excision of rectal lesion	12.48	NA	NA	5.36	5.33	1.35	090
45190		A	Destruction, rectal tumor	10.29	NA	NA	5.50	5.28	1.13	090
45300		A	Proctosigmoidoscopy dx	0.80	1.96	1.86	0.45	0.41	0.04	000
45303		A	Proctosigmoidoscopy dilate	1.50	19.88	19.60	0.65	0.57	0.05	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.21	3.07	0.60	0.57	0.11	000
45307		A	Proctosigmoidoscopy fb	1.70	3.12	3.10	0.67	0.62	0.11	000
45308		A	Proctosigmoidoscopy removal	1.40	3.35	3.01	0.62	0.58	0.09	000
45309		A	Proctosigmoidoscopy removal	1.50	3.59	3.40	0.69	0.73	0.22	000
45315		A	Proctosigmoidoscopy removal	1.80	3.75	3.53	0.84	0.79	0.15	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.33	3.11	0.75	0.73	0.15	000
45320		A	Proctosigmoidoscopy ablate	1.78	3.56	3.40	0.85	0.82	0.16	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	0.84	0.77	0.13	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.02	0.94	0.16	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.56	2.49	0.63	0.60	0.08	000

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45331		A	Sigmoidoscopy and biopsy	1.15	3.31	3.25	0.80	0.75	0.09	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.60	5.45	1.01	0.96	0.16	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.70	5.49	0.99	0.94	0.15	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.53	1.44	0.20	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.33	4.80	0.89	0.84	0.11	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.25	1.18	0.21	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.92	5.75	1.29	1.22	0.19	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.75	5.18	1.65	1.56	0.26	000
45340		A	Sig w/balloon dilation	1.89	10.42	9.36	1.05	1.00	0.15	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.49	1.38	0.19	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.18	2.02	0.30	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.58	1.48	0.23	000
45355		A	Surgical colonoscopy	3.51	NA	NA	1.52	1.49	0.36	000
45378		A	Diagnostic colonoscopy	3.69	6.42	6.36	1.83	1.74	0.30	000
45378	53	A	Diagnostic colonoscopy	0.96	2.56	2.49	0.63	0.60	0.08	000
45379		A	Colonoscopy w/fb removal	4.68	8.20	8.08	2.21	2.11	0.39	000
45380		A	Colonoscopy and biopsy	4.43	7.80	7.66	2.25	2.13	0.35	000
45381		A	Colonoscopy, submucous inj	4.19	7.76	7.60	2.17	2.04	0.30	000
45382		A	Colonoscopy/control bleeding	5.68	10.39	10.29	2.90	2.72	0.41	000
45383		A	Lesion removal colonoscopy	5.86	8.57	8.42	2.64	2.54	0.48	000
45384		A	Lesion remove colonoscopy	4.69	7.21	7.12	2.19	2.10	0.38	000
45385		A	Lesion removal colonoscopy	5.30	8.43	8.28	2.61	2.47	0.42	000
45386		A	Colonoscopy dilate stricture	4.57	12.40	12.41	2.18	2.08	0.39	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	2.96	2.81	0.48	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	2.57	2.42	0.42	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.25	3.06	0.42	000
45395		A	Lap, removal of rectum	32.79	NA	NA	13.08	13.24	3.63	090
45397		A	Lap, remove rectum w/pouch	36.29	NA	NA	13.47	13.68	3.67	090
45400		A	Laparoscopic proc	19.31	NA	NA	7.08	7.28	2.03	090
45402		A	Lap proctopexy w/sig resect	26.38	NA	NA	8.76	9.07	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	4.43	4.21	0.75	090
45505		A	Repair of rectum	8.20	NA	NA	5.09	4.78	0.86	090
45520		A	Treatment of rectal prolapse	0.55	2.87	2.56	0.38	0.38	0.05	000
45540		A	Correct rectal prolapse	18.02	NA	NA	6.40	6.51	1.85	090
45541		A	Correct rectal prolapse	14.72	NA	NA	6.58	6.43	1.55	090
45550		A	Repair rectum/remove sigmoid	24.67	NA	NA	8.95	9.02	2.62	090
45560		A	Repair of rectocele	11.42	NA	NA	5.51	5.40	1.13	090
45562		A	Exploration/repair of rectum	17.82	NA	NA	8.14	7.85	1.84	090
45563		A	Exploration/repair of rectum	26.22	NA	NA	10.72	10.68	3.11	090
45800		A	Repair rect/bladder fistula	20.18	NA	NA	9.20	8.76	1.86	090
45805		A	Repair fistula w/colostomy	23.19	NA	NA	9.60	9.59	2.03	090
45820		A	Repair rectourethral fistula	20.24	NA	NA	8.92	8.60	1.58	090
45825		A	Repair fistula w/colostomy	24.01	NA	NA	10.71	10.50	2.32	090

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45900		A	Reduction of rectal prolapse	2.96	NA	NA	1.67	1.63	0.30	010
45905		A	Dilation of anal sphincter	2.32	NA	NA	1.61	1.56	0.27	010
45910		A	Dilation of rectal narrowing	2.82	NA	NA	1.84	1.79	0.30	010
45915		A	Remove rectal obstruction	3.16	4.22	4.25	2.03	2.04	0.30	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	0.73	0.75	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	3.18	2.97	2.30	2.19	0.31	010
46030		A	Removal of rectal marker	1.24	1.89	1.75	0.81	0.78	0.14	010
46040		A	Incision of rectal abscess	5.26	6.55	6.29	3.99	3.89	0.62	090
46045		A	Incision of rectal abscess	5.79	NA	NA	3.94	3.68	0.54	090
46050		A	Incision of anal abscess	1.21	3.19	3.03	0.98	0.94	0.14	010
46060		A	Incision of rectal abscess	6.24	NA	NA	4.43	4.14	0.67	090
46070		A	Incision of anal septum	2.74	NA	NA	2.83	2.58	0.36	090
46080		A	Incision of anal sphincter	2.50	3.07	2.90	1.12	1.13	0.30	010
46083		A	Incise external hemorrhoid	1.42	2.38	2.42	0.96	0.95	0.15	010
46200		A	Removal of anal fissure	3.48	6.28	5.68	3.72	3.51	0.39	090
46210		A	Removal of anal crypt	2.73	5.93	5.73	3.36	3.18	0.31	090
46211		A	Removal of anal crypts	4.31	7.74	7.17	4.58	4.31	0.48	090
46220		A	Removal of anal tag	1.58	3.03	2.85	1.10	1.07	0.17	010
46221		A	Ligation of hemorrhoid(s)	2.31	3.74	3.47	2.00	1.94	0.23	010
46230		A	Removal of anal tags	2.59	3.53	3.42	1.34	1.33	0.30	010
46250		A	Hemorrhoidectomy	4.17	6.02	5.85	2.86	2.80	0.48	090
46255		A	Hemorrhoidectomy	4.88	6.37	6.25	3.08	3.02	0.58	090
46257		A	Remove hemorrhoids & fissure	5.68	NA	NA	3.82	3.59	0.64	090
46258		A	Remove hemorrhoids & fistula	6.28	NA	NA	4.05	3.86	0.68	090
46260		A	Hemorrhoidectomy	6.65	NA	NA	4.06	3.85	0.76	090
46261		A	Remove hemorrhoids & fissure	7.63	NA	NA	4.29	4.13	0.79	090
46262		A	Remove hemorrhoids & fistula	7.80	NA	NA	4.73	4.48	0.83	090
46270		A	Removal of anal fistula	4.81	6.38	6.04	3.91	3.64	0.46	090
46275		A	Removal of anal fistula	5.31	6.63	6.13	3.97	3.72	0.52	090
46280		A	Removal of anal fistula	6.28	NA	NA	4.27	4.02	0.66	090
46285		A	Removal of anal fistula	5.31	6.54	5.85	3.95	3.65	0.44	090
46288		A	Repair anal fistula	7.68	NA	NA	4.72	4.46	0.79	090
46320		A	Removal of hemorrhoid clot	1.62	2.42	2.35	0.89	0.88	0.18	010
46500		A	Injection into hemorrhoid(s)	1.64	3.62	3.25	1.25	1.23	0.16	010
46505		A	Chemodenervation anal musc	3.13	3.30	3.24	2.29	2.21	0.14	010
46600		A	Diagnostic anoscopy	0.55	1.38	1.43	0.38	0.37	0.05	000
46604		A	Anoscopy and dilation	1.03	12.33	11.54	0.50	0.53	0.12	000
46606		A	Anoscopy and biopsy	1.20	3.94	3.90	0.59	0.55	0.09	000
46608		A	Anoscopy, remove for body	1.30	3.74	3.91	0.57	0.59	0.16	000
46610		A	Anoscopy, remove lesion	1.28	3.84	3.89	0.60	0.60	0.15	000
46611		A	Anoscopy	1.30	2.50	2.71	0.56	0.62	0.19	000
46612		A	Anoscopy, remove lesions	1.50	4.43	4.62	0.66	0.74	0.28	000
46614		A	Anoscopy, control bleeding	1.00	1.93	2.03	0.51	0.60	0.20	000

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46615		A	Anoscopy	1.50	1.73	1.92	0.64	0.75	0.33	000
46700		A	Repair of anal stricture	9.68	NA	NA	5.16	4.92	0.94	090
46705		A	Repair of anal stricture	7.32	NA	NA	5.04	4.70	0.91	090
46706		A	Repr of anal fistula w/glue	2.41	NA	NA	1.51	1.44	0.28	010
46710		A	Repr per/vag pouch sngl proc	17.01	NA	NA	7.45	7.53	1.38	090
46712		A	Repr per/vag pouch dbl proc	36.32	NA	NA	13.61	13.98	3.67	090
46715		A	Rep perf anoper fistu	7.54	NA	NA	4.52	4.29	0.92	090
46716		A	Rep perf anoper/vestib fistu	17.14	NA	NA	13.03	11.78	1.58	090
46730		A	Construction of absent anus	30.17	NA	NA	14.88	14.18	2.47	090
46735		A	Construction of absent anus	35.66	NA	NA	16.63	15.88	3.21	090
46740		A	Construction of absent anus	33.42	NA	NA	14.54	14.22	2.42	090
46742		A	Repair of imperforated anus	39.66	NA	NA	16.05	16.40	3.20	090
46744		A	Repair of cloacal anomaly	58.46	NA	NA	19.82	20.17	6.40	090
46746		A	Repair of cloacal anomaly	64.93	NA	NA	26.09	25.88	7.70	090
46748		A	Repair of cloacal anomaly	70.91	NA	NA	28.00	26.94	3.37	090
46750		A	Repair of anal sphincter	12.02	NA	NA	5.83	5.64	1.10	090
46751		A	Repair of anal sphincter	9.19	NA	NA	5.56	5.53	0.94	090
46753		A	Reconstruction of anus	8.81	NA	NA	4.68	4.47	0.94	090
46754		A	Removal of suture from anus	2.88	3.77	3.73	2.30	2.14	0.19	010
46760		A	Repair of anal sphincter	17.21	NA	NA	7.98	7.77	1.59	090
46761		A	Repair of anal sphincter	15.16	NA	NA	6.48	6.37	1.43	090
46762		A	Implant artificial sphincter	14.66	NA	NA	7.01	6.64	1.24	090
46900		A	Destruction, anal lesion(s)	1.91	3.71	3.43	1.33	1.32	0.17	010
46910		A	Destruction, anal lesion(s)	1.88	3.93	3.68	1.22	1.18	0.19	010
46916		A	Cryosurgery, anal lesion(s)	1.88	3.84	3.67	1.61	1.56	0.11	010
46917		A	Laser surgery, anal lesions	1.88	8.85	8.93	1.23	1.20	0.21	010
46922		A	Excision of anal lesion(s)	1.88	4.13	3.92	1.20	1.17	0.22	010
46924		A	Destruction, anal lesion(s)	2.78	9.66	9.43	1.53	1.49	0.26	010
46934		A	Destruction of hemorrhoids	3.79	5.76	5.60	2.97	2.97	0.32	090
46935		A	Destruction of hemorrhoids	2.44	3.83	3.74	1.12	1.14	0.23	010
46936		A	Destruction of hemorrhoids	3.70	6.43	6.04	2.77	2.70	0.34	090
46937		A	Cryotherapy of rectal lesion	2.70	3.56	3.36	1.56	1.48	0.14	010
46938		A	Cryotherapy of rectal lesion	4.70	6.06	5.54	3.84	3.65	0.58	090
46940		A	Treatment of anal fissure	2.33	2.84	2.63	1.05	1.06	0.23	010
46942		A	Treatment of anal fissure	2.05	2.80	2.56	0.96	0.97	0.19	010
46945		A	Ligation of hemorrhoids	2.13	4.78	4.40	2.96	2.84	0.19	090
46946		A	Ligation of hemorrhoids	2.60	4.65	4.42	2.66	2.59	0.27	090
46947		A	Hemorrhoidopexy by stapling	5.49	NA	NA	3.11	3.01	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	7.76	6.59	0.72	0.70	0.12	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.49	0.53	0.25	ZZZ
47010		A	Open drainage, liver lesion	19.27	NA	NA	8.30	8.33	1.81	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.38	1.34	0.22	000
47015		A	Inject/aspirate liver cyst	18.37	NA	NA	7.80	7.73	1.84	090

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47100		A	Wedge biopsy of liver	12.78	NA	NA	6.33	6.27	1.53	090
47120		A	Partial removal of liver	38.82	NA	NA	14.09	14.37	4.66	090
47122		A	Extensive removal of liver	59.35	NA	NA	18.82	19.50	7.21	090
47125		A	Partial removal of liver	52.91	NA	NA	17.11	17.73	6.47	090
47130		A	Partial removal of liver	57.06	NA	NA	18.17	18.89	6.96	090
47135		R	Transplantation of liver	83.29	NA	NA	27.77	28.74	9.96	090
47136		R	Transplantation of liver	70.39	NA	NA	24.58	25.22	8.44	090
47140		A	Partial removal, donor liver	59.22	NA	NA	21.65	21.83	5.19	090
47141		A	Partial removal, donor liver	71.27	NA	NA	25.38	25.79	5.19	090
47142		A	Partial removal, donor liver	79.21	NA	NA	27.40	27.95	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	1.52	1.66	0.83	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	1.78	1.93	0.97	XXX
47300		A	Surgery for liver lesion	18.01	NA	NA	7.66	7.56	1.99	090
47350		A	Repair liver wound	22.36	NA	NA	8.91	8.91	2.59	090
47360		A	Repair liver wound	31.18	NA	NA	11.35	11.42	3.38	090
47361		A	Repair liver wound	52.47	NA	NA	16.88	17.31	5.87	090
47362		A	Repair liver wound	23.41	NA	NA	9.29	9.16	2.51	090
47370		A	Laparo ablate liver tumor rf	20.67	NA	NA	7.65	7.78	2.56	090
47371		A	Laparo ablate liver cryosurg	20.67	NA	NA	8.31	8.28	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	8.72	8.89	2.87	090
47381		A	Open ablate liver tumor cryo	24.72	NA	NA	9.16	9.28	2.85	090
47382		A	Percut ablate liver rf	15.19	NA	NA	6.49	6.39	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	12.64	12.85	3.08	090
47420		A	Incision of bile duct	21.92	NA	NA	8.57	8.63	2.63	090
47425		A	Incision of bile duct	22.20	NA	NA	8.62	8.67	2.62	090
47460		A	Incise bile duct sphincter	20.41	NA	NA	9.14	8.95	2.21	090
47480		A	Incision of gallbladder	13.12	NA	NA	6.68	6.49	1.42	090
47490		A	Incision of gallbladder	8.05	NA	NA	5.46	5.49	0.43	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.74	0.72	0.12	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.29	0.28	0.04	000
47510		A	Insert catheter, bile duct	7.94	NA	NA	4.77	4.83	0.46	090
47511		A	Insert bile duct drain	10.74	NA	NA	5.27	5.23	0.62	090
47525		A	Change bile duct catheter	5.55	15.24	15.22	2.82	2.82	0.33	010
47530		A	Revise/reinsert bile tube	5.96	31.22	31.90	3.59	3.62	0.37	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	0.80	0.86	0.40	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.63	2.57	0.42	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.35	2.28	0.37	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.32	3.33	0.96	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.89	2.79	0.45	000

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47556		A	Biliary endoscopy thru skin	8.55	NA	NA	3.26	3.15	0.50	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	1.28	1.38	0.65	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	1.57	1.66	0.66	000
47562		A	Laparoscopic cholecystectomy	11.63	NA	NA	5.28	5.21	1.46	090
47563		A	Laparo cholecystectomy/graph	12.03	NA	NA	5.08	5.14	1.58	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	NA	5.42	5.56	1.89	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	5.08	5.16	1.65	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.35	NA	NA	7.23	6.96	1.80	090
47605		A	Removal of gallbladder	15.90	NA	NA	6.38	6.41	1.95	090
47610		A	Removal of gallbladder	20.84	NA	NA	7.67	7.74	2.49	090
47612		A	Removal of gallbladder	21.13	NA	NA	7.72	7.77	2.48	090
47620		A	Removal of gallbladder	22.99	NA	NA	8.28	8.34	2.74	090
47630		A	Remove bile duct stone	9.57	NA	NA	4.88	4.89	0.65	090
47700		A	Exploration of bile ducts	16.39	NA	NA	7.50	7.48	2.07	090
47701		A	Bile duct revision	28.62	NA	NA	12.57	12.31	3.68	090
47711		A	Excision of bile duct tumor	25.77	NA	NA	9.67	9.74	3.05	090
47712		A	Excision of bile duct tumor	33.59	NA	NA	11.62	11.83	3.93	090
47715		A	Excision of bile duct cyst	21.42	NA	NA	8.51	8.50	2.49	090
47720		A	Fuse gallbladder & bowel	18.21	NA	NA	7.73	7.67	2.11	090
47721		A	Fuse upper gi structures	21.86	NA	NA	8.65	8.63	2.53	090
47740		A	Fuse gallbladder & bowel	21.10	NA	NA	8.39	8.39	2.42	090
47741		A	Fuse gallbladder & bowel	24.08	NA	NA	9.24	9.26	2.83	090
47760		A	Fuse bile ducts and bowel	38.14	NA	NA	13.08	12.53	3.42	090
47765		A	Fuse liver ducts & bowel	52.01	NA	NA	17.19	15.60	3.30	090
47780		A	Fuse bile ducts and bowel	42.14	NA	NA	14.12	13.40	3.50	090
47785		A	Fuse bile ducts and bowel	56.01	NA	NA	17.89	16.66	4.10	090
47800		A	Reconstruction of bile ducts	26.04	NA	NA	9.76	9.84	3.08	090
47801		A	Placement, bile duct support	17.47	NA	NA	8.68	8.55	1.16	090
47802		A	Fuse liver duct & intestine	24.80	NA	NA	9.71	9.70	2.86	090
47900		A	Suture bile duct injury	22.31	NA	NA	8.70	8.75	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	11.20	11.29	3.48	090
48001		A	Placement of drain, pancreas	39.56	NA	NA	12.86	13.13	4.69	090
48020		A	Removal of pancreatic stone	18.96	NA	NA	7.77	7.66	2.13	090
48100		A	Biopsy of pancreas, open	14.38	NA	NA	5.92	5.84	1.62	090
48102		A	Needle biopsy, pancreas	4.68	9.81	9.35	1.98	1.98	0.28	010
48105		A	Resect/debride pancreas	49.05	NA	NA	15.85	16.04	5.56	090
48120		A	Removal of pancreas lesion	18.33	NA	NA	6.85	6.86	2.10	090
48140		A	Partial removal of pancreas	26.19	NA	NA	9.37	9.42	3.03	090
48145		A	Partial removal of pancreas	27.26	NA	NA	9.67	9.72	3.18	090
48146		A	Pancreatectomy	30.42	NA	NA	11.85	11.89	3.50	090
48148		A	Removal of pancreatic duct	20.26	NA	NA	7.92	7.85	2.30	090
48150		A	Partial removal of pancreas	52.63	NA	NA	18.03	18.42	6.32	090

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48152		A	Pancreatectomy	48.47	NA	NA	16.92	17.26	5.80	090
48153		A	Pancreatectomy	52.61	NA	NA	17.92	18.35	6.31	090
48154		A	Pancreatectomy	48.70	NA	NA	16.81	17.18	5.84	090
48155		A	Removal of pancreas	29.27	NA	NA	11.92	11.86	3.27	090
48400		A	Injection, intraop add-on	1.95	NA	NA	0.69	0.68	0.15	ZZZ
48500		A	Surgery of pancreatic cyst	18.03	NA	NA	7.92	7.78	2.03	090
48510		A	Drain pancreatic pseudocyst	17.06	NA	NA	7.55	7.53	1.83	090
48511		A	Drain pancreatic pseudocyst	3.99	20.64	20.73	1.50	1.45	0.24	000
48520		A	Fuse pancreas cyst and bowel	18.07	NA	NA	6.90	6.86	2.06	090
48540		A	Fuse pancreas cyst and bowel	21.86	NA	NA	7.79	7.88	2.61	090
48545		A	Pancreatorrhaphy	22.10	NA	NA	8.16	8.12	2.38	090
48547		A	Duodenal exclusion	30.25	NA	NA	10.26	10.33	3.42	090
48548		A	Fuse pancreas and bowel	27.96	NA	NA	9.95	10.01	3.28	090
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	1.14	1.22	0.31	XXX
48554		R	Transpl allograft pancreas	37.03	NA	NA	20.67	20.09	4.19	090
48556		A	Removal, allograft pancreas	19.24	NA	NA	9.54	9.17	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	5.22	5.27	1.52	090
49002		A	Reopening of abdomen	17.55	NA	NA	6.39	6.05	1.37	090
49010		A	Exploration behind abdomen	15.98	NA	NA	6.23	6.16	1.51	090
49020		A	Drain abdominal abscess	26.46	NA	NA	9.91	9.99	2.85	090
49021		A	Drain abdominal abscess	3.37	20.00	20.29	1.27	1.23	0.20	000
49040		A	Drain, open, abdom abscess	16.41	NA	NA	6.51	6.50	1.70	090
49041		A	Drain, percut, abdom abscess	3.99	20.29	20.12	1.49	1.45	0.24	000
49060		A	Drain, open, retrop abscess	18.42	NA	NA	7.26	7.31	1.75	090
49061		A	Drain, percut, retroper absc	3.69	20.12	20.02	1.38	1.34	0.22	000
49062		A	Drain to peritoneal cavity	12.12	NA	NA	5.17	5.24	1.39	090
49080		A	Puncture, peritoneal cavity	1.35	2.76	3.07	0.49	0.49	0.08	000
49081		A	Removal of abdominal fluid	1.26	2.99	2.89	0.47	0.46	0.09	000
49180		A	Biopsy, abdominal mass	1.73	2.53	2.68	0.64	0.62	0.10	000
49203		A	Exc abd tum 5 cm or less	20.00	NA	NA	7.70	7.70	2.27	090
49204		A	Exc abd tum over 5 cm	26.00	NA	NA	9.33	9.33	2.94	090
49205		A	Exc abd tum over 10 cm	30.00	NA	NA	10.40	10.40	3.40	090
49215		A	Excise sacral spine tumor	37.66	NA	NA	12.71	13.06	4.38	090
49220		A	Multiple surgery, abdomen	15.70	NA	NA	6.36	6.44	1.89	090
49250		A	Excision of umbilicus	8.93	NA	NA	4.38	4.35	1.08	090
49255		A	Removal of omentum	12.41	NA	NA	5.64	5.63	1.43	090
49320		A	Diag laparo separate proc	5.09	NA	NA	2.46	2.50	0.65	010
49321		A	Laparoscopy, biopsy	5.39	NA	NA	2.57	2.59	0.70	010
49322		A	Laparoscopy, aspiration	5.96	NA	NA	2.66	2.75	0.71	010
49323		A	Laparo drain lymphocele	10.13	NA	NA	4.66	4.63	1.20	090
49324		A	Lap insertion perm ip cath	6.27	NA	NA	2.77	2.77	0.73	010
49325		A	Lap revision perm ip cath	6.77	NA	NA	2.88	2.88	0.86	010

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49326		A	Lap w/omentopexy add-on	3.50	NA	NA	0.89	0.89	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	2.54	2.67	0.66	0.65	0.15	000
49402		A	Remove foreign body, adbomen	14.01	NA	NA	5.57	5.56	1.62	090
49419		A	Insrt abdom cath for chemotx	7.03	NA	NA	3.47	3.50	0.81	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.18	1.16	0.21	000
49421		A	Insert abdom drain, perm	5.87	NA	NA	3.14	3.15	0.74	090
49422		A	Remove perm cannula/catheter	6.26	NA	NA	2.63	2.70	0.83	010
49423		A	Exchange drainage catheter	1.46	13.39	13.57	0.60	0.58	0.09	000
49424		A	Assess cyst, contrast inject	0.76	3.14	3.29	0.32	0.31	0.04	000
49425		A	Insert abdomen-venous drain	12.13	NA	NA	5.32	5.39	1.54	090
49426		A	Revise abdomen-venous shunt	10.33	NA	NA	4.61	4.65	1.28	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.33	0.32	0.07	000
49428		A	Ligation of shunt	6.79	NA	NA	3.08	3.30	0.80	010
49429		A	Removal of shunt	7.41	NA	NA	3.02	3.12	1.02	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.56	0.56	0.28	ZZZ
49436		A	Embedded ip cath exit-site	2.69	NA	NA	1.59	1.59	0.28	010
49440		A	Place gastrostomy tube perc	4.18	25.11	25.11	1.84	1.84	0.49	010
49441		A	Place duod/jej tube perc	4.77	30.19	30.19	2.04	2.04	0.29	010
49442		A	Place cecostomy tube perc	4.00	24.61	24.61	1.64	1.64	0.24	010
49446		A	Change g-tube to g-j perc	3.31	26.23	26.23	1.21	1.21	0.18	000
49450		A	Replace g/c tube perc	1.36	19.04	19.04	0.45	0.45	0.08	000
49451		A	Replace duod/jej tube perc	1.84	20.05	20.05	0.67	0.67	0.11	000
49452		A	Replace g-j tube perc	2.86	23.93	23.93	1.05	1.05	0.18	000
49460		A	Fix g/colon tube w/device	0.96	21.40	21.40	0.33	0.33	0.05	000
49465		A	Fluoro exam of g/colon tube	0.62	3.95	3.95	0.23	0.23	0.03	000
49491		A	Rpr hern preemie reduc	12.42	NA	NA	5.42	5.33	1.40	090
49492		A	Rpr ing hern premie, blocked	15.32	NA	NA	6.23	6.21	1.81	090
49495		A	Rpr ing hernia baby, reduc	6.15	NA	NA	2.84	2.87	0.74	090
49496		A	Rpr ing hernia baby, blocked	9.32	NA	NA	4.45	4.41	1.07	090
49500		A	Rpr ing hernia, init, reduce	5.76	NA	NA	3.31	3.26	0.71	090
49501		A	Rpr ing hernia, init blocked	9.28	NA	NA	4.32	4.30	1.12	090
49505		A	Prp i/hern init reduc >5 yr	7.88	NA	NA	3.89	3.85	1.03	090
49507		A	Prp i/hern init block >5 yr	9.97	NA	NA	4.46	4.46	1.27	090
49520		A	Rerepair ing hernia, reduce	9.91	NA	NA	4.38	4.40	1.28	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	NA	4.99	5.05	1.59	090
49525		A	Repair ing hernia, sliding	8.85	NA	NA	4.12	4.11	1.13	090
49540		A	Repair lumbar hernia	10.66	NA	NA	4.60	4.64	1.37	090
49550		A	Rpr rem hernia, init, reduce	8.91	NA	NA	4.11	4.12	1.14	090
49553		A	Rpr fem hernia, init blocked	9.84	NA	NA	4.41	4.41	1.24	090
49555		A	Rerepair fem hernia, reduce	9.31	NA	NA	4.22	4.24	1.20	090
49557		A	Rerepair fem hernia, blocked	11.54	NA	NA	4.85	4.89	1.47	090
49560		A	Rpr ventral hern init, reduc	11.84	NA	NA	4.88	4.95	1.52	090

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49561		A	Rpr ventral hern init, block	15.30	NA	NA	5.80	5.87	1.89	090
49565		A	Rerepair ventrl hern, reduce	12.29	NA	NA	5.11	5.14	1.52	090
49566		A	Rerepair ventrl hern, block	15.45	NA	NA	5.86	5.93	1.91	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	1.25	1.35	0.64	ZZZ
49570		A	Rpr epigastric hern, reduce	5.97	NA	NA	3.38	3.33	0.75	090
49572		A	Rpr epigastric hern, blocked	7.79	NA	NA	3.83	3.74	0.88	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.39	NA	NA	3.00	2.90	0.54	090
49582		A	Rpr umbil hern, block < 5 yr	7.05	NA	NA	3.74	3.68	0.88	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.51	NA	NA	3.52	3.46	0.82	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	NA	3.87	3.84	0.99	090
49590		A	Repair spigelian hernia	8.82	NA	NA	4.10	4.10	1.13	090
49600		A	Repair umbilical lesion	11.47	NA	NA	5.20	5.24	1.32	090
49605		A	Repair umbilical lesion	86.85	NA	NA	27.50	27.78	9.39	090
49606		A	Repair umbilical lesion	18.92	NA	NA	6.71	6.96	2.46	090
49610		A	Repair umbilical lesion	10.83	NA	NA	4.67	4.81	1.07	090
49611		A	Repair umbilical lesion	9.26	NA	NA	4.34	5.01	0.78	090
49650		A	Laparo hernia repair initial	6.30	NA	NA	3.35	3.32	0.93	090
49651		A	Laparo hernia repair recur	8.29	NA	NA	4.22	4.18	1.14	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	6.31	6.29	1.62	090
49904		A	Omental flap, extra-abdom	22.16	NA	NA	11.63	12.54	2.70	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	1.69	1.84	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	6.75	6.37	0.93	090
50020		A	Renal abscess, open drain	17.88	NA	NA	8.87	8.59	1.34	090
50021		A	Renal abscess, percut drain	3.37	21.48	21.55	1.27	1.23	0.20	000
50040		A	Drainage of kidney	16.48	NA	NA	8.98	8.44	1.03	090
50045		A	Exploration of kidney	16.67	NA	NA	9.10	8.48	1.24	090
50060		A	Removal of kidney stone	20.80	NA	NA	10.82	10.08	1.36	090
50065		A	Incision of kidney	22.17	NA	NA	11.49	10.15	1.59	090
50070		A	Incision of kidney	21.70	NA	NA	11.31	10.54	1.44	090
50075		A	Removal of kidney stone	26.91	NA	NA	13.59	12.68	1.81	090
50080		A	Removal of kidney stone	15.61	NA	NA	8.57	8.00	1.04	090
50081		A	Removal of kidney stone	23.32	NA	NA	12.15	11.31	1.54	090
50100		A	Revise kidney blood vessels	17.30	NA	NA	7.31	7.44	2.07	090
50120		A	Exploration of kidney	17.06	NA	NA	9.04	8.48	1.21	090
50125		A	Explore and drain kidney	17.67	NA	NA	9.19	8.64	1.43	090
50130		A	Removal of kidney stone	18.67	NA	NA	10.04	9.33	1.22	090
50135		A	Exploration of kidney	20.44	NA	NA	10.56	9.87	1.33	090
50200		A	Biopsy of kidney	2.63	NA	NA	1.22	1.24	0.16	000
50205		A	Biopsy of kidney	12.19	NA	NA	5.50	5.38	1.30	090
50220		A	Remove kidney, open	18.53	NA	NA	9.53	8.97	1.35	090
50225		A	Removal kidney open, complex	21.73	NA	NA	10.82	10.16	1.50	090

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50230		A	Removal kidney open, radical	23.68	NA	NA	11.63	10.88	1.55	090
50234		A	Removal of kidney & ureter	23.90	NA	NA	11.95	11.18	1.59	090
50236		A	Removal of kidney & ureter	26.74	NA	NA	13.90	13.00	1.77	090
50240		A	Partial removal of kidney	24.01	NA	NA	12.60	11.71	1.55	090
50250		A	Cryoablate renal mass open	22.06	NA	NA	11.78	11.13	1.39	090
50280		A	Removal of kidney lesion	16.94	NA	NA	9.10	8.50	1.19	090
50290		A	Removal of kidney lesion	16.00	NA	NA	7.65	7.36	1.41	090
50320		A	Remove kidney, living donor	22.28	NA	NA	12.63	12.15	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	1.10	1.16	0.29	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	0.98	1.03	0.26	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.13	1.13	0.25	XXX
50340		A	Removal of kidney	13.86	NA	NA	7.47	7.23	1.65	090
50360		A	Transplantation of kidney	40.45	NA	NA	18.68	17.89	3.82	090
50365		A	Transplantation of kidney	45.68	NA	NA	20.42	19.88	4.43	090
50370		A	Remove transplanted kidney	18.68	NA	NA	9.17	8.67	1.68	090
50380		A	Reimplantation of kidney	29.66	NA	NA	18.12	16.61	2.51	090
50382		A	Change ureter stent, percut	5.50	27.17	29.45	2.16	2.09	0.34	000
50384		A	Remove ureter stent, percut	5.00	21.55	25.01	1.97	1.90	0.31	000
50385		A	Change stent via transureth	4.44	30.28	30.28	2.04	2.04	0.27	000
50386		A	Remove stent via transureth	3.30	19.16	19.16	1.60	1.60	0.20	000
50387		A	Change ext/int ureter stent	2.00	12.87	14.23	0.77	0.75	0.12	000
50389		A	Remove renal tube w/fluoro	1.10	6.80	8.30	0.42	0.41	0.07	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.74	0.72	0.12	000
50391		A	Instll rx agnt into rnal tub	1.96	1.47	1.50	0.77	0.74	0.14	000
50392		A	Insert kidney drain	3.37	NA	NA	1.58	1.57	0.20	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.88	1.86	0.25	000
50394		A	Injection for kidney x-ray	0.76	1.91	2.11	0.60	0.62	0.05	000
50395		A	Create passage to kidney	3.37	NA	NA	1.62	1.59	0.21	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.14	1.13	0.13	000
50398		A	Change kidney tube	1.46	12.06	13.14	0.59	0.57	0.09	000
50400		A	Revision of kidney/ureter	21.12	NA	NA	10.78	10.06	1.38	090
50405		A	Revision of kidney/ureter	25.68	NA	NA	13.03	12.04	1.79	090
50500		A	Repair of kidney wound	21.07	NA	NA	8.95	8.82	2.02	090
50520		A	Close kidney-skin fistula	18.73	NA	NA	9.66	9.11	1.49	090
50525		A	Repair renal-abdomen fistula	24.21	NA	NA	11.14	10.62	1.84	090
50526		A	Repair renal-abdomen fistula	26.13	NA	NA	10.77	10.55	1.97	090
50540		A	Revision of horseshoe kidney	20.95	NA	NA	10.05	9.63	1.36	090
50541		A	Laparo ablate renal cyst	16.76	NA	NA	8.66	8.12	1.13	090
50542		A	Laparo ablate renal mass	21.18	NA	NA	11.15	10.40	1.39	090
50543		A	Laparo partial nephrectomy	27.18	NA	NA	14.05	13.10	1.81	090
50544		A	Laparoscopy, pyeloplasty	23.27	NA	NA	11.29	10.61	1.58	090
50545		A	Laparo radical nephrectomy	24.93	NA	NA	12.17	11.43	1.71	090

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50546		A	Laparoscopic nephrectomy	21.69	NA	NA	11.28	10.56	1.57	090
50547		A	Laparo removal donor kidney	26.24	NA	NA	12.47	12.14	2.77	090
50548		A	Laparo remove w/ureter	25.26	NA	NA	12.11	11.38	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	4.58	4.47	2.64	2.47	0.40	000
50553		A	Kidney endoscopy	5.98	4.63	4.57	2.72	2.59	0.39	000
50555		A	Kidney endoscopy & biopsy	6.52	4.98	4.94	2.98	2.82	0.45	000
50557		A	Kidney endoscopy & treatment	6.61	5.22	5.06	3.04	2.86	0.47	000
50561		A	Kidney endoscopy & treatment	7.58	5.84	5.65	3.42	3.23	0.54	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	5.32	5.07	0.73	090
50570		A	Kidney endoscopy	9.53	NA	NA	4.19	3.95	0.68	000
50572		A	Kidney endoscopy	10.33	NA	NA	4.51	4.26	0.85	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	4.75	4.50	0.77	000
50575		A	Kidney endoscopy	13.96	NA	NA	5.95	5.62	0.99	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	4.77	4.49	0.78	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	4.98	4.73	0.83	000
50590		A	Fragmenting of kidney stone	9.64	17.07	15.92	6.12	5.62	0.65	090
50592		A	Perc rf ablate renal tumor	6.77	74.15	93.04	3.16	3.12	0.43	010
50593		A	Perc cryo ablate renal tum	9.08	121.37	121.37	3.44	3.44	0.58	010
50600		A	Exploration of ureter	17.04	NA	NA	8.77	8.25	1.13	090
50605		A	Insert ureteral support	16.66	NA	NA	7.82	7.56	1.45	090
50610		A	Removal of ureter stone	17.12	NA	NA	9.01	8.51	1.43	090
50620		A	Removal of ureter stone	16.30	NA	NA	8.78	8.18	1.07	090
50630		A	Removal of ureter stone	16.08	NA	NA	8.28	7.79	1.09	090
50650		A	Removal of ureter	18.67	NA	NA	9.89	9.23	1.23	090
50660		A	Removal of ureter	20.87	NA	NA	10.68	10.01	1.38	090
50684		A	Injection for ureter x-ray	0.76	3.99	4.24	0.64	0.60	0.05	000
50686		A	Measure ureter pressure	1.51	.	0.86	0.99	0.95	0.11	000
50688		A	Change of ureter tube/stent	1.18	NA	NA	0.98	1.00	0.07	010
50690		A	Injection for ureter x-ray	1.16	1.48	1.57	0.76	0.75	0.07	000
50700		A	Revision of ureter	16.54	NA	NA	8.82	8.40	1.27	090
50715		A	Release of ureter	20.49	NA	NA	8.57	8.62	2.14	090
50722		A	Release of ureter	17.80	NA	NA	7.40	7.51	1.91	090
50725		A	Release/revise ureter	20.05	NA	NA	9.63	9.24	1.52	090
50727		A	Revise ureter	8.17	NA	NA	5.74	5.38	0.61	090
50728		A	Revise ureter	12.00	NA	NA	6.87	6.55	1.00	090
50740		A	Fusion of ureter & kidney	19.92	NA	NA	8.93	8.64	1.97	090
50750		A	Fusion of ureter & kidney	21.07	NA	NA	11.06	10.29	1.38	090
50760		A	Fusion of ureters	19.92	NA	NA	9.75	9.24	1.55	090
50770		A	Splicing of ureters	21.07	NA	NA	9.76	9.32	1.45	090
50780		A	Reimplant ureter in bladder	19.80	NA	NA	10.06	9.45	1.51	090
50782		A	Reimplant ureter in bladder	19.51	NA	NA	9.20	9.10	1.61	090
50783		A	Reimplant ureter in bladder	20.52	NA	NA	9.30	9.04	1.99	090
50785		A	Reimplant ureter in bladder	22.08	NA	NA	11.20	10.48	1.45	090

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50800		A	Implant ureter in bowel	16.23	NA	NA	9.15	8.48	1.19	090
50810		A	Fusion of ureter & bowel	22.38	NA	NA	10.05	9.82	2.32	090
50815		A	Urine shunt to intestine	22.06	NA	NA	11.72	10.91	1.54	090
50820		A	Construct bowel bladder	23.89	NA	NA	11.84	11.05	1.90	090
50825		A	Construct bowel bladder	30.48	NA	NA	14.99	14.03	2.08	090
50830		A	Revise urine flow	33.57	NA	NA	15.49	14.67	2.38	090
50840		A	Replace ureter by bowel	22.19	NA	NA	11.89	11.03	1.47	090
50845		A	Appendico-vesicostomy	22.21	NA	NA	12.29	11.46	1.57	090
50860		A	Transplant ureter to skin	16.93	NA	NA	9.13	8.51	1.29	090
50900		A	Repair of ureter	14.89	NA	NA	7.99	7.53	1.14	090
50920		A	Closure ureter/skin fistula	15.66	NA	NA	8.66	8.14	1.01	090
50930		A	Closure ureter/bowel fistula	20.04	NA	NA	9.06	8.79	1.28	090
50940		A	Release of ureter	15.78	NA	NA	8.55	8.02	1.26	090
50945		A	Laparoscopy ureterolithotomy	17.87	NA	NA	9.01	8.52	1.36	090
50947		A	Laparo new ureter/bladder	25.63	NA	NA	12.20	11.58	2.17	090
50948		A	Laparo new ureter/bladder	23.69	NA	NA	11.81	11.04	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	4.81	4.69	2.75	2.58	0.41	000
50953		A	Endoscopy of ureter	6.23	5.02	4.87	3.29	3.06	0.43	000
50955		A	Ureter endoscopy & biopsy	6.74	5.24	5.54	3.49	3.29	0.48	000
50957		A	Ureter endoscopy & treatment	6.78	5.34	5.15	3.10	2.92	0.48	000
50961		A	Ureter endoscopy & treatment	6.04	4.87	4.75	2.82	2.66	0.41	000
50970		A	Ureter endoscopy	7.13	NA	NA	3.23	3.04	0.52	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	3.07	2.92	0.49	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	4.05	3.81	0.64	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.95	3.73	0.66	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	3.12	2.94	0.48	000
51020		A	Incise & treat bladder	7.56	NA	NA	5.44	5.05	0.47	090
51030		A	Incise & treat bladder	7.68	NA	NA	5.02	4.76	0.58	090
51040		A	Incise & drain bladder	4.43	NA	NA	3.68	3.46	0.31	090
51045		A	Incise bladder/drain ureter	7.68	NA	NA	5.19	4.87	0.52	090
51050		A	Removal of bladder stone	7.87	NA	NA	5.32	4.91	0.49	090
51060		A	Removal of ureter stone	9.82	NA	NA	6.36	5.90	0.62	090
51065		A	Remove ureter calculus	9.82	NA	NA	6.24	5.77	0.63	090
51080		A	Drainage of bladder abscess	6.61	NA	NA	4.63	4.36	0.43	090
51100		A	Drain bladder by needle	0.78	0.89	0.89	0.26	0.26	0.05	000
51101		A	Drain bladder by trocar/cath	1.02	2.44	2.44	0.35	0.35	0.10	000
51102		A	Drain bl w/cath insertion	4.27	4.75	4.75	2.37	2.37	0.28	010
51500		A	Removal of bladder cyst	10.92	NA	NA	5.90	5.68	1.03	090
51520		A	Removal of bladder lesion	10.08	NA	NA	6.06	5.72	0.69	090
51525		A	Removal of bladder lesion	15.29	NA	NA	8.48	7.90	0.99	090
51530		A	Removal of bladder lesion	13.58	NA	NA	7.42	7.01	1.05	090
51535		A	Repair of ureter lesion	13.77	NA	NA	7.38	7.07	1.23	090
51550		A	Partial removal of bladder	17.10	NA	NA	8.77	8.27	1.31	090

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51555		A	Partial removal of bladder	23.03	NA	NA	11.36	10.69	1.70	090
51565		A	Revise bladder & ureter(s)	23.50	NA	NA	11.72	11.04	1.63	090
51570		A	Removal of bladder	27.31	NA	NA	13.07	12.24	1.72	090
51575		A	Removal of bladder & nodes	34.00	NA	NA	16.44	15.35	2.17	090
51580		A	Remove bladder/revise tract	35.14	NA	NA	17.54	16.29	2.25	090
51585		A	Removal of bladder & nodes	39.41	NA	NA	19.27	17.89	2.49	090
51590		A	Remove bladder/revise tract	36.15	NA	NA	17.17	16.04	2.28	090
51595		A	Remove bladder/revise tract	41.12	NA	NA	19.51	18.18	2.60	090
51596		A	Remove bladder/create pouch	44.01	NA	NA	21.23	19.75	2.78	090
51597		A	Removal of pelvic structures	42.61	NA	NA	20.13	18.82	2.82	090
51600		A	Injection for bladder x-ray	0.88	4.29	4.48	0.33	0.32	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.42	0.40	0.04	000
51610		A	Injection for bladder x-ray	1.05	1.91	2.01	0.71	0.68	0.07	000
51700		A	Irrigation of bladder	0.88	1.49	1.52	0.33	0.32	0.06	000
51701		A	Insert bladder catheter	0.50	1.04	1.17	0.24	0.23	0.04	000
51702		A	Insert temp bladder cath	0.50	1.53	1.67	0.33	0.31	0.04	000
51703		A	Insert bladder cath, complex	1.47	2.27	2.39	0.80	0.74	0.10	000
51705		A	Change of bladder tube	1.03	2.02	2.09	0.84	0.79	0.07	010
51710		A	Change of bladder tube	1.50	2.72	2.88	1.17	1.07	0.11	010
51715		A	Endoscopic injection/implant	3.73	4.41	4.28	1.72	1.63	0.29	000
51720		A	Treatment of bladder lesion	1.50	1.61	1.65	0.74	0.73	0.14	000
51725		A	Simple cystometrogram	1.51	4.24	4.58	4.24	4.58	0.16	000
51725	TC	A	Simple cystometrogram	0.00	3.68	4.04	3.68	4.04	0.04	000
51725	26	A	Simple cystometrogram	1.51	0.55	0.54	0.55	0.54	0.12	000
51726		A	Complex cystometrogram	1.71	7.09	7.20	7.09	7.20	0.18	000
51726	TC	A	Complex cystometrogram	0.00	6.45	6.58	6.45	6.58	0.05	000
51726	26	A	Complex cystometrogram	1.71	0.63	0.62	0.63	0.62	0.13	000
51736		A	Urine flow measurement	0.61	0.94	0.85	0.94	0.85	0.06	000
51736	TC	A	Urine flow measurement	0.00	0.71	0.62	0.71	0.62	0.01	000
51736	26	A	Urine flow measurement	0.61	0.24	0.23	0.24	0.23	0.05	000
51741		A	Electro-uroflowmetry, first	1.14	1.27	1.15	1.27	1.15	0.11	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.83	0.73	0.83	0.73	0.02	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.44	0.42	0.44	0.42	0.09	000
51772		A	Urethra pressure profile	1.61	5.09	5.21	5.09	5.21	0.20	000
51772	TC	A	Urethra pressure profile	0.00	4.54	4.66	4.54	4.66	0.05	000
51772	26	A	Urethra pressure profile	1.61	0.55	0.55	0.55	0.55	0.15	000
51784		A	Anal/urinary muscle study	1.53	4.05	4.04	4.05	4.04	0.16	000
51784	TC	A	Anal/urinary muscle study	0.00	3.50	3.50	3.50	3.50	0.04	000
51784	26	A	Anal/urinary muscle study	1.53	0.55	0.54	0.55	0.54	0.12	000
51785		A	Anal/urinary muscle study	1.53	4.57	4.54	4.57	4.54	0.15	000
51785	TC	A	Anal/urinary muscle study	0.00	4.00	3.99	4.00	3.99	0.04	000
51785	26	A	Anal/urinary muscle study	1.53	0.57	0.55	0.57	0.55	0.11	000
51792		A	Urinary reflex study	1.10	5.02	5.27	5.02	5.27	0.20	000
51792	TC	A	Urinary reflex study	0.00	4.63	4.87	4.63	4.87	0.13	000

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51792	26	A	Urinary reflex study	1.10	0.39	0.40	0.39	0.40	0.07	000
51795		A	Urine voiding pressure study	1.53	6.69	6.85	6.69	6.85	0.22	000
51795	TC	A	Urine voiding pressure study	0.00	6.13	6.30	6.13	6.30	0.10	000
51795	26	A	Urine voiding pressure study	1.53	0.56	0.55	0.56	0.55	0.12	000
51797		A	Intraabdominal pressure test	0.80	2.43	3.28	2.43	3.28	0.17	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	2.14	2.92	2.14	2.92	0.05	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.29	0.35	0.29	0.35	0.12	ZZZ
51798		A	Us urine capacity measure	0.00	0.59	0.53	NA	NA	0.08	XXX
51800		A	Revision of bladder/urethra	18.74	NA	NA	9.96	9.37	1.32	090
51820		A	Revision of urinary tract	19.41	NA	NA	9.29	9.05	1.75	090
51840		A	Attach bladder/urethra	11.28	NA	NA	5.79	5.74	1.06	090
51841		A	Attach bladder/urethra	13.60	NA	NA	6.64	6.58	1.24	090
51845		A	Repair bladder neck	10.07	NA	NA	5.79	5.53	0.79	090
51860		A	Repair of bladder wound	12.49	NA	NA	6.71	6.48	1.16	090
51865		A	Repair of bladder wound	15.69	NA	NA	8.29	7.89	1.23	090
51880		A	Repair of bladder opening	7.81	NA	NA	4.71	4.52	0.72	090
51900		A	Repair bladder/vagina lesion	14.48	NA	NA	7.77	7.35	1.21	090
51920		A	Close bladder-uterus fistula	13.26	NA	NA	7.32	6.91	1.18	090
51925		A	Hysterectomy/bladder repair	17.35	NA	NA	8.66	8.65	2.04	090
51940		A	Correction of bladder defect	30.48	NA	NA	12.99	12.78	2.15	090
51960		A	Revision of bladder & bowel	25.20	NA	NA	13.05	12.21	1.63	090
51980		A	Construct bladder opening	12.44	NA	NA	7.20	6.75	0.86	090
51990		A	Laparo urethral suspension	13.26	NA	NA	6.23	6.22	1.39	090
51992		A	Laparo sling operation	14.77	NA	NA	6.63	6.53	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	3.65	3.57	1.31	1.17	0.14	000
52001		A	Cystoscopy, removal of clots	5.44	5.06	5.06	2.57	2.40	0.39	000
52005		A	Cystoscopy & ureter catheter	2.37	5.72	5.69	1.37	1.25	0.17	000
52007		A	Cystoscopy and biopsy	3.02	10.74	12.19	1.62	1.50	0.22	000
52010		A	Cystoscopy & duct catheter	3.02	7.33	8.20	1.44	1.37	0.21	000
52204		A	Cystoscopy w/biopsy(s)	2.59	8.30	9.87	1.37	1.25	0.17	000
52214		A	Cystoscopy and treatment	3.70	19.85	24.46	1.82	1.70	0.26	000
52224		A	Cystoscopy and treatment	3.14	19.05	23.44	1.60	1.49	0.22	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	2.26	2.11	0.33	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.63	2.46	0.39	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	4.33	4.08	0.69	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	2.29	2.13	0.32	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.92	1.80	0.28	000
52265		A	Cystoscopy and treatment	2.94	7.44	8.93	1.45	1.37	0.22	000
52270		A	Cystoscopy & revise urethra	3.36	7.01	8.02	1.74	1.61	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	9.29	10.88	2.27	2.12	0.33	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	2.44	2.28	0.35	000
52277		A	Cystoscopy and treatment	6.16	NA	NA	2.88	2.72	0.44	000
52281		A	Cystoscopy and treatment	2.80	5.28	5.74	1.54	1.42	0.20	000

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52282		A	Cystoscopy, implant stent	6.39	NA	NA	2.94	2.77	0.45	000
52283		A	Cystoscopy and treatment	3.73	4.07	4.04	1.87	1.74	0.26	000
52285		A	Cystoscopy and treatment	3.60	4.31	4.24	1.82	1.70	0.26	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	2.26	2.11	0.32	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.53	2.38	0.38	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.70	2.52	0.46	000
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.48	2.32	0.38	000
52310		A	Cystoscopy and treatment	2.81	4.00	4.17	1.42	1.32	0.20	000
52315		A	Cystoscopy and treatment	5.20	6.62	7.14	2.47	2.31	0.37	000
52317		A	Remove bladder stone	6.71	17.04	20.05	2.98	2.81	0.48	000
52318		A	Remove bladder stone	9.18	NA	NA	4.02	3.79	0.65	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	2.20	2.06	0.33	000
52325		A	Cystoscopy, stone removal	6.15	NA	NA	2.78	2.62	0.44	000
52327		A	Cystoscopy, inject material	5.18	2.03	9.51	2.03	1.98	0.37	000
52330		A	Cystoscopy and treatment	5.03	20.31	24.98	2.33	2.19	0.36	000
52332		A	Cystoscopy and treatment	2.83	12.40	10.74	1.55	1.43	0.21	000
52334		A	Create passage to kidney	4.82	NA	NA	2.34	2.19	0.35	000
52341		A	Cysto w/ureter stricture tx	6.11	NA	NA	3.05	2.84	0.43	000
52342		A	Cysto w/up stricture tx	6.61	NA	NA	3.25	3.03	0.46	000
52343		A	Cysto w/renal stricture tx	7.31	NA	NA	3.54	3.30	0.51	000
52344		A	Cysto/uretero, stricture tx	7.81	NA	NA	3.89	3.62	0.55	000
52345		A	Cysto/uretero w/up stricture	8.31	NA	NA	4.11	3.82	0.58	000
52346		A	Cystouretero w/renal strict	9.34	NA	NA	4.52	4.21	0.65	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.94	2.75	0.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	3.46	3.22	0.49	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.89	3.63	0.57	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	3.63	3.40	0.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	4.23	3.96	0.63	000
52400		A	Cystouretero w/congen repr	10.06	NA	NA	5.39	4.98	0.68	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	2.16	2.04	0.40	000
52450		A	Incision of prostate	7.63	NA	NA	5.46	5.02	0.54	090
52500		A	Revision of bladder neck	9.39	NA	NA	6.17	5.61	0.60	090
52601		A	Prostatectomy (TURP)	15.13	NA	NA	8.41	7.58	0.87	090
52606		A	Control postop bleeding	8.84	NA	NA	5.48	5.00	0.57	090
52612		A	Prostatectomy, first stage	9.07	NA	NA	5.86	5.33	0.56	090
52614		A	Prostatectomy, second stage	7.81	NA	NA	5.37	4.87	0.48	090
52620		A	Remove residual prostate	7.19	NA	NA	4.60	4.20	0.47	090
52630		A	Remove prostate regrowth	7.65	NA	NA	4.78	4.39	0.51	090
52640		A	Relieve bladder contracture	6.89	NA	NA	4.40	4.05	0.47	090
52647		A	Laser surgery of prostate	11.15	41.89	49.99	6.88	6.29	0.73	090
52648		A	Laser surgery of prostate	12.00	42.41	50.38	7.20	6.60	0.79	090
52649		A	2Prostate laser enucleation	17.16	NA	NA	9.30	9.30	1.11	090
52700		A	Drainage of prostate abscess	7.39	NA	NA	4.73	4.35	0.48	090
53000		A	Incision of urethra	2.30	NA	NA	1.80	1.73	0.16	010

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53010		A	Incision of urethra	4.35	NA	NA	3.86	3.63	0.24	090
53020		A	Incision of urethra	1.77	NA	NA	0.95	0.88	0.13	000
53025		A	Incision of urethra	1.13	NA	NA	0.67	0.63	0.08	000
53040		A	Drainage of urethra abscess	6.49	NA	NA	4.34	4.12	0.45	090
53060		A	Drainage of urethra abscess	2.65	1.98	2.01	1.46	1.44	0.28	010
53080		A	Drainage of urinary leakage	6.82	NA	NA	4.64	4.97	0.52	090
53085		A	Drainage of urinary leakage	11.05	NA	NA	4.94	5.56	0.92	090
53200		A	Biopsy of urethra	2.59	1.69	1.60	1.29	1.21	0.20	000
53210		A	Removal of urethra	13.59	NA	NA	7.65	7.21	0.89	090
53215		A	Removal of urethra	16.72	NA	NA	9.10	8.49	1.10	090
53220		A	Treatment of urethra lesion	7.53	NA	NA	4.97	4.66	0.49	090
53230		A	Removal of urethra lesion	10.31	NA	NA	6.26	5.88	0.73	090
53235		A	Removal of urethra lesion	10.86	NA	NA	6.89	6.40	0.72	090
53240		A	Surgery for urethra pouch	6.98	NA	NA	4.98	4.62	0.52	090
53250		A	Removal of urethra gland	6.42	NA	NA	4.66	4.32	0.49	090
53260		A	Treatment of urethra lesion	3.00	2.42	2.38	1.81	1.71	0.25	010
53265		A	Treatment of urethra lesion	3.14	2.90	2.86	1.96	1.82	0.24	010
53270		A	Removal of urethra gland	3.11	2.39	2.35	1.79	1.73	0.30	010
53275		A	Repair of urethra defect	4.54	NA	NA	2.76	2.63	0.32	010
53400		A	Revise urethra, stage 1	13.98	NA	NA	8.14	7.62	0.98	090
53405		A	Revise urethra, stage 2	15.51	NA	NA	8.88	8.24	1.10	090
53410		A	Reconstruction of urethra	17.53	NA	NA	9.64	9.00	1.16	090
53415		A	Reconstruction of urethra	20.55	NA	NA	10.89	10.01	1.37	090
53420		A	Reconstruct urethra, stage 1	15.04	NA	NA	6.99	6.82	0.96	090
53425		A	Reconstruct urethra, stage 2	16.94	NA	NA	9.16	8.60	1.13	090
53430		A	Reconstruction of urethra	17.30	NA	NA	8.59	8.20	1.15	090
53431		A	Reconstruct urethra/bladder	21.03	NA	NA	10.91	10.21	1.41	090
53440		A	Male sling procedure	15.34	NA	NA	9.21	8.41	0.96	090
53442		A	Remove/revise male sling	13.29	NA	NA	8.39	7.66	0.82	090
53444		A	Insert tandem cuff	14.06	NA	NA	8.02	7.49	0.94	090
53445		A	Insert uro/ves nck sphincter	15.21	NA	NA	8.74	8.33	0.99	090
53446		A	Remove uro sphincter	10.89	NA	NA	6.99	6.55	0.72	090
53447		A	Remove/replace ur sphincter	14.15	NA	NA	8.35	7.87	0.95	090
53448		A	Remov/replc ur sphinctr comp	23.26	NA	NA	12.28	11.48	1.50	090
53449		A	Repair uro sphincter	10.43	NA	NA	6.62	6.15	0.68	090
53450		A	Revision of urethra	6.67	NA	NA	4.75	4.39	0.43	090
53460		A	Revision of urethra	7.65	NA	NA	5.11	4.76	0.50	090
53500		A	Urethrlys, transvag w/ scope	12.87	NA	NA	7.31	7.04	0.90	090
53502		A	Repair of urethra injury	8.16	NA	NA	5.22	4.92	0.62	090
53505		A	Repair of urethra injury	8.16	NA	NA	5.40	5.02	0.54	090
53510		A	Repair of urethra injury	10.83	NA	NA	6.66	6.29	0.74	090
53515		A	Repair of urethra injury	14.09	NA	NA	7.87	7.39	1.05	090
53520		A	Repair of urethra defect	9.35	NA	NA	6.11	5.70	0.61	090
53600		A	Dilate urethra stricture	1.21	1.16	1.15	0.57	0.54	0.09	000

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53601		A	Dilate urethra stricture	0.98	1.36	1.34	0.52	0.48	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.50	0.48	0.09	000
53620		A	Dilate urethra stricture	1.62	1.69	1.77	0.83	0.77	0.11	000
53621		A	Dilate urethra stricture	1.35	1.81	1.87	0.67	0.62	0.10	000
53660		A	Dilation of urethra	0.71	1.32	1.32	0.46	0.42	0.05	000
53661		A	Dilation of urethra	0.72	1.29	1.29	0.41	0.38	0.05	000
53665		A	Dilation of urethra	0.76	NA	NA	0.27	0.26	0.06	000
53850		A	Prostatic microwave thermotx	9.98	49.17	60.50	5.85	5.38	0.67	090
53852		A	Prostatic rf thermotx	10.68	46.31	57.03	6.64	6.08	0.70	090
53853		A	Prostatic water thermother	5.54	29.22	35.81	4.37	3.99	0.37	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	2.71	2.76	1.49	1.35	0.11	010
54001		A	Slitting of prepuce	2.21	3.05	3.09	1.66	1.52	0.15	010
54015		A	Drain penis lesion	5.33	NA	NA	3.20	3.04	0.38	010
54050		A	Destruction, penis lesion(s)	1.26	2.13	2.01	1.42	1.32	0.08	010
54055		A	Destruction, penis lesion(s)	1.23	1.98	1.88	1.24	1.13	0.08	010
54056		A	Cryosurgery, penis lesion(s)	1.26	2.34	2.18	1.51	1.42	0.06	010
54057		A	Laser surg, penis lesion(s)	1.26	2.59	2.50	1.34	1.22	0.09	010
54060		A	Excision of penis lesion(s)	1.95	3.10	3.10	1.64	1.49	0.13	010
54065		A	Destruction, penis lesion(s)	2.44	3.24	3.09	1.96	1.78	0.13	010
54100		A	Biopsy of penis	1.90	3.35	3.21	1.36	1.22	0.10	000
54105		A	Biopsy of penis	3.51	3.98	4.06	2.44	2.32	0.25	010
54110		A	Treatment of penis lesion	10.79	NA	NA	6.56	6.12	0.72	090
54111		A	Treat penis lesion, graft	14.29	NA	NA	7.99	7.44	0.96	090
54112		A	Treat penis lesion, graft	16.83	NA	NA	9.31	8.69	1.11	090
54115		A	Treatment of penis lesion	6.82	5.79	5.44	4.97	4.59	0.43	090
54120		A	Partial removal of penis	10.88	NA	NA	6.71	6.20	0.68	090
54125		A	Removal of penis	14.43	NA	NA	8.07	7.52	0.95	090
54130		A	Remove penis & nodes	21.66	NA	NA	11.55	10.71	1.52	090
54135		A	Remove penis & nodes	27.99	NA	NA	14.08	13.11	1.88	090
54150		A	Circumcision w/regionl block	1.90	2.36	2.74	0.72	0.72	0.16	000
54160		A	Circumcision, neonate	2.50	3.83	3.91	1.51	1.41	0.19	010
54161		A	Circum 28 days or older	3.29	NA	NA	2.20	2.04	0.23	010
54162		A	Lysis penil circumic lesion	3.27	3.98	4.15	2.24	2.04	0.21	010
54163		A	Repair of circumcision	3.27	NA	NA	2.87	2.65	0.21	010
54164		A	Frenulotomy of penis	2.77	NA	NA	2.66	2.46	0.18	010
54200		A	Treatment of penis lesion	1.08	2.01	1.96	1.30	1.22	0.08	010
54205		A	Treatment of penis lesion	8.84	NA	NA	6.04	5.71	0.56	090
54220		A	Treatment of penis lesion	2.42	3.31	3.45	1.33	1.23	0.17	000
54230		A	Prepare penis study	1.34	1.42	1.34	0.91	0.84	0.09	000
54231		A	Dynamic cavernosometry	2.04	1.96	1.81	1.24	1.15	0.16	000
54235		A	Penile injection	1.19	1.40	1.29	0.89	0.82	0.08	000
54240		A	Penis study	1.31	1.56	1.43	1.56	1.43	0.17	000
54240	TC	A	Penis study	0.00	1.06	0.95	1.06	0.95	0.06	000

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54240	26	A	Penis study	1.31	0.50	0.48	0.50	0.48	0.11	000
54250		A	Penis study	2.22	1.25	1.17	1.25	1.17	0.18	000
54250	TC	A	Penis study	0.00	0.38	0.33	0.38	0.33	0.02	000
54250	26	A	Penis study	2.22	0.88	0.83	0.88	0.83	0.16	000
54300		A	Revision of penis	11.07	NA	NA	6.82	6.51	0.76	090
54304		A	Revision of penis	13.15	NA	NA	7.78	7.42	0.88	090
54308		A	Reconstruction of urethra	12.49	NA	NA	7.47	7.10	0.84	090
54312		A	Reconstruction of urethra	14.36	NA	NA	8.46	8.10	1.24	090
54316		A	Reconstruction of urethra	17.90	NA	NA	9.92	9.43	1.21	090
54318		A	Reconstruction of urethra	12.28	NA	NA	7.55	7.11	1.39	090
54322		A	Reconstruction of urethra	13.85	NA	NA	7.92	7.56	0.92	090
54324		A	Reconstruction of urethra	17.40	NA	NA	9.59	9.19	1.14	090
54326		A	Reconstruction of urethra	16.87	NA	NA	8.30	8.17	1.11	090
54328		A	Revise penis/urethra	16.74	NA	NA	9.18	8.71	0.98	090
54332		A	Revise penis/urethra	18.22	NA	NA	10.04	9.47	1.21	090
54336		A	Revise penis/urethra	21.44	NA	NA	9.54	9.74	2.21	090
54340		A	Secondary urethral surgery	9.58	NA	NA	5.96	5.73	0.63	090
54344		A	Secondary urethral surgery	16.91	NA	NA	9.52	9.08	1.54	090
54348		A	Secondary urethral surgery	18.17	NA	NA	10.10	9.67	1.23	090
54352		A	Reconstruct urethra/penis	25.95	NA	NA	13.50	12.93	2.25	090
54360		A	Penis plastic surgery	12.65	NA	NA	7.44	7.09	0.84	090
54380		A	Repair penis	14.03	NA	NA	8.25	7.84	0.93	090
54385		A	Repair penis	16.38	NA	NA	11.34	10.58	0.86	090
54390		A	Repair penis and bladder	22.59	NA	NA	9.73	9.66	1.54	090
54400		A	Insert semi-rigid prosthesis	9.09	NA	NA	5.72	5.38	0.64	090
54401		A	Insert self-contd prosthesis	10.26	NA	NA	8.12	7.53	0.73	090
54405		A	Insert multi-comp penis pros	14.39	NA	NA	8.10	7.56	0.95	090
54406		A	Remove muti-comp penis pros	12.76	NA	NA	7.58	7.05	0.86	090
54408		A	Repair multi-comp penis pros	13.73	NA	NA	8.23	7.61	0.90	090
54410		A	Remove/replace penis prosth	16.48	NA	NA	9.34	8.66	1.10	090
54411		A	Remov/replc penis pros, comp	18.14	NA	NA	10.40	9.56	1.13	090
54415		A	Remove self-contd penis pros	8.75	NA	NA	5.97	5.53	0.58	090
54416		A	Remv/repl penis contain pros	11.87	NA	NA	7.89	7.27	0.77	090
54417		A	Remv/replc penis pros, compl	15.94	NA	NA	9.09	8.36	1.00	090
54420		A	Revision of penis	12.26	NA	NA	7.41	6.96	0.81	090
54430		A	Revision of penis	10.93	NA	NA	6.95	6.50	0.72	090
54435		A	Revision of penis	6.71	NA	NA	4.96	4.63	0.43	090
54440		C	Repair of penis	0.00	NA	NA	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.85	0.88	0.48	0.47	0.08	000
54500		A	Biopsy of testis	1.31	NA	NA	0.80	0.74	0.10	000
54505		A	Biopsy of testis	3.47	NA	NA	2.43	2.30	0.27	010
54512		A	Excise lesion testis	9.23	NA	NA	5.60	5.23	0.67	090
54520		A	Removal of testis	5.25	NA	NA	3.70	3.47	0.50	090
54522		A	Orchiectomy, partial	10.15	NA	NA	5.69	5.49	0.89	090

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54530		A	Removal of testis	9.31	NA	NA	6.06	5.61	0.66	090
54535		A	Extensive testis surgery	13.06	NA	NA	7.22	6.80	0.95	090
54550		A	Exploration for testis	8.31	NA	NA	5.28	4.91	0.59	090
54560		A	Exploration for testis	11.97	NA	NA	6.29	6.01	0.90	090
54600		A	Reduce testis torsion	7.54	NA	NA	5.09	4.70	0.51	090
54620		A	Suspension of testis	5.16	NA	NA	3.23	3.03	0.37	010
54640		A	Suspension of testis	7.57	NA	NA	5.40	4.98	0.62	090
54650		A	Orchiopexy (Fowler-Stephens)	12.24	NA	NA	7.23	6.78	1.16	090
54660		A	Revision of testis	5.64	NA	NA	4.30	3.98	0.44	090
54670		A	Repair testis injury	6.57	NA	NA	4.65	4.37	0.47	090
54680		A	Relocation of testis(es)	13.91	NA	NA	7.53	7.19	1.16	090
54690		A	Laparoscopy, orchiectomy	11.60	NA	NA	5.56	5.41	1.02	090
54692		A	Laparoscopy, orchiopexy	13.64	NA	NA	7.54	7.02	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	2.36	2.25	0.28	010
54800		A	Biopsy of epididymis	2.33	NA	NA	1.31	1.21	0.23	000
54830		A	Remove epididymis lesion	5.91	NA	NA	4.42	4.07	0.41	090
54840		A	Remove epididymis lesion	5.22	NA	NA	3.79	3.54	0.37	090
54860		A	Removal of epididymis	6.85	NA	NA	4.85	4.46	0.45	090
54861		A	Removal of epididymis	9.57	NA	NA	6.16	5.70	0.63	090
54865		A	Explore epididymis	5.67	NA	NA	4.31	3.97	0.40	090
54900		A	Fusion of spermatic ducts	14.05	NA	NA	6.76	6.53	0.93	090
54901		A	Fusion of spermatic ducts	18.92	NA	NA	10.49	9.75	1.83	090
55000		A	Drainage of hydrocele	1.43	1.85	1.91	0.91	0.85	0.11	000
55040		A	Removal of hydrocele	5.39	NA	NA	3.96	3.69	0.43	090
55041		A	Removal of hydroceles	8.41	NA	NA	5.68	5.25	0.60	090
55060		A	Repair of hydrocele	6.05	NA	NA	4.46	4.11	0.46	090
55100		A	Drainage of scrotum abscess	2.40	3.47	3.53	2.09	1.96	0.17	010
55110		A	Explore scrotum	6.23	NA	NA	4.45	4.12	0.43	090
55120		A	Removal of scrotum lesion	5.62	NA	NA	4.21	3.90	0.39	090
55150		A	Removal of scrotum	8.01	NA	NA	5.51	5.09	0.56	090
55175		A	Revision of scrotum	5.77	NA	NA	4.34	4.01	0.37	090
55180		A	Revision of scrotum	11.63	NA	NA	7.24	6.77	0.90	090
55200		A	Incision of sperm duct	4.50	8.01	9.10	3.17	2.97	0.33	090
55250		A	Removal of sperm duct(s)	3.32	7.78	8.72	3.03	2.83	0.25	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.41	1.39	0.25	000
55400		A	Repair of sperm duct	8.53	NA	NA	5.42	5.09	0.64	090
55450		A	Ligation of sperm duct	4.38	5.83	6.13	2.72	2.51	0.29	010
55500		A	Removal of hydrocele	6.12	NA	NA	4.19	3.92	0.55	090
55520		A	Removal of sperm cord lesion	6.56	NA	NA	3.82	3.68	0.75	090
55530		A	Revise spermatic cord veins	5.69	NA	NA	4.10	3.83	0.45	090
55535		A	Revise spermatic cord veins	7.09	NA	NA	4.81	4.46	0.47	090
55540		A	Revise hernia & sperm veins	8.20	NA	NA	4.29	4.17	0.94	090
55550		A	Laparo ligate spermatic vein	7.10	NA	NA	4.60	4.27	0.57	090

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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	4.89	4.50	0.62	090
55605		A	Incise sperm duct pouch	8.63	NA	NA	4.94	4.78	0.64	090
55650		A	Remove sperm duct pouch	12.52	NA	NA	7.09	6.64	0.92	090
55680		A	Remove sperm pouch lesion	5.59	NA	NA	3.76	3.57	0.47	090
55700		A	Biopsy of prostate	2.58	3.71	3.83	1.32	1.15	0.11	000
55705		A	Biopsy of prostate	4.58	NA	NA	2.86	2.72	0.32	010
55720		A	Drainage of prostate abscess	7.67	NA	NA	4.85	4.59	0.95	090
55725		A	Drainage of prostate abscess	9.90	NA	NA	6.46	5.97	0.70	090
55801		A	Removal of prostate	19.62	NA	NA	10.47	9.76	1.34	090
55810		A	Extensive prostate surgery	24.14	NA	NA	12.18	11.38	1.60	090
55812		A	Extensive prostate surgery	29.69	NA	NA	14.87	13.91	2.05	090
55815		A	Extensive prostate surgery	32.75	NA	NA	16.16	15.10	2.17	090
55821		A	Removal of prostate	15.63	NA	NA	8.66	8.05	1.01	090
55831		A	Removal of prostate	17.06	NA	NA	9.24	8.60	1.10	090
55840		A	Extensive prostate surgery	24.45	NA	NA	12.65	11.82	1.61	090
55842		A	Extensive prostate surgery	26.31	NA	NA	13.45	12.56	1.73	090
55845		A	Extensive prostate surgery	30.52	NA	NA	14.83	13.86	2.03	090
55860		A	Surgical exposure, prostate	15.71	NA	NA	8.57	8.04	1.02	090
55862		A	Extensive prostate surgery	19.89	NA	NA	10.67	9.97	1.49	090
55865		A	Extensive prostate surgery	24.39	NA	NA	12.76	11.89	1.63	090
55866		A	Laparo radical prostatectomy	32.25	NA	NA	15.96	14.91	2.17	090
55870		A	Electroejaculation	2.58	2.47	2.24	1.44	1.35	0.16	000
55873		A	Cryoablate prostate	20.25	NA	NA	11.25	10.68	1.38	090
55875		A	Transperi needle place, pros	13.31	NA	NA	7.81	7.32	0.89	090
55876		A	Place rt device/marker, pros	1.73	2.06	2.06	1.04	1.04	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	3.19	3.19	0.58	000
56405		A	I & D of vulva/perineum	1.46	1.19	1.22	1.17	1.16	0.17	010
56420		A	Drainage of gland abscess	1.41	1.53	1.72	0.78	0.85	0.16	010
56440		A	Surgery for vulva lesion	2.86	NA	NA	1.57	1.61	0.34	010
56441		A	Lysis of labial lesion(s)	1.99	1.71	1.74	1.56	1.52	0.20	010
56442		A	Hymenotomy	0.68	NA	NA	0.54	0.53	0.08	000
56501		A	Destroy, vulva lesions, sim	1.55	1.65	1.68	1.23	1.23	0.18	010
56515		A	Destroy vulva lesion/s compl	3.03	2.42	2.45	1.76	1.78	0.33	010
56605		A	Biopsy of vulva/perineum	1.10	0.93	0.97	0.35	0.38	0.13	000
56606		A	Biopsy of vulva/perineum	0.55	0.36	0.40	0.15	0.17	0.07	ZZZ
56620		A	Partial removal of vulva	8.44	NA	NA	4.44	4.53	0.90	090
56625		A	Complete removal of vulva	9.55	NA	NA	4.80	4.93	1.02	090
56630		A	Extensive vulva surgery	14.67	NA	NA	6.33	6.46	1.49	090
56631		A	Extensive vulva surgery	18.81	NA	NA	7.76	8.03	1.96	090
56632		A	Extensive vulva surgery	21.61	NA	NA	9.36	9.41	2.39	090
56633		A	Extensive vulva surgery	19.47	NA	NA	7.87	8.06	1.98	090
56634		A	Extensive vulva surgery	20.48	NA	NA	8.25	8.55	2.17	090

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56637		A	Extensive vulva surgery	24.57	NA	NA	9.22	9.69	2.61	090
56640		A	Extensive vulva surgery	24.65	NA	NA	8.90	9.34	2.89	090
56700		A	Partial removal of hymen	2.79	NA	NA	1.76	1.78	0.30	010
56740		A	Remove vagina gland lesion	4.83	NA	NA	2.33	2.39	0.56	010
56800		A	Repair of vagina	3.90	NA	NA	2.00	2.05	0.44	010
56805		A	Repair clitoris	19.75	NA	NA	7.78	8.20	2.15	090
56810		A	Repair of perineum	4.26	NA	NA	2.06	2.12	0.49	010
56820		A	Exam of vulva w/scope	1.50	1.20	1.23	0.53	0.56	0.18	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.55	1.60	0.69	0.75	0.25	000
57000		A	Exploration of vagina	2.99	NA	NA	1.69	1.70	0.31	010
57010		A	Drainage of pelvic abscess	6.74	NA	NA	3.79	3.80	0.71	090
57020		A	Drainage of pelvic fluid	1.50	0.77	0.81	0.45	0.49	0.18	000
57022		A	I & d vaginal hematoma, pp	2.70	NA	NA	1.36	1.40	0.26	010
57023		A	I & d vag hematoma, non-ob	5.13	NA	NA	2.42	2.46	0.58	010
57061		A	Destroy vag lesions, simple	1.27	1.53	1.56	1.12	1.12	0.15	010
57065		A	Destroy vag lesions, complex	2.63	2.03	2.10	1.50	1.54	0.31	010
57100		A	Biopsy of vagina	1.20	0.96	0.99	0.37	0.40	0.14	000
57105		A	Biopsy of vagina	1.71	1.60	1.65	1.34	1.36	0.20	010
57106		A	Remove vagina wall, partial	7.35	NA	NA	4.32	4.29	0.73	090
57107		A	Remove vagina tissue, part	24.43	NA	NA	9.16	9.49	2.72	090
57109		A	Vaginectomy partial w/nodes	28.25	NA	NA	10.16	10.44	3.22	090
57110		A	Remove vagina wall, complete	15.38	NA	NA	6.25	6.51	1.74	090
57111		A	Remove vagina tissue, compl	28.25	NA	NA	10.35	10.93	3.18	090
57112		A	Vaginectomy w/nodes, compl	30.37	NA	NA	11.08	11.35	3.08	090
57120		A	Closure of vagina	8.18	NA	NA	4.24	4.33	0.89	090
57130		A	Remove vagina lesion	2.44	1.98	2.03	1.49	1.50	0.29	010
57135		A	Remove vagina lesion	2.68	2.04	2.10	1.54	1.57	0.31	010
57150		A	Treat vagina infection	0.55	0.59	0.72	0.15	0.17	0.07	000
57155		A	Insert uteri tandems/ovoids	6.79	NA	NA	3.40	3.69	0.43	090
57160		A	Insert pessary/other device	0.89	1.05	1.04	0.26	0.28	0.10	000
57170		A	Fitting of diaphragm/cap	0.91	0.58	0.80	0.25	0.27	0.11	000
57180		A	Treat vaginal bleeding	1.60	1.88	1.96	0.94	1.02	0.19	010
57200		A	Repair of vagina	4.34	NA	NA	2.97	2.96	0.46	090
57210		A	Repair vagina/perineum	5.63	NA	NA	3.34	3.37	0.62	090
57220		A	Revision of urethra	4.77	NA	NA	3.07	3.08	0.51	090
57230		A	Repair of urethral lesion	6.22	NA	NA	3.69	3.62	0.54	090
57240		A	Repair bladder & vagina	11.42	NA	NA	5.51	5.09	0.62	090
57250		A	Repair rectum & vagina	11.42	NA	NA	5.12	4.73	0.65	090
57260		A	Repair of vagina	14.36	NA	NA	5.93	5.66	0.97	090
57265		A	Extensive repair of vagina	15.86	NA	NA	6.43	6.34	1.32	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	1.52	1.63	0.64	ZZZ
57268		A	Repair of bowel bulge	7.47	NA	NA	4.37	4.33	0.79	090
57270		A	Repair of bowel pouch	13.57	NA	NA	5.76	5.89	1.42	090
57280		A	Suspension of vagina	16.62	NA	NA	6.94	7.05	1.68	090

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57282		A	Colpopexy, extraperitoneal	7.84	NA	NA	4.56	4.55	1.02	090
57283		A	Colpopexy, intraperitoneal	11.58	NA	NA	5.16	5.35	1.02	090
57284		A	Repair paravag defect, open	14.25	NA	NA	6.01	6.30	1.41	090
57285		A	Repair paravag defect, vag	11.52	NA	NA	5.17	5.17	0.63	090
57287		A	Revise/remove sling repair	11.49	NA	NA	6.45	6.21	0.90	090
57288		A	Repair bladder defect	14.01	NA	NA	6.99	6.73	1.12	090
57289		A	Repair bladder & vagina	12.69	NA	NA	6.57	6.44	1.21	090
57291		A	Construction of vagina	8.54	NA	NA	4.58	4.67	0.93	090
57292		A	Construct vagina with graft	13.91	NA	NA	6.03	6.26	1.58	090
57295		A	Revise vag graft via vagina	7.74	NA	NA	4.24	4.29	0.91	090
57296		A	Revise vag graft, open abd	16.46	NA	NA	6.57	6.57	1.68	090
57300		A	Repair rectum-vagina fistula	8.58	NA	NA	4.48	4.43	0.87	090
57305		A	Repair rectum-vagina fistula	15.24	NA	NA	6.25	6.26	1.73	090
57307		A	Fistula repair & colostomy	17.02	NA	NA	6.96	6.98	2.02	090
57308		A	Fistula repair, transperine	10.48	NA	NA	4.91	4.96	1.14	090
57310		A	Repair urethrovaginal lesion	7.55	NA	NA	5.00	4.71	0.54	090
57311		A	Repair urethrovaginal lesion	8.81	NA	NA	5.49	5.15	0.65	090
57320		A	Repair bladder-vagina lesion	8.78	NA	NA	5.35	5.11	0.69	090
57330		A	Repair bladder-vagina lesion	13.11	NA	NA	6.76	6.51	1.06	090
57335		A	Repair vagina	19.87	NA	NA	8.49	8.63	1.92	090
57400		A	Dilation of vagina	2.27	NA	NA	1.01	1.04	0.26	000
57410		A	Pelvic examination	1.75	NA	NA	0.87	0.88	0.18	000
57415		A	Remove vaginal foreign body	2.44	NA	NA	1.52	1.50	0.24	010
57420		A	Exam of vagina w/scope	1.60	1.25	1.27	0.57	0.59	0.19	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.60	1.67	0.73	0.79	0.27	000
57423		A	Repair paravag defect, lap	16.00	NA	NA	6.54	6.54	1.65	090
57425		A	Laparoscopy, surg, colpopexy	16.93	NA	NA	6.98	6.90	1.76	090
57452		A	Exam of cervix w/scope	1.50	1.19	1.21	0.74	0.75	0.18	000
57454		A	Bx/curett of cervix w/scope	2.33	1.41	1.47	0.96	1.01	0.28	000
57455		A	Biopsy of cervix w/scope	1.99	1.51	1.56	0.67	0.72	0.24	000
57456		A	Endocerv curettage w/scope	1.85	1.47	1.51	0.63	0.68	0.22	000
57460		A	Bx of cervix w/scope, leep	2.83	4.32	4.71	1.10	1.17	0.34	000
57461		A	Conz of cervix w/scope, leep	3.43	4.62	5.00	1.07	1.17	0.41	000
57500		A	Biopsy of cervix	1.20	2.03	2.16	0.65	0.64	0.12	000
57505		A	Endocervical curettage	1.16	1.33	1.37	1.08	1.08	0.14	010
57510		A	Cauterization of cervix	1.90	1.31	1.38	0.90	0.94	0.23	010
57511		A	Cryocautery of cervix	1.92	1.62	1.67	1.28	1.30	0.23	010
57513		A	Laser surgery of cervix	1.92	1.59	1.62	1.29	1.32	0.23	010
57520		A	Conization of cervix	4.06	3.40	3.54	2.53	2.62	0.49	090
57522		A	Conization of cervix	3.62	2.79	2.89	2.27	2.32	0.41	090
57530		A	Removal of cervix	5.19	NA	NA	3.17	3.23	0.58	090
57531		A	Removal of cervix, radical	29.77	NA	NA	10.81	11.42	3.35	090
57540		A	Removal of residual cervix	13.19	NA	NA	5.54	5.72	1.49	090
57545		A	Remove cervix/repair pelvis	14.00	NA	NA	5.76	5.99	1.52	090

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57550		A	Removal of residual cervix	6.24	NA	NA	3.68	3.72	0.67	090
57555		A	Remove cervix/repair vagina	9.84	NA	NA	4.66	4.77	1.09	090
57556		A	Remove cervix, repair bowel	9.26	NA	NA	4.69	4.74	0.92	090
57558		A	D&c of cervical stump	1.69	1.37	1.40	1.07	1.09	0.20	010
57700		A	Revision of cervix	4.22	NA	NA	3.44	3.36	0.41	090
57720		A	Revision of cervix	4.53	NA	NA	2.94	2.99	0.49	090
57800		A	Dilation of cervical canal	0.77	0.73	0.74	0.41	0.43	0.09	000
58100		A	Biopsy of uterus lining	1.53	1.15	1.20	0.58	0.62	0.18	000
58110		A	Bx done w/colposcopy add-on	0.77	0.40	0.44	0.21	0.24	0.09	ZZZ
58120		A	Dilation and curettage	3.54	2.72	2.62	1.67	1.73	0.39	010
58140		A	Myomectomy abdom method	15.69	NA	NA	6.20	6.44	1.82	090
58145		A	Myomectomy vag method	8.81	NA	NA	4.28	4.41	0.97	090
58146		A	Myomectomy abdom complex	20.24	NA	NA	7.54	7.92	2.33	090
58150		A	Total hysterectomy	17.21	NA	NA	6.60	6.83	1.85	090
58152		A	Total hysterectomy	21.73	NA	NA	8.07	8.53	2.48	090
58180		A	Partial hysterectomy	16.50	NA	NA	6.41	6.68	1.64	090
58200		A	Extensive hysterectomy	23.00	NA	NA	8.19	8.65	2.55	090
58210		A	Extensive hysterectomy	30.76	NA	NA	10.79	11.41	3.38	090
58240		A	Removal of pelvis contents	49.02	NA	NA	17.97	17.90	4.23	090
58260		A	Vaginal hysterectomy	14.02	NA	NA	5.85	6.07	1.57	090
58262		A	Vag hyst including t/o	15.81	NA	NA	6.32	6.59	1.80	090
58263		A	Vag hyst w/t/o & vag repair	17.10	NA	NA	6.73	7.03	1.95	090
58267		A	Vag hyst w/urinary repair	18.23	NA	NA	7.08	7.41	2.07	090
58270		A	Vag hyst w/enterocele repair	15.20	NA	NA	6.00	6.27	1.74	090
58275		A	Hysterectomy/revise vagina	16.90	NA	NA	6.73	7.00	1.92	090
58280		A	Hysterectomy/revise vagina	18.20	NA	NA	7.05	7.36	2.07	090
58285		A	Extensive hysterectomy	23.30	NA	NA	8.13	8.59	2.71	090
58290		A	Vag hyst complex	20.17	NA	NA	7.44	7.87	2.30	090
58291		A	Vag hyst incl t/o, complex	21.96	NA	NA	8.00	8.48	2.53	090
58292		A	Vag hyst t/o & repair, compl	23.25	NA	NA	8.30	8.82	2.68	090
58293		A	Vag hyst w/uro repair, compl	24.23	NA	NA	8.52	9.06	2.79	090
58294		A	Vag hyst w/enterocele, compl	21.45	NA	NA	7.73	8.19	2.40	090
58300		N	Insert intrauterine device	1.01	0.78	0.94	0.32	0.34	0.12	XXX
58301		A	Remove intrauterine device	1.27	1.06	1.12	0.35	0.38	0.15	000
58321		A	Artificial insemination	0.92	1.03	1.06	0.28	0.30	0.10	000
58322		A	Artificial insemination	1.10	1.04	1.08	0.31	0.34	0.13	000
58323		A	Sperm washing	0.23	0.15	0.25	0.07	0.07	0.03	000
58340		A	Catheter for hysterography	0.88	2.17	2.42	0.57	0.59	0.09	000
58345		A	Reopen fallopian tube	4.67	NA	NA	2.11	2.19	0.41	010
58346		A	Insert heyman uteri capsule	7.48	NA	NA	3.64	3.71	0.56	090
58350		A	Reopen fallopian tube	1.03	1.36	1.40	0.89	0.90	0.12	010
58353		A	Endometr ablate, thermal	3.57	22.98	26.19	1.72	1.81	0.43	010
58356		A	Endometrial cryoablation	6.36	43.67	48.18	1.87	2.08	0.82	010
58400		A	Suspension of uterus	7.06	NA	NA	3.88	3.90	0.75	090

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58410		A	Suspension of uterus	13.70	NA	NA	5.59	5.81	1.45	090
58520		A	Repair of ruptured uterus	13.38	NA	NA	5.51	5.65	1.47	090
58540		A	Revision of uterus	15.61	NA	NA	6.24	6.43	1.79	090
58541		A	Lsh, uterus 250 g or less	14.57	NA	NA	6.20	6.20	1.68	090
58542		A	Lsh w/t/o ut 250 g or less	16.43	NA	NA	6.74	6.74	1.69	090
58543		A	Lsh uterus above 250 g	16.74	NA	NA	6.81	6.81	1.73	090
58544		A	Lsh w/t/o uterus above 250 g	18.24	NA	NA	7.18	7.18	1.89	090
58545		A	Laparoscopic myomectomy	15.45	NA	NA	5.90	6.23	1.78	090
58546		A	Laparo-myomectomy, complex	19.84	NA	NA	7.14	7.60	2.31	090
58548		A	Lap radical hyst	31.45	NA	NA	11.17	11.17	3.52	090
58550		A	Laparo-asst vag hysterectomy	14.97	NA	NA	6.20	6.48	1.73	090
58552		A	Laparo-vag hyst incl t/o	16.78	NA	NA	6.63	6.98	1.73	090
58553		A	Laparo-vag hyst, complex	19.96	NA	NA	7.17	7.61	2.31	090
58554		A	Laparo-vag hyst w/t/o, compl	22.98	NA	NA	8.32	8.85	2.28	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.77	2.63	1.24	1.32	0.40	000
58558		A	Hysteroscopy, biopsy	4.74	3.65	3.29	1.67	1.80	0.57	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	2.07	2.24	0.74	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	2.31	2.50	0.84	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	3.14	3.43	1.21	000
58562		A	Hysteroscopy, remove fb	5.20	3.55	3.25	1.77	1.92	0.63	000
58563		A	Hysteroscopy, ablation	6.16	37.51	42.25	2.07	2.24	0.74	000
58565		A	Hysteroscopy, sterilization	7.06	42.30	44.17	3.42	3.54	1.19	090
58570		A	Tlh, uterus 250 g or less	15.75	NA	NA	6.53	6.53	1.82	090
58571		A	Tlh w/t/o 250 g or less	17.56	NA	NA	7.02	7.02	1.81	090
58572		A	Tlh, uterus over 250 g	19.96	NA	NA	7.68	7.68	2.31	090
58573		A	Tlh w/t/o uterus over 250 g	22.98	NA	NA	8.49	8.49	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	2.87	2.99	0.66	090
58605		A	Division of fallopian tube	5.25	NA	NA	2.71	2.81	0.59	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.41	0.45	0.18	ZZZ
58615		A	Occlude fallopian tube(s)	3.91	NA	NA	2.00	2.18	0.47	010
58660		A	Laparoscopy, lysis	11.54	NA	NA	4.53	4.72	1.40	090
58661		A	Laparoscopy, remove adnexa	11.30	NA	NA	4.03	4.31	1.34	010
58662		A	Laparoscopy, excise lesions	12.08	NA	NA	4.80	5.06	1.43	090
58670		A	Laparoscopy, tubal cautery	5.86	NA	NA	2.98	3.05	0.67	090
58671		A	Laparoscopy, tubal block	5.86	NA	NA	2.97	3.05	0.68	090
58672		A	Laparoscopy, fimbrioplasty	12.88	NA	NA	4.73	5.10	1.60	090
58673		A	Laparoscopy, salpingostomy	13.99	NA	NA	5.23	5.57	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	5.52	5.64	1.51	090
58720		A	Removal of ovary/tube(s)	12.08	NA	NA	5.13	5.30	1.39	090
58740		A	Revise fallopian tube(s)	14.79	NA	NA	6.11	6.37	1.72	090
58750		A	Repair oviduct	15.56	NA	NA	6.13	6.44	1.85	090

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58752		A	Revise ovarian tube(s)	15.56	NA	NA	6.48	6.60	1.81	090
58760		A	Remove tubal obstruction	13.85	NA	NA	5.73	5.99	1.80	090
58770		A	Create new tubal opening	14.69	NA	NA	5.33	5.73	1.74	090
58800		A	Drainage of ovarian cyst(s)	4.54	3.29	3.38	2.76	2.80	0.43	090
58805		A	Drainage of ovarian cyst(s)	6.34	NA	NA	3.56	3.55	0.69	090
58820		A	Drain ovary abscess, open	4.62	NA	NA	2.97	3.06	0.52	090
58822		A	Drain ovary abscess, percut	11.71	NA	NA	5.50	5.44	1.16	090
58823		A	Drain pelvic abscess, percut	3.37	20.26	20.55	1.21	1.19	0.24	000
58825		A	Transposition, ovary(s)	11.70	NA	NA	4.99	5.20	1.32	090
58900		A	Biopsy of ovary(s)	6.51	NA	NA	3.58	3.58	0.69	090
58920		A	Partial removal of ovary(s)	11.87	NA	NA	4.92	5.09	1.43	090
58925		A	Removal of ovarian cyst(s)	12.33	NA	NA	5.31	5.41	1.41	090
58940		A	Removal of ovary(s)	8.12	NA	NA	4.07	4.08	0.91	090
58943		A	Removal of ovary(s)	19.42	NA	NA	7.21	7.58	2.23	090
58950		A	Resect ovarian malignancy	18.24	NA	NA	7.28	7.57	2.05	090
58951		A	Resect ovarian malignancy	24.15	NA	NA	8.65	9.11	2.64	090
58952		A	Resect ovarian malignancy	27.15	NA	NA	9.84	10.33	3.03	090
58953		A	Tah, rad dissect for debulk	33.97	NA	NA	11.73	12.45	3.84	090
58954		A	Tah rad debulk/lymph remove	36.97	NA	NA	12.62	13.41	4.18	090
58956		A	Bso, omentectomy w/tah	22.65	NA	NA	8.64	9.07	4.01	090
58957		A	Resect recurrent gyn mal	26.06	NA	NA	9.58	9.58	2.95	090
58958		A	Resect recur gyn mal w/lym	29.06	NA	NA	10.52	10.52	3.29	090
58960		A	Exploration of abdomen	15.68	NA	NA	6.35	6.60	1.80	090
58970		A	Retrieval of oocyte	3.52	1.84	1.96	1.27	1.33	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	2.43	2.49	1.58	1.65	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	1.76	1.84	0.55	0.58	0.31	000
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.25	1.29	0.71	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.15	1.25	0.82	000
59015		A	Chorion biopsy	2.20	1.43	1.46	0.80	0.86	0.52	000
59020		A	Fetal contract stress test	0.66	1.08	1.01	1.08	1.01	0.26	000
59020	TC	A	Fetal contract stress test	0.00	0.90	0.80	0.90	0.80	0.10	000
59020	26	A	Fetal contract stress test	0.66	0.18	0.20	0.18	0.20	0.16	000
59025		A	Fetal non-stress test	0.53	0.63	0.59	0.63	0.59	0.15	000
59025	TC	A	Fetal non-stress test	0.00	0.48	0.42	0.48	0.42	0.02	000
59025	26	A	Fetal non-stress test	0.53	0.15	0.16	0.15	0.16	0.13	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.56	0.61	0.47	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.24	0.27	0.21	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.20	0.22	0.17	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.69	4.81	1.96	2.05	0.28	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	3.24	3.21	0.16	000
59074		A	Fetal fluid drainage w/us	5.24	4.14	4.25	1.87	1.98	0.28	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	2.87	2.93	0.16	000

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59100		A	Remove uterus lesion	13.26	NA	NA	5.52	5.76	2.95	090
59120		A	Treat ectopic pregnancy	12.56	NA	NA	5.48	5.67	2.73	090
59121		A	Treat ectopic pregnancy	12.64	NA	NA	5.41	5.65	2.79	090
59130		A	Treat ectopic pregnancy	14.98	NA	NA	6.75	6.26	3.39	090
59135		A	Treat ectopic pregnancy	14.82	NA	NA	6.63	6.79	3.31	090
59136		A	Treat ectopic pregnancy	14.15	NA	NA	5.77	5.99	3.14	090
59140		A	Treat ectopic pregnancy	5.86	NA	NA	3.65	3.30	1.29	090
59150		A	Treat ectopic pregnancy	12.19	NA	NA	5.26	5.45	2.79	090
59151		A	Treat ectopic pregnancy	12.01	NA	NA	4.92	5.21	2.74	090
59160		A	D & c after delivery	2.73	2.01	2.34	1.19	1.43	0.64	010
59200		A	Insert cervical dilator	0.79	0.94	1.01	0.22	0.24	0.19	000
59300		A	Episiotomy or vaginal repair	2.41	2.16	2.16	0.97	0.97	0.57	000
59320		A	Revision of cervix	2.48	NA	NA	1.01	1.07	0.59	000
59325		A	Revision of cervix	4.06	NA	NA	1.44	1.55	0.88	000
59350		A	Repair of uterus	4.94	NA	NA	1.25	1.41	1.17	000
59400		A	Obstetrical care	26.80	NA	NA	14.26	14.54	5.50	MMM
59409		A	Obstetrical care	13.48	NA	NA	3.75	4.14	3.22	MMM
59410		A	Obstetrical care	15.29	NA	NA	4.99	5.33	3.52	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.64	0.69	0.40	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.44	0.49	0.38	MMM
59425		A	Antepartum care only	6.22	4.29	4.27	1.71	1.75	1.14	MMM
59426		A	Antepartum care only	11.04	7.86	7.79	3.03	3.08	1.98	MMM
59430		A	Care after delivery	2.13	1.09	1.13	0.72	0.77	0.50	MMM
59510		A	Cesarean delivery	30.34	NA	NA	16.15	16.45	6.25	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	4.48	4.92	3.80	MMM
59515		A	Cesarean delivery	18.26	NA	NA	6.24	6.65	4.13	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	2.39	2.62	1.95	ZZZ
59610		A	Vbac delivery	28.21	NA	NA	15.04	15.27	5.87	MMM
59612		A	Vbac delivery only	15.04	NA	NA	4.26	4.71	3.59	MMM
59614		A	Vbac care after delivery	16.59	NA	NA	5.18	5.63	3.89	MMM
59618		A	Attempted vbac delivery	31.78	NA	NA	16.72	17.12	6.61	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	4.94	5.40	4.17	MMM
59622		A	Attempted vbac after care	19.70	NA	NA	6.83	7.29	4.50	MMM
59812		A	Treatment of miscarriage	4.39	3.13	2.99	2.38	2.43	0.95	090
59820		A	Care of miscarriage	4.68	4.11	4.19	3.49	3.51	0.95	090
59821		A	Treatment of miscarriage	4.97	3.88	3.98	3.21	3.26	1.06	090
59830		A	Treat uterus infection	6.51	NA	NA	3.47	3.61	1.44	090
59840		R	Abortion	3.01	2.05	2.07	1.82	1.90	0.71	010
59841		R	Abortion	5.57	3.14	3.23	2.57	2.67	1.24	010
59850		R	Abortion	5.90	NA	NA	3.13	3.16	1.28	090
59851		R	Abortion	5.92	NA	NA	3.28	3.40	1.28	090
59852		R	Abortion	8.23	NA	NA	4.81	4.87	1.81	090
59855		R	Abortion	6.38	NA	NA	3.11	3.22	1.45	090
59856		R	Abortion	7.74	NA	NA	3.35	3.53	1.79	090

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59857		R	Abortion	9.30	NA	NA	4.11	4.26	2.02	090
59866		R	Abortion (mpr)	3.99	NA	NA	1.46	1.57	0.87	000
59870		A	Evacuate mole of uterus	6.40	NA	NA	4.66	4.62	1.42	090
59871		A	Remove cerclage suture	2.13	NA	NA	0.93	0.98	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	2.20	2.14	1.80	1.78	0.15	010
60100		A	Biopsy of thyroid	1.56	1.34	1.36	0.54	0.54	0.10	000
60200		A	Remove thyroid lesion	9.91	NA	NA	5.51	5.63	1.01	090
60210		A	Partial thyroid excision	11.15	NA	NA	5.26	5.36	1.23	090
60212		A	Partial thyroid excision	16.32	NA	NA	7.08	7.24	1.95	090
60220		A	Partial removal of thyroid	12.29	NA	NA	5.68	5.81	1.32	090
60225		A	Partial removal of thyroid	14.67	NA	NA	6.94	7.06	1.64	090
60240		A	Removal of thyroid	16.18	NA	NA	6.41	6.71	1.86	090
60252		A	Removal of thyroid	21.88	NA	NA	8.85	9.17	2.30	090
60254		A	Extensive thyroid surgery	28.29	NA	NA	11.29	12.02	2.61	090
60260		A	Repeat thyroid surgery	18.18	NA	NA	7.41	7.73	1.94	090
60270		A	Removal of thyroid	23.07	NA	NA	9.30	9.60	2.33	090
60271		A	Removal of thyroid	17.54	NA	NA	7.23	7.58	1.75	090
60280		A	Remove thyroid duct lesion	6.05	NA	NA	4.48	4.53	0.54	090
60281		A	Remove thyroid duct lesion	8.71	NA	NA	5.21	5.37	0.73	090
60300		A	Aspir/inj thyroid cyst	0.97	1.95	1.82	0.31	0.31	0.07	000
60500		A	Explore parathyroid glands	16.69	NA	NA	6.88	7.02	2.01	090
60502		A	Re-explore parathyroids	21.01	NA	NA	8.51	8.73	2.54	090
60505		A	Explore parathyroid glands	22.91	NA	NA	9.45	9.83	2.65	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	1.21	1.31	0.53	ZZZ
60520		A	Removal of thymus gland	17.07	NA	NA	6.92	7.27	2.20	090
60521		A	Removal of thymus gland	19.11	NA	NA	8.17	8.52	2.82	090
60522		A	Removal of thymus gland	23.37	NA	NA	9.59	10.02	3.27	090
60540		A	Explore adrenal gland	17.91	NA	NA	8.22	8.07	1.75	090
60545		A	Explore adrenal gland	20.82	NA	NA	8.72	8.68	2.08	090
60600		A	Remove carotid body lesion	24.99	NA	NA	8.92	9.44	2.20	090
60605		A	Remove carotid body lesion	31.86	NA	NA	11.52	11.72	2.50	090
60650		A	Laparoscopy adrenalectomy	20.63	NA	NA	8.11	8.08	2.29	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
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	1.18	1.12	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	1.60	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	1.18	1.20	0.11	000
61055		A	Injection into brain canal	2.10	NA	NA	1.34	1.36	0.17	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.11	1.09	0.17	000

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61105		A	Twist drill hole	5.40	NA	NA	4.59	4.43	1.32	090
61107		A	Drill skull for implantation	4.99	NA	NA	1.83	2.01	1.29	000
61108		A	Drill skull for drainage	11.51	NA	NA	8.25	7.98	2.64	090
61120		A	Burr hole for puncture	9.52	NA	NA	6.65	6.49	2.10	090
61140		A	Pierce skull for biopsy	17.10	NA	NA	10.42	10.30	4.12	090
61150		A	Pierce skull for drainage	18.80	NA	NA	10.57	10.53	4.32	090
61151		A	Pierce skull for drainage	13.41	NA	NA	7.96	7.93	3.01	090
61154		A	Pierce skull & remove clot	16.92	NA	NA	10.83	10.50	4.21	090
61156		A	Pierce skull for drainage	17.37	NA	NA	9.88	9.88	4.23	090
61210		A	Pierce skull, implant device	5.83	NA	NA	2.15	2.34	1.50	000
61215		A	Insert brain-fluid device	5.77	NA	NA	5.44	5.09	1.26	090
61250		A	Pierce skull & explore	11.41	NA	NA	7.15	7.09	2.77	090
61253		A	Pierce skull & explore	13.41	NA	NA	7.00	7.19	2.62	090
61304		A	Open skull for exploration	23.31	NA	NA	12.47	12.57	5.63	090
61305		A	Open skull for exploration	28.51	NA	NA	15.17	15.22	6.09	090
61312		A	Open skull for drainage	30.07	NA	NA	15.28	15.24	6.36	090
61313		A	Open skull for drainage	27.94	NA	NA	15.29	15.19	6.45	090
61314		A	Open skull for drainage	25.77	NA	NA	14.20	13.93	6.28	090
61315		A	Open skull for drainage	29.52	NA	NA	15.48	15.63	7.16	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.51	0.54	0.35	ZZZ
61320		A	Open skull for drainage	27.32	NA	NA	14.31	14.44	6.62	090
61321		A	Open skull for drainage	30.40	NA	NA	15.17	15.43	7.14	090
61322		A	Decompressive craniotomy	34.08	NA	NA	17.46	17.03	7.63	090
61323		A	Decompressive lobectomy	34.93	NA	NA	16.90	16.72	8.03	090
61330		A	Decompress eye socket	25.17	NA	NA	11.80	12.29	2.32	090
61332		A	Explore/biopsy eye socket	28.50	NA	NA	12.70	13.44	4.83	090
61333		A	Explore orbit/remove lesion	29.17	NA	NA	13.26	13.85	3.92	090
61334		A	Explore orbit/remove object	19.50	NA	NA	8.38	8.96	1.75	090
61340		A	Subtemporal decompression	20.01	NA	NA	11.14	11.15	4.84	090
61343		A	Incise skull (press relief)	31.73	NA	NA	16.07	16.27	7.64	090
61345		A	Relieve cranial pressure	29.10	NA	NA	15.35	15.38	7.04	090
61440		A	Incise skull for surgery	28.53	NA	NA	15.25	15.01	6.90	090
61450		A	Incise skull for surgery	27.59	NA	NA	14.05	14.13	5.79	090
61458		A	Incise skull for brain wound	28.71	NA	NA	15.11	15.22	7.03	090
61460		A	Incise skull for surgery	30.11	NA	NA	14.63	15.10	6.04	090
61470		A	Incise skull for surgery	27.52	NA	NA	14.39	14.27	5.90	090
61480		A	Incise skull for surgery	27.95	NA	NA	10.86	11.98	6.73	090
61490		A	Incise skull for surgery	27.12	NA	NA	14.25	14.28	6.92	090
61500		A	Removal of skull lesion	19.05	NA	NA	10.72	10.75	4.11	090
61501		A	Remove infected skull bone	16.22	NA	NA	9.67	9.56	3.22	090
61510		A	Removal of brain lesion	30.63	NA	NA	17.02	16.96	7.35	090
61512		A	Remove brain lining lesion	36.99	NA	NA	18.54	18.85	9.08	090
61514		A	Removal of brain abscess	27.10	NA	NA	14.49	14.49	6.54	090
61516		A	Removal of brain lesion	26.45	NA	NA	14.10	14.16	6.35	090

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61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.51	0.54	0.35	ZZZ
61518		A	Removal of brain lesion	39.69	NA	NA	20.23	20.47	9.65	090
61519		A	Remove brain lining lesion	43.28	NA	NA	20.77	21.27	10.63	090
61520		A	Removal of brain lesion	56.89	NA	NA	26.01	27.13	11.21	090
61521		A	Removal of brain lesion	46.84	NA	NA	21.87	22.48	11.39	090
61522		A	Removal of brain abscess	31.41	NA	NA	16.33	16.37	7.62	090
61524		A	Removal of brain lesion	29.76	NA	NA	15.26	15.38	7.16	090
61526		A	Removal of brain lesion	53.90	NA	NA	22.48	24.26	7.07	090
61530		A	Removal of brain lesion	45.43	NA	NA	19.31	20.77	6.15	090
61531		A	Implant brain electrodes	16.28	NA	NA	10.58	10.23	3.79	090
61533		A	Implant brain electrodes	21.36	NA	NA	11.86	11.79	5.12	090
61534		A	Removal of brain lesion	22.88	NA	NA	13.14	12.89	5.44	090
61535		A	Remove brain electrodes	13.05	NA	NA	8.97	8.59	3.02	090
61536		A	Removal of brain lesion	37.59	NA	NA	18.64	18.95	9.21	090
61537		A	Removal of brain tissue	36.35	NA	NA	17.32	16.69	6.94	090
61538		A	Removal of brain tissue	39.35	NA	NA	18.66	17.84	6.94	090
61539		A	Removal of brain tissue	34.15	NA	NA	16.74	17.01	8.32	090
61540		A	Removal of brain tissue	31.30	NA	NA	16.11	16.41	8.32	090
61541		A	Incision of brain tissue	30.81	NA	NA	15.79	15.91	6.60	090
61542		A	Removal of brain tissue	33.03	NA	NA	16.80	17.08	8.03	090
61543		A	Removal of brain tissue	31.18	NA	NA	15.29	15.59	7.56	090
61544		A	Remove & treat brain lesion	27.26	NA	NA	10.71	11.50	5.97	090
61545		A	Excision of brain tumor	46.23	NA	NA	22.53	22.98	10.63	090
61546		A	Removal of pituitary gland	33.31	NA	NA	16.74	16.95	7.67	090
61548		A	Removal of pituitary gland	23.27	NA	NA	11.65	11.95	3.43	090
61550		A	Release of skull seams	15.44	NA	NA	9.05	8.53	0.98	090
61552		A	Release of skull seams	20.27	NA	NA	12.17	11.41	1.06	090
61556		A	Incise skull/sutures	24.00	NA	NA	12.66	12.35	4.65	090
61557		A	Incise skull/sutures	23.16	NA	NA	13.66	13.66	5.80	090
61558		A	Excision of skull/sutures	26.35	NA	NA	14.71	14.60	1.36	090
61559		A	Excision of skull/sutures	33.82	NA	NA	18.40	18.65	8.51	090
61563		A	Excision of skull tumor	28.35	NA	NA	14.85	14.97	5.17	090
61564		A	Excision of skull tumor	34.59	NA	NA	17.93	18.04	8.78	090
61566		A	Removal of brain tissue	32.32	NA	NA	16.76	17.03	6.94	090
61567		A	Incision of brain tissue	36.84	NA	NA	19.10	19.52	6.54	090
61570		A	Remove foreign body, brain	26.38	NA	NA	13.81	13.85	5.88	090
61571		A	Incise skull for brain wound	28.29	NA	NA	15.16	15.18	6.79	090
61575		A	Skull base/brainstem surgery	36.43	NA	NA	16.08	16.99	5.34	090
61576		A	Skull base/brainstem surgery	55.11	NA	NA	31.99	32.72	5.58	090
61580		A	Craniofacial approach, skull	34.34	NA	NA	22.87	23.58	3.37	090
61581		A	Craniofacial approach, skull	38.88	NA	NA	26.83	26.01	3.92	090
61582		A	Craniofacial approach, skull	34.93	NA	NA	30.75	29.92	7.21	090
61583		A	Craniofacial approach, skull	38.41	NA	NA	25.95	25.77	9.21	090
61584		A	Orbitocranial approach/skull	37.61	NA	NA	25.66	25.40	8.18	090

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61585		A	Orbitocranial approach/skull	42.46	NA	NA	24.52	25.04	7.03	090
61586		A	Resect nasopharynx, skull	27.28	NA	NA	21.81	22.03	4.37	090
61590		A	Infratemporal approach/skull	46.87	NA	NA	24.99	25.93	5.31	090
61591		A	Infratemporal approach/skull	46.87	NA	NA	25.07	26.22	5.66	090
61592		A	Orbitocranial approach/skull	42.98	NA	NA	27.44	27.24	10.07	090
61595		A	Transtemporal approach/skull	33.57	NA	NA	21.58	21.80	3.98	090
61596		A	Transcochlear approach/skull	39.31	NA	NA	21.20	22.04	3.40	090
61597		A	Transcondylar approach/skull	40.73	NA	NA	22.88	22.94	8.84	090
61598		A	Transpetrosal approach/skull	36.41	NA	NA	20.88	21.49	5.70	090
61600		A	Resect/excise cranial lesion	29.84	NA	NA	19.81	19.82	3.79	090
61601		A	Resect/excise cranial lesion	31.04	NA	NA	22.09	21.72	6.63	090
61605		A	Resect/excise cranial lesion	32.40	NA	NA	19.59	20.21	2.86	090
61606		A	Resect/excise cranial lesion	41.94	NA	NA	25.16	25.18	8.97	090
61607		A	Resect/excise cranial lesion	40.82	NA	NA	21.66	22.22	6.90	090
61608		A	Resect/excise cranial lesion	45.45	NA	NA	26.02	26.19	10.75	090
61609		A	Transect artery, sinus	9.88	NA	NA	3.15	3.58	2.56	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	11.08	11.61	7.68	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	2.77	3.04	1.89	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	9.48	10.45	4.31	ZZZ
61613		A	Remove aneurysm, sinus	44.94	NA	NA	25.83	25.97	8.45	090
61615		A	Resect/excise lesion, skull	35.63	NA	NA	21.48	21.82	4.73	090
61616		A	Resect/excise lesion, skull	46.60	NA	NA	27.08	27.50	8.26	090
61618		A	Repair dura	18.58	NA	NA	10.30	10.35	3.72	090
61619		A	Repair dura	22.01	NA	NA	11.27	11.53	3.95	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	3.76	3.84	1.05	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	7.53	7.38	1.96	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	6.22	6.05	1.24	000
61630		R	Intracranial angioplasty	22.07	NA	NA	8.58	9.57	2.02	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	9.29	10.37	2.21	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	3.93	3.93	0.71	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.38	1.38	0.25	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	2.76	2.76	0.50	ZZZ
61680		A	Intracranial vessel surgery	32.40	NA	NA	16.92	17.07	7.95	090
61682		A	Intracranial vessel surgery	63.31	NA	NA	27.54	28.74	15.90	090
61684		A	Intracranial vessel surgery	41.49	NA	NA	19.34	20.03	10.31	090
61686		A	Intracranial vessel surgery	67.32	NA	NA	30.35	31.49	16.71	090
61690		A	Intracranial vessel surgery	31.18	NA	NA	16.11	16.29	6.94	090
61692		A	Intracranial vessel surgery	54.43	NA	NA	24.74	25.45	13.43	090
61697		A	Brain aneurysm repr, complx	63.22	NA	NA	28.80	28.63	12.85	090
61698		A	Brain aneurysm repr, complx	69.45	NA	NA	31.36	30.23	12.54	090
61700		A	Brain aneurysm repr, simple	50.44	NA	NA	23.89	24.90	13.02	090
61702		A	Inner skull vessel surgery	59.86	NA	NA	27.29	27.01	10.79	090
61703		A	Clamp neck artery	18.70	NA	NA	11.10	10.95	4.06	090
61705		A	Revise circulation to head	37.97	NA	NA	17.54	17.99	8.87	090

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61708		A	Revise circulation to head	37.07	NA	NA	14.23	14.47	2.51	090
61710		A	Revise circulation to head	31.19	NA	NA	14.59	14.37	4.52	090
61711		A	Fusion of skull arteries	38.10	NA	NA	18.24	18.65	9.42	090
61720		A	Incise skull/brain surgery	17.52	NA	NA	8.41	8.81	2.79	090
61735		A	Incise skull/brain surgery	22.22	NA	NA	9.91	10.49	2.73	090
61750		A	Incise skull/brain biopsy	19.73	NA	NA	11.03	10.93	4.72	090
61751		A	Brain biopsy w/ct/mr guide	18.64	NA	NA	11.46	11.31	4.56	090
61760		A	Implant brain electrodes	22.24	NA	NA	12.16	11.31	5.42	090
61770		A	Incise skull for treatment	23.09	NA	NA	10.84	11.20	3.55	090
61790		A	Treat trigeminal nerve	11.50	NA	NA	7.55	7.14	2.82	090
61791		A	Treat trigeminal tract	15.31	NA	NA	9.06	9.03	3.40	090
61793		A	Focus radiation beam	17.75	NA	NA	9.48	9.65	4.46	090
61795		A	Brain surgery using computer	4.03	NA	NA	1.43	1.58	0.79	ZZZ
61850		A	Implant neuroelectrodes	13.26	NA	NA	8.31	8.16	3.22	090
61860		A	Implant neuroelectrodes	22.16	NA	NA	11.95	11.99	4.95	090
61863		A	Implant neuroelectrode	20.56	NA	NA	12.38	12.24	5.43	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	1.67	1.83	5.43	ZZZ
61867		A	Implant neuroelectrode	32.88	NA	NA	16.69	17.04	5.43	090
61868		A	Implant neuroelectrde, addl	7.91	NA	NA	2.93	3.21	5.43	ZZZ
61870		A	Implant neuroelectrodes	16.24	NA	NA	9.70	9.71	3.87	090
61875		A	Implant neuroelectrodes	16.36	NA	NA	9.75	9.46	2.95	090
61880		A	Revise/remove neuroelectrode	6.87	NA	NA	5.44	5.23	1.66	090
61885		A	Insrt/redo neurostim 1 array	7.37	NA	NA	7.44	6.91	1.59	090
61886		A	Implant neurostim arrays	9.73	NA	NA	8.93	8.29	1.97	090
61888		A	Revise/remove neuroreceiver	5.20	NA	NA	3.49	3.54	1.33	010
62000		A	Treat skull fracture	13.83	NA	NA	6.92	6.58	1.06	090
62005		A	Treat skull fracture	17.53	NA	NA	10.05	9.75	3.87	090
62010		A	Treatment of head injury	21.30	NA	NA	11.71	11.72	5.14	090
62100		A	Repair brain fluid leakage	23.40	NA	NA	11.88	12.12	4.84	090
62115		A	Reduction of skull defect	22.71	NA	NA	7.02	8.18	5.51	090
62116		A	Reduction of skull defect	24.90	NA	NA	13.90	13.78	6.11	090
62117		A	Reduction of skull defect	28.26	NA	NA	14.61	14.82	4.53	090
62120		A	Repair skull cavity lesion	24.39	NA	NA	17.14	17.50	3.00	090
62121		A	Incise skull repair	22.93	NA	NA	14.05	14.42	4.17	090
62140		A	Repair of skull defect	14.45	NA	NA	8.53	8.49	3.47	090
62141		A	Repair of skull defect	15.97	NA	NA	9.30	9.25	3.76	090
62142		A	Remove skull plate/flap	11.73	NA	NA	7.83	7.63	2.73	090
62143		A	Replace skull plate/flap	14.05	NA	NA	8.61	8.48	3.37	090
62145		A	Repair of skull & brain	19.99	NA	NA	10.88	10.89	4.50	090
62146		A	Repair of skull with graft	17.18	NA	NA	9.45	9.50	3.62	090
62147		A	Repair of skull with graft	20.57	NA	NA	11.17	11.21	4.32	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	0.74	0.77	0.48	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.11	1.22	0.77	ZZZ
62161		A	Dissect brain w/scope	21.10	NA	NA	11.84	11.92	5.19	090

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62162		A	Remove colloid cyst w/scope	26.67	NA	NA	14.67	14.73	5.91	090
62163		A	Neuroendoscopy w/fb removal	16.40	NA	NA	10.48	10.35	4.01	090
62164		A	Remove brain tumor w/scope	29.27	NA	NA	15.60	15.46	5.38	090
62165		A	Remove pituit tumor w/scope	23.10	NA	NA	11.97	12.34	3.01	090
62180		A	Establish brain cavity shunt	22.45	NA	NA	12.46	12.43	4.98	090
62190		A	Establish brain cavity shunt	12.07	NA	NA	8.11	7.86	2.80	090
62192		A	Establish brain cavity shunt	13.25	NA	NA	8.04	7.94	3.02	090
62194		A	Replace/irrigate catheter	5.68	NA	NA	3.42	3.18	0.92	010
62200		A	Establish brain cavity shunt	19.19	NA	NA	10.71	10.76	4.65	090
62201		A	Brain cavity shunt w/scope	15.89	NA	NA	10.31	10.10	3.68	090
62220		A	Establish brain cavity shunt	14.00	NA	NA	8.18	8.14	3.35	090
62223		A	Establish brain cavity shunt	13.90	NA	NA	9.36	9.09	3.14	090
62225		A	Replace/irrigate catheter	6.11	NA	NA	5.27	4.98	1.39	090
62230		A	Replace/revise brain shunt	11.35	NA	NA	7.18	7.01	2.71	090
62252		A	Csf shunt reprogram	0.74	1.76	1.69	NA	NA	0.21	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.49	1.39	NA	NA	0.02	XXX
62252	26	A	Csf shunt reprogram	0.74	0.27	0.29	0.27	0.29	0.19	XXX
62256		A	Remove brain cavity shunt	7.30	NA	NA	5.91	5.61	1.72	090
62258		A	Replace brain cavity shunt	15.54	NA	NA	9.15	9.05	3.74	090
62263		A	Epidural lysis mult sessions	6.41	9.85	10.57	3.15	3.16	0.41	010
62264		A	Epidural lysis on single day	4.42	5.74	6.25	1.29	1.32	0.27	010
62268		A	Drain spinal cord cyst	4.73	6.76	7.97	1.79	1.88	0.43	000
62269		A	Needle biopsy, spinal cord	5.01	6.67	8.69	1.69	1.76	0.37	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.41	2.56	0.59	0.58	0.08	000
62272		A	Drain cerebro spinal fluid	1.35	3.11	3.24	0.62	0.64	0.18	000
62273		A	Inject epidural patch	2.15	1.71	1.96	0.59	0.62	0.13	000
62280		A	Treat spinal cord lesion	2.63	4.34	4.99	1.10	1.08	0.30	010
62281		A	Treat spinal cord lesion	2.66	4.06	4.47	1.02	0.99	0.19	010
62282		A	Treat spinal canal lesion	2.33	3.96	5.07	1.07	1.03	0.17	010
62284		A	Injection for myelogram	1.54	3.83	4.11	0.73	0.72	0.13	000
62287		A	Percutaneous diskectomy	8.88	NA	NA	4.32	4.64	0.58	090
62290		A	Inject for spine disk x-ray	3.00	4.55	5.20	1.16	1.22	0.23	000
62291		A	Inject for spine disk x-ray	2.91	4.31	4.72	1.10	1.14	0.26	000
62292		A	Injection into disk lesion	9.14	NA	NA	2.28	2.83	0.82	090
62294		A	Injection into spinal artery	12.77	NA	NA	6.68	6.42	1.24	090
62310		A	Inject spine c/t	1.91	3.09	3.52	0.59	0.61	0.12	000
62311		A	Inject spine l/s (cd)	1.54	2.72	3.27	0.54	0.55	0.09	000
62318		A	Inject spine w/cath, c/t	2.04	3.11	3.77	0.44	0.49	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	2.85	3.39	0.46	0.49	0.11	000
62350		A	Implant spinal canal cath	8.04	NA	NA	4.12	4.08	1.02	090
62351		A	Implant spinal canal cath	11.54	NA	NA	7.59	7.48	2.25	090
62355		A	Remove spinal canal catheter	6.60	NA	NA	3.45	3.38	0.71	090
62360		A	Insert spine infusion device	3.68	NA	NA	3.26	3.12	0.34	090
62361		A	Implant spine infusion pump	6.59	NA	NA	4.74	4.54	0.80	090

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62362		A	Implant spine infusion pump	8.58	NA	NA	4.73	4.64	1.18	090
62365		A	Remove spine infusion device	6.57	NA	NA	3.86	3.79	0.86	090
62367		A	Analyze spine infusion pump	0.48	0.44	0.48	0.12	0.11	0.03	XXX
62368		A	Analyze spine infusion pump	0.75	0.58	0.61	0.18	0.18	0.06	XXX
63001		A	Removal of spinal lamina	17.51	NA	NA	9.77	9.72	3.77	090
63003		A	Removal of spinal lamina	17.64	NA	NA	9.73	9.78	3.73	090
63005		A	Removal of spinal lamina	16.28	NA	NA	9.88	9.92	3.35	090
63011		A	Removal of spinal lamina	15.78	NA	NA	8.94	8.78	3.38	090
63012		A	Removal of spinal lamina	16.72	NA	NA	9.77	9.87	3.49	090
63015		A	Removal of spinal lamina	20.70	NA	NA	11.87	11.89	4.76	090
63016		A	Removal of spinal lamina	21.90	NA	NA	11.72	11.75	4.59	090
63017		A	Removal of spinal lamina	17.18	NA	NA	10.38	10.39	3.64	090
63020		A	Neck spine disk surgery	16.05	NA	NA	9.91	9.86	3.72	090
63030		A	Low back disk surgery	13.03	NA	NA	8.59	8.56	3.01	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.19	1.29	0.79	ZZZ
63040		A	Laminotomy, single cervical	20.18	NA	NA	10.96	11.11	4.68	090
63042		A	Laminotomy, single lumbar	18.61	NA	NA	10.57	10.77	4.26	090
63043		C	Laminotomy, add ╞l cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, add ╞l lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.82	NA	NA	10.32	10.34	3.99	090
63046		A	Removal of spinal lamina	17.12	NA	NA	9.84	9.94	3.56	090
63047		A	Removal of spinal lamina	15.22	NA	NA	9.35	9.50	3.24	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.32	1.41	0.72	ZZZ
63050		A	Cervical laminoplasty	21.88	NA	NA	12.04	12.00	4.67	090
63051		A	C-laminoplasty w/graft/plate	25.38	NA	NA	13.07	13.19	4.67	090
63055		A	Decompress spinal cord	23.42	NA	NA	12.50	12.67	5.29	090
63056		A	Decompress spinal cord	21.73	NA	NA	11.31	11.64	4.76	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	1.97	2.14	1.22	ZZZ
63064		A	Decompress spinal cord	26.09	NA	NA	13.00	13.37	5.71	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.24	1.34	0.69	ZZZ
63075		A	Neck spine disk surgery	19.47	NA	NA	10.99	11.28	4.63	090
63076		A	Neck spine disk surgery	4.04	NA	NA	1.52	1.66	0.96	ZZZ
63077		A	Spine disk surgery, thorax	22.75	NA	NA	11.18	11.60	3.99	090
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.21	1.32	0.66	ZZZ
63081		A	Removal of vertebral body	25.97	NA	NA	13.49	13.71	5.56	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	1.65	1.80	1.02	ZZZ
63085		A	Removal of vertebral body	29.34	NA	NA	13.45	13.97	4.49	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.15	1.26	0.59	ZZZ
63087		A	Removal of vertebral body	37.38	NA	NA	16.92	17.57	6.22	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	1.63	1.77	0.82	ZZZ
63090		A	Removal of vertebral body	30.78	NA	NA	14.33	14.78	4.22	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.13	1.21	0.48	ZZZ
63101		A	Removal of vertebral body	33.92	NA	NA	17.24	17.77	5.71	090
63102		A	Removal of vertebral body	33.92	NA	NA	16.75	17.41	5.71	090

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63103		A	Remove vertebral body add-on	4.82	NA	NA	1.83	2.00	0.69	ZZZ
63170		A	Incise spinal cord tract(s)	22.08	NA	NA	11.97	11.96	4.87	090
63172		A	Drainage of spinal cyst	19.66	NA	NA	10.96	10.89	4.49	090
63173		A	Drainage of spinal cyst	24.18	NA	NA	13.58	13.40	5.70	090
63180		A	Revise spinal cord ligaments	20.40	NA	NA	10.57	10.69	3.96	090
63182		A	Revise spinal cord ligaments	22.69	NA	NA	9.46	9.85	5.32	090
63185		A	Incise spinal column/nerves	16.36	NA	NA	9.56	9.20	2.80	090
63190		A	Incise spinal column/nerves	18.76	NA	NA	10.76	10.62	3.25	090
63191		A	Incise spinal column/nerves	18.79	NA	NA	5.96	7.10	6.36	090
63194		A	Incise spinal column & cord	21.97	NA	NA	11.62	11.65	3.27	090
63195		A	Incise spinal column & cord	21.54	NA	NA	11.56	11.44	4.88	090
63196		A	Incise spinal column & cord	25.14	NA	NA	13.81	13.72	5.78	090
63197		A	Incise spinal column & cord	23.95	NA	NA	13.50	13.19	5.38	090
63198		A	Incise spinal column & cord	29.75	NA	NA	11.85	11.00	6.45	090
63199		A	Incise spinal column & cord	31.32	NA	NA	15.32	15.26	1.40	090
63200		A	Release of spinal cord	21.31	NA	NA	11.94	11.79	4.97	090
63250		A	Revise spinal cord vessels	43.73	NA	NA	20.94	20.71	9.04	090
63251		A	Revise spinal cord vessels	44.49	NA	NA	21.39	21.71	10.44	090
63252		A	Revise spinal cord vessels	44.48	NA	NA	21.37	21.61	10.67	090
63265		A	Excise intraspinal lesion	23.69	NA	NA	13.04	12.99	5.45	090
63266		A	Excise intraspinal lesion	24.55	NA	NA	13.13	13.15	5.56	090
63267		A	Excise intraspinal lesion	19.32	NA	NA	11.16	11.15	4.38	090
63268		A	Excise intraspinal lesion	19.89	NA	NA	11.39	11.15	3.70	090
63270		A	Excise intraspinal lesion	29.67	NA	NA	15.43	15.45	6.84	090
63271		A	Excise intraspinal lesion	29.79	NA	NA	15.43	15.48	6.92	090
63272		A	Excise intraspinal lesion	27.37	NA	NA	14.33	14.44	6.20	090
63273		A	Excise intraspinal lesion	26.34	NA	NA	12.83	13.22	5.76	090
63275		A	Biopsy/excise spinal tumor	25.73	NA	NA	13.59	13.65	5.82	090
63276		A	Biopsy/excise spinal tumor	25.56	NA	NA	13.60	13.63	5.85	090
63277		A	Biopsy/excise spinal tumor	22.26	NA	NA	12.09	12.21	5.03	090
63278		A	Biopsy/excise spinal tumor	21.99	NA	NA	11.85	12.00	4.56	090
63280		A	Biopsy/excise spinal tumor	30.14	NA	NA	16.12	16.18	7.29	090
63281		A	Biopsy/excise spinal tumor	29.84	NA	NA	15.88	15.97	7.19	090
63282		A	Biopsy/excise spinal tumor	28.00	NA	NA	15.26	15.29	6.78	090
63283		A	Biopsy/excise spinal tumor	26.61	NA	NA	14.32	14.42	6.28	090
63285		A	Biopsy/excise spinal tumor	37.90	NA	NA	18.28	18.72	9.21	090
63286		A	Biopsy/excise spinal tumor	37.47	NA	NA	18.56	18.92	9.24	090
63287		A	Biopsy/excise spinal tumor	39.93	NA	NA	19.48	19.73	9.42	090
63290		A	Biopsy/excise spinal tumor	40.67	NA	NA	19.81	20.03	9.05	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	1.91	1.97	1.03	ZZZ
63300		A	Removal of vertebral body	26.67	NA	NA	13.76	13.91	5.99	090
63301		A	Removal of vertebral body	31.42	NA	NA	14.74	14.96	5.41	090
63302		A	Removal of vertebral body	31.00	NA	NA	14.49	14.85	5.55	090
63303		A	Removal of vertebral body	33.42	NA	NA	14.58	15.18	4.69	090

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63304		A	Removal of vertebral body	33.70	NA	NA	17.03	17.11	6.43	090
63305		A	Removal of vertebral body	36.09	NA	NA	15.59	16.22	5.73	090
63306		A	Removal of vertebral body	35.40	NA	NA	18.23	18.14	8.35	090
63307		A	Removal of vertebral body	34.81	NA	NA	16.82	16.84	4.47	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	1.96	2.12	1.29	ZZZ
63600		A	Remove spinal cord lesion	15.02	NA	NA	4.39	4.65	1.52	090
63610		A	Stimulation of spinal cord	8.72	15.42	26.55	1.75	1.88	0.86	000
63615		A	Remove lesion of spinal cord	17.22	NA	NA	8.55	8.74	2.85	090
63650		A	Implant neuroelectrodes	7.57	NA	NA	3.12	3.13	0.53	090
63655		A	Implant neuroelectrodes	11.43	NA	NA	7.69	7.50	2.44	090
63660		A	Revise/remove neuroelectrode	6.87	NA	NA	3.44	3.49	0.78	090
63685		A	Insrt/redo spine n generator	7.87	NA	NA	3.77	3.86	1.05	090
63688		A	Revise/remove neuroreceiver	6.10	NA	NA	3.52	3.53	0.89	090
63700		A	Repair of spinal herniation	17.32	NA	NA	9.97	10.07	3.53	090
63702		A	Repair of spinal herniation	19.26	NA	NA	11.66	11.51	4.13	090
63704		A	Repair of spinal herniation	22.23	NA	NA	11.63	11.97	4.58	090
63706		A	Repair of spinal herniation	25.15	NA	NA	14.29	14.12	6.25	090
63707		A	Repair spinal fluid leakage	12.52	NA	NA	7.83	7.81	2.52	090
63709		A	Repair spinal fluid leakage	15.52	NA	NA	8.98	9.10	3.10	090
63710		A	Graft repair of spine defect	15.27	NA	NA	9.19	9.16	3.41	090
63740		A	Install spinal shunt	12.50	NA	NA	8.58	8.28	2.94	090
63741		A	Install spinal shunt	9.02	NA	NA	4.57	4.62	1.66	090
63744		A	Revision of spinal shunt	8.86	NA	NA	5.40	5.37	1.90	090
63746		A	Removal of spinal shunt	7.25	NA	NA	5.82	5.31	1.53	090
64400		A	N block inj, trigeminal	1.11	1.43	1.55	0.44	0.44	0.07	000
64402		A	N block inj, facial	1.25	1.42	1.47	0.48	0.51	0.09	000
64405		A	N block inj, occipital	1.32	1.16	1.24	0.49	0.49	0.08	000
64408		A	N block inj, vagus	1.41	1.51	1.53	0.75	0.77	0.10	000
64410		A	N block inj, phrenic	1.43	1.84	2.01	0.52	0.51	0.09	000
64412		A	N block inj, spinal accessor	1.18	2.17	2.29	0.60	0.55	0.08	000
64413		A	N block inj, cervical plexus	1.40	1.32	1.45	0.48	0.49	0.08	000
64415		A	N block inj, brachial plexus	1.48	1.42	1.77	0.30	0.34	0.09	000
64416		A	N block cont infuse, b plex	3.85	NA	NA	0.45	0.54	0.31	010
64417		A	N block inj, axillary	1.44	1.42	1.83	0.31	0.36	0.11	000
64418		A	N block inj, suprascapular	1.32	1.84	2.04	0.50	0.49	0.07	000
64420		A	N block inj, intercost, sng	1.18	2.49	2.84	0.46	0.45	0.08	000
64421		A	N block inj, intercost, mlt	1.68	3.62	4.24	0.55	0.54	0.11	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.31	1.40	0.54	0.54	0.13	000
64430		A	N block inj, pudendal	1.46	2.39	2.42	0.77	0.71	0.10	000
64435		A	N block inj, paracervical	1.45	2.00	2.13	0.57	0.60	0.16	000
64445		A	N block inj, sciatic, sng	1.48	1.61	1.88	0.50	0.50	0.10	000
64446		A	N blk inj, sciatic, cont inf	3.61	NA	NA	0.45	0.59	0.20	010
64447		A	N block inj fem, single	1.50	NA	NA	0.17	0.24	0.09	000
64448		A	N block inj fem, cont inf	3.36	NA	NA	0.39	0.49	0.18	010

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64449		A	N block inj, lumbar plexus	3.24	NA	NA	0.43	0.56	0.15	010
64450		A	N block, other peripheral	1.27	1.28	1.27	0.49	0.49	0.13	000
64470		A	Inj paravertebral c/t	1.85	3.89	4.73	0.72	0.71	0.11	000
64472		A	Inj paravertebral c/t add-on	1.29	1.24	1.52	0.34	0.34	0.08	ZZZ
64475		A	Inj paravertebral l/s	1.41	3.69	4.50	0.59	0.60	0.10	000
64476		A	Inj paravertebral l/s add-on	0.98	1.12	1.38	0.23	0.23	0.07	ZZZ
64479		A	Inj foramen epidural c/t	2.20	3.84	4.76	0.83	0.85	0.12	000
64480		A	Inj foramen epidural add-on	1.54	1.60	1.91	0.40	0.42	0.10	ZZZ
64483		A	Inj foramen epidural l/s	1.90	3.88	4.89	0.76	0.78	0.11	000
64484		A	Inj foramen epidural add-on	1.33	1.67	2.08	0.34	0.34	0.08	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.11	1.14	0.72	0.71	0.10	000
64508		A	N block, carotid sinus s/p	1.12	2.14	2.44	0.56	0.60	0.07	000
64510		A	N block, stellate ganglion	1.22	1.94	2.32	0.44	0.46	0.07	000
64517		A	N block inj, hypogas plxs	2.20	1.77	2.01	0.71	0.75	0.11	000
64520		A	N block, lumbar/thoracic	1.35	2.69	3.31	0.54	0.55	0.08	000
64530		A	N block inj, celiac pelus	1.58	2.79	3.21	0.65	0.65	0.10	000
64550		A	Apply neurostimulator	0.18	0.19	0.21	0.05	0.05	0.01	000
64553		A	Implant neuroelectrodes	2.33	2.61	2.67	1.43	1.54	0.18	010
64555		A	Implant neuroelectrodes	2.29	2.96	3.00	1.59	1.49	0.19	010
64560		A	Implant neuroelectrodes	2.38	2.90	2.83	1.57	1.50	0.22	010
64561		A	Implant neuroelectrodes	7.07	19.46	22.14	3.72	3.49	0.51	010
64565		A	Implant neuroelectrodes	1.78	2.15	2.43	1.11	1.15	0.13	010
64573		A	Implant neuroelectrodes	8.15	NA	NA	5.28	5.28	1.60	090
64575		A	Implant neuroelectrodes	4.37	NA	NA	2.26	2.36	0.61	090
64577		A	Implant neuroelectrodes	4.64	NA	NA	3.58	3.51	1.04	090
64580		A	Implant neuroelectrodes	4.14	NA	NA	2.79	2.99	0.36	090
64581		A	Implant neuroelectrodes	14.15	NA	NA	6.56	6.27	1.05	090
64585		A	Revise/remove neuroelectrode	2.08	5.98	7.32	2.31	2.27	0.20	010
64590		A	Insrt/redo pn/gastr stimul	2.42	6.39	6.59	2.45	2.41	0.19	010
64595		A	Revise/rmv pn/gastr stimul	1.75	6.51	7.50	2.20	2.13	0.19	010
64600		A	Injection treatment of nerve	3.46	5.51	6.49	1.68	1.67	0.34	010
64605		A	Injection treatment of nerve	5.62	7.65	8.14	2.43	2.37	0.79	010
64610		A	Injection treatment of nerve	7.17	9.34	9.23	3.80	3.78	1.58	010
64612		A	Destroy nerve, face muscle	1.98	1.58	1.81	1.34	1.34	0.11	010
64613		A	Destroy nerve, neck muscle	1.98	1.37	1.76	1.14	1.16	0.11	010
64614		A	Destroy nerve, extrem musc	2.20	1.61	2.02	1.30	1.31	0.10	010
64620		A	Injection treatment of nerve	2.86	3.45	3.86	1.17	1.21	0.20	010
64622		A	Destr paravertebrl nerve l/s	3.02	4.15	5.06	1.29	1.31	0.18	010
64623		A	Destr paravertebral n add-on	0.99	1.70	2.02	0.23	0.22	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.82	4.84	5.58	1.92	1.94	0.20	010
64627		A	Destr paravertebral n add-on	1.16	2.43	2.96	0.26	0.26	0.07	ZZZ
64630		A	Injection treatment of nerve	3.02	2.69	2.70	1.78	1.69	0.22	010
64640		A	Injection treatment of nerve	2.78	2.43	2.87	1.42	1.53	0.29	010
64650		A	Chemodenerv eccrine glands	0.70	1.00	0.97	0.25	0.27	0.06	000

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64653		A	Chemodenerv eccrine glands	0.88	1.07	1.03	0.30	0.32	0.08	000
64680		A	Injection treatment of nerve	2.64	4.44	5.02	1.28	1.32	0.18	010
64681		A	Injection treatment of nerve	3.78	4.92	6.03	1.32	1.51	0.28	010
64702		A	Revise finger/toe nerve	6.10	NA	NA	5.20	4.87	0.61	090
64704		A	Revise hand/foot nerve	4.61	NA	NA	3.43	3.41	0.61	090
64708		A	Revise arm/leg nerve	6.22	NA	NA	4.34	4.48	0.96	090
64712		A	Revision of sciatic nerve	7.98	NA	NA	4.94	4.95	0.95	090
64713		A	Revision of arm nerve(s)	11.29	NA	NA	6.58	6.41	1.83	090
64714		A	Revise low back nerve(s)	10.44	NA	NA	5.17	4.93	1.19	090
64716		A	Revision of cranial nerve	6.86	NA	NA	5.52	5.64	0.63	090
64718		A	Revise ulnar nerve at elbow	7.06	NA	NA	6.21	6.16	1.05	090
64719		A	Revise ulnar nerve at wrist	4.89	NA	NA	4.16	4.25	0.77	090
64721		A	Carpal tunnel surgery	4.84	4.72	4.89	4.66	4.84	0.73	090
64722		A	Relieve pressure on nerve(s)	4.74	NA	NA	3.29	3.23	0.48	090
64726		A	Release foot/toe nerve	4.21	NA	NA	2.76	2.77	0.54	090
64727		A	Internal nerve revision	3.10	NA	NA	1.20	1.28	0.48	ZZZ
64732		A	Incision of brow nerve	4.81	NA	NA	4.22	4.04	0.98	090
64734		A	Incision of cheek nerve	5.45	NA	NA	4.22	4.19	0.89	090
64736		A	Incision of chin nerve	5.13	NA	NA	4.23	4.18	0.52	090
64738		A	Incision of jaw nerve	6.26	NA	NA	4.35	4.42	1.08	090
64740		A	Incision of tongue nerve	6.12	NA	NA	4.66	4.78	0.69	090
64742		A	Incision of facial nerve	6.75	NA	NA	4.21	4.34	0.73	090
64744		A	Incise nerve, back of head	5.64	NA	NA	3.83	3.82	1.16	090
64746		A	Incise diaphragm nerve	6.46	NA	NA	3.74	3.94	0.82	090
64752		A	Incision of vagus nerve	7.59	NA	NA	4.14	4.18	0.93	090
64755		A	Incision of stomach nerves	14.97	NA	NA	5.84	5.80	1.84	090
64760		A	Incision of vagus nerve	7.49	NA	NA	3.82	3.73	0.81	090
64761		A	Incision of pelvis nerve	6.94	NA	NA	3.93	3.83	0.53	090
64763		A	Incise hip/thigh nerve	7.46	NA	NA	5.48	5.42	0.94	090
64766		A	Incise hip/thigh nerve	9.34	NA	NA	5.51	5.45	1.06	090
64771		A	Sever cranial nerve	8.02	NA	NA	5.82	5.76	1.23	090
64772		A	Incision of spinal nerve	7.74	NA	NA	5.49	5.35	1.40	090
64774		A	Remove skin nerve lesion	5.70	NA	NA	3.98	3.95	0.74	090
64776		A	Remove digit nerve lesion	5.52	NA	NA	3.72	3.71	0.76	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	1.18	1.26	0.46	ZZZ
64782		A	Remove limb nerve lesion	6.76	NA	NA	4.27	4.15	0.86	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	1.42	1.53	0.51	ZZZ
64784		A	Remove nerve lesion	10.49	NA	NA	6.31	6.39	1.38	090
64786		A	Remove sciatic nerve lesion	16.12	NA	NA	8.44	8.80	2.61	090
64787		A	Implant nerve end	4.29	NA	NA	1.62	1.75	0.58	ZZZ
64788		A	Remove skin nerve lesion	5.14	NA	NA	4.04	3.90	0.73	090
64790		A	Removal of nerve lesion	11.97	NA	NA	6.89	6.97	2.11	090
64792		A	Removal of nerve lesion	15.71	NA	NA	9.08	9.03	2.49	090
64795		A	Biopsy of nerve	3.01	NA	NA	1.43	1.46	0.52	000

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64802		A	Remove sympathetic nerves	10.24	NA	NA	3.49	3.91	1.29	090
64804		A	Remove sympathetic nerves	15.78	NA	NA	5.02	5.56	2.15	090
64809		A	Remove sympathetic nerves	14.61	NA	NA	5.54	5.61	1.50	090
64818		A	Remove sympathetic nerves	11.24	NA	NA	4.19	4.47	1.33	090
64820		A	Remove sympathetic nerves	10.64	NA	NA	6.93	6.99	1.49	090
64821		A	Remove sympathetic nerves	9.19	NA	NA	6.62	6.81	1.24	090
64822		A	Remove sympathetic nerves	9.19	NA	NA	6.31	6.55	1.30	090
64823		A	Remove sympathetic nerves	10.80	NA	NA	6.62	7.01	1.57	090
64831		A	Repair of digit nerve	10.23	NA	NA	6.61	6.74	1.41	090
64832		A	Repair nerve add-on	5.65	NA	NA	2.29	2.45	0.85	ZZZ
64834		A	Repair of hand or foot nerve	10.71	NA	NA	6.52	6.67	1.54	090
64835		A	Repair of hand or foot nerve	11.60	NA	NA	7.03	7.20	1.74	090
64836		A	Repair of hand or foot nerve	11.60	NA	NA	7.08	7.23	1.68	090
64837		A	Repair nerve add-on	6.25	NA	NA	2.58	2.75	0.97	ZZZ
64840		A	Repair of leg nerve	13.87	NA	NA	7.74	7.88	1.37	090
64856		A	Repair/transpose nerve	14.94	NA	NA	8.53	8.71	2.13	090
64857		A	Repair arm/leg nerve	15.69	NA	NA	8.83	9.04	2.22	090
64858		A	Repair sciatic nerve	17.69	NA	NA	10.23	10.38	3.34	090
64859		A	Nerve surgery	4.25	NA	NA	1.71	1.83	0.67	ZZZ
64861		A	Repair of arm nerves	20.74	NA	NA	10.30	10.68	4.09	090
64862		A	Repair of low back nerves	20.94	NA	NA	8.89	9.67	4.32	090
64864		A	Repair of facial nerve	13.31	NA	NA	7.19	7.60	1.26	090
64865		A	Repair of facial nerve	15.96	NA	NA	11.39	11.94	1.50	090
64866		A	Fusion of facial/other nerve	16.70	NA	NA	11.49	11.93	2.05	090
64868		A	Fusion of facial/other nerve	14.80	NA	NA	10.35	10.63	1.43	090
64870		A	Fusion of facial/other nerve	16.95	NA	NA	7.42	7.76	1.30	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	0.81	0.88	0.29	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	1.12	1.23	0.42	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.08	1.25	0.47	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	NA	9.01	9.67	1.63	090
64886		A	Nerve graft, head or neck	20.72	NA	NA	10.71	11.44	2.09	090
64890		A	Nerve graft, hand or foot	16.11	NA	NA	9.15	9.37	2.30	090
64891		A	Nerve graft, hand or foot	17.22	NA	NA	10.28	9.61	1.63	090
64892		A	Nerve graft, arm or leg	15.61	NA	NA	9.09	9.04	2.48	090
64893		A	Nerve graft, arm or leg	16.74	NA	NA	8.96	9.19	2.62	090
64895		A	Nerve graft, hand or foot	20.26	NA	NA	10.74	10.48	2.58	090
64896		A	Nerve graft, hand or foot	21.81	NA	NA	12.10	11.84	3.17	090
64897		A	Nerve graft, arm or leg	19.25	NA	NA	10.29	10.41	2.55	090
64898		A	Nerve graft, arm or leg	20.82	NA	NA	11.45	11.54	2.78	090
64901		A	Nerve graft add-on	10.20	NA	NA	3.86	4.22	1.37	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	4.35	4.76	1.55	ZZZ
64905		A	Nerve pedicle transfer	14.98	NA	NA	9.01	8.89	2.01	090
64907		A	Nerve pedicle transfer	19.90	NA	NA	10.36	10.92	3.17	090
64910		A	Nerve repair w/allograft	11.21	NA	NA	7.86	7.86	1.74	090

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64911		A	Neurorraphy w/vein autograft	14.21	NA	NA	8.88	8.88	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	6.76	7.17	0.32	090
65093		A	Revise eye with implant	6.93	NA	NA	6.86	7.33	0.34	090
65101		A	Removal of eye	8.10	NA	NA	8.01	8.40	0.35	090
65103		A	Remove eye/insert implant	8.64	NA	NA	8.18	8.58	0.37	090
65105		A	Remove eye/attach implant	9.70	NA	NA	8.87	9.28	0.42	090
65110		A	Removal of eye	15.42	NA	NA	11.49	12.05	0.81	090
65112		A	Remove eye/revise socket	18.18	NA	NA	13.23	13.98	1.30	090
65114		A	Remove eye/revise socket	19.32	NA	NA	13.54	14.26	1.02	090
65125		A	Revise ocular implant	3.18	6.68	7.22	3.18	3.29	0.19	090
65130		A	Insert ocular implant	8.22	NA	NA	7.73	8.10	0.35	090
65135		A	Insert ocular implant	8.40	NA	NA	7.82	8.21	0.36	090
65140		A	Attach ocular implant	9.23	NA	NA	8.52	8.87	0.40	090
65150		A	Revise ocular implant	6.32	NA	NA	6.40	6.80	0.31	090
65155		A	Reinsert ocular implant	9.87	NA	NA	8.70	9.16	0.50	090
65175		A	Removal of ocular implant	7.22	NA	NA	7.15	7.49	0.31	090
65205		A	Remove foreign body from eye	0.71	0.57	0.59	0.32	0.31	0.03	000
65210		A	Remove foreign body from eye	0.84	0.72	0.74	0.39	0.39	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	0.78	0.81	0.42	0.41	0.04	000
65235		A	Remove foreign body from eye	8.78	NA	NA	6.83	6.82	0.37	090
65260		A	Remove foreign body from eye	12.29	NA	NA	8.83	9.04	0.57	090
65265		A	Remove foreign body from eye	14.06	NA	NA	9.73	9.96	0.62	090
65270		A	Repair of eye wound	1.92	3.83	4.19	1.20	1.25	0.09	010
65272		A	Repair of eye wound	4.49	6.38	6.72	3.21	3.23	0.19	090
65273		A	Repair of eye wound	5.03	NA	NA	3.35	3.41	0.22	090
65275		A	Repair of eye wound	6.14	6.38	6.37	3.95	3.95	0.26	090
65280		A	Repair of eye wound	8.87	NA	NA	5.91	5.99	0.38	090
65285		A	Repair of eye wound	14.43	NA	NA	8.50	8.69	0.64	090
65286		A	Repair of eye wound	6.45	8.80	9.40	4.44	4.49	0.27	090
65290		A	Repair of eye socket wound	6.35	NA	NA	4.50	4.57	0.31	090
65400		A	Removal of eye lesion	7.27	7.52	7.73	5.91	5.97	0.30	090
65410		A	Biopsy of cornea	1.47	1.68	1.79	0.87	0.90	0.07	000
65420		A	Removal of eye lesion	4.24	6.91	7.41	4.00	4.12	0.21	090
65426		A	Removal of eye lesion	5.93	8.26	8.75	4.62	4.70	0.25	090
65430		A	Corneal smear	1.47	1.10	1.15	0.87	0.90	0.07	000
65435		A	Curette/treat cornea	0.92	0.86	0.90	0.65	0.67	0.04	000
65436		A	Curette/treat cornea	4.72	3.80	3.88	3.47	3.53	0.21	090
65450		A	Treatment of corneal lesion	3.35	3.71	3.80	3.63	3.71	0.16	090
65600		A	Revision of cornea	4.07	4.48	4.62	3.43	3.42	0.17	090
65710		A	Corneal transplant	14.09	NA	NA	10.26	10.51	0.61	090
65730		A	Corneal transplant	15.99	NA	NA	11.09	11.33	0.70	090
65750		A	Corneal transplant	16.60	NA	NA	10.74	11.06	0.74	090

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65755		A	Corneal transplant	16.49	NA	NA	10.71	11.02	0.73	090
65770		A	Revise cornea with implant	19.41	NA	NA	11.80	12.16	0.87	090
65772		A	Correction of astigmatism	4.96	4.89	5.06	3.95	4.00	0.21	090
65775		A	Correction of astigmatism	6.73	NA	NA	5.37	5.52	0.28	090
65780		A	Ocular reconst, transplant	10.43	NA	NA	9.01	9.34	0.44	090
65781		A	Ocular reconst, transplant	17.84	NA	NA	11.71	12.22	0.44	090
65782		A	Ocular reconst, transplant	15.16	NA	NA	10.31	10.74	0.44	090
65800		A	Drainage of eye	1.91	1.41	1.51	1.03	1.07	0.09	000
65805		A	Drainage of eye	1.91	1.71	1.83	1.04	1.07	0.09	000
65810		A	Drainage of eye	5.67	NA	NA	4.73	4.73	0.24	090
65815		A	Drainage of eye	5.85	7.99	8.50	4.63	4.68	0.25	090
65820		A	Relieve inner eye pressure	8.72	NA	NA	7.67	8.03	0.40	090
65850		A	Incision of eye	11.24	NA	NA	7.42	7.68	0.52	090
65855		A	Laser surgery of eye	3.90	3.52	3.72	2.65	2.77	0.19	010
65860		A	Incise inner eye adhesions	3.56	3.29	3.48	2.10	2.20	0.18	090
65865		A	Incise inner eye adhesions	5.66	NA	NA	4.73	4.96	0.28	090
65870		A	Incise inner eye adhesions	7.21	NA	NA	5.76	5.93	0.31	090
65875		A	Incise inner eye adhesions	7.61	NA	NA	6.20	6.36	0.32	090
65880		A	Incise inner eye adhesions	8.16	NA	NA	6.38	6.55	0.35	090
65900		A	Remove eye lesion	12.26	NA	NA	8.94	9.28	0.54	090
65920		A	Remove implant of eye	9.74	NA	NA	7.56	7.72	0.41	090
65930		A	Remove blood clot from eye	8.24	NA	NA	5.84	6.10	0.37	090
66020		A	Injection treatment of eye	1.61	2.44	2.62	1.29	1.33	0.08	010
66030		A	Injection treatment of eye	1.27	2.32	2.48	1.16	1.19	0.06	010
66130		A	Remove eye lesion	7.74	7.60	8.12	4.93	5.11	0.38	090
66150		A	Glaucoma surgery	10.18	NA	NA	8.90	9.04	0.46	090
66155		A	Glaucoma surgery	10.17	NA	NA	8.90	9.03	0.41	090
66160		A	Glaucoma surgery	12.04	NA	NA	9.59	9.75	0.50	090
66165		A	Glaucoma surgery	9.89	NA	NA	8.80	8.92	0.40	090
66170		A	Glaucoma surgery	14.57	NA	NA	11.67	11.82	0.60	090
66172		A	Incision of eye	18.26	NA	NA	14.80	14.92	0.74	090
66180		A	Implant eye shunt	16.02	NA	NA	9.81	10.06	0.71	090
66185		A	Revise eye shunt	9.35	NA	NA	7.13	7.20	0.40	090
66220		A	Repair eye lesion	8.98	NA	NA	7.23	7.20	0.40	090
66225		A	Repair/graft eye lesion	12.38	NA	NA	8.21	8.35	0.55	090
66250		A	Follow-up surgery of eye	6.92	9.32	9.93	5.31	5.36	0.30	090
66500		A	Incision of iris	3.75	NA	NA	3.98	4.15	0.18	090
66505		A	Incision of iris	4.13	NA	NA	4.35	4.51	0.20	090
66600		A	Remove iris and lesion	9.89	NA	NA	8.37	8.34	0.43	090
66605		A	Removal of iris	13.99	NA	NA	9.32	9.51	0.77	090
66625		A	Removal of iris	5.19	NA	NA	4.25	4.37	0.26	090
66630		A	Removal of iris	7.10	NA	NA	5.40	5.49	0.31	090
66635		A	Removal of iris	7.19	NA	NA	5.43	5.52	0.31	090
66680		A	Repair iris & ciliary body	6.24	NA	NA	5.11	5.15	0.27	090

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66682		A	Repair iris & ciliary body	7.15	NA	NA	6.78	6.75	0.31	090
66700		A	Destruction, ciliary body	5.06	4.85	4.95	3.64	3.72	0.24	090
66710		A	Ciliary transsleral therapy	5.06	4.65	4.78	3.64	3.69	0.23	090
66711		A	Ciliary endoscopic ablation	7.70	NA	NA	6.37	6.40	0.30	090
66720		A	Destruction, ciliary body	4.86	5.39	5.50	4.33	4.43	0.26	090
66740		A	Destruction, ciliary body	5.06	4.57	4.71	3.65	3.73	0.23	090
66761		A	Revision of iris	4.87	5.07	5.21	4.24	4.26	0.20	090
66762		A	Revision of iris	5.25	5.15	5.29	4.11	4.16	0.23	090
66770		A	Removal of inner eye lesion	5.98	5.58	5.72	4.64	4.68	0.26	090
66820		A	Incision, secondary cataract	3.93	NA	NA	4.67	4.96	0.19	090
66821		A	After cataract laser surgery	3.32	3.86	3.92	3.45	3.50	0.11	090
66825		A	Reposition intraocular lens	8.82	NA	NA	7.85	8.16	0.40	090
66830		A	Removal of lens lesion	9.27	NA	NA	6.45	6.59	0.36	090
66840		A	Removal of lens material	8.98	NA	NA	6.30	6.45	0.39	090
66850		A	Removal of lens material	10.32	NA	NA	7.15	7.28	0.45	090
66852		A	Removal of lens material	11.18	NA	NA	7.47	7.64	0.49	090
66920		A	Extraction of lens	9.93	NA	NA	6.71	6.86	0.44	090
66930		A	Extraction of lens	11.38	NA	NA	7.55	7.70	0.49	090
66940		A	Extraction of lens	10.14	NA	NA	7.09	7.22	0.43	090
66982		A	Cataract surgery, complex	14.83	NA	NA	9.07	9.28	0.63	090
66983		A	Cataract surg w/iol, 1 stage	10.20	NA	NA	6.55	6.45	0.14	090
66984		A	Cataract surg w/iol, 1 stage	10.36	NA	NA	6.55	6.78	0.39	090
66985		A	Insert lens prosthesis	9.73	NA	NA	7.20	7.27	0.36	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	8.15	8.42	0.60	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	0.55	0.58	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	4.63	4.69	0.28	090
67010		A	Partial removal of eye fluid	6.94	NA	NA	5.05	5.15	0.34	090
67015		A	Release of eye fluid	7.00	NA	NA	5.75	5.94	0.34	090
67025		A	Replace eye fluid	7.91	7.94	8.27	5.98	6.05	0.34	090
67027		A	Implant eye drug system	11.43	NA	NA	7.46	7.60	0.54	090
67028		A	Injection eye drug	2.52	2.17	2.31	1.26	1.31	0.12	000
67030		A	Incise inner eye strands	5.91	NA	NA	5.65	5.71	0.24	090
67031		A	Laser surgery, eye strands	4.34	4.14	4.26	3.46	3.51	0.18	090
67036		A	Removal of inner eye fluid	13.09	NA	NA	8.16	8.41	0.58	090
67039		A	Laser treatment of retina	16.39	NA	NA	10.83	11.19	0.71	090
67040		A	Laser treatment of retina	19.23	NA	NA	12.15	12.55	0.85	090
67041		A	Vit for macular pucker	19.00	NA	NA	10.51	10.51	0.86	090
67042		A	Vit for macular hole	22.13	NA	NA	11.64	11.64	1.00	090
67043		A	Vit for membrane dissect	22.94	NA	NA	12.52	12.52	1.04	090
67101		A	Repair detached retina	8.60	8.57	8.72	6.24	6.32	0.37	090
67105		A	Repair detached retina	8.35	7.48	7.64	5.85	5.93	0.37	090
67107		A	Repair detached retina	16.35	NA	NA	10.47	10.69	0.73	090
67108		A	Repair detached retina	22.49	NA	NA	13.10	13.45	1.02	090

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67110		A	Repair detached retina	10.02	9.02	9.34	7.05	7.14	0.44	090
67112		A	Rerepair detached retina	18.45	NA	NA	10.99	11.21	0.83	090
67113		A	Repair retinal detach, cplx	25.00	NA	NA	13.84	13.84	1.13	090
67115		A	Release encircling material	5.93	NA	NA	5.00	5.03	0.25	090
67120		A	Remove eye implant material	6.92	7.43	7.72	5.34	5.39	0.29	090
67121		A	Remove eye implant material	12.00	NA	NA	8.05	8.18	0.53	090
67141		A	Treatment of retina	6.00	5.47	5.57	4.70	4.75	0.26	090
67145		A	Treatment of retina	6.17	5.40	5.48	4.77	4.81	0.27	090
67208		A	Treatment of retinal lesion	7.50	5.71	5.82	5.26	5.33	0.33	090
67210		A	Treatment of retinal lesion	9.35	5.99	6.14	5.50	5.61	0.44	090
67218		A	Treatment of retinal lesion	20.22	NA	NA	10.76	11.12	0.92	090
67220		A	Treatment of choroid lesion	14.19	9.33	9.61	8.26	8.46	0.65	090
67221		R	Ocular photodynamic ther	3.45	2.95	3.30	1.40	1.50	0.20	000
67225		A	Eye photodynamic ther add-on	0.47	0.23	0.23	0.17	0.18	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.38	6.06	6.20	5.22	5.30	0.33	090
67228		A	Treatment of retinal lesion	13.67	13.74	13.18	10.31	9.88	0.63	090
67229		A	Tr retinal les preterm inf	16.00	NA	NA	9.64	9.64	0.71	090
67250		A	Reinforce eye wall	9.46	NA	NA	7.75	8.12	0.47	090
67255		A	Reinforce/graft eye wall	9.97	NA	NA	8.52	8.88	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	5.57	5.69	0.37	090
67312		A	Revise two eye muscles	9.48	NA	NA	6.27	6.40	0.43	090
67314		A	Revise eye muscle	8.59	NA	NA	6.23	6.32	0.39	090
67316		A	Revise two eye muscles	10.73	NA	NA	6.93	7.08	0.49	090
67318		A	Revise eye muscle(s)	8.92	NA	NA	6.58	6.68	0.41	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	1.95	1.96	0.22	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	1.84	1.84	0.21	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	2.01	2.01	0.23	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	1.83	1.82	0.20	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	0.89	0.95	0.13	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	2.17	2.18	0.25	ZZZ
67343		A	Release eye tissue	8.29	NA	NA	6.10	6.21	0.37	090
67345		A	Destroy nerve of eye muscle	2.98	2.20	2.30	1.72	1.79	0.17	010
67346		A	Biopsy, eye muscle	2.87	NA	NA	1.65	1.71	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	9.51	9.96	0.56	090
67405		A	Explore/drain eye socket	9.00	NA	NA	8.54	8.86	0.44	090
67412		A	Explore/treat eye socket	10.17	NA	NA	8.65	9.23	0.48	090
67413		A	Explore/treat eye socket	10.09	NA	NA	8.81	9.31	0.50	090
67414		A	Explr/decompress eye socket	17.78	NA	NA	11.82	11.89	0.65	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	0.62	0.65	0.09	000
67420		A	Explore/treat eye socket	21.62	NA	NA	14.38	15.15	1.15	090
67430		A	Explore/treat eye socket	14.99	NA	NA	12.43	13.06	0.86	090
67440		A	Explore/drain eye socket	14.56	NA	NA	11.98	12.56	0.70	090

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67445		A	Explr/decompress eye socket	18.96	NA	NA	12.33	12.74	0.90	090
67450		A	Explore/biopsy eye socket	15.11	NA	NA	12.49	13.05	0.68	090
67500		A	Inject/treat eye socket	1.44	0.59	0.61	0.46	0.42	0.05	000
67505		A	Inject/treat eye socket	1.27	0.74	0.73	0.58	0.51	0.05	000
67515		A	Inject/treat eye socket	1.40	0.78	0.73	0.62	0.56	0.03	000
67550		A	Insert eye socket implant	11.52	NA	NA	9.83	10.21	0.72	090
67560		A	Revise eye socket implant	11.93	NA	NA	9.89	10.27	0.60	090
67570		A	Decompress optic nerve	14.21	NA	NA	11.26	11.86	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	4.34	4.77	1.19	1.21	0.07	010
67710		A	Incision of eyelid	1.04	3.73	4.15	1.09	1.12	0.05	010
67715		A	Incision of eyelid fold	1.24	3.83	4.22	1.16	1.19	0.06	010
67800		A	Remove eyelid lesion	1.39	1.40	1.46	0.91	0.94	0.07	010
67801		A	Remove eyelid lesions	1.89	1.69	1.76	1.09	1.13	0.09	010
67805		A	Remove eyelid lesions	2.24	2.20	2.29	1.43	1.48	0.11	010
67808		A	Remove eyelid lesion(s)	4.47	NA	NA	3.62	3.66	0.19	090
67810		A	Biopsy of eyelid	1.48	3.94	3.79	0.68	0.68	0.06	000
67820		A	Revise eyelashes	0.71	0.44	0.48	0.51	0.52	0.04	000
67825		A	Revise eyelashes	1.40	1.41	1.50	1.27	1.31	0.07	010
67830		A	Revise eyelashes	1.72	4.02	4.41	1.33	1.38	0.08	010
67835		A	Revise eyelashes	5.61	NA	NA	4.11	4.24	0.28	090
67840		A	Remove eyelid lesion	2.06	3.94	4.33	1.47	1.51	0.10	010
67850		A	Treat eyelid lesion	1.71	3.45	3.43	1.52	1.51	0.07	010
67875		A	Closure of eyelid by suture	1.35	2.40	2.63	0.84	0.87	0.07	000
67880		A	Revision of eyelid	4.47	5.49	5.78	3.61	3.66	0.19	090
67882		A	Revision of eyelid	5.87	6.43	6.74	4.52	4.60	0.25	090
67900		A	Repair brow defect	6.69	7.43	7.85	4.65	4.81	0.38	090
67901		A	Repair eyelid defect	7.47	9.03	8.13	5.32	5.35	0.54	090
67902		A	Repair eyelid defect	9.68	NA	NA	6.46	6.22	0.60	090
67903		A	Repair eyelid defect	6.42	6.65	7.39	4.36	4.65	0.47	090
67904		A	Repair eyelid defect	7.83	8.25	8.60	5.43	5.39	0.41	090
67906		A	Repair eyelid defect	6.84	NA	NA	4.51	4.65	0.46	090
67908		A	Repair eyelid defect	5.19	5.61	5.87	4.17	4.47	0.28	090
67909		A	Revise eyelid defect	5.46	6.25	6.70	4.21	4.40	0.31	090
67911		A	Revise eyelid defect	7.38	NA	NA	5.10	5.02	0.31	090
67912		A	Correction eyelid w/implant	6.23	13.21	14.66	4.77	4.96	0.28	090
67914		A	Repair eyelid defect	3.70	4.79	5.19	2.71	2.80	0.19	090
67915		A	Repair eyelid defect	3.21	4.36	4.77	2.46	2.55	0.16	090
67916		A	Repair eyelid defect	5.37	6.43	6.84	4.19	4.34	0.28	090
67917		A	Repair eyelid defect	6.08	6.78	7.21	4.45	4.61	0.36	090
67921		A	Repair eyelid defect	3.42	4.66	5.05	2.59	2.67	0.17	090
67922		A	Repair eyelid defect	3.09	4.21	4.64	2.36	2.46	0.15	090
67923		A	Repair eyelid defect	5.94	6.50	6.91	4.37	4.52	0.30	090
67924		A	Repair eyelid defect	5.84	6.98	7.48	4.11	4.26	0.30	090

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67930		A	Repair eyelid wound	3.62	4.43	4.76	1.82	1.91	0.19	010
67935		A	Repair eyelid wound	6.27	6.82	7.25	3.63	3.83	0.39	090
67938		A	Remove eyelid foreign body	1.35	3.86	4.25	1.24	1.24	0.06	010
67950		A	Revision of eyelid	5.88	6.71	7.20	4.42	4.62	0.36	090
67961		A	Revision of eyelid	5.75	6.87	7.33	4.34	4.52	0.33	090
67966		A	Revision of eyelid	8.83	8.12	8.39	5.80	5.75	0.37	090
67971		A	Reconstruction of eyelid	9.87	NA	NA	6.25	6.51	0.53	090
67973		A	Reconstruction of eyelid	12.96	NA	NA	7.83	8.21	0.75	090
67974		A	Reconstruction of eyelid	12.93	NA	NA	7.79	8.16	0.75	090
67975		A	Reconstruction of eyelid	9.21	NA	NA	6.02	6.26	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	1.25	1.29	1.06	1.10	0.06	010
68040		A	Treatment of eyelid lesions	0.85	0.61	0.63	0.36	0.37	0.04	000
68100		A	Biopsy of eyelid lining	1.35	2.37	2.60	0.87	0.89	0.07	000
68110		A	Remove eyelid lining lesion	1.79	3.09	3.35	1.49	1.53	0.09	010
68115		A	Remove eyelid lining lesion	2.38	4.35	4.76	1.70	1.76	0.12	010
68130		A	Remove eyelid lining lesion	4.99	6.71	7.22	4.07	4.21	0.24	090
68135		A	Remove eyelid lining lesion	1.86	1.60	1.66	1.49	1.53	0.09	010
68200		A	Treat eyelid by injection	0.49	0.45	0.48	0.29	0.30	0.02	000
68320		A	Revise/graft eyelid lining	6.44	9.26	9.78	5.37	5.42	0.27	090
68325		A	Revise/graft eyelid lining	8.43	NA	NA	6.10	6.22	0.44	090
68326		A	Revise/graft eyelid lining	8.22	NA	NA	5.98	6.10	0.35	090
68328		A	Revise/graft eyelid lining	9.25	NA	NA	6.40	6.63	0.54	090
68330		A	Revise eyelid lining	5.63	7.48	7.97	4.49	4.55	0.24	090
68335		A	Revise/graft eyelid lining	8.26	NA	NA	5.99	6.09	0.36	090
68340		A	Separate eyelid adhesions	4.84	6.93	7.43	3.90	3.96	0.21	090
68360		A	Revise eyelid lining	5.04	6.50	6.89	4.00	4.05	0.22	090
68362		A	Revise eyelid lining	8.41	NA	NA	6.05	6.14	0.36	090
68371		A	Harvest eye tissue, alograft	4.97	NA	NA	4.10	4.26	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	4.37	4.76	1.20	1.36	0.08	010
68420		A	Incise/drain tear sac	2.32	4.63	5.03	1.43	1.60	0.11	010
68440		A	Incise tear duct opening	0.96	1.26	1.47	1.20	1.22	0.05	010
68500		A	Removal of tear gland	12.49	NA	NA	8.99	9.18	0.55	090
68505		A	Partial removal, tear gland	12.41	NA	NA	8.99	9.41	0.55	090
68510		A	Biopsy of tear gland	4.60	5.25	5.77	2.04	2.06	0.23	000
68520		A	Removal of tear sac	8.58	NA	NA	6.57	6.79	0.37	090
68525		A	Biopsy of tear sac	4.42	NA	NA	1.58	1.69	0.22	000
68530		A	Clearance of tear duct	3.67	5.65	6.29	2.10	2.24	0.18	010
68540		A	Remove tear gland lesion	11.93	NA	NA	8.61	8.81	0.52	090
68550		A	Remove tear gland lesion	14.86	NA	NA	10.27	10.55	0.80	090
68700		A	Repair tear ducts	7.67	NA	NA	5.63	5.73	0.32	090
68705		A	Revise tear duct opening	2.08	3.06	3.34	1.60	1.65	0.10	010
68720		A	Create tear sac drain	9.78	NA	NA	6.96	7.20	0.44	090

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68745		A	Create tear duct drain	9.70	NA	NA	7.11	7.31	0.52	090
68750		A	Create tear duct drain	9.87	NA	NA	7.48	7.68	0.43	090
68760		A	Close tear duct opening	1.75	2.61	2.85	1.47	1.51	0.09	010
68761		A	Close tear duct opening	1.38	1.85	1.96	1.26	1.28	0.06	010
68770		A	Close tear system fistula	8.09	NA	NA	5.75	5.12	0.35	090
68801		A	Dilate tear duct opening	0.96	1.78	1.83	1.42	1.44	0.05	010
68810		A	Probe nasolacrimal duct	2.63	3.43	3.49	2.71	2.70	0.10	010
68811		A	Probe nasolacrimal duct	2.39	NA	NA	2.15	2.22	0.13	010
68815		A	Probe nasolacrimal duct	3.24	6.47	6.92	2.46	2.55	0.17	010
68816		A	Probe nl duct w/balloon	3.00	12.85	12.85	2.54	2.54	0.16	010
68840		A	Explore/irrigate tear ducts	1.27	1.52	1.54	1.29	1.25	0.06	010
68850		A	Injection for tear sac x-ray	0.80	0.73	0.77	0.61	0.63	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	2.90	2.90	1.34	1.35	0.12	010
69005		A	Drain external ear lesion	2.13	3.02	3.00	1.63	1.68	0.17	010
69020		A	Drain outer ear canal lesion	1.50	4.15	4.11	1.93	1.96	0.12	010
69100		A	Biopsy of external ear	0.81	1.84	1.81	0.39	0.39	0.03	000
69105		A	Biopsy of external ear canal	0.85	2.65	2.58	0.71	0.72	0.07	000
69110		A	Remove external ear, partial	3.47	7.90	7.62	4.49	4.49	0.30	090
69120		A	Removal of external ear	4.08	NA	NA	5.41	5.61	0.38	090
69140		A	Remove ear canal lesion(s)	8.03	NA	NA	13.27	13.29	0.65	090
69145		A	Remove ear canal lesion(s)	2.65	7.03	6.72	3.38	3.36	0.21	090
69150		A	Extensive ear canal surgery	13.49	NA	NA	11.57	12.04	1.22	090
69155		A	Extensive ear/neck surgery	23.06	NA	NA	17.25	17.85	1.93	090
69200		A	Clear outer ear canal	0.77	2.16	2.22	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	0.60	0.17	0.19	0.05	000
69220		A	Clean out mastoid cavity	0.83	2.56	2.52	0.68	0.69	0.07	000
69222		A	Clean out mastoid cavity	1.42	3.97	3.94	1.90	1.94	0.12	010
69300		R	Revise external ear	6.69	10.58	9.00	5.11	4.90	0.72	YYY
69310		A	Rebuild outer ear canal	10.85	NA	NA	15.46	15.69	0.85	090
69320		A	Rebuild outer ear canal	17.03	NA	NA	20.07	20.53	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	2.81	2.65	0.68	0.68	0.07	000
69401		A	Inflate middle ear canal	0.63	1.44	1.39	0.56	0.58	0.05	000
69405		A	Catheterize middle ear canal	2.65	3.66	3.63	1.97	2.06	0.21	010
69420		A	Incision of eardrum	1.35	3.32	3.28	1.56	1.57	0.11	010
69421		A	Incision of eardrum	1.75	NA	NA	1.85	1.93	0.15	010
69424		A	Remove ventilating tube	0.85	2.34	2.31	0.68	0.68	0.07	000
69433		A	Create eardrum opening	1.54	3.32	3.27	1.59	1.61	0.13	010
69436		A	Create eardrum opening	1.98	NA	NA	1.90	2.00	0.19	010
69440		A	Exploration of middle ear	7.62	NA	NA	9.10	9.03	0.61	090
69450		A	Eardrum revision	5.61	NA	NA	7.63	7.49	0.45	090
69501		A	Mastoidectomy	9.12	NA	NA	8.50	8.64	0.73	090

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69502		A	Mastoidectomy	12.44	NA	NA	10.99	11.16	1.00	090
69505		A	Remove mastoid structures	13.05	NA	NA	16.08	16.38	1.05	090
69511		A	Extensive mastoid surgery	13.58	NA	NA	16.34	16.64	1.09	090
69530		A	Extensive mastoid surgery	20.24	NA	NA	19.84	20.31	1.54	090
69535		A	Remove part of temporal bone	37.27	NA	NA	26.80	28.13	2.93	090
69540		A	Remove ear lesion	1.22	3.89	3.86	1.85	1.89	0.10	010
69550		A	Remove ear lesion	11.04	NA	NA	14.24	14.41	0.89	090
69552		A	Remove ear lesion	19.69	NA	NA	18.18	18.83	1.59	090
69554		A	Remove ear lesion	35.71	NA	NA	23.13	24.97	2.92	090
69601		A	Mastoid surgery revision	13.31	NA	NA	11.96	12.15	1.07	090
69602		A	Mastoid surgery revision	13.64	NA	NA	12.70	12.85	1.10	090
69603		A	Mastoid surgery revision	14.08	NA	NA	16.50	16.99	1.14	090
69604		A	Mastoid surgery revision	14.08	NA	NA	13.08	13.25	1.14	090
69605		A	Mastoid surgery revision	18.55	NA	NA	19.28	19.72	1.50	090
69610		A	Repair of eardrum	4.44	4.92	5.08	2.59	2.76	0.36	010
69620		A	Repair of eardrum	5.94	10.91	10.98	5.83	5.95	0.48	090
69631		A	Repair eardrum structures	9.93	NA	NA	11.53	11.46	0.80	090
69632		A	Rebuild eardrum structures	12.82	NA	NA	13.33	13.38	1.03	090
69633		A	Rebuild eardrum structures	12.17	NA	NA	13.09	13.10	0.98	090
69635		A	Repair eardrum structures	13.39	NA	NA	16.30	16.43	1.08	090
69636		A	Rebuild eardrum structures	15.29	NA	NA	18.20	18.50	1.23	090
69637		A	Rebuild eardrum structures	15.18	NA	NA	18.17	18.46	1.22	090
69641		A	Revise middle ear & mastoid	12.77	NA	NA	12.47	12.57	1.03	090
69642		A	Revise middle ear & mastoid	16.91	NA	NA	15.51	15.72	1.36	090
69643		A	Revise middle ear & mastoid	15.45	NA	NA	14.17	14.35	1.24	090
69644		A	Revise middle ear & mastoid	17.09	NA	NA	18.76	19.20	1.37	090
69645		A	Revise middle ear & mastoid	16.57	NA	NA	18.62	18.99	1.33	090
69646		A	Revise middle ear & mastoid	18.23	NA	NA	19.10	19.54	1.46	090
69650		A	Release middle ear bone	9.71	NA	NA	9.47	9.59	0.78	090
69660		A	Revise middle ear bone	11.94	NA	NA	10.52	10.70	0.96	090
69661		A	Revise middle ear bone	15.80	NA	NA	13.45	13.78	1.27	090
69662		A	Revise middle ear bone	15.49	NA	NA	12.50	12.83	1.25	090
69666		A	Repair middle ear structures	9.80	NA	NA	9.72	9.80	0.79	090
69667		A	Repair middle ear structures	9.81	NA	NA	9.78	9.84	0.79	090
69670		A	Remove mastoid air cells	11.62	NA	NA	11.23	11.37	0.93	090
69676		A	Remove middle ear nerve	9.58	NA	NA	10.61	10.66	0.81	090
69700		A	Close mastoid fistula	8.28	NA	NA	8.34	8.58	0.67	090
69711		A	Remove/repair hearing aid	10.50	NA	NA	10.53	10.60	0.83	090
69714		A	Implant temple bone w/stimul	14.31	NA	NA	11.70	11.96	1.13	090
69715		A	Temple bne implnt w/stimulat	18.80	NA	NA	13.32	13.77	1.48	090
69717		A	Temple bone implant revision	15.29	NA	NA	12.01	12.64	0.90	090
69718		A	Revise temple bone implant	19.05	NA	NA	13.41	13.90	3.22	090
69720		A	Release facial nerve	14.57	NA	NA	13.88	14.06	1.16	090
69725		A	Release facial nerve	27.44	NA	NA	18.02	18.57	2.45	090

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69740		A	Repair facial nerve	16.18	NA	NA	12.01	12.38	1.27	090
69745		A	Repair facial nerve	16.91	NA	NA	13.20	13.66	1.14	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.61	NA	NA	9.61	9.59	0.69	090
69802		A	Incise inner ear	13.39	NA	NA	11.86	11.99	1.06	090
69805		A	Explore inner ear	14.55	NA	NA	10.84	11.11	1.12	090
69806		A	Explore inner ear	12.52	NA	NA	10.39	10.57	1.00	090
69820		A	Establish inner ear window	10.40	NA	NA	10.37	10.60	0.90	090
69840		A	Revise inner ear window	10.32	NA	NA	11.37	11.83	0.79	090
69905		A	Remove inner ear	11.15	NA	NA	11.22	11.27	0.90	090
69910		A	Remove inner ear & mastoid	13.80	NA	NA	10.89	11.16	1.07	090
69915		A	Incise inner ear nerve	22.65	NA	NA	14.50	15.01	1.70	090
69930		A	Implant cochlear device	17.60	NA	NA	13.13	13.55	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	16.60	17.19	2.29	090
69955		A	Release facial nerve	29.22	NA	NA	18.62	19.33	2.49	090
69960		A	Release inner ear canal	29.22	NA	NA	17.33	18.03	2.18	090
69970		A	Remove inner ear lesion	32.21	NA	NA	19.56	20.51	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	1.27	1.40	0.89	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.84	3.31	NA	NA	0.27	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.42	2.90	NA	NA	0.22	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.42	0.41	0.42	0.41	0.05	XXX
70015		A	Contrast x-ray of brain	1.19	2.92	2.62	NA	NA	0.16	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.48	2.20	NA	NA	0.08	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.44	0.43	0.44	0.43	0.08	XXX
70030		A	X-ray eye for foreign body	0.17	0.62	0.58	NA	NA	0.03	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.56	0.52	NA	NA	0.02	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.64	0.62	NA	NA	0.03	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.58	0.57	NA	NA	0.02	XXX
70100	26	A	X-ray exam of jaw	0.18	0.05	0.06	0.05	0.06	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.82	0.79	NA	NA	0.05	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.73	0.70	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	0.70	0.69	NA	NA	0.05	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.64	0.64	NA	NA	0.04	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.05	0.06	0.05	0.06	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.17	1.10	NA	NA	0.07	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.06	0.99	NA	NA	0.05	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.11	0.11	0.02	XXX
70134		A	X-ray exam of middle ear	0.34	0.91	0.90	NA	NA	0.07	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.79	0.78	NA	NA	0.05	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.12	0.12	0.12	0.12	0.02	XXX

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70140		A	X-ray exam of facial bones	0.19	0.55	0.58	NA	NA	0.05	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.49	0.52	NA	NA	0.04	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.05	0.05	0.05	0.05	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.86	0.86	NA	NA	0.06	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.77	0.78	NA	NA	0.05	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.08	0.08	0.08	0.08	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.71	0.68	NA	NA	0.03	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.66	0.62	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	0.11	0.11	0.11	0.11	0.01	XXX
70190		A	X-ray exam of eye sockets	0.21	0.73	0.72	NA	NA	0.05	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.66	0.65	NA	NA	0.04	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.07	0.07	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.88	0.88	NA	NA	0.06	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.79	0.79	NA	NA	0.05	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.10	0.09	0.10	0.09	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.58	0.61	NA	NA	0.05	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.53	0.56	NA	NA	0.04	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.05	0.05	0.05	0.05	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.74	0.77	NA	NA	0.06	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.66	0.69	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	0.61	0.58	NA	NA	0.03	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.55	0.52	NA	NA	0.02	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.06	0.06	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.70	0.70	NA	NA	0.05	XXX
70250	TC	A	X-ray exam of skull	0.00	0.63	0.63	NA	NA	0.04	XXX
70250	26	A	X-ray exam of skull	0.24	0.07	0.07	0.07	0.07	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.88	0.91	NA	NA	0.08	XXX
70260	TC	A	X-ray exam of skull	0.00	0.78	0.80	NA	NA	0.06	XXX
70260	26	A	X-ray exam of skull	0.34	0.10	0.11	0.10	0.11	0.02	XXX
70300		A	X-ray exam of teeth	0.10	0.24	0.26	NA	NA	0.03	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.21	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	0.82	0.74	NA	NA	0.03	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.77	0.68	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	1.09	1.03	NA	NA	0.06	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	1.01	0.96	NA	NA	0.05	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.07	0.07	0.07	0.07	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.63	0.61	NA	NA	0.03	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.57	0.55	NA	NA	0.02	XXX

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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	1.02	1.00	NA	NA	0.06	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.94	0.92	NA	NA	0.05	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.08	0.08	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	1.27	1.48	NA	NA	0.12	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.16	0.17	0.16	0.17	0.02	XXX
70336		A	Magnetic image, jaw joint	1.48	12.30	12.16	NA	NA	0.66	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.79	11.65	NA	NA	0.59	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.51	0.51	0.51	0.51	0.07	XXX
70350		A	X-ray head for orthodontia	0.17	0.33	0.36	NA	NA	0.03	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.28	0.30	NA	NA	0.02	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.30	0.39	NA	NA	0.05	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.24	0.32	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	0.57	0.55	NA	NA	0.03	XXX
70360	TC	A	X-ray exam of neck	0.00	0.51	0.49	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	1.74	1.66	NA	NA	0.08	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.64	1.55	NA	NA	0.07	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.10	0.10	0.10	0.10	0.01	XXX
70371		A	Speech evaluation, complex	0.84	1.48	1.71	NA	NA	0.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.23	1.45	NA	NA	0.12	XXX
70371	26	A	Speech evaluation, complex	0.84	0.25	0.26	0.25	0.26	0.04	XXX
70373		A	Contrast x-ray of larynx	0.44	1.57	1.66	NA	NA	0.13	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.46	1.54	NA	NA	0.11	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.11	0.12	0.11	0.12	0.02	XXX
70380		A	X-ray exam of salivary gland	0.17	0.83	0.80	NA	NA	0.05	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.77	0.75	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	2.37	2.25	NA	NA	0.13	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.23	2.12	NA	NA	0.11	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.14	0.13	0.14	0.13	0.02	XXX
70450		A	Ct head/brain w/o dye	0.85	4.98	4.99	NA	NA	0.29	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.67	4.69	NA	NA	0.25	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.31	0.30	0.31	0.30	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	6.57	6.45	NA	NA	0.35	XXX
70460	TC	A	Ct head/brain w/dye	0.00	6.16	6.04	NA	NA	0.30	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.41	0.40	0.41	0.40	0.05	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	8.02	7.89	NA	NA	0.43	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.56	7.45	NA	NA	0.37	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.46	0.45	0.46	0.45	0.06	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	8.58	7.72	NA	NA	0.31	XXX

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70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	8.12	7.27	NA	NA	0.25	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.46	0.45	0.46	0.45	0.06	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	10.10	9.11	NA	NA	0.36	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	9.59	8.62	NA	NA	0.30	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.50	0.49	0.50	0.49	0.06	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	11.54	10.55	NA	NA	0.43	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	11.02	10.04	NA	NA	0.37	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.52	0.51	0.52	0.51	0.06	XXX
70486		A	Ct maxillofacial w/o dye	1.14	6.88	6.43	NA	NA	0.30	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	6.47	6.04	NA	NA	0.25	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.40	0.40	0.40	0.40	0.05	XXX
70487		A	Ct maxillofacial w/dye	1.30	8.45	7.87	NA	NA	0.36	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	7.98	7.41	NA	NA	0.30	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.47	0.46	0.47	0.46	0.06	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	10.48	9.75	NA	NA	0.43	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	9.97	9.26	NA	NA	0.37	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.51	0.49	0.51	0.49	0.06	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	6.56	6.21	NA	NA	0.31	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	6.10	5.76	NA	NA	0.25	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.46	0.45	0.46	0.45	0.06	XXX
70491		A	Ct soft tissue neck w/dye	1.38	8.12	7.63	NA	NA	0.36	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	7.62	7.14	NA	NA	0.30	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.50	0.49	0.50	0.49	0.06	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	10.14	9.50	NA	NA	0.43	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	9.62	8.99	NA	NA	0.37	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.52	0.51	0.52	0.51	0.06	XXX
70496		A	Ct angiography, head	1.75	17.32	15.80	NA	NA	0.66	XXX
70496	TC	A	Ct angiography, head	0.00	16.67	15.16	NA	NA	0.58	XXX
70496	26	A	Ct angiography, head	1.75	0.65	0.63	0.65	0.63	0.08	XXX
70498		A	Ct angiography, neck	1.75	17.46	15.90	NA	NA	0.66	XXX
70498	TC	A	Ct angiography, neck	0.00	16.80	15.26	NA	NA	0.58	XXX
70498	26	A	Ct angiography, neck	1.75	0.67	0.64	0.67	0.64	0.08	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	14.29	13.64	NA	NA	0.45	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	13.82	13.18	NA	NA	0.39	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.47	0.46	0.47	0.46	0.06	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	15.34	15.02	NA	NA	0.54	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	14.77	14.45	NA	NA	0.47	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.57	0.56	0.57	0.56	0.07	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	18.89	20.59	NA	NA	0.94	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	18.13	19.85	NA	NA	0.84	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.75	0.74	0.75	0.74	0.10	XXX
70544		A	Mr angiography head w/o dye	1.20	16.01	14.92	NA	NA	0.64	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	15.58	14.50	NA	NA	0.59	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.43	0.42	0.43	0.42	0.05	XXX

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70545		A	Mr angiography head w/dye	1.20	15.92	14.85	NA	NA	0.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	15.48	14.43	NA	NA	0.59	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.43	0.42	0.43	0.42	0.05	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	24.24	23.96	NA	NA	0.67	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	23.60	23.33	NA	NA	0.59	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.64	0.63	0.64	0.63	0.08	XXX
70547		A	Mr angiography neck w/o dye	1.20	15.94	14.86	NA	NA	0.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	15.51	14.45	NA	NA	0.59	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.42	0.42	0.42	0.42	0.05	XXX
70548		A	Mr angiography neck w/dye	1.20	16.84	15.54	NA	NA	0.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	16.41	15.12	NA	NA	0.59	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.43	0.42	0.43	0.42	0.05	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	24.28	23.98	NA	NA	0.67	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	23.63	23.35	NA	NA	0.59	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.65	0.63	0.65	0.63	0.08	XXX
70551		A	Mri brain w/o dye	1.48	14.60	13.88	NA	NA	0.66	XXX
70551	TC	A	Mri brain w/o dye	0.00	14.07	13.37	NA	NA	0.59	XXX
70551	26	A	Mri brain w/o dye	1.48	0.52	0.51	0.52	0.51	0.07	XXX
70552		A	Mri brain w/dye	1.78	15.78	15.36	NA	NA	0.78	XXX
70552	TC	A	Mri brain w/dye	0.00	15.15	14.74	NA	NA	0.70	XXX
70552	26	A	Mri brain w/dye	1.78	0.64	0.62	0.64	0.62	0.08	XXX
70553		A	Mri brain w/o & w/dye	2.36	18.25	20.13	NA	NA	1.41	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	17.42	19.31	NA	NA	1.31	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.84	0.82	0.84	0.82	0.10	XXX
70554		A	Fmri brain by tech	2.11	14.45	14.45	NA	NA	0.92	XXX
70554	TC	A	Fmri brain by tech	0.00	13.70	13.70	NA	NA	0.82	XXX
70554	26	A	Fmri brain by tech	2.11	0.75	0.75	0.75	0.75	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	0.93	0.93	0.93	0.93	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	1.06	1.08	1.06	1.08	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	1.10	1.14	1.10	1.14	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	1.18	1.19	1.18	1.19	0.12	XXX
71010		A	Chest x-ray	0.18	0.44	0.46	NA	NA	0.03	XXX
71010	TC	A	Chest x-ray	0.00	0.38	0.40	NA	NA	0.02	XXX

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71010	26	A	Chest x-ray	0.18	0.06	0.06	0.06	0.06	0.01	XXX
71015		A	Chest x-ray	0.21	0.57	0.58	NA	NA	0.03	XXX
71015	TC	A	Chest x-ray	0.00	0.51	0.51	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	0.58	0.61	NA	NA	0.05	XXX
71020	TC	A	Chest x-ray	0.00	0.51	0.54	NA	NA	0.04	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.07	0.07	0.01	XXX
71021		A	Chest x-ray	0.27	0.71	0.74	NA	NA	0.06	XXX
71021	TC	A	Chest x-ray	0.00	0.62	0.65	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	0.93	0.91	NA	NA	0.06	XXX
71022	TC	A	Chest x-ray	0.00	0.83	0.81	NA	NA	0.05	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.10	0.10	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.60	1.42	NA	NA	0.06	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.45	1.28	NA	NA	0.05	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.15	0.14	0.15	0.14	0.01	XXX
71030		A	Chest x-ray	0.31	0.93	0.92	NA	NA	0.06	XXX
71030	TC	A	Chest x-ray	0.00	0.82	0.81	NA	NA	0.05	XXX
71030	26	A	Chest x-ray	0.31	0.11	0.10	0.11	0.10	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	2.16	2.02	NA	NA	0.10	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.95	1.82	NA	NA	0.08	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.22	0.20	0.22	0.20	0.02	XXX
71035		A	Chest x-ray	0.18	0.80	0.74	NA	NA	0.03	XXX
71035	TC	A	Chest x-ray	0.00	0.73	0.68	NA	NA	0.02	XXX
71035	26	A	Chest x-ray	0.18	0.07	0.06	0.07	0.06	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.07	1.97	NA	NA	0.11	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.87	1.77	NA	NA	0.08	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.20	0.20	0.20	0.20	0.03	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.14	2.97	NA	NA	0.16	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.89	2.72	NA	NA	0.13	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.26	0.25	0.26	0.25	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	0.63	0.63	NA	NA	0.05	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.56	0.56	NA	NA	0.04	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.07	0.07	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.78	0.77	NA	NA	0.05	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.68	0.68	NA	NA	0.04	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.78	0.80	NA	NA	0.06	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.70	0.72	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	1.07	1.05	NA	NA	0.07	XXX

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71111	TC	A	X-ray exam of ribs/chest	0.00	0.97	0.95	NA	NA	0.06	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.10	0.10	0.10	0.10	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.64	0.66	NA	NA	0.05	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.57	0.59	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	0.77	0.77	NA	NA	0.05	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.69	0.70	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	6.53	6.48	NA	NA	0.36	XXX
71250	TC	A	Ct thorax w/o dye	0.00	6.11	6.07	NA	NA	0.31	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.42	0.41	0.42	0.41	0.05	XXX
71260		A	Ct thorax w/dye	1.24	8.09	7.95	NA	NA	0.42	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.64	7.50	NA	NA	0.37	XXX
71260	26	A	Ct thorax w/dye	1.24	0.45	0.44	0.45	0.44	0.05	XXX
71270		A	Ct thorax w/o & w/dye	1.38	10.17	9.96	NA	NA	0.52	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	9.67	9.48	NA	NA	0.46	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.50	0.49	0.50	0.49	0.06	XXX
71275		A	Ct angiography, chest	1.92	11.88	12.18	NA	NA	0.48	XXX
71275	TC	A	Ct angiography, chest	0.00	11.17	11.49	NA	NA	0.39	XXX
71275	26	A	Ct angiography, chest	1.92	0.71	0.69	0.71	0.69	0.09	XXX
71550		A	Mri chest w/o dye	1.46	16.50	15.31	NA	NA	0.51	XXX
71550	TC	A	Mri chest w/o dye	0.00	15.98	14.80	NA	NA	0.45	XXX
71550	26	A	Mri chest w/o dye	1.46	0.52	0.51	0.52	0.51	0.06	XXX
71551		A	Mri chest w/dye	1.73	18.25	17.21	NA	NA	0.60	XXX
71551	TC	A	Mri chest w/dye	0.00	17.65	16.61	NA	NA	0.52	XXX
71551	26	A	Mri chest w/dye	1.73	0.60	0.60	0.60	0.60	0.08	XXX
71552		A	Mri chest w/o & w/dye	2.26	22.77	23.52	NA	NA	0.78	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	21.95	22.71	NA	NA	0.68	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.83	0.81	0.83	0.81	0.10	XXX
71555		R	Mri angio chest w or w/o dye	1.81	15.50	14.59	NA	NA	0.67	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	14.82	13.93	NA	NA	0.59	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.68	0.66	0.68	0.66	0.08	XXX
72010		A	X-ray exam of spine	0.45	1.46	1.39	NA	NA	0.08	XXX
72010	TC	A	X-ray exam of spine	0.00	1.33	1.25	NA	NA	0.06	XXX
72010	26	A	X-ray exam of spine	0.45	0.13	0.14	0.13	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	0.42	0.42	NA	NA	0.02	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.05	0.05	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.78	0.75	NA	NA	0.05	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.70	0.68	NA	NA	0.04	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.07	0.07	0.01	XXX
72050		A	X-ray exam of neck spine	0.31	1.09	1.06	NA	NA	0.07	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.98	0.96	NA	NA	0.06	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.11	0.11	0.11	0.11	0.01	XXX

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72052		A	X-ray exam of neck spine	0.36	1.42	1.38	NA	NA	0.08	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.29	1.25	NA	NA	0.06	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.13	0.12	0.13	0.12	0.02	XXX
72069		A	X-ray exam of trunk spine	0.22	0.76	0.71	NA	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.68	0.64	NA	NA	0.02	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.65	0.66	NA	NA	0.05	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.57	0.59	NA	NA	0.04	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.07	0.07	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.79	0.79	NA	NA	0.06	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.71	0.71	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	0.96	0.97	NA	NA	0.07	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.89	0.89	NA	NA	0.06	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.08	0.07	0.08	0.07	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.70	0.71	NA	NA	0.05	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.62	0.64	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	1.01	0.95	NA	NA	0.05	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.90	0.85	NA	NA	0.04	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.11	0.10	0.11	0.10	0.01	XXX
72100		A	X-ray exam of lower spine	0.22	0.82	0.80	NA	NA	0.05	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.74	0.73	NA	NA	0.04	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.07	0.07	0.01	XXX
72110		A	X-ray exam of lower spine	0.31	1.16	1.12	NA	NA	0.07	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.05	1.01	NA	NA	0.06	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.11	0.11	0.11	0.11	0.01	XXX
72114		A	X-ray exam of lower spine	0.36	1.59	1.52	NA	NA	0.08	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.46	1.39	NA	NA	0.06	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.13	0.13	0.02	XXX
72120		A	X-ray exam of lower spine	0.22	1.09	1.06	NA	NA	0.07	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.01	0.98	NA	NA	0.06	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72125		A	Ct neck spine w/o dye	1.16	6.55	6.49	NA	NA	0.36	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	6.13	6.08	NA	NA	0.31	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.42	0.41	0.42	0.41	0.05	XXX
72126		A	Ct neck spine w/dye	1.22	8.09	7.94	NA	NA	0.42	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.65	7.51	NA	NA	0.37	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	10.10	9.90	NA	NA	0.52	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	9.65	9.46	NA	NA	0.46	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.45	0.44	0.45	0.44	0.06	XXX
72128		A	Ct chest spine w/o dye	1.16	6.53	6.48	NA	NA	0.36	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	6.11	6.07	NA	NA	0.31	XXX

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72128	26	A	Ct chest spine w/o dye	1.16	0.42	0.41	0.42	0.41	0.05	XXX
72129		A	Ct chest spine w/dye	1.22	8.09	7.94	NA	NA	0.42	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.65	7.51	NA	NA	0.37	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	10.12	9.92	NA	NA	0.52	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	9.67	9.47	NA	NA	0.46	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.45	0.45	0.45	0.45	0.06	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.50	6.46	NA	NA	0.36	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	6.09	6.05	NA	NA	0.31	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.41	0.41	0.41	0.41	0.05	XXX
72132		A	Ct lumbar spine w/dye	1.22	8.07	7.93	NA	NA	0.42	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.63	7.50	NA	NA	0.37	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	10.11	9.91	NA	NA	0.52	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	9.65	9.46	NA	NA	0.46	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.45	0.44	0.45	0.44	0.06	XXX
72141		A	Mri neck spine w/o dye	1.60	12.57	12.37	NA	NA	0.66	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	12.01	11.82	NA	NA	0.59	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.56	0.55	0.56	0.55	0.07	XXX
72142		A	Mri neck spine w/dye	1.92	15.80	15.38	NA	NA	0.79	XXX
72142	TC	A	Mri neck spine w/dye	0.00	15.12	14.71	NA	NA	0.70	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.68	0.67	0.68	0.67	0.09	XXX
72146		A	Mri chest spine w/o dye	1.60	12.59	12.70	NA	NA	0.71	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.03	12.15	NA	NA	0.64	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.56	0.56	0.56	0.56	0.07	XXX
72147		A	Mri chest spine w/dye	1.92	13.71	13.82	NA	NA	0.79	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.03	13.15	NA	NA	0.70	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.68	0.67	0.68	0.67	0.09	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.53	12.64	NA	NA	0.71	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.01	12.13	NA	NA	0.64	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.52	0.51	0.52	0.51	0.07	XXX
72149		A	Mri lumbar spine w/dye	1.78	15.73	15.32	NA	NA	0.78	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	15.09	14.70	NA	NA	0.70	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.63	0.62	0.63	0.62	0.08	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	17.93	19.91	NA	NA	1.42	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	17.03	19.02	NA	NA	1.31	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.90	0.89	0.90	0.89	0.11	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	16.35	18.72	NA	NA	1.42	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	15.44	17.83	NA	NA	1.31	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.92	0.90	0.92	0.90	0.11	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	17.85	19.83	NA	NA	1.41	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	17.01	19.01	NA	NA	1.31	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.83	0.82	0.83	0.82	0.10	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	16.80	15.84	NA	NA	0.74	XXX

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72159	TC	N	Mr angio spine w/o&w/dye	0.00	16.22	15.24	NA	NA	0.64	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.58	0.60	0.58	0.60	0.10	XXX
72170		A	X-ray exam of pelvis	0.17	0.50	0.52	NA	NA	0.03	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.44	0.46	NA	NA	0.02	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.06	0.06	0.01	XXX
72190		A	X-ray exam of pelvis	0.21	0.86	0.83	NA	NA	0.05	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.78	0.75	NA	NA	0.04	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.07	0.07	0.01	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	11.47	11.78	NA	NA	0.47	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	10.81	11.12	NA	NA	0.39	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.67	0.65	0.67	0.65	0.08	XXX
72192		A	Ct pelvis w/o dye	1.09	6.11	6.16	NA	NA	0.36	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.71	5.77	NA	NA	0.31	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.40	0.39	0.40	0.39	0.05	XXX
72193		A	Ct pelvis w/dye	1.16	7.64	7.54	NA	NA	0.41	XXX
72193	TC	A	Ct pelvis w/dye	0.00	7.22	7.13	NA	NA	0.36	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.42	0.41	0.42	0.41	0.05	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	10.26	9.93	NA	NA	0.48	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	9.82	9.50	NA	NA	0.43	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
72195		A	Mri pelvis w/o dye	1.46	14.56	13.85	NA	NA	0.51	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	14.04	13.34	NA	NA	0.45	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.52	0.51	0.52	0.51	0.06	XXX
72196		A	Mri pelvis w/dye	1.73	15.59	15.21	NA	NA	0.60	XXX
72196	TC	A	Mri pelvis w/dye	0.00	14.97	14.60	NA	NA	0.52	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.62	0.61	0.62	0.61	0.08	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	19.11	20.76	NA	NA	1.02	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	18.30	19.97	NA	NA	0.92	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.80	0.79	0.80	0.79	0.10	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	15.33	14.46	NA	NA	0.67	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	14.67	13.81	NA	NA	0.59	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.66	0.64	0.66	0.64	0.08	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.60	0.59	NA	NA	0.03	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.54	0.54	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	0.75	0.73	NA	NA	0.05	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.68	0.66	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	0.58	0.60	NA	NA	0.05	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.53	0.54	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	2.61	3.22	NA	NA	0.29	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.29	2.91	NA	NA	0.25	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.32	0.32	0.32	0.32	0.04	XXX

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72255		A	Contrast x-ray, thorax spine	0.91	2.28	2.87	NA	NA	0.26	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.99	2.58	NA	NA	0.22	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.29	0.28	0.29	0.28	0.04	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.58	3.02	NA	NA	0.26	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.28	2.73	NA	NA	0.22	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.30	0.28	0.30	0.28	0.04	XXX
72270		A	Contrast x-ray, spine	1.33	4.07	4.69	NA	NA	0.39	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.58	4.22	NA	NA	0.33	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.49	0.47	0.49	0.47	0.06	XXX
72275		A	Epidurography	0.76	1.78	1.91	NA	NA	0.26	XXX
72275	TC	A	Epidurography	0.00	1.57	1.71	NA	NA	0.22	XXX
72275	26	A	Epidurography	0.76	0.21	0.20	0.21	0.20	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	1.50	3.32	NA	NA	0.50	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.18	2.99	NA	NA	0.43	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.32	0.33	0.32	0.33	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	0.49	0.48	0.49	0.48	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	0.53	0.52	0.53	0.52	0.07	XXX
72295		A	X-ray of lower spine disk	0.83	1.48	3.15	NA	NA	0.46	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.24	2.90	NA	NA	0.40	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.25	0.25	0.25	0.25	0.06	XXX
73000		A	X-ray exam of collar bone	0.16	0.56	0.56	NA	NA	0.03	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.51	0.51	NA	NA	0.02	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.59	0.59	NA	NA	0.03	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.53	0.53	NA	NA	0.02	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73020		A	X-ray exam of shoulder	0.15	0.45	0.47	NA	NA	0.03	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.40	0.41	NA	NA	0.02	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.05	0.05	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.58	0.59	NA	NA	0.05	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.51	0.53	NA	NA	0.04	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.06	0.06	0.01	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.27	2.28	NA	NA	0.14	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.08	2.09	NA	NA	0.12	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.20	0.19	0.20	0.19	0.02	XXX
73050		A	X-ray exam of shoulders	0.20	0.75	0.75	NA	NA	0.05	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.67	0.67	NA	NA	0.04	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.07	0.08	0.07	0.01	XXX
73060		A	X-ray exam of humerus	0.17	0.58	0.59	NA	NA	0.05	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.52	0.53	NA	NA	0.04	XXX

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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	0.56	0.56	NA	NA	0.03	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.51	0.51	NA	NA	0.02	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.05	0.05	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.77	0.73	NA	NA	0.05	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.71	0.67	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	1.90	2.00	NA	NA	0.14	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.71	1.81	NA	NA	0.12	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.19	0.19	0.02	XXX
73090		A	X-ray exam of forearm	0.16	0.56	0.56	NA	NA	0.03	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.50	0.51	NA	NA	0.02	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73092		A	X-ray exam of arm, infant	0.16	0.60	0.58	NA	NA	0.03	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.55	0.53	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	0.61	0.59	NA	NA	0.03	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.55	0.53	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	0.78	0.74	NA	NA	0.03	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.72	0.68	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	2.30	2.17	NA	NA	0.12	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.11	1.98	NA	NA	0.10	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.19	0.19	0.19	0.19	0.02	XXX
73120		A	X-ray exam of hand	0.16	0.56	0.55	NA	NA	0.03	XXX
73120	TC	A	X-ray exam of hand	0.00	0.51	0.50	NA	NA	0.02	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.67	0.65	NA	NA	0.03	XXX
73130	TC	A	X-ray exam of hand	0.00	0.61	0.59	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	0.69	0.63	NA	NA	0.03	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.64	0.59	NA	NA	0.02	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.04	0.05	0.04	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	6.46	6.18	NA	NA	0.30	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	6.07	5.80	NA	NA	0.25	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.39	0.38	0.39	0.38	0.05	XXX
73201		A	Ct upper extremity w/dye	1.16	8.00	7.58	NA	NA	0.36	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	7.58	7.17	NA	NA	0.31	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.42	0.41	0.42	0.41	0.05	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	10.71	10.00	NA	NA	0.44	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	10.28	9.57	NA	NA	0.39	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	11.09	11.22	NA	NA	0.47	XXX

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73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.39	10.55	NA	NA	0.39	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.70	0.67	0.70	0.67	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	14.80	14.02	NA	NA	0.45	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	14.34	13.57	NA	NA	0.39	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.46	0.46	0.46	0.46	0.06	XXX
73219		A	Mri upper extremity w/dye	1.62	15.60	15.21	NA	NA	0.54	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	15.03	14.65	NA	NA	0.47	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.57	0.56	0.57	0.56	0.07	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	19.19	20.82	NA	NA	0.94	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	18.43	20.07	NA	NA	0.84	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.76	0.75	0.76	0.75	0.10	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	13.66	13.17	NA	NA	0.45	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	13.18	12.70	NA	NA	0.39	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.47	0.46	0.47	0.46	0.06	XXX
73222		A	Mri joint upr extrem w/dye	1.62	14.43	14.33	NA	NA	0.54	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.86	13.77	NA	NA	0.47	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.57	0.56	0.57	0.56	0.07	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	17.78	19.76	NA	NA	0.94	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	17.03	19.02	NA	NA	0.84	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.75	0.74	0.75	0.74	0.10	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	16.77	15.51	NA	NA	0.69	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	16.22	14.93	NA	NA	0.59	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.55	0.58	0.55	0.58	0.10	XXX
73500		A	X-ray exam of hip	0.17	0.49	0.50	NA	NA	0.03	XXX
73500	TC	A	X-ray exam of hip	0.00	0.43	0.44	NA	NA	0.02	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73510		A	X-ray exam of hip	0.21	0.78	0.74	NA	NA	0.05	XXX
73510	TC	A	X-ray exam of hip	0.00	0.71	0.67	NA	NA	0.04	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.07	0.07	0.01	XXX
73520		A	X-ray exam of hips	0.26	0.79	0.78	NA	NA	0.05	XXX
73520	TC	A	X-ray exam of hips	0.00	0.70	0.70	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	1.89	1.99	NA	NA	0.15	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.70	1.80	NA	NA	0.12	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.19	0.19	0.19	0.19	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	0.81	0.77	NA	NA	0.05	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.74	0.70	NA	NA	0.04	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.07	0.07	0.01	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.18	1.45	NA	NA	0.15	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.03	1.30	NA	NA	0.12	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.15	0.15	0.15	0.15	0.03	XXX

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73550		A	X-ray exam of thigh	0.17	0.55	0.57	NA	NA	0.05	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.49	0.51	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	0.59	0.59	NA	NA	0.03	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.53	0.53	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	0.73	0.71	NA	NA	0.05	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.67	0.64	NA	NA	0.04	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.06	0.07	0.06	0.01	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.87	0.82	NA	NA	0.05	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.79	0.75	NA	NA	0.04	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.08	0.08	0.08	0.08	0.01	XXX
73565		A	X-ray exam of knees	0.17	0.65	0.63	NA	NA	0.03	XXX
73565	TC	A	X-ray exam of knees	0.00	0.59	0.56	NA	NA	0.02	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.58	2.63	NA	NA	0.17	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.38	2.45	NA	NA	0.14	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.19	0.19	0.19	0.19	0.03	XXX
73590		A	X-ray exam of lower leg	0.17	0.54	0.55	NA	NA	0.03	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.49	0.49	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	0.60	0.58	NA	NA	0.03	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.55	0.53	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	0.56	0.56	NA	NA	0.03	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.51	0.50	NA	NA	0.02	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.68	0.66	NA	NA	0.03	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.62	0.60	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	1.99	2.07	NA	NA	0.15	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.81	1.89	NA	NA	0.12	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.18	0.18	0.18	0.18	0.03	XXX
73620		A	X-ray exam of foot	0.16	0.53	0.53	NA	NA	0.03	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	0.49	NA	NA	0.02	XXX
73620	26	A	X-ray exam of foot	0.16	0.04	0.05	0.04	0.05	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.66	0.64	NA	NA	0.03	XXX
73630	TC	A	X-ray exam of foot	0.00	0.61	0.59	NA	NA	0.02	XXX
73630	26	A	X-ray exam of foot	0.17	0.05	0.06	0.05	0.06	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.55	0.55	NA	NA	0.03	XXX
73650	TC	A	X-ray exam of heel	0.00	0.50	0.49	NA	NA	0.02	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.64	0.60	NA	NA	0.03	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.60	0.55	NA	NA	0.02	XXX

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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	6.48	6.19	NA	NA	0.30	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	6.09	5.81	NA	NA	0.25	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.39	0.38	0.39	0.38	0.05	XXX
73701		A	Ct lower extremity w/dye	1.16	8.09	7.64	NA	NA	0.36	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	7.66	7.23	NA	NA	0.31	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.43	0.41	0.43	0.41	0.05	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	10.74	10.02	NA	NA	0.44	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	10.30	9.59	NA	NA	0.39	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.44	0.43	0.44	0.43	0.05	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	12.52	12.30	NA	NA	0.47	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	11.78	11.59	NA	NA	0.39	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.74	0.71	0.74	0.71	0.08	XXX
73718		A	Mri lower extremity w/o dye	1.35	14.40	13.72	NA	NA	0.45	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	13.93	13.26	NA	NA	0.39	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.47	0.46	0.47	0.46	0.06	XXX
73719		A	Mri lower extremity w/dye	1.62	15.34	15.02	NA	NA	0.54	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	14.77	14.45	NA	NA	0.47	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.57	0.56	0.57	0.56	0.07	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	19.18	20.81	NA	NA	0.94	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	18.42	20.06	NA	NA	0.84	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.77	0.75	0.77	0.75	0.10	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	13.99	13.42	NA	NA	0.45	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	13.51	12.95	NA	NA	0.39	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.48	0.47	0.48	0.47	0.06	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	14.63	14.48	NA	NA	0.54	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	14.04	13.91	NA	NA	0.47	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.58	0.57	0.58	0.57	0.07	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	17.72	19.72	NA	NA	0.94	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	16.96	18.97	NA	NA	0.84	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.76	0.75	0.76	0.75	0.10	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	15.32	14.45	NA	NA	0.67	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	14.66	13.81	NA	NA	0.59	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.66	0.65	0.66	0.65	0.08	XXX
74000		A	X-ray exam of abdomen	0.18	0.47	0.50	NA	NA	0.03	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.41	0.44	NA	NA	0.02	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.06	0.06	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.80	0.76	NA	NA	0.05	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.72	0.68	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	0.82	0.80	NA	NA	0.05	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.73	0.70	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	1.00	0.96	NA	NA	0.06	XXX

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74022	TC	A	X-ray exam series, abdomen	0.00	0.89	0.85	NA	NA	0.05	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.11	0.11	0.11	0.11	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	6.15	6.13	NA	NA	0.35	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.71	5.71	NA	NA	0.30	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.44	0.42	0.44	0.42	0.05	XXX
74160		A	Ct abdomen w/dye	1.27	8.93	8.52	NA	NA	0.42	XXX
74160	TC	A	Ct abdomen w/dye	0.00	8.46	8.07	NA	NA	0.36	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.46	0.45	0.46	0.45	0.06	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	12.33	11.49	NA	NA	0.49	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	11.82	11.00	NA	NA	0.43	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.51	0.49	0.51	0.49	0.06	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.45	12.51	NA	NA	0.47	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	11.74	11.83	NA	NA	0.39	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.71	0.69	0.71	0.69	0.08	XXX
74181		A	Mri abdomen w/o dye	1.46	12.59	12.37	NA	NA	0.51	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	12.06	11.86	NA	NA	0.45	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.53	0.52	0.53	0.52	0.06	XXX
74182		A	Mri abdomen w/dye	1.73	17.59	16.71	NA	NA	0.60	XXX
74182	TC	A	Mri abdomen w/dye	0.00	16.97	16.10	NA	NA	0.52	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.62	0.61	0.62	0.61	0.08	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	19.15	20.80	NA	NA	1.02	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	18.34	20.01	NA	NA	0.92	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.81	0.79	0.81	0.79	0.10	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	15.26	14.40	NA	NA	0.67	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	14.60	13.77	NA	NA	0.59	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.65	0.64	0.65	0.64	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	0.18	0.17	0.18	0.17	0.02	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.80	1.68	NA	NA	0.08	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.67	1.55	NA	NA	0.06	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.13	0.13	0.13	0.13	0.02	XXX
74220		A	Contrast x-ray, esophagus	0.46	2.04	1.86	NA	NA	0.08	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.87	1.70	NA	NA	0.06	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.17	0.16	0.17	0.16	0.02	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.98	1.86	NA	NA	0.09	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.78	1.67	NA	NA	0.07	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.20	0.19	0.20	0.19	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	0.48	0.46	0.48	0.46	0.05	XXX

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74240		A	X-ray exam, upper gi tract	0.69	2.34	2.18	NA	NA	0.11	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	2.09	1.93	NA	NA	0.08	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.25	0.25	0.25	0.25	0.03	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.60	2.38	NA	NA	0.11	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.35	2.14	NA	NA	0.08	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.25	0.24	0.25	0.24	0.03	XXX
74245		A	X-ray exam, upper gi tract	0.91	4.01	3.68	NA	NA	0.17	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.68	3.36	NA	NA	0.13	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.33	0.32	0.33	0.32	0.04	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	2.83	2.59	NA	NA	0.13	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.58	2.35	NA	NA	0.10	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.25	0.25	0.25	0.25	0.03	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.26	2.93	NA	NA	0.14	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	3.01	2.68	NA	NA	0.11	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.25	0.25	0.25	0.25	0.03	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.40	4.02	NA	NA	0.18	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	4.07	3.70	NA	NA	0.14	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.33	0.32	0.33	0.32	0.04	XXX
74250		A	X-ray exam of small bowel	0.47	2.52	2.25	NA	NA	0.09	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.35	2.09	NA	NA	0.07	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.17	0.17	0.17	0.17	0.02	XXX
74251		A	X-ray exam of small bowel	0.69	10.15	8.00	NA	NA	0.10	XXX
74251	TC	A	X-ray exam of small bowel	0.00	9.89	7.75	NA	NA	0.07	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.25	0.25	0.25	0.25	0.03	XXX
74260		A	X-ray exam of small bowel	0.50	8.41	6.72	NA	NA	0.10	XXX
74260	TC	A	X-ray exam of small bowel	0.00	8.23	6.55	NA	NA	0.08	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.18	0.18	0.18	0.18	0.02	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.63	3.21	NA	NA	0.14	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	3.38	2.96	NA	NA	0.11	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.25	0.25	0.25	0.25	0.03	XXX
74280		A	Contrast x-ray exam of colon	0.99	5.02	4.41	NA	NA	0.17	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.66	4.06	NA	NA	0.13	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.36	0.35	0.36	0.35	0.04	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.56	3.48	NA	NA	0.23	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.84	2.77	NA	NA	0.14	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.72	0.71	0.72	0.71	0.09	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.60	1.41	NA	NA	0.06	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.49	1.30	NA	NA	0.05	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.11	0.11	0.11	0.11	0.01	XXX
74291		A	Contrast x-rays, gallbladder	0.20	1.61	1.33	NA	NA	0.03	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.53	1.26	NA	NA	0.02	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.07	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

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74300	26	A	X-ray bile ducts/pancreas	0.36	0.13	0.13	0.13	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	0.07	0.07	0.07	0.07	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	0.16	0.15	0.16	0.15	0.02	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.17	2.47	NA	NA	0.19	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.97	2.27	NA	NA	0.17	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.21	0.20	0.21	0.20	0.02	XXX
74327		A	X-ray bile stone removal	0.70	3.05	2.79	NA	NA	0.14	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.78	2.53	NA	NA	0.11	XXX
74327	26	A	X-ray bile stone removal	0.70	0.26	0.25	0.26	0.25	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	0.27	0.26	0.27	0.26	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	0.27	0.26	0.27	0.26	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	0.34	0.33	0.34	0.33	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	0.20	0.20	0.20	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	0.29	0.28	0.29	0.28	0.03	XXX
74360		C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
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	0.33	0.32	0.33	0.32	0.04	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.63	2.43	NA	NA	0.13	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.45	2.26	NA	NA	0.11	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.18	0.17	0.18	0.17	0.02	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.73	2.58	NA	NA	0.13	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.55	2.41	NA	NA	0.11	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.18	0.18	0.18	0.18	0.02	XXX
74415		A	Contrst x-ray, urinary tract	0.49	3.31	3.06	NA	NA	0.14	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	3.13	2.88	NA	NA	0.12	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.18	0.17	0.18	0.17	0.02	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX

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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	0.14	0.13	0.14	0.13	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	0.13	0.14	0.13	0.02	XXX
74430		A	Contrast x-ray, bladder	0.32	1.98	1.77	NA	NA	0.08	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.86	1.66	NA	NA	0.06	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.12	0.11	0.12	0.11	0.02	XXX
74440		A	X-ray, male genital tract	0.38	2.09	1.88	NA	NA	0.08	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.96	1.75	NA	NA	0.06	XXX
74440	26	A	X-ray, male genital tract	0.38	0.14	0.13	0.14	0.13	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	0.44	0.42	0.44	0.42	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	0.12	0.12	0.12	0.12	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	2.20	2.08	NA	NA	0.12	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	2.08	1.95	NA	NA	0.10	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.13	0.12	0.13	0.12	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	0.21	0.20	0.21	0.20	0.02	XXX
74475		A	X-ray control, cath insert	0.54	2.16	2.69	NA	NA	0.24	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.95	2.49	NA	NA	0.22	XXX
74475	26	A	X-ray control, cath insert	0.54	0.21	0.20	0.21	0.20	0.02	XXX
74480		A	X-ray control, cath insert	0.54	2.17	2.70	NA	NA	0.24	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.97	2.50	NA	NA	0.22	XXX
74480	26	A	X-ray control, cath insert	0.54	0.21	0.20	0.21	0.20	0.02	XXX
74485		A	X-ray guide, GU dilation	0.54	2.31	2.57	NA	NA	0.20	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	2.10	2.37	NA	NA	0.17	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.21	0.20	0.21	0.20	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.68	0.80	NA	NA	0.08	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.55	0.68	NA	NA	0.06	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.13	0.12	0.13	0.12	0.02	XXX
74740		A	X-ray, female genital tract	0.38	1.78	1.69	NA	NA	0.09	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.65	1.56	NA	NA	0.07	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.13	0.13	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	0.22	0.21	0.22	0.21	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	0.23	0.22	0.23	0.22	0.03	XXX

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75557		A	Cardiac mri for morph	2.35	11.35	11.35	NA	NA	0.97	XXX
75557	TC	A	Cardiac mri for morph	0.00	10.39	10.39	NA	NA	0.87	XXX
75557	26	A	Cardiac mri for morph	2.35	0.96	0.96	0.96	0.96	0.10	XXX
75558		N	Cardiac mri flow/velocity	2.60	14.23	14.23	NA	NA	1.07	XXX
75558	TC	N	Cardiac mri flow/velocity	0.00	13.40	13.40	NA	NA	0.96	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.83	0.83	0.83	0.83	0.11	XXX
75559		A	Cardiac mri w/stress img	2.95	17.50	17.50	NA	NA	0.97	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	16.18	16.18	NA	NA	0.87	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.32	1.32	1.32	1.32	0.10	XXX
75560		N	Cardiac mri flow/vel/stress	3.00	19.31	19.31	NA	NA	1.00	XXX
75560	TC	N	Cardiac mri flow/vel/stress	0.00	18.36	18.36	NA	NA	0.89	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	0.96	0.96	0.96	0.96	0.11	XXX
75561		A	Cardiac mri for morph w/dye	2.60	16.10	16.10	NA	NA	1.07	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	15.04	15.04	NA	NA	0.96	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	1.06	1.06	1.06	1.06	0.11	XXX
75562		N	Card mri flow/vel w/dye	2.86	19.22	19.22	NA	NA	1.03	XXX
75562	TC	N	Card mri flow/vel w/dye	0.00	18.31	18.31	NA	NA	0.92	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	0.91	0.91	0.91	0.91	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	20.37	20.37	NA	NA	1.08	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	18.97	18.97	NA	NA	0.97	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.40	1.40	1.40	1.40	0.11	XXX
75564		N	Ht mri w/flo/vel/strs & dye	3.35	22.62	22.62	NA	NA	1.21	XXX
75564	TC	N	Ht mri w/flo/vel/strs & dye	0.00	21.55	21.55	NA	NA	1.08	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	1.07	1.07	1.07	1.07	0.13	XXX
75600		A	Contrast x-ray exam of aorta	0.49	6.40	8.02	NA	NA	0.67	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	6.16	7.79	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	3.55	5.93	NA	NA	0.70	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	3.06	5.46	NA	NA	0.65	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.49	0.47	0.49	0.47	0.05	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.38	5.80	NA	NA	0.71	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.96	5.38	NA	NA	0.65	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.43	0.42	0.43	0.42	0.06	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.77	6.28	NA	NA	0.80	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	3.06	5.59	NA	NA	0.69	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.72	0.69	0.72	0.69	0.11	XXX
75635		A	Ct angio abdominal arteries	2.40	13.12	14.04	NA	NA	0.50	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	12.17	13.12	NA	NA	0.39	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.95	0.91	0.95	0.91	0.11	XXX
75650		A	Artery x-rays, head & neck	1.49	3.58	5.98	NA	NA	0.72	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	3.00	5.41	NA	NA	0.65	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.59	0.56	0.59	0.56	0.07	XXX
75658		A	Artery x-rays, arm	1.31	3.71	6.06	NA	NA	0.72	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.28	5.62	NA	NA	0.65	XXX

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75658	26	A	Artery x-rays, arm	1.31	0.43	0.44	0.43	0.44	0.07	XXX
75660		A	Artery x-rays, head & neck	1.31	3.92	6.22	NA	NA	0.71	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.42	5.73	NA	NA	0.65	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.50	0.49	0.50	0.49	0.06	XXX
75662		A	Artery x-rays, head & neck	1.66	5.07	7.12	NA	NA	0.71	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	4.37	6.44	NA	NA	0.65	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.70	0.68	0.70	0.68	0.06	XXX
75665		A	Artery x-rays, head & neck	1.31	4.20	6.43	NA	NA	0.74	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.70	5.94	NA	NA	0.65	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.50	0.48	0.50	0.48	0.09	XXX
75671		A	Artery x-rays, head & neck	1.66	5.20	7.20	NA	NA	0.72	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	4.55	6.58	NA	NA	0.65	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.65	0.63	0.65	0.63	0.07	XXX
75676		A	Artery x-rays, neck	1.31	3.95	6.24	NA	NA	0.72	XXX
75676	TC	A	Artery x-rays, neck	0.00	3.45	5.75	NA	NA	0.65	XXX
75676	26	A	Artery x-rays, neck	1.31	0.50	0.48	0.50	0.48	0.07	XXX
75680		A	Artery x-rays, neck	1.66	4.69	6.82	NA	NA	0.72	XXX
75680	TC	A	Artery x-rays, neck	0.00	4.02	6.18	NA	NA	0.65	XXX
75680	26	A	Artery x-rays, neck	1.66	0.67	0.64	0.67	0.64	0.07	XXX
75685		A	Artery x-rays, spine	1.31	3.97	6.25	NA	NA	0.71	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.46	5.76	NA	NA	0.65	XXX
75685	26	A	Artery x-rays, spine	1.31	0.51	0.49	0.51	0.49	0.06	XXX
75705		A	Artery x-rays, spine	2.18	4.22	6.51	NA	NA	0.78	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.39	5.71	NA	NA	0.65	XXX
75705	26	A	Artery x-rays, spine	2.18	0.83	0.81	0.83	0.81	0.13	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.96	6.24	NA	NA	0.72	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.54	5.82	NA	NA	0.65	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.42	0.41	0.42	0.41	0.07	XXX
75716		A	Artery x-rays, arms/legs	1.31	4.98	7.01	NA	NA	0.72	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	4.47	6.52	NA	NA	0.65	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.51	0.49	0.51	0.49	0.07	XXX
75722		A	Artery x-rays, kidney	1.14	3.87	6.17	NA	NA	0.70	XXX
75722	TC	A	Artery x-rays, kidney	0.00	3.40	5.71	NA	NA	0.65	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.48	0.46	0.48	0.46	0.05	XXX
75724		A	Artery x-rays, kidneys	1.49	5.14	7.16	NA	NA	0.70	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	4.40	6.47	NA	NA	0.65	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.74	0.70	0.74	0.70	0.05	XXX
75726		A	Artery x-rays, abdomen	1.14	3.84	6.14	NA	NA	0.70	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	3.41	5.72	NA	NA	0.65	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.44	0.42	0.44	0.42	0.05	XXX
75731		A	Artery x-rays, adrenal gland	1.14	4.28	6.47	NA	NA	0.71	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	3.73	5.96	NA	NA	0.65	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.56	0.51	0.56	0.51	0.06	XXX
75733		A	Artery x-rays, adrenals	1.31	5.55	7.44	NA	NA	0.71	XXX

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75733	TC	A	Artery x-rays, adrenals	0.00	4.87	6.82	NA	NA	0.65	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.69	0.62	0.69	0.62	0.06	XXX
75736		A	Artery x-rays, pelvis	1.14	3.94	6.22	NA	NA	0.71	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	3.50	5.79	NA	NA	0.65	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.45	0.43	0.45	0.43	0.06	XXX
75741		A	Artery x-rays, lung	1.31	3.24	5.70	NA	NA	0.71	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.73	5.22	NA	NA	0.65	XXX
75741	26	A	Artery x-rays, lung	1.31	0.51	0.49	0.51	0.49	0.06	XXX
75743		A	Artery x-rays, lungs	1.66	3.69	6.07	NA	NA	0.72	XXX
75743	TC	A	Artery x-rays, lungs	0.00	3.02	5.43	NA	NA	0.65	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.66	0.63	0.66	0.63	0.07	XXX
75746		A	Artery x-rays, lung	1.14	3.61	5.96	NA	NA	0.70	XXX
75746	TC	A	Artery x-rays, lung	0.00	3.18	5.55	NA	NA	0.65	XXX
75746	26	A	Artery x-rays, lung	1.14	0.42	0.41	0.42	0.41	0.05	XXX
75756		A	Artery x-rays, chest	1.14	4.33	6.52	NA	NA	0.69	XXX
75756	TC	A	Artery x-rays, chest	0.00	3.76	5.98	NA	NA	0.65	XXX
75756	26	A	Artery x-rays, chest	1.14	0.57	0.54	0.57	0.54	0.04	XXX
75774		A	Artery x-ray, each vessel	0.36	2.53	5.09	2.53	5.09	0.67	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.39	4.96	2.39	4.96	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	3.15	2.85	NA	NA	0.17	XXX
75790	TC	A	Visualize A-V shunt	0.00	2.55	2.25	NA	NA	0.08	XXX
75790	26	A	Visualize A-V shunt	1.84	0.60	0.60	0.60	0.60	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	0.23	0.24	0.23	0.24	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	0.45	0.43	0.45	0.43	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	0.30	0.29	0.30	0.29	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	0.45	0.43	0.45	0.43	0.05	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.20	1.88	NA	NA	0.07	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	2.04	1.72	NA	NA	0.05	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.16	0.16	0.16	0.16	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	0.44	0.42	0.44	0.42	0.05	XXX
75820		A	Vein x-ray, arm/leg	0.70	3.03	2.57	NA	NA	0.09	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.74	2.29	NA	NA	0.06	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.29	0.27	0.29	0.27	0.03	XXX

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75822		A	Vein x-ray, arms/legs	1.06	3.22	2.87	NA	NA	0.13	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	2.84	2.50	NA	NA	0.08	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.38	0.37	0.38	0.37	0.05	XXX
75825		A	Vein x-ray, trunk	1.14	2.98	5.49	NA	NA	0.72	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.58	5.10	NA	NA	0.65	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.40	0.39	0.40	0.39	0.07	XXX
75827		A	Vein x-ray, chest	1.14	2.99	5.50	NA	NA	0.70	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.61	5.12	NA	NA	0.65	XXX
75827	26	A	Vein x-ray, chest	1.14	0.38	0.38	0.38	0.38	0.05	XXX
75831		A	Vein x-ray, kidney	1.14	3.11	5.59	NA	NA	0.71	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.71	5.19	NA	NA	0.65	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.41	0.40	0.41	0.40	0.06	XXX
75833		A	Vein x-ray, kidneys	1.49	3.69	6.06	NA	NA	0.74	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	3.19	5.56	NA	NA	0.65	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.50	0.50	0.50	0.50	0.09	XXX
75840		A	Vein x-ray, adrenal gland	1.14	3.02	5.53	NA	NA	0.72	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.65	5.16	NA	NA	0.65	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.37	0.37	0.37	0.37	0.07	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.77	6.11	NA	NA	0.72	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	3.22	5.58	NA	NA	0.65	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.55	0.53	0.55	0.53	0.07	XXX
75860		A	Vein x-ray, neck	1.14	3.35	5.78	NA	NA	0.69	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.88	5.33	NA	NA	0.65	XXX
75860	26	A	Vein x-ray, neck	1.14	0.47	0.45	0.47	0.45	0.04	XXX
75870		A	Vein x-ray, skull	1.14	3.18	5.65	NA	NA	0.70	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.79	5.26	NA	NA	0.65	XXX
75870	26	A	Vein x-ray, skull	1.14	0.40	0.40	0.40	0.40	0.05	XXX
75872		A	Vein x-ray, skull	1.14	4.06	6.31	NA	NA	0.79	XXX
75872	TC	A	Vein x-ray, skull	0.00	3.62	5.88	NA	NA	0.65	XXX
75872	26	A	Vein x-ray, skull	1.14	0.45	0.43	0.45	0.43	0.14	XXX
75880		A	Vein x-ray, eye socket	0.70	3.04	2.57	NA	NA	0.09	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	2.81	2.35	NA	NA	0.06	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.22	0.23	0.22	0.23	0.03	XXX
75885		A	Vein x-ray, liver	1.44	3.27	5.74	NA	NA	0.71	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.72	5.21	NA	NA	0.65	XXX
75885	26	A	Vein x-ray, liver	1.44	0.55	0.53	0.55	0.53	0.06	XXX
75887		A	Vein x-ray, liver	1.44	3.38	5.82	NA	NA	0.71	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.82	5.28	NA	NA	0.65	XXX
75887	26	A	Vein x-ray, liver	1.44	0.56	0.54	0.56	0.54	0.06	XXX
75889		A	Vein x-ray, liver	1.14	3.15	5.62	NA	NA	0.70	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.71	5.20	NA	NA	0.65	XXX
75889	26	A	Vein x-ray, liver	1.14	0.43	0.42	0.43	0.42	0.05	XXX
75891		A	Vein x-ray, liver	1.14	3.14	5.61	NA	NA	0.70	XXX
75891	TC	A	Vein x-ray, liver	0.00	2.71	5.20	NA	NA	0.65	XXX

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75891	26	A	Vein x-ray, liver	1.14	0.43	0.42	0.43	0.42	0.05	XXX
75893		A	Venous sampling by catheter	0.54	2.89	5.38	NA	NA	0.67	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.69	5.18	NA	NA	0.65	XXX
75893	26	A	Venous sampling by catheter	0.54	0.20	0.20	0.20	0.20	0.02	XXX
75894		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
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	0.48	0.47	0.48	0.47	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	0.52	0.50	0.52	0.50	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	0.64	0.62	0.64	0.62	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	0.17	0.17	0.17	0.17	0.03	XXX
75901		A	Remove cva device obstruct	0.49	4.25	3.56	NA	NA	0.85	XXX
75901	TC	A	Remove cva device obstruct	0.00	4.07	3.38	NA	NA	0.83	XXX
75901	26	A	Remove cva device obstruct	0.49	0.18	0.17	0.18	0.17	0.02	XXX
75902		A	Remove cva lumen obstruct	0.39	1.66	1.61	NA	NA	0.85	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.52	1.47	NA	NA	0.83	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.14	0.14	0.14	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	0.19	0.19	0.19	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	0.14	0.14	0.14	0.14	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	0.12	0.12	0.12	0.12	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	1.31	1.35	1.31	1.35	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	0.40	0.41	0.40	0.41	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	0.64	0.68	0.64	0.68	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	1.94	2.13	1.94	2.13	0.69	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX

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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	1.67	1.83	1.67	1.83	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	1.05	1.18	1.05	1.18	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	0.93	1.03	0.93	1.03	0.34	XXX
75960		A	Transcath iv stent rs&i	0.82	2.71	5.84	NA	NA	0.82	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.40	5.54	NA	NA	0.77	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.31	0.31	0.31	0.31	0.05	XXX
75961		A	Retrieval, broken catheter	4.24	4.79	6.58	NA	NA	0.73	XXX
75961	TC	A	Retrieval, broken catheter	0.00	3.22	5.05	NA	NA	0.55	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.57	1.52	1.57	1.52	0.18	XXX
75962		A	Repair arterial blockage	0.54	3.51	6.63	NA	NA	0.86	XXX
75962	TC	A	Repair arterial blockage	0.00	3.31	6.44	NA	NA	0.83	XXX
75962	26	A	Repair arterial blockage	0.54	0.20	0.19	0.20	0.19	0.03	XXX
75964		A	Repair artery blockage, each	0.36	2.37	3.91	2.37	3.91	0.46	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	2.24	3.79	2.24	3.79	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	4.17	7.20	NA	NA	0.89	XXX
75966	TC	A	Repair arterial blockage	0.00	3.61	6.66	NA	NA	0.83	XXX
75966	26	A	Repair arterial blockage	1.31	0.57	0.54	0.57	0.54	0.06	XXX
75968		A	Repair artery blockage, each	0.36	2.42	3.95	2.42	3.95	0.45	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	2.26	3.80	2.26	3.80	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	0.32	0.31	0.32	0.31	0.04	XXX
75978		A	Repair venous blockage	0.54	3.30	6.48	NA	NA	0.85	XXX
75978	TC	A	Repair venous blockage	0.00	3.13	6.30	NA	NA	0.83	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.18	0.18	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	0.54	0.53	0.54	0.53	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	0.55	0.53	0.55	0.53	0.06	XXX
75984		A	Xray control catheter change	0.72	2.37	2.32	NA	NA	0.14	XXX
75984	TC	A	Xray control catheter change	0.00	2.09	2.06	NA	NA	0.11	XXX
75984	26	A	Xray control catheter change	0.72	0.27	0.26	0.27	0.26	0.03	XXX
75989		A	Abscess drainage under x-ray	1.19	2.30	2.61	NA	NA	0.22	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.85	2.18	NA	NA	0.17	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.44	0.43	0.44	0.43	0.05	XXX

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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	0.22	0.21	0.22	0.21	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	0.32	0.36	0.32	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	0.48	0.48	0.48	0.48	0.05	XXX
75996		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
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	0.12	0.12	0.12	0.12	0.02	ZZZ
76000		A	Fluoroscope examination	0.17	2.80	2.44	NA	NA	0.08	XXX
76000	TC	A	Fluoroscope examination	0.00	2.74	2.38	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	0.25	0.24	0.25	0.24	0.05	XXX
76010		A	X-ray, nose to rectum	0.18	0.55	0.56	NA	NA	0.03	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.49	0.50	NA	NA	0.02	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.06	0.06	0.01	XXX
76080		A	X-ray exam of fistula	0.54	1.12	1.15	NA	NA	0.08	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.92	0.95	NA	NA	0.06	XXX
76080	26	A	X-ray exam of fistula	0.54	0.20	0.20	0.20	0.20	0.02	XXX
76098		A	X-ray exam, breast specimen	0.16	0.33	0.36	NA	NA	0.03	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.27	0.31	NA	NA	0.02	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.06	0.05	0.06	0.05	0.01	XXX
76100		A	X-ray exam of body section	0.58	3.61	3.07	NA	NA	0.10	XXX
76100	TC	A	X-ray exam of body section	0.00	3.41	2.87	NA	NA	0.07	XXX
76100	26	A	X-ray exam of body section	0.58	0.20	0.20	0.20	0.20	0.03	XXX
76101		A	Complex body section x-ray	0.58	5.47	4.51	NA	NA	0.11	XXX
76101	TC	A	Complex body section x-ray	0.00	5.28	4.32	NA	NA	0.08	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.19	0.19	0.03	XXX
76102		A	Complex body section x-rays	0.58	7.71	6.27	NA	NA	0.14	XXX
76102	TC	A	Complex body section x-rays	0.00	7.53	6.08	NA	NA	0.11	XXX
76102	26	A	Complex body section x-rays	0.58	0.18	0.18	0.18	0.18	0.03	XXX
76120		A	Cine/video x-rays	0.38	1.79	1.64	NA	NA	0.08	XXX
76120	TC	A	Cine/video x-rays	0.00	1.67	1.52	NA	NA	0.06	XXX
76120	26	A	Cine/video x-rays	0.38	0.11	0.12	0.11	0.12	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

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76125	26	A	Cine/video x-rays add-on	0.27	0.12	0.11	0.12	0.11	0.01	ZZZ
76150		A	X-ray exam, dry process	0.00	0.52	0.50	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	1.42	1.94	NA	NA	0.10	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.35	1.87	NA	NA	0.08	XXX
76376	26	A	3d render w/o postprocess	0.20	0.07	0.07	0.07	0.07	0.02	XXX
76377		A	3d rendering w/postprocess	0.79	1.42	1.99	NA	NA	0.39	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.13	1.71	NA	NA	0.31	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.29	0.28	0.29	0.28	0.08	XXX
76380		A	CAT scan follow-up study	0.98	4.77	4.53	NA	NA	0.22	XXX
76380	TC	A	CAT scan follow-up study	0.00	4.42	4.20	NA	NA	0.18	XXX
76380	26	A	CAT scan follow-up study	0.98	0.35	0.34	0.35	0.34	0.04	XXX
76390		N	Mr spectroscopy	1.40	10.81	10.99	NA	NA	0.66	XXX
76390	TC	N	Mr spectroscopy	0.00	10.36	10.54	NA	NA	0.59	XXX
76390	26	N	Mr spectroscopy	1.40	0.45	0.45	0.45	0.45	0.07	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
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	2.75	2.48	NA	NA	0.14	XXX
76506	TC	A	Echo exam of head	0.00	2.53	2.26	NA	NA	0.08	XXX
76506	26	A	Echo exam of head	0.63	0.22	0.22	0.22	0.22	0.06	XXX
76510		A	Ophth us, b & quant a	1.55	2.27	2.42	NA	NA	0.10	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.71	1.83	NA	NA	0.07	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.56	0.59	0.56	0.59	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	1.03	1.28	NA	NA	0.07	XXX
76511	26	A	Ophth us, quant a only	0.94	0.33	0.35	0.33	0.35	0.03	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.17	1.44	NA	NA	0.12	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.83	1.08	NA	NA	0.10	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.33	0.36	0.33	0.36	0.02	XXX
76513		A	Echo exam of eye, water bath	0.66	1.46	1.55	NA	NA	0.12	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.25	1.32	NA	NA	0.10	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.21	0.23	0.21	0.23	0.02	XXX
76514		A	Echo exam of eye, thickness	0.17	0.16	0.15	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.11	0.09	NA	NA	0.01	XXX

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76514	26	A	Echo exam of eye, thickness	0.17	0.06	0.06	0.06	0.06	0.01	XXX
76516		A	Echo exam of eye	0.54	1.17	1.24	NA	NA	0.08	XXX
76516	TC	A	Echo exam of eye	0.00	0.98	1.04	NA	NA	0.07	XXX
76516	26	A	Echo exam of eye	0.54	0.19	0.20	0.19	0.20	0.01	XXX
76519		A	Echo exam of eye	0.54	1.30	1.36	NA	NA	0.08	XXX
76519	TC	A	Echo exam of eye	0.00	1.10	1.16	NA	NA	0.07	XXX
76519	26	A	Echo exam of eye	0.54	0.20	0.21	0.20	0.21	0.01	XXX
76529		A	Echo exam of eye	0.57	1.17	1.22	NA	NA	0.10	XXX
76529	TC	A	Echo exam of eye	0.00	0.97	1.01	NA	NA	0.08	XXX
76529	26	A	Echo exam of eye	0.57	0.20	0.21	0.20	0.21	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.70	2.43	NA	NA	0.10	XXX
76536	TC	A	Us exam of head and neck	0.00	2.52	2.25	NA	NA	0.08	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.18	0.18	0.02	XXX
76604		A	Us exam, chest	0.55	1.86	1.77	NA	NA	0.09	XXX
76604	TC	A	Us exam, chest	0.00	1.67	1.58	NA	NA	0.07	XXX
76604	26	A	Us exam, chest	0.55	0.20	0.19	0.20	0.19	0.02	XXX
76645		A	Us exam, breast(s)	0.54	2.14	1.91	NA	NA	0.08	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.95	1.73	NA	NA	0.06	XXX
76645	26	A	Us exam, breast(s)	0.54	0.19	0.19	0.19	0.19	0.02	XXX
76700		A	Us exam, abdom, complete	0.81	3.06	2.86	NA	NA	0.15	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.78	2.58	NA	NA	0.11	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.28	0.28	0.28	0.28	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.38	2.19	NA	NA	0.11	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.17	1.98	NA	NA	0.08	XXX
76705	26	A	Echo exam of abdomen	0.59	0.21	0.21	0.21	0.21	0.03	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.96	2.78	NA	NA	0.14	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.70	2.52	NA	NA	0.11	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.26	0.26	0.26	0.26	0.03	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.44	2.23	NA	NA	0.11	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	2.22	2.02	NA	NA	0.08	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.21	0.21	0.21	0.21	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.47	3.16	NA	NA	0.14	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.19	2.89	NA	NA	0.11	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.28	0.27	0.28	0.27	0.03	XXX
76800		A	Us exam, spinal canal	1.13	2.28	2.15	NA	NA	0.13	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.98	1.84	NA	NA	0.08	XXX
76800	26	A	Us exam, spinal canal	1.13	0.30	0.31	0.30	0.31	0.05	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.51	2.49	NA	NA	0.16	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.18	2.16	NA	NA	0.12	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.33	0.33	0.33	0.33	0.04	XXX
76802		A	Ob us < 14 wks, add ╞I fetus	0.83	0.98	1.07	0.98	1.07	0.16	ZZZ
76802	TC	A	Ob us < 14 wks, add ╞I fetus	0.00	0.72	0.80	0.72	0.80	0.12	ZZZ
76802	26	A	Ob us < 14 wks, add ╞I fetus	0.83	0.26	0.27	0.26	0.27	0.04	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	3.08	2.92	NA	NA	0.16	XXX

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76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.76	2.60	NA	NA	0.12	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.31	0.32	0.31	0.32	0.04	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.66	1.59	1.66	1.59	0.26	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.35	1.28	1.35	1.28	0.22	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.31	0.32	0.31	0.32	0.04	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	3.07	3.37	NA	NA	0.52	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.53	2.78	NA	NA	0.43	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.54	0.59	0.54	0.59	0.09	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.97	3.41	3.97	3.41	0.49	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.46	2.86	3.46	2.86	0.41	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.51	0.55	0.51	0.55	0.08	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.21	2.21	NA	NA	0.19	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.87	1.87	NA	NA	0.14	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.34	0.34	0.34	0.34	0.05	XXX
76814		A	Ob us nuchal meas, add-on	0.99	1.15	1.15	NA	NA	0.19	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.86	0.86	NA	NA	0.14	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.28	0.28	0.28	0.28	0.05	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.82	1.78	NA	NA	0.11	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.62	1.57	NA	NA	0.08	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.20	0.21	0.20	0.21	0.03	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.40	2.16	NA	NA	0.10	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	2.15	1.89	NA	NA	0.06	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.25	0.27	0.25	0.27	0.04	XXX
76817		A	Transvaginal us, obstetric	0.75	2.05	1.98	NA	NA	0.09	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.81	1.74	NA	NA	0.06	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.24	0.24	0.24	0.24	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.23	2.18	NA	NA	0.15	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.93	1.85	NA	NA	0.10	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.30	0.33	0.30	0.33	0.05	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.64	1.71	NA	NA	0.13	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.41	1.46	NA	NA	0.10	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.24	0.25	0.24	0.25	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.57	0.88	NA	NA	0.15	XXX
76820	TC	A	Umbilical artery echo	0.00	0.43	0.72	NA	NA	0.12	XXX
76820	26	A	Umbilical artery echo	0.50	0.14	0.16	0.14	0.16	0.03	XXX
76821		A	Middle cerebral artery echo	0.70	1.88	1.88	NA	NA	0.15	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.68	1.66	NA	NA	0.12	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.20	0.22	0.20	0.22	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.43	3.97	NA	NA	0.18	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.92	3.44	NA	NA	0.11	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.51	0.53	0.51	0.53	0.07	XXX
76826		A	Echo exam of fetal heart	0.83	2.73	2.30	NA	NA	0.08	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.50	2.05	NA	NA	0.05	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.23	0.25	0.23	0.25	0.03	XXX

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76827		A	Echo exam of fetal heart	0.58	1.08	1.29	NA	NA	0.14	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.90	1.11	NA	NA	0.12	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.18	0.18	0.18	0.18	0.02	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	0.81	NA	NA	0.11	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.48	0.64	NA	NA	0.08	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.15	0.17	0.15	0.17	0.03	XXX
76830		A	Transvaginal us, non-ob	0.69	2.79	2.53	NA	NA	0.13	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.56	2.30	NA	NA	0.10	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.23	0.23	0.03	XXX
76831		A	Echo exam, uterus	0.72	2.75	2.51	NA	NA	0.13	XXX
76831	TC	A	Echo exam, uterus	0.00	2.54	2.29	NA	NA	0.10	XXX
76831	26	A	Echo exam, uterus	0.72	0.21	0.22	0.21	0.22	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.82	2.55	NA	NA	0.13	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.58	2.31	NA	NA	0.10	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.24	0.24	0.24	0.24	0.03	XXX
76857		A	Us exam, pelvic, limited	0.38	2.50	2.33	NA	NA	0.08	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	2.36	2.20	NA	NA	0.06	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.14	0.14	0.14	0.14	0.02	XXX
76870		A	Us exam, scrotum	0.64	2.85	2.57	NA	NA	0.13	XXX
76870	TC	A	Us exam, scrotum	0.00	2.62	2.34	NA	NA	0.10	XXX
76870	26	A	Us exam, scrotum	0.64	0.23	0.23	0.23	0.23	0.03	XXX
76872		A	Us, transrectal	0.69	3.42	3.13	NA	NA	0.14	XXX
76872	TC	A	Us, transrectal	0.00	3.15	2.87	NA	NA	0.10	XXX
76872	26	A	Us, transrectal	0.69	0.27	0.26	0.27	0.26	0.04	XXX
76873		A	Echograp trans r, pros study	1.55	3.34	3.16	NA	NA	0.25	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.81	2.63	NA	NA	0.16	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.53	0.53	0.53	0.53	0.09	XXX
76880		A	Us exam, extremity	0.59	3.22	2.82	NA	NA	0.11	XXX
76880	TC	A	Us exam, extremity	0.00	3.04	2.63	NA	NA	0.08	XXX
76880	26	A	Us exam, extremity	0.59	0.18	0.19	0.18	0.19	0.03	XXX
76885		A	Us exam infant hips, dynamic	0.74	3.32	2.93	NA	NA	0.13	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	3.06	2.67	NA	NA	0.10	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.26	0.26	0.26	0.26	0.03	XXX
76886		A	Us exam infant hips, static	0.62	2.23	2.08	NA	NA	0.11	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.03	1.88	NA	NA	0.08	XXX
76886	26	A	Us exam infant hips, static	0.62	0.20	0.20	0.20	0.20	0.03	XXX
76930		A	Echo guide, cardiocentesis	0.67	2.09	2.01	NA	NA	0.12	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.75	1.69	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	0.34	0.32	0.34	0.32	0.02	XXX
76936		A	Echo guide for artery repair	1.99	6.17	6.37	NA	NA	0.47	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.45	5.67	NA	NA	0.34	XXX

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76936	26	A	Echo guide for artery repair	1.99	0.72	0.71	0.72	0.71	0.13	XXX
76937		A	Us guide, vascular access	0.30	0.63	0.59	0.63	0.59	0.13	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.52	0.49	0.52	0.49	0.10	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.10	0.10	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	0.65	0.65	0.65	0.65	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	0.41	0.42	0.41	0.42	0.07	XXX
76942		A	Echo guide for biopsy	0.67	4.82	4.38	NA	NA	0.13	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.58	4.14	NA	NA	0.10	XXX
76942	26	A	Echo guide for biopsy	0.67	0.24	0.23	0.24	0.23	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	0.21	0.21	0.21	0.21	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.45	0.75	NA	NA	0.12	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.34	0.64	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	0.46	0.75	NA	NA	0.12	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.35	0.64	NA	NA	0.10	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.11	0.11	0.11	0.11	0.02	XXX
76950		A	Echo guidance radiotherapy	0.58	1.19	1.27	NA	NA	0.10	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.01	1.09	NA	NA	0.07	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.18	0.19	0.18	0.19	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.19	2.40	NA	NA	0.37	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.70	1.92	NA	NA	0.29	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.49	0.48	0.49	0.48	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	2.07	1.85	NA	NA	0.08	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.96	1.73	NA	NA	0.06	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.11	0.12	0.11	0.12	0.02	XXX
76975		C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
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	0.30	0.30	0.30	0.30	0.04	XXX
76977		A	Us bone density measure	0.05	0.11	0.29	NA	NA	0.06	XXX
76977	TC	A	Us bone density measure	0.00	0.09	0.28	NA	NA	0.05	XXX
76977	26	A	Us bone density measure	0.05	0.01	0.01	0.01	0.01	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	0.35	0.37	0.35	0.37	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	2.77	2.44	NA	NA	0.11	ZZZ

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77001	TC	A	Fluoroguide for vein device	0.00	2.64	2.30	NA	NA	0.10	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.13	0.13	0.01	ZZZ
77002		A	Needle localization by xray	0.54	1.30	1.35	NA	NA	0.09	XXX
77002	TC	A	Needle localization by xray	0.00	1.13	1.17	NA	NA	0.07	XXX
77002	26	A	Needle localization by xray	0.54	0.17	0.17	0.17	0.17	0.02	XXX
77003		A	Fluoroguide for spine inject	0.60	0.78	0.95	NA	NA	0.10	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.63	0.80	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	20.24	17.35	NA	NA	0.47	XXX
77011	TC	A	Ct scan for localization	0.00	19.83	16.94	NA	NA	0.42	XXX
77011	26	A	Ct scan for localization	1.21	0.41	0.41	0.41	0.41	0.05	XXX
77012		A	Ct scan for needle biopsy	1.16	2.37	3.95	NA	NA	0.47	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.95	3.53	NA	NA	0.42	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.43	0.42	0.43	0.42	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	1.50	1.45	1.50	1.45	0.18	XXX
77014		A	Ct scan for therapy guide	0.85	4.39	4.10	NA	NA	0.20	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.11	3.83	NA	NA	0.16	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.27	0.27	0.27	0.27	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.98	10.43	NA	NA	0.64	XXX
77021	TC	A	Mr guidance for needle place	0.00	9.44	9.90	NA	NA	0.55	XXX
77021	26	A	Mr guidance for needle place	1.50	0.54	0.53	0.54	0.53	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	1.42	1.41	1.42	1.41	0.24	XXX
77031		A	Stereotact guide for brst bx	1.59	1.90	3.35	NA	NA	0.46	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.35	2.81	NA	NA	0.37	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.55	0.54	0.55	0.54	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	0.65	0.82	NA	NA	0.07	XXX
77032	26	A	Guidance for needle, breast	0.56	0.20	0.20	0.20	0.20	0.02	XXX
77051		A	Computer dx mammogram add-on	0.06	0.20	0.26	0.20	0.26	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.18	0.24	0.18	0.24	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	0.20	0.26	0.20	0.26	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.18	0.24	0.18	0.24	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	1.25	1.63	NA	NA	0.16	XXX

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77053	TC	A	X-ray of mammary duct	0.00	1.12	1.50	NA	NA	0.14	XXX
77053	26	A	X-ray of mammary duct	0.36	0.13	0.13	0.13	0.13	0.02	XXX
77054		A	X-ray of mammary ducts	0.45	1.70	2.23	NA	NA	0.21	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.54	2.07	NA	NA	0.19	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.16	0.16	0.16	0.16	0.02	XXX
77055		A	Mammogram, one breast	0.70	1.67	1.57	NA	NA	0.09	XXX
77055	TC	A	Mammogram, one breast	0.00	1.42	1.33	NA	NA	0.06	XXX
77055	26	A	Mammogram, one breast	0.70	0.25	0.25	0.25	0.25	0.03	XXX
77056		A	Mammogram, both breasts	0.87	2.17	2.03	NA	NA	0.11	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.86	1.72	NA	NA	0.07	XXX
77056	26	A	Mammogram, both breasts	0.87	0.31	0.31	0.31	0.31	0.04	XXX
77057		A	Mammogram, screening	0.70	1.47	1.47	NA	NA	0.10	XXX
77057	TC	A	Mammogram, screening	0.00	1.22	1.22	NA	NA	0.07	XXX
77057	26	A	Mammogram, screening	0.70	0.25	0.25	0.25	0.25	0.03	XXX
77058		A	Mri, one breast	1.63	21.96	21.03	NA	NA	0.99	XXX
77058	TC	A	Mri, one breast	0.00	21.37	20.46	NA	NA	0.92	XXX
77058	26	A	Mri, one breast	1.63	0.58	0.57	0.58	0.57	0.07	XXX
77059		A	Mri, both breasts	1.63	21.81	22.49	NA	NA	1.31	XXX
77059	TC	A	Mri, both breasts	0.00	21.23	21.92	NA	NA	1.24	XXX
77059	26	A	Mri, both breasts	1.63	0.58	0.57	0.58	0.57	0.07	XXX
77071		A	X-ray stress view	0.41	0.77	0.62	0.77	0.62	0.06	XXX
77072		A	X-rays for bone age	0.19	0.44	0.34	NA	NA	0.03	XXX
77072	TC	A	X-rays for bone age	0.00	0.37	0.37	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	0.68	0.73	NA	NA	0.06	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.57	0.62	NA	NA	0.05	XXX
77073	26	A	X-rays, bone length studies	0.27	0.10	0.10	0.10	0.10	0.01	XXX
77074		A	X-rays, bone survey, limited	0.45	1.46	1.39	NA	NA	0.08	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.30	1.22	NA	NA	0.06	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.17	0.16	0.17	0.16	0.02	XXX
77075		A	X-rays, bone survey complete	0.54	2.33	2.15	NA	NA	0.10	XXX
77075	TC	A	X-rays, bone survey complete	0.00	2.13	1.96	NA	NA	0.08	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.20	0.19	0.20	0.19	0.02	XXX
77076		A	X-rays, bone survey, infant	0.70	2.11	1.82	NA	NA	0.08	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.90	1.61	NA	NA	0.05	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.20	0.21	0.20	0.21	0.03	XXX
77077		A	Joint survey, single view	0.31	0.66	0.80	NA	NA	0.08	XXX
77077	TC	A	Joint survey, single view	0.00	0.55	0.69	NA	NA	0.06	XXX
77077	26	A	Joint survey, single view	0.31	0.11	0.11	0.11	0.11	0.02	XXX
77078		A	Ct bone density, axial	0.25	4.82	4.38	NA	NA	0.17	XXX
77078	TC	A	Ct bone density, axial	0.00	4.74	4.29	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	0.76	1.33	NA	NA	0.06	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.71	1.27	NA	NA	0.05	XXX

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77079	26	A	Ct bone density, peripheral	0.22	0.06	0.06	0.06	0.06	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.12	1.64	NA	NA	0.18	XXX
77080	TC	A	Dxa bone density, axial	0.00	1.05	1.57	NA	NA	0.17	XXX
77080	26	A	Dxa bone density, axial	0.20	0.06	0.07	0.06	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.48	0.57	NA	NA	0.06	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.42	0.50	NA	NA	0.05	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.06	0.07	0.06	0.07	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.52	0.60	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.48	0.54	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	0.37	0.48	NA	NA	0.06	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.32	0.43	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	14.77	14.02	NA	NA	0.66	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	14.19	13.45	NA	NA	0.59	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.58	0.57	0.58	0.57	0.07	XXX
77261		A	Radiation therapy planning	1.39	0.46	0.47	0.46	0.47	0.07	XXX
77262		A	Radiation therapy planning	2.11	0.67	0.69	0.67	0.69	0.11	XXX
77263		A	Radiation therapy planning	3.14	0.99	1.02	0.99	1.02	0.16	XXX
77280		A	Set radiation therapy field	0.70	4.37	4.20	NA	NA	0.22	XXX
77280	TC	A	Set radiation therapy field	0.00	4.15	3.98	NA	NA	0.18	XXX
77280	26	A	Set radiation therapy field	0.70	0.22	0.22	0.22	0.22	0.04	XXX
77285		A	Set radiation therapy field	1.05	7.93	7.43	NA	NA	0.35	XXX
77285	TC	A	Set radiation therapy field	0.00	7.60	7.10	NA	NA	0.30	XXX
77285	26	A	Set radiation therapy field	1.05	0.33	0.33	0.33	0.33	0.05	XXX
77290		A	Set radiation therapy field	1.56	13.25	11.70	NA	NA	0.43	XXX
77290	TC	A	Set radiation therapy field	0.00	12.76	11.21	NA	NA	0.35	XXX
77290	26	A	Set radiation therapy field	1.56	0.49	0.49	0.49	0.49	0.08	XXX
77295		A	Set radiation therapy field	4.56	7.31	12.86	NA	NA	1.71	XXX
77295	TC	A	Set radiation therapy field	0.00	5.87	11.41	NA	NA	1.48	XXX
77295	26	A	Set radiation therapy field	4.56	1.44	1.45	1.44	1.45	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	0.97	1.06	NA	NA	0.07	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.20	0.20	0.03	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	56.76	50.23	NA	NA	1.88	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	54.24	47.69	NA	NA	1.48	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.53	2.54	2.53	2.54	0.40	XXX
77305		A	Teletx isodose plan simple	0.70	0.88	1.19	NA	NA	0.15	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.66	0.96	NA	NA	0.11	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.22	0.22	0.22	0.22	0.04	XXX
77310		A	Teletx isodose plan intermed	1.05	1.22	1.59	NA	NA	0.18	XXX

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77310	TC	A	Teletx isodose plan intermed	0.00	0.89	1.26	NA	NA	0.13	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.33	0.33	0.33	0.33	0.05	XXX
77315		A	Teletx isodose plan complex	1.56	2.04	2.32	NA	NA	0.22	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.55	1.83	NA	NA	0.14	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.49	0.49	0.49	0.49	0.08	XXX
77321		A	Special teletx port plan	0.95	1.48	2.20	NA	NA	0.26	XXX
77321	TC	A	Special teletx port plan	0.00	1.18	1.90	NA	NA	0.21	XXX
77321	26	A	Special teletx port plan	0.95	0.30	0.30	0.30	0.30	0.05	XXX
77326		A	Brachytx isodose calc simp	0.93	2.92	2.86	NA	NA	0.18	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.63	2.57	NA	NA	0.13	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.29	0.29	0.29	0.29	0.05	XXX
77327		A	Brachytx isodose calc interm	1.39	4.03	4.00	NA	NA	0.25	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.59	3.57	NA	NA	0.18	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.44	0.44	0.44	0.44	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.16	5.28	NA	NA	0.36	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.50	4.62	NA	NA	0.25	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.66	0.66	0.66	0.66	0.11	XXX
77331		A	Special radiation dosimetry	0.87	0.78	0.78	NA	NA	0.06	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.51	0.51	NA	NA	0.02	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.28	0.28	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	1.36	1.35	NA	NA	0.07	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.17	0.17	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.50	0.92	NA	NA	0.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.24	0.65	NA	NA	0.11	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.26	0.27	0.26	0.27	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	2.67	2.92	NA	NA	0.23	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.28	2.53	NA	NA	0.17	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.39	0.39	0.39	0.39	0.06	XXX
77336		A	Radiation physics consult	0.00	1.12	1.59	NA	NA	0.16	XXX
77370		A	Radiation physics consult	0.00	3.00	3.12	NA	NA	0.18	XXX
77371		A	Srs, multisource	0.00	32.30	32.30	NA	NA	0.13	XXX
77372		A	Srs, linear based	0.00	22.60	22.60	NA	NA	0.13	XXX
77373		A	Sbrt delivery	0.00	41.82	41.82	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	0.46	0.79	NA	NA	0.11	XXX
77402		A	Radiation treatment delivery	0.00	4.30	3.67	NA	NA	0.11	XXX
77403		A	Radiation treatment delivery	0.00	3.71	3.23	NA	NA	0.11	XXX
77404		A	Radiation treatment delivery	0.00	4.16	3.57	NA	NA	0.11	XXX
77406		A	Radiation treatment delivery	0.00	4.19	3.59	NA	NA	0.11	XXX
77407		A	Radiation treatment delivery	0.00	7.16	5.89	NA	NA	0.12	XXX
77408		A	Radiation treatment delivery	0.00	5.09	4.35	NA	NA	0.12	XXX

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77409		A	Radiation treatment delivery	0.00	5.70	4.80	NA	NA	0.12	XXX
77411		A	Radiation treatment delivery	0.00	5.66	4.77	NA	NA	0.12	XXX
77412		A	Radiation treatment delivery	0.00	6.71	5.62	NA	NA	0.13	XXX
77413		A	Radiation treatment delivery	0.00	6.77	5.66	NA	NA	0.13	XXX
77414		A	Radiation treatment delivery	0.00	7.62	6.30	NA	NA	0.13	XXX
77416		A	Radiation treatment delivery	0.00	7.66	6.33	NA	NA	0.13	XXX
77417		A	Radiology port film(s)	0.00	0.36	0.42	NA	NA	0.04	XXX
77418		A	Radiation tx delivery, imrt	0.00	13.04	14.30	NA	NA	0.13	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.35	2.64	NA	NA	0.12	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.23	2.51	NA	NA	0.10	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.12	0.12	0.12	0.12	0.02	XXX
77422		A	Neutron beam tx, simple	0.00	6.64	5.41	NA	NA	0.13	XXX
77423		A	Neutron beam tx, complex	0.00	7.36	6.08	NA	NA	0.13	XXX
77427		A	Radiation tx management, x5	3.70	1.34	1.27	1.34	1.27	0.17	XXX
77431		A	Radiation therapy management	1.81	0.75	0.73	0.75	0.73	0.09	XXX
77432		A	Stereotactic radiation trmt	7.92	2.49	2.59	2.49	2.59	0.41	XXX
77435		A	Sbrt management	13.00	4.36	4.36	NA	NA	0.67	XXX
77470		A	Special radiation treatment	2.09	1.88	4.38	NA	NA	0.70	XXX
77470	TC	A	Special radiation treatment	0.00	1.22	3.72	NA	NA	0.59	XXX
77470	26	A	Special radiation treatment	2.09	0.66	0.66	0.66	0.66	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	10.12	8.48	NA	NA	0.24	XXX
77600	TC	R	Hyperthermia treatment	0.00	9.63	7.99	NA	NA	0.16	XXX
77600	26	R	Hyperthermia treatment	1.56	0.49	0.49	0.49	0.49	0.08	XXX
77605		R	Hyperthermia treatment	2.09	20.10	16.26	NA	NA	0.38	XXX
77605	TC	R	Hyperthermia treatment	0.00	19.55	15.68	NA	NA	0.22	XXX
77605	26	R	Hyperthermia treatment	2.09	0.55	0.58	0.55	0.58	0.16	XXX
77610		R	Hyperthermia treatment	1.56	19.67	15.64	NA	NA	0.24	XXX
77610	TC	R	Hyperthermia treatment	0.00	19.23	15.19	NA	NA	0.16	XXX
77610	26	R	Hyperthermia treatment	1.56	0.43	0.45	0.43	0.45	0.08	XXX
77615		R	Hyperthermia treatment	2.09	27.83	22.05	NA	NA	0.33	XXX
77615	TC	R	Hyperthermia treatment	0.00	27.17	21.40	NA	NA	0.22	XXX
77615	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.66	0.66	0.11	XXX
77620		R	Hyperthermia treatment	1.56	10.84	9.03	NA	NA	0.36	XXX
77620	TC	R	Hyperthermia treatment	0.00	10.43	8.59	NA	NA	0.16	XXX
77620	26	R	Hyperthermia treatment	1.56	0.41	0.43	0.41	0.43	0.20	XXX
77750		A	Infuse radioactive materials	4.94	4.44	4.06	4.44	4.06	0.32	090
77750	TC	A	Infuse radioactive materials	0.00	2.88	2.50	2.88	2.50	0.07	090

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77750	26	A	Infuse radioactive materials	4.94	1.56	1.57	1.56	1.57	0.25	090
77761		A	Apply intrcav radiat simple	3.82	6.22	5.56	6.22	5.56	0.33	090
77761	TC	A	Apply intrcav radiat simple	0.00	5.02	4.39	5.02	4.39	0.14	090
77761	26	A	Apply intrcav radiat simple	3.82	1.20	1.17	1.20	1.17	0.19	090
77762		A	Apply intrcav radiat interm	5.73	7.53	7.01	7.53	7.01	0.48	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.71	5.19	5.71	5.19	0.19	090
77762	26	A	Apply intrcav radiat interm	5.73	1.81	1.82	1.81	1.82	0.29	090
77763		A	Apply intrcav radiat compl	8.60	10.15	9.43	10.15	9.43	0.66	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.42	6.70	7.42	6.70	0.23	090
77763	26	A	Apply intrcav radiat compl	8.60	2.73	2.74	2.73	2.74	0.43	090
77776		A	Apply interstit radiat simpl	4.67	7.22	6.20	7.22	6.20	0.57	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.61	4.76	5.61	4.76	0.13	090
77776	26	A	Apply interstit radiat simpl	4.67	1.61	1.44	1.61	1.44	0.44	090
77777		A	Apply interstit radiat inter	7.49	8.10	7.74	8.10	7.74	0.61	090
77777	TC	A	Apply interstit radiat inter	0.00	5.56	5.23	5.56	5.23	0.22	090
77777	26	A	Apply interstit radiat inter	7.49	2.54	2.50	2.54	2.50	0.39	090
77778		A	Apply interstit radiat compl	11.23	11.11	10.51	11.11	10.51	0.84	090
77778	TC	A	Apply interstit radiat compl	0.00	7.54	6.94	7.54	6.94	0.27	090
77778	26	A	Apply interstit radiat compl	11.23	3.57	3.57	3.57	3.57	0.57	090
77781		A	High intensity brachytherapy	1.21	4.34	8.49	NA	NA	1.14	XXX
77781	TC	A	High intensity brachytherapy	0.00	3.96	8.07	NA	NA	1.06	XXX
77781	26	A	High intensity brachytherapy	1.21	0.38	0.42	0.38	0.42	0.08	XXX
77782		A	High intensity brachytherapy	2.04	12.22	14.47	NA	NA	1.19	XXX
77782	TC	A	High intensity brachytherapy	0.00	11.58	13.79	NA	NA	1.06	XXX
77782	26	A	High intensity brachytherapy	2.04	0.64	0.68	0.64	0.68	0.13	XXX
77783		A	High intensity brachytherapy	3.27	23.93	23.35	NA	NA	1.25	XXX
77783	TC	A	High intensity brachytherapy	0.00	22.90	22.28	NA	NA	1.06	XXX
77783	26	A	High intensity brachytherapy	3.27	1.03	1.07	1.03	1.07	0.19	XXX
77784		A	High intensity brachytherapy	5.15	45.01	39.31	NA	NA	1.35	XXX
77784	TC	A	High intensity brachytherapy	0.00	43.40	37.65	NA	NA	1.06	XXX
77784	26	A	High intensity brachytherapy	5.15	1.61	1.66	1.61	1.66	0.29	XXX
77789		A	Apply surface radiation	1.14	1.94	1.66	1.94	1.66	0.08	000
77789	TC	A	Apply surface radiation	0.00	1.58	1.30	1.58	1.30	0.02	000
77789	26	A	Apply surface radiation	1.14	0.37	0.37	0.37	0.37	0.06	000
77790		A	Radiation handling	1.05	1.44	1.29	NA	NA	0.07	XXX
77790	TC	A	Radiation handling	0.00	1.11	0.95	NA	NA	0.02	XXX
77790	26	A	Radiation handling	1.05	0.33	0.33	0.33	0.33	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	1.90	1.68	NA	NA	0.07	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.83	1.62	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	2.36	2.12	NA	NA	0.08	XXX

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78001	TC	A	Thyroid, multiple uptakes	0.00	2.27	2.03	NA	NA	0.07	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.09	0.09	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.97	1.75	NA	NA	0.07	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.85	1.63	NA	NA	0.06	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.12	0.12	0.12	0.12	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.35	5.40	NA	NA	0.15	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	6.17	5.23	NA	NA	0.13	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.18	0.17	0.18	0.17	0.02	XXX
78007		A	Thyroid image, mult uptakes	0.50	3.12	3.03	NA	NA	0.16	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.94	2.85	NA	NA	0.14	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.18	0.18	0.18	0.18	0.02	XXX
78010		A	Thyroid imaging	0.39	4.27	3.70	NA	NA	0.13	XXX
78010	TC	A	Thyroid imaging	0.00	4.14	3.56	NA	NA	0.11	XXX
78010	26	A	Thyroid imaging	0.39	0.14	0.13	0.14	0.13	0.02	XXX
78011		A	Thyroid imaging with flow	0.45	4.77	4.22	NA	NA	0.15	XXX
78011	TC	A	Thyroid imaging with flow	0.00	4.59	4.05	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	5.52	4.84	NA	NA	0.17	XXX
78015	TC	A	Thyroid met imaging	0.00	5.28	4.60	NA	NA	0.14	XXX
78015	26	A	Thyroid met imaging	0.67	0.24	0.24	0.24	0.24	0.03	XXX
78016		A	Thyroid met imaging/studies	0.82	8.92	7.64	NA	NA	0.21	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	8.61	7.34	NA	NA	0.18	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.31	0.30	0.31	0.30	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	8.15	7.55	NA	NA	0.33	XXX
78018	TC	A	Thyroid met imaging, body	0.00	7.84	7.24	NA	NA	0.29	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.32	0.31	0.32	0.31	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.89	1.80	1.89	1.80	0.16	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.67	1.58	1.67	1.58	0.14	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.22	0.22	0.22	0.22	0.02	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.57	3.82	NA	NA	0.15	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	3.27	3.53	NA	NA	0.11	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.30	0.29	0.30	0.29	0.04	XXX
78075		A	Adrenal nuclear imaging	0.74	11.85	10.32	NA	NA	0.32	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	11.58	10.05	NA	NA	0.29	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.27	0.27	0.27	0.27	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	4.30	3.79	NA	NA	0.14	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	4.10	3.59	NA	NA	0.12	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.20	0.20	0.20	0.20	0.02	XXX
78103		A	Bone marrow imaging, mult	0.75	5.61	5.07	NA	NA	0.20	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	5.34	4.80	NA	NA	0.17	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.28	0.27	0.28	0.27	0.03	XXX

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78104		A	Bone marrow imaging, body	0.80	6.34	5.85	NA	NA	0.25	XXX
78104	TC	A	Bone marrow imaging, body	0.00	6.04	5.55	NA	NA	0.22	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.30	0.29	0.30	0.29	0.03	XXX
78110		A	Plasma volume, single	0.19	2.19	1.90	NA	NA	0.07	XXX
78110	TC	A	Plasma volume, single	0.00	2.12	1.83	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	2.30	2.39	NA	NA	0.15	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.22	2.31	NA	NA	0.14	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.08	0.08	0.01	XXX
78120		A	Red cell mass, single	0.23	2.19	2.10	NA	NA	0.12	XXX
78120	TC	A	Red cell mass, single	0.00	2.10	2.01	NA	NA	0.11	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.08	0.08	0.01	XXX
78121		A	Red cell mass, multiple	0.32	2.32	2.50	NA	NA	0.15	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.20	2.38	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	2.38	2.98	NA	NA	0.26	XXX
78122	TC	A	Blood volume	0.00	2.21	2.81	NA	NA	0.24	XXX
78122	26	A	Blood volume	0.45	0.17	0.17	0.17	0.17	0.02	XXX
78130		A	Red cell survival study	0.61	3.63	3.49	NA	NA	0.17	XXX
78130	TC	A	Red cell survival study	0.00	3.41	3.28	NA	NA	0.14	XXX
78130	26	A	Red cell survival study	0.61	0.22	0.22	0.22	0.22	0.03	XXX
78135		A	Red cell survival kinetics	0.64	8.96	8.00	NA	NA	0.28	XXX
78135	TC	A	Red cell survival kinetics	0.00	8.73	7.77	NA	NA	0.25	XXX
78135	26	A	Red cell survival kinetics	0.64	0.23	0.23	0.23	0.23	0.03	XXX
78140		A	Red cell sequestration	0.61	3.01	3.30	NA	NA	0.24	XXX
78140	TC	A	Red cell sequestration	0.00	2.79	3.08	NA	NA	0.21	XXX
78140	26	A	Red cell sequestration	0.61	0.23	0.22	0.23	0.22	0.03	XXX
78185		A	Spleen imaging	0.40	5.36	4.65	NA	NA	0.15	XXX
78185	TC	A	Spleen imaging	0.00	5.22	4.51	NA	NA	0.13	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.14	0.14	0.02	XXX
78190		A	Platelet survival, kinetics	1.09	9.67	8.78	NA	NA	0.38	XXX
78190	TC	A	Platelet survival, kinetics	0.00	9.32	8.42	NA	NA	0.30	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.35	0.36	0.35	0.36	0.08	XXX
78191		A	Platelet survival	0.61	3.58	4.58	NA	NA	0.40	XXX
78191	TC	A	Platelet survival	0.00	3.36	4.37	NA	NA	0.37	XXX
78191	26	A	Platelet survival	0.61	0.22	0.21	0.22	0.21	0.03	XXX
78195		A	Lymph system imaging	1.20	8.88	7.79	NA	NA	0.28	XXX
78195	TC	A	Lymph system imaging	0.00	8.45	7.36	NA	NA	0.22	XXX
78195	26	A	Lymph system imaging	1.20	0.44	0.43	0.44	0.43	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	4.76	4.20	NA	NA	0.15	XXX
78201	TC	A	Liver imaging	0.00	4.62	4.06	NA	NA	0.13	XXX

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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	5.48	4.88	NA	NA	0.16	XXX
78202	TC	A	Liver imaging with flow	0.00	5.31	4.70	NA	NA	0.14	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.17	0.17	0.02	XXX
78205		A	Liver imaging (3D)	0.71	5.39	5.59	NA	NA	0.34	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.13	5.33	NA	NA	0.31	XXX
78205	26	A	Liver imaging (3D)	0.71	0.26	0.26	0.26	0.26	0.03	XXX
78206		A	Liver image (3d) with flow	0.96	8.75	8.13	NA	NA	0.15	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.40	7.79	NA	NA	0.11	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.35	0.35	0.35	0.35	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.91	4.46	NA	NA	0.16	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.73	4.29	NA	NA	0.14	XXX
78215	26	A	Liver and spleen imaging	0.49	0.18	0.17	0.18	0.17	0.02	XXX
78216		A	Liver & spleen image/flow	0.57	2.92	3.11	NA	NA	0.20	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.72	2.91	NA	NA	0.18	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.20	0.20	0.20	0.20	0.02	XXX
78220		A	Liver function study	0.49	3.16	3.34	NA	NA	0.21	XXX
78220	TC	A	Liver function study	0.00	2.98	3.17	NA	NA	0.19	XXX
78220	26	A	Liver function study	0.49	0.18	0.17	0.18	0.17	0.02	XXX
78223		A	Hepatobiliary imaging	0.84	8.66	7.48	NA	NA	0.23	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.35	7.18	NA	NA	0.19	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.31	0.30	0.31	0.30	0.04	XXX
78230		A	Salivary gland imaging	0.45	4.24	3.77	NA	NA	0.15	XXX
78230	TC	A	Salivary gland imaging	0.00	4.08	3.61	NA	NA	0.13	XXX
78230	26	A	Salivary gland imaging	0.45	0.16	0.16	0.16	0.16	0.02	XXX
78231		A	Serial salivary imaging	0.52	2.92	3.03	NA	NA	0.19	XXX
78231	TC	A	Serial salivary imaging	0.00	2.74	2.85	NA	NA	0.17	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.18	0.18	0.02	XXX
78232		A	Salivary gland function exam	0.47	2.96	3.15	NA	NA	0.20	XXX
78232	TC	A	Salivary gland function exam	0.00	2.78	2.98	NA	NA	0.18	XXX
78232	26	A	Salivary gland function exam	0.47	0.17	0.17	0.17	0.17	0.02	XXX
78258		A	Esophageal motility study	0.74	5.86	5.18	NA	NA	0.17	XXX
78258	TC	A	Esophageal motility study	0.00	5.57	4.90	NA	NA	0.14	XXX
78258	26	A	Esophageal motility study	0.74	0.29	0.28	0.29	0.28	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	6.28	5.80	NA	NA	0.25	XXX
78261	TC	A	Gastric mucosa imaging	0.00	6.02	5.54	NA	NA	0.22	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.26	0.25	0.26	0.25	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	6.10	5.70	NA	NA	0.25	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.87	5.47	NA	NA	0.22	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.23	0.23	0.03	XXX
78264		A	Gastric emptying study	0.78	7.30	6.58	NA	NA	0.25	XXX
78264	TC	A	Gastric emptying study	0.00	7.02	6.30	NA	NA	0.22	XXX
78264	26	A	Gastric emptying study	0.78	0.29	0.28	0.29	0.28	0.03	XXX
78270		A	Vit B-12 absorption exam	0.20	2.05	1.94	NA	NA	0.11	XXX

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78270	TC	A	Vit B-12 absorption exam	0.00	1.97	1.87	NA	NA	0.10	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.08	0.07	0.08	0.07	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	2.02	1.94	NA	NA	0.11	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.96	1.88	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	2.04	2.14	NA	NA	0.14	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.97	2.06	NA	NA	0.13	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.07	0.08	0.07	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	8.77	7.88	NA	NA	0.29	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	8.41	7.53	NA	NA	0.25	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.36	0.36	0.36	0.36	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	0.14	0.13	0.14	0.13	0.02	XXX
78290		A	Meckel s divert exam	0.68	8.66	7.32	NA	NA	0.19	XXX
78290	TC	A	Meckel s divert exam	0.00	8.41	7.07	NA	NA	0.16	XXX
78290	26	A	Meckel s divert exam	0.68	0.25	0.24	0.25	0.24	0.03	XXX
78291		A	Leveen/shunt patency exam	0.88	6.33	5.59	NA	NA	0.20	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	6.01	5.28	NA	NA	0.16	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.32	0.31	0.32	0.31	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	4.30	3.90	NA	NA	0.17	XXX
78300	TC	A	Bone imaging, limited area	0.00	4.07	3.68	NA	NA	0.14	XXX
78300	26	A	Bone imaging, limited area	0.62	0.23	0.22	0.23	0.22	0.03	XXX
78305		A	Bone imaging, multiple areas	0.83	5.58	5.18	NA	NA	0.23	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	5.29	4.89	NA	NA	0.19	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.29	0.29	0.29	0.29	0.04	XXX
78306		A	Bone imaging, whole body	0.86	6.18	5.78	NA	NA	0.26	XXX
78306	TC	A	Bone imaging, whole body	0.00	5.87	5.47	NA	NA	0.22	XXX
78306	26	A	Bone imaging, whole body	0.86	0.31	0.31	0.31	0.31	0.04	XXX
78315		A	Bone imaging, 3 phase	1.02	8.77	7.86	NA	NA	0.29	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	8.39	7.50	NA	NA	0.25	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.37	0.37	0.37	0.37	0.04	XXX
78320		A	Bone imaging (3D)	1.04	5.51	5.71	NA	NA	0.35	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.13	5.33	NA	NA	0.31	XXX
78320	26	A	Bone imaging (3D)	1.04	0.38	0.38	0.38	0.38	0.04	XXX
78350		N	Bone mineral, single photon	0.22	0.61	0.66	NA	NA	0.06	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.54	0.59	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	0.09	0.10	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

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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	5.24	4.57	NA	NA	0.16	XXX
78428	TC	A	Cardiac shunt imaging	0.00	4.90	4.24	NA	NA	0.13	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.35	0.33	0.35	0.33	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.61	3.97	NA	NA	0.13	XXX
78445	TC	A	Vascular flow imaging	0.00	4.43	3.79	NA	NA	0.11	XXX
78445	26	A	Vascular flow imaging	0.49	0.18	0.18	0.18	0.18	0.02	XXX
78456		A	Acute venous thrombus image	1.00	9.93	8.53	NA	NA	0.33	XXX
78456	TC	A	Acute venous thrombus image	0.00	9.43	8.07	NA	NA	0.29	XXX
78456	26	A	Acute venous thrombus image	1.00	0.50	0.46	0.50	0.46	0.04	XXX
78457		A	Venous thrombosis imaging	0.77	4.76	4.30	NA	NA	0.17	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.49	4.03	NA	NA	0.14	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.27	0.27	0.27	0.27	0.03	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.77	4.66	NA	NA	0.25	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.43	4.33	NA	NA	0.21	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.34	0.33	0.34	0.33	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	0.66	0.64	0.66	0.64	0.05	XXX
78460		A	Heart muscle blood, single	0.86	4.75	4.23	NA	NA	0.17	XXX
78460	TC	A	Heart muscle blood, single	0.00	4.42	3.91	NA	NA	0.13	XXX
78460	26	A	Heart muscle blood, single	0.86	0.33	0.32	0.33	0.32	0.04	XXX
78461		A	Heart muscle blood, multiple	1.23	4.12	4.38	NA	NA	0.30	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	3.65	3.93	NA	NA	0.25	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.47	0.46	0.47	0.46	0.05	XXX
78464		A	Heart image (3d), single	1.09	5.90	6.30	NA	NA	0.41	XXX
78464	TC	A	Heart image (3d), single	0.00	5.39	5.82	NA	NA	0.37	XXX
78464	26	A	Heart image (3d), single	1.09	0.51	0.48	0.51	0.48	0.04	XXX
78465		A	Heart image (3d), multiple	1.46	11.52	11.73	NA	NA	0.67	XXX
78465	TC	A	Heart image (3d), multiple	0.00	10.80	11.06	NA	NA	0.62	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.72	0.67	0.72	0.67	0.05	XXX
78466		A	Heart infarct image	0.69	4.60	4.17	NA	NA	0.17	XXX
78466	TC	A	Heart infarct image	0.00	4.31	3.89	NA	NA	0.14	XXX
78466	26	A	Heart infarct image	0.69	0.29	0.28	0.29	0.28	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	5.87	5.39	NA	NA	0.22	XXX
78468	TC	A	Heart infarct image (ef)	0.00	5.47	5.02	NA	NA	0.19	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.39	0.36	0.39	0.36	0.03	XXX
78469		A	Heart infarct image (3D)	0.92	6.22	6.06	NA	NA	0.31	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.80	5.66	NA	NA	0.28	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.42	0.40	0.42	0.40	0.03	XXX
78472		A	Gated heart, planar, single	0.98	6.11	6.05	NA	NA	0.34	XXX

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78472	TC	A	Gated heart, planar, single	0.00	5.69	5.65	NA	NA	0.30	XXX
78472	26	A	Gated heart, planar, single	0.98	0.42	0.40	0.42	0.40	0.04	XXX
78473		A	Gated heart, multiple	1.47	7.92	8.14	NA	NA	0.48	XXX
78473	TC	A	Gated heart, multiple	0.00	7.25	7.51	NA	NA	0.42	XXX
78473	26	A	Gated heart, multiple	1.47	0.67	0.63	0.67	0.63	0.06	XXX
78478		A	Heart wall motion add-on	0.50	0.81	1.06	NA	NA	0.12	XXX
78478	TC	A	Heart wall motion add-on	0.00	0.57	0.81	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	0.71	0.98	NA	NA	0.12	XXX
78480	TC	A	Heart function add-on	0.00	0.56	0.81	NA	NA	0.10	XXX
78480	26	A	Heart function add-on	0.30	0.14	0.16	0.14	0.16	0.02	XXX
78481		A	Heart first pass, single	0.98	5.09	5.22	NA	NA	0.31	XXX
78481	TC	A	Heart first pass, single	0.00	4.59	4.76	NA	NA	0.28	XXX
78481	26	A	Heart first pass, single	0.98	0.50	0.46	0.50	0.46	0.03	XXX
78483		A	Heart first pass, multiple	1.47	6.88	7.27	NA	NA	0.46	XXX
78483	TC	A	Heart first pass, multiple	0.00	6.10	6.55	NA	NA	0.41	XXX
78483	26	A	Heart first pass, multiple	1.47	0.78	0.72	0.78	0.72	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	0.68	0.66	0.68	0.66	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	0.90	0.86	0.90	0.86	0.07	XXX
78494		A	Heart image, spect	1.19	6.19	6.53	NA	NA	0.35	XXX
78494	TC	A	Heart image, spect	0.00	5.66	6.02	NA	NA	0.30	XXX
78494	26	A	Heart image, spect	1.19	0.53	0.50	0.53	0.50	0.05	XXX
78496		A	Heart first pass add-on	0.50	0.90	2.49	0.90	2.49	0.32	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.66	2.27	0.66	2.27	0.30	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.24	0.22	0.24	0.22	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	5.23	4.85	NA	NA	0.21	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.95	4.58	NA	NA	0.18	XXX
78580	26	A	Lung perfusion imaging	0.74	0.27	0.27	0.27	0.27	0.03	XXX
78584		A	Lung V/Q image single breath	0.99	3.08	3.19	NA	NA	0.21	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.71	2.84	NA	NA	0.17	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.36	0.35	0.36	0.35	0.04	XXX
78585		A	Lung V/Q imaging	1.09	8.81	8.12	NA	NA	0.35	XXX
78585	TC	A	Lung V/Q imaging	0.00	8.41	7.72	NA	NA	0.30	XXX
78585	26	A	Lung V/Q imaging	1.09	0.40	0.39	0.40	0.39	0.05	XXX
78586		A	Aerosol lung image, single	0.40	4.24	3.86	NA	NA	0.16	XXX
78586	TC	A	Aerosol lung image, single	0.00	4.09	3.72	NA	NA	0.14	XXX
78586	26	A	Aerosol lung image, single	0.40	0.14	0.14	0.14	0.14	0.02	XXX

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78587		A	Aerosol lung image, multiple	0.49	5.54	4.90	NA	NA	0.16	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	5.37	4.73	NA	NA	0.14	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.18	0.18	0.18	0.18	0.02	XXX
78588		A	Perfusion lung image	1.09	8.83	7.52	NA	NA	0.23	XXX
78588	TC	A	Perfusion lung image	0.00	8.43	7.13	NA	NA	0.18	XXX
78588	26	A	Perfusion lung image	1.09	0.40	0.39	0.40	0.39	0.05	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	4.22	3.91	NA	NA	0.16	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	4.08	3.77	NA	NA	0.14	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.15	0.14	0.15	0.14	0.02	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.93	4.60	NA	NA	0.20	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	4.75	4.43	NA	NA	0.18	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.18	0.17	0.18	0.17	0.02	XXX
78594		A	Vent image, mult proj, gas	0.53	5.46	5.39	NA	NA	0.27	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	5.26	5.20	NA	NA	0.25	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.19	0.19	0.19	0.19	0.02	XXX
78596		A	Lung differential function	1.27	8.95	8.59	NA	NA	0.42	XXX
78596	TC	A	Lung differential function	0.00	8.53	8.17	NA	NA	0.37	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.42	0.42	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	4.61	4.22	NA	NA	0.16	XXX
78600	TC	A	Brain image < 4 views	0.00	4.45	4.06	NA	NA	0.14	XXX
78600	26	A	Brain image < 4 views	0.44	0.17	0.16	0.17	0.16	0.02	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.50	5.02	NA	NA	0.20	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.31	4.84	NA	NA	0.18	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.19	0.18	0.19	0.18	0.02	XXX
78605		A	Brain image 4+ views	0.53	4.99	4.64	NA	NA	0.20	XXX
78605	TC	A	Brain image 4+ views	0.00	4.79	4.44	NA	NA	0.18	XXX
78605	26	A	Brain image 4+ views	0.53	0.21	0.20	0.21	0.20	0.02	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.64	7.51	NA	NA	0.24	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.41	7.28	NA	NA	0.21	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.23	0.22	0.23	0.22	0.03	XXX
78607		A	Brain imaging (3D)	1.23	8.91	8.44	NA	NA	0.40	XXX
78607	TC	A	Brain imaging (3D)	0.00	8.47	8.00	NA	NA	0.35	XXX
78607	26	A	Brain imaging (3D)	1.23	0.44	0.44	0.44	0.44	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	0.55	0.54	0.55	0.54	0.06	XXX
78609		N	Brain imaging (PET)	1.50	0.48	0.48	NA	NA	0.06	XXX
78609	26	N	Brain imaging (PET)	1.50	0.48	0.49	0.48	0.49	0.06	XXX
78610		A	Brain flow imaging only	0.30	4.57	4.43	NA	NA	0.11	XXX
78610	TC	A	Brain flow imaging only	0.00	4.46	4.31	NA	NA	0.10	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.12	0.11	0.12	0.01	XXX

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78630		A	Cerebrospinal fluid scan	0.68	8.81	7.93	NA	NA	0.30	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.56	7.69	NA	NA	0.27	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.25	0.24	0.25	0.24	0.03	XXX
78635		A	CSF ventriculography	0.61	8.85	7.33	NA	NA	0.16	XXX
78635	TC	A	CSF ventriculography	0.00	8.62	7.10	NA	NA	0.14	XXX
78635	26	A	CSF ventriculography	0.61	0.23	0.23	0.23	0.23	0.02	XXX
78645		A	CSF shunt evaluation	0.57	8.71	7.44	NA	NA	0.20	XXX
78645	TC	A	CSF shunt evaluation	0.00	8.50	7.24	NA	NA	0.18	XXX
78645	26	A	CSF shunt evaluation	0.57	0.21	0.21	0.21	0.21	0.02	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.82	8.17	NA	NA	0.35	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.50	7.86	NA	NA	0.31	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.32	0.32	0.32	0.32	0.04	XXX
78650		A	CSF leakage imaging	0.61	8.81	7.83	NA	NA	0.27	XXX
78650	TC	A	CSF leakage imaging	0.00	8.59	7.61	NA	NA	0.24	XXX
78650	26	A	CSF leakage imaging	0.61	0.22	0.22	0.22	0.22	0.03	XXX
78660		A	Nuclear exam of tear flow	0.53	4.37	3.85	NA	NA	0.14	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.17	3.66	NA	NA	0.12	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.19	0.19	0.19	0.19	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	4.45	4.14	NA	NA	0.18	XXX
78700	TC	A	Kidney imaging, morphol	0.00	4.29	3.98	NA	NA	0.16	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.17	0.16	0.17	0.16	0.02	XXX
78701		A	Kidney imaging with flow	0.49	5.45	5.02	NA	NA	0.20	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.27	4.85	NA	NA	0.18	XXX
78701	26	A	Kidney imaging with flow	0.49	0.18	0.17	0.18	0.17	0.02	XXX
78707		A	K flow/funct image w/o drug	0.96	5.62	5.42	NA	NA	0.27	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	5.27	5.07	NA	NA	0.23	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.35	0.34	0.35	0.34	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.57	3.90	NA	NA	0.28	XXX
78708	TC	A	K flow/funct image w/drug	0.00	3.13	3.47	NA	NA	0.23	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.45	0.44	0.45	0.44	0.05	XXX
78709		A	K flow/funct image, multiple	1.41	9.10	8.06	NA	NA	0.29	XXX
78709	TC	A	K flow/funct image, multiple	0.00	8.58	7.56	NA	NA	0.23	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.52	0.51	0.52	0.51	0.06	XXX
78710		A	Kidney imaging (3D)	0.66	5.40	5.59	NA	NA	0.34	XXX
78710	TC	A	Kidney imaging (3D)	0.00	5.16	5.35	NA	NA	0.31	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.24	0.24	0.24	0.24	0.03	XXX
78725		A	Kidney function study	0.38	2.41	2.29	NA	NA	0.13	XXX
78725	TC	A	Kidney function study	0.00	2.28	2.16	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	1.96	1.87	NA	NA	0.10	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.91	1.80	NA	NA	0.08	ZZZ

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78730	26	A	Urinary bladder retention	0.15	0.06	0.07	0.06	0.07	0.02	ZZZ
78740		A	Ureteral reflux study	0.57	5.81	4.94	NA	NA	0.15	XXX
78740	TC	A	Ureteral reflux study	0.00	5.60	4.74	NA	NA	0.12	XXX
78740	26	A	Ureteral reflux study	0.57	0.21	0.21	0.21	0.21	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.22	4.78	NA	NA	0.20	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.95	4.52	NA	NA	0.17	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.27	0.26	0.27	0.26	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	4.41	4.22	NA	NA	0.22	XXX
78800	TC	A	Tumor imaging, limited area	0.00	4.19	4.00	NA	NA	0.18	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.22	0.22	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	6.16	5.75	NA	NA	0.27	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.88	5.47	NA	NA	0.22	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.28	0.28	0.28	0.28	0.05	XXX
78802		A	Tumor imaging, whole body	0.86	8.36	7.73	NA	NA	0.34	XXX
78802	TC	A	Tumor imaging, whole body	0.00	8.05	7.42	NA	NA	0.30	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.32	0.31	0.32	0.31	0.04	XXX
78803		A	Tumor imaging (3D)	1.09	8.82	8.36	NA	NA	0.40	XXX
78803	TC	A	Tumor imaging (3D)	0.00	8.42	7.96	NA	NA	0.35	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.40	0.40	0.40	0.40	0.05	XXX
78804		A	Tumor imaging, whole body	1.07	15.20	14.27	NA	NA	0.34	XXX
78804	TC	A	Tumor imaging, whole body	0.00	14.81	13.88	NA	NA	0.30	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.39	0.39	0.39	0.39	0.04	XXX
78805		A	Abscess imaging, ltd area	0.73	4.32	4.16	NA	NA	0.21	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	4.06	3.90	NA	NA	0.18	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.26	0.26	0.26	0.26	0.03	XXX
78806		A	Abscess imaging, whole body	0.86	8.56	8.11	NA	NA	0.39	XXX
78806	TC	A	Abscess imaging, whole body	0.00	8.24	7.80	NA	NA	0.35	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.32	0.31	0.32	0.31	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.85	8.38	NA	NA	0.39	XXX
78807	TC	A	Nuclear localization/abscess	0.00	8.45	7.98	NA	NA	0.35	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.40	0.40	0.40	0.40	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	0.57	0.56	0.57	0.56	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	0.71	0.70	0.71	0.70	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	0.73	0.72	0.73	0.72	0.11	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX

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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	0.80	0.79	0.80	0.79	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
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.89	0.88	0.89	0.88	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	0.92	0.90	0.92	0.90	0.11	XXX
78890		B	Nuclear medicine data proc	0.05	0.46	0.67	NA	NA	0.07	XXX
78890	TC	B	Nuclear medicine data proc	0.00	0.44	0.66	NA	NA	0.06	XXX
78890	26	B	Nuclear medicine data proc	0.05	0.01	0.02	0.01	0.02	0.01	XXX
78891		B	Nuclear med data proc	0.10	1.04	1.45	NA	NA	0.14	XXX
78891	TC	B	Nuclear med data proc	0.00	1.00	1.41	NA	NA	0.13	XXX
78891	26	B	Nuclear med data proc	0.10	0.03	0.03	0.03	0.03	0.01	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	1.91	2.24	NA	NA	0.22	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.29	1.63	NA	NA	0.14	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.62	0.61	0.62	0.61	0.08	XXX
79101		A	Nuclear rx, iv admin	1.96	2.40	2.63	NA	NA	0.22	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.52	1.80	NA	NA	0.14	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.88	0.83	0.88	0.83	0.08	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.42	2.65	NA	NA	0.23	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.70	1.94	NA	NA	0.14	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.72	0.71	0.72	0.71	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	0.54	0.54	0.54	0.54	0.13	XXX
79403		A	Hematopoietic nuclear tx	2.25	3.05	3.58	NA	NA	0.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.24	2.76	NA	NA	0.14	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.80	0.82	0.80	0.82	0.10	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.93	2.29	NA	NA	0.22	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.21	1.56	NA	NA	0.14	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.72	0.72	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	0.88	0.87	0.88	0.87	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	0.10	0.12	0.01	XXX
80502		A	Lab pathology consultation	1.33	0.34	0.39	0.28	0.34	0.04	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.11	0.12	0.11	0.12	0.01	XXX

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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	0.11	0.12	0.11	0.12	0.01	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.11	0.12	0.11	0.12	0.01	XXX
84181	26	A	Western blot test	0.37	0.11	0.12	0.11	0.12	0.01	XXX
84182	26	A	Protein, western blot test	0.37	0.11	0.13	0.11	0.13	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.14	0.15	0.14	0.15	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.23	1.40	0.26	0.30	0.04	XXX
85390	26	A	Fibrinolysins screen	0.37	0.12	0.13	0.12	0.13	0.01	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.10	0.11	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	0.37	0.37	0.28	0.31	0.03	XXX
86078		A	Physician blood bank service	0.94	0.37	0.39	0.28	0.31	0.03	XXX
86079		A	Physician blood bank service	0.94	0.38	0.40	0.29	0.32	0.03	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.11	0.12	0.11	0.12	0.01	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.12	0.12	0.12	0.12	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	0.13	0.14	0.13	0.14	0.02	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.11	0.12	0.11	0.12	0.01	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.11	0.12	0.11	0.12	0.01	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	NA	NA	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.13	0.13	NA	NA	0.02	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.13	0.17	NA	NA	0.02	XXX
86510		A	Histoplasmosis skin test	0.00	0.13	0.17	NA	NA	0.02	XXX
86580		A	TB intradermal test	0.00	0.16	0.18	NA	NA	0.02	XXX
87164	26	A	Dark field examination	0.37	0.11	0.12	0.11	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	1.17	1.09	NA	NA	0.04	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	1.02	0.92	NA	NA	0.02	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.15	0.17	0.15	0.17	0.02	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.56	1.51	NA	NA	0.04	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.41	1.34	NA	NA	0.02	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.15	0.17	0.15	0.17	0.02	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.95	1.85	NA	NA	0.05	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.74	1.60	NA	NA	0.02	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.22	0.25	0.22	0.25	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.46	1.40	NA	NA	0.04	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.31	1.23	NA	NA	0.02	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.15	0.17	0.15	0.17	0.02	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.45	1.58	NA	NA	0.04	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.17	1.24	NA	NA	0.02	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.28	0.34	0.28	0.34	0.02	XXX
88125		A	Forensic cytopathology	0.26	0.32	0.31	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.24	0.22	NA	NA	0.01	XXX

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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	0.90	0.88	NA	NA	0.04	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.77	0.73	NA	NA	0.02	XXX
88160	26	A	Cytopath smear, other source	0.50	0.13	0.15	0.13	0.15	0.02	XXX
88161		A	Cytopath smear, other source	0.50	0.96	0.95	NA	NA	0.04	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.83	0.81	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	1.48	1.36	NA	NA	0.05	XXX
88162	TC	A	Cytopath smear, other source	0.00	1.26	1.12	NA	NA	0.02	XXX
88162	26	A	Cytopath smear, other source	0.76	0.21	0.24	0.21	0.24	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.84	0.82	NA	NA	0.04	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.67	0.62	NA	NA	0.02	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.17	0.20	0.17	0.20	0.02	XXX
88173		A	Cytopath eval, fna, report	1.39	2.22	2.20	NA	NA	0.07	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.85	1.78	NA	NA	0.02	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.37	0.43	0.37	0.43	0.05	XXX
88182		A	Cell marker study	0.77	1.97	1.97	NA	NA	0.07	XXX
88182	TC	A	Cell marker study	0.00	1.84	1.79	NA	NA	0.04	XXX
88182	26	A	Cell marker study	0.77	0.12	0.18	0.12	0.18	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.44	2.16	NA	NA	0.02	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.49	1.28	NA	NA	0.02	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.37	0.39	0.37	0.39	0.01	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.44	0.47	0.44	0.47	0.01	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.44	0.52	0.44	0.52	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	0.27	0.25	0.27	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	0.58	0.55	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.56	0.52	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.02	0.02	0.02	0.02	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.27	1.21	NA	NA	0.03	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.23	1.17	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	1.52	1.47	NA	NA	0.03	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.47	1.41	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	2.13	2.08	NA	NA	0.07	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.93	1.84	NA	NA	0.04	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.20	0.24	0.20	0.24	0.03	XXX
88307		A	Tissue exam by pathologist	1.59	4.43	4.11	NA	NA	0.12	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.97	3.60	NA	NA	0.06	XXX

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88307	26	A	Tissue exam by pathologist	1.59	0.46	0.52	0.46	0.52	0.06	XXX
88309		A	Tissue exam by pathologist	2.80	6.28	5.82	NA	NA	0.14	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.47	4.96	NA	NA	0.06	XXX
88309	26	A	Tissue exam by pathologist	2.80	0.81	0.85	0.81	0.85	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	0.18	0.17	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.07	0.07	0.07	0.07	0.01	XXX
88312		A	Special stains	0.54	2.39	2.17	NA	NA	0.03	XXX
88312	TC	A	Special stains	0.00	2.25	2.01	NA	NA	0.01	XXX
88312	26	A	Special stains	0.54	0.14	0.16	0.14	0.16	0.02	XXX
88313		A	Special stains	0.24	1.92	1.76	NA	NA	0.02	XXX
88313	TC	A	Special stains	0.00	1.86	1.69	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	1.92	1.96	NA	NA	0.04	XXX
88314	TC	A	Histochemical stain	0.00	1.79	1.81	NA	NA	0.02	XXX
88314	26	A	Histochemical stain	0.45	0.13	0.15	0.13	0.15	0.02	XXX
88318		A	Chemical histochemistry	0.42	2.55	2.32	NA	NA	0.03	XXX
88318	TC	A	Chemical histochemistry	0.00	2.44	2.20	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.10	0.12	0.10	0.12	0.02	XXX
88319		A	Enzyme histochemistry	0.53	3.23	3.28	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.08	3.11	NA	NA	0.02	XXX
88319	26	A	Enzyme histochemistry	0.53	0.15	0.17	0.15	0.17	0.02	XXX
88321		A	Microslide consultation	1.63	0.70	0.72	0.45	0.48	0.05	XXX
88323		A	Microslide consultation	1.83	2.09	2.01	NA	NA	0.07	XXX
88323	TC	A	Microslide consultation	0.00	1.68	1.56	NA	NA	0.02	XXX
88323	26	A	Microslide consultation	1.83	0.42	0.46	0.42	0.46	0.05	XXX
88325		A	Comprehensive review of data	2.50	2.53	2.63	0.72	0.78	0.07	XXX
88329		A	Path consult introp	0.67	0.67	0.67	0.20	0.22	0.02	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.23	1.20	NA	NA	0.08	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.86	0.80	NA	NA	0.04	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.36	0.40	0.36	0.40	0.04	XXX
88332		A	Path consult intraop, add ╞I	0.59	0.47	0.47	NA	NA	0.04	XXX
88332	TC	A	Path consult intraop, add ╞I	0.00	0.29	0.27	NA	NA	0.02	XXX
88332	26	A	Path consult intraop, add ╞I	0.59	0.17	0.19	0.17	0.19	0.02	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.30	1.25	NA	NA	0.08	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.95	0.85	NA	NA	0.04	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.35	0.39	0.35	0.39	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	0.58	0.52	NA	NA	0.02	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.21	0.23	0.21	0.23	0.02	XXX
88342		A	Immunohistochemistry	0.85	1.97	1.85	NA	NA	0.05	XXX
88342	TC	A	Immunohistochemistry	0.00	1.76	1.59	NA	NA	0.02	XXX
88342	26	A	Immunohistochemistry	0.85	0.22	0.25	0.22	0.25	0.03	XXX
88346		A	Immunofluorescent study	0.86	1.91	1.83	NA	NA	0.05	XXX

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88346	TC	A	Immunofluorescent study	0.00	1.69	1.57	NA	NA	0.02	XXX
88346	26	A	Immunofluorescent study	0.86	0.22	0.26	0.22	0.26	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	1.08	1.04	NA	NA	0.02	XXX
88347	26	A	Immunofluorescent study	0.86	0.16	0.21	0.16	0.21	0.03	XXX
88348		A	Electron microscopy	1.51	17.93	15.80	NA	NA	0.13	XXX
88348	TC	A	Electron microscopy	0.00	17.53	15.34	NA	NA	0.07	XXX
88348	26	A	Electron microscopy	1.51	0.40	0.46	0.40	0.46	0.06	XXX
88349		A	Scanning electron microscopy	0.76	8.80	7.49	NA	NA	0.09	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.58	7.24	NA	NA	0.06	XXX
88349	26	A	Scanning electron microscopy	0.76	0.22	0.25	0.22	0.25	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	2.81	4.11	NA	NA	0.06	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.35	0.46	0.35	0.46	0.07	XXX
88356		A	Analysis, nerve	3.02	4.90	4.72	NA	NA	0.19	XXX
88356	TC	A	Analysis, nerve	0.00	4.44	4.06	NA	NA	0.07	XXX
88356	26	A	Analysis, nerve	3.02	0.46	0.66	0.46	0.66	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	0.94	0.81	NA	NA	0.07	XXX
88358	26	A	Analysis, tumor	0.95	0.15	0.21	0.15	0.21	0.10	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.27	2.13	NA	NA	0.08	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	2.00	1.81	NA	NA	0.02	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.27	0.32	0.27	0.32	0.06	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.76	2.83	NA	NA	0.17	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.51	2.52	NA	NA	0.07	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.25	0.31	0.25	0.31	0.10	XXX
88362		A	Nerve teasing preparations	2.17	5.04	4.96	NA	NA	0.15	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.48	4.30	NA	NA	0.06	XXX
88362	26	A	Nerve teasing preparations	2.17	0.57	0.66	0.57	0.66	0.09	XXX
88365		A	Insitu hybridization (fish)	1.20	3.39	3.08	NA	NA	0.05	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.09	2.73	NA	NA	0.02	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.30	0.35	0.30	0.35	0.03	XXX
88367		A	Insitu hybridization, auto	1.30	5.56	5.18	NA	NA	0.12	XXX
88367	TC	A	Insitu hybridization, auto	0.00	5.30	4.85	NA	NA	0.06	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.26	0.33	0.26	0.33	0.06	XXX
88368		A	Insitu hybridization, manual	1.40	4.91	4.29	NA	NA	0.12	XXX
88368	TC	A	Insitu hybridization, manual	0.00	4.68	3.96	NA	NA	0.06	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.24	0.33	0.24	0.33	0.06	XXX
88371	26	A	Protein, western blot tissue	0.37	0.12	0.12	0.12	0.12	0.01	XXX

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88372	26	A	Protein analysis w/probe	0.37	0.10	0.12	0.10	0.12	0.01	XXX
88380		A	Microdissection, laser	1.56	3.85	3.85	NA	NA	0.14	XXX
88380	TC	A	Microdissection, laser	0.00	3.37	3.37	NA	NA	0.07	XXX
88380	26	A	Microdissection, laser	1.56	0.47	0.47	0.47	0.47	0.07	XXX
88381		A	Microdissection, manual	1.18	4.84	4.84	NA	NA	0.08	XXX
88381	TC	A	Microdissection, manual	0.00	4.48	4.48	NA	NA	0.02	XXX
88381	26	A	Microdissection, manual	1.18	0.36	0.36	0.36	0.36	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	14.70	12.81	NA	NA	0.12	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	14.49	12.48	NA	NA	0.06	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.22	0.33	0.22	0.33	0.06	XXX
88386		A	Eval molecul probes, 251-500	1.88	19.90	16.69	NA	NA	0.16	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	19.25	16.00	NA	NA	0.08	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.65	0.69	0.65	0.69	0.08	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	Ç	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	5.79	5.23	0.45	0.40	0.06	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.11	0.12	0.11	0.12	0.01	XXX
89100		A	Sample intestinal contents	0.60	7.66	6.21	0.52	0.44	0.03	XXX
89105		A	Sample intestinal contents	0.50	7.94	6.51	0.47	0.39	0.02	XXX
89130		A	Sample stomach contents	0.45	6.67	5.44	0.38	0.32	0.02	XXX
89132		A	Sample stomach contents	0.19	8.36	6.66	0.39	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	9.13	7.32	0.70	0.59	0.04	XXX
89136		A	Sample stomach contents	0.21	6.77	5.51	0.31	0.25	0.01	XXX
89140		A	Sample stomach contents	0.94	6.89	5.69	0.51	0.45	0.04	XXX
89141		A	Sample stomach contents	0.85	7.07	6.01	0.52	0.47	0.03	XXX
89220		A	Sputum specimen collection	0.00	0.38	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
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.44	0.41	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.12	0.12	0.04	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.18	0.18	0.07	0.08	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.11	0.11	0.04	0.05	0.01	ZZZ
90471		A	Immunization admin	0.17	0.44	0.41	NA	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.12	0.12	0.04	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.18	0.18	0.04	0.05	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.11	0.11	0.04	0.05	0.01	ZZZ
90760		A	Hydration iv infusion, init	0.17	1.33	1.36	NA	NA	0.07	XXX
90761		A	Hydrate iv infusion, add-on	0.09	0.32	0.34	NA	NA	0.04	ZZZ
90765		A	Ther/proph/diag iv inf, init	0.21	1.64	1.67	NA	NA	0.07	XXX
90766		A	Ther/proph/dg iv inf, add-on	0.18	0.38	0.40	NA	NA	0.04	ZZZ

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90767		A	Tx/proph/dg addl seq iv inf	0.19	0.69	0.74	NA	NA	0.04	ZZZ
90768		A	Ther/diag concurrent inf	0.17	0.34	0.36	NA	NA	0.04	ZZZ
90769		A	Sc ther infusion, up to 1 hr	0.21	3.95	3.95	NA	NA	0.06	XXX
90770		A	Sc ther infusion, addl hr	0.18	0.22	0.22	NA	NA	0.04	ZZZ
90771		A	Sc ther infusion, reset pump	0.00	2.11	2.11	NA	NA	0.01	ZZZ
90772		A	Ther/proph/diag inj, sc/im	0.17	0.44	0.41	NA	NA	0.01	XXX
90773		A	Ther/proph/diag inj, ia	0.17	0.31	0.31	NA	NA	0.02	XXX
90774		A	Ther/proph/diag inj, iv push	0.18	1.33	1.33	NA	NA	0.04	XXX
90775		A	Tx/pro/dx inj new drug addon	0.10	0.52	0.53	NA	NA	0.04	ZZZ
90779		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.49	1.41	0.60	0.68	0.06	XXX
90802		A	Intac psy dx interview	3.01	1.54	1.46	0.64	0.73	0.07	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.56	0.54	0.22	0.26	0.03	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.60	0.57	0.24	0.28	0.03	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.53	0.57	0.33	0.40	0.04	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.70	0.35	0.42	0.05	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.70	0.78	0.50	0.60	0.06	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.85	0.89	0.52	0.62	0.07	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.54	0.53	0.23	0.28	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.71	0.68	0.26	0.31	0.04	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.66	0.69	0.35	0.42	0.04	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.83	0.82	0.37	0.45	0.05	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.88	0.94	0.59	0.69	0.06	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	0.99	1.01	0.53	0.64	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	0.35	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	0.46	0.51	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	0.62	0.71	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	0.37	0.40	0.04	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	NA	0.47	0.53	0.05	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	NA	0.48	0.53	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	0.64	0.73	0.07	XXX
90845		A	Psychoanalysis	1.79	0.39	0.44	0.32	0.38	0.04	XXX
90846		R	Family psytx w/o patient	1.83	0.52	0.55	0.43	0.48	0.04	XXX
90847		R	Family psytx w/patient	2.21	0.74	0.76	0.50	0.56	0.05	XXX
90849		R	Multiple family group psytx	0.59	0.32	0.31	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	0.36	0.34	0.21	0.22	0.01	XXX
90862		A	Medication management	0.95	0.62	0.57	0.27	0.28	0.02	XXX
90865		A	Narcosynthesis	2.84	1.32	1.33	0.65	0.71	0.12	XXX

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90870		A	Electroconvulsive therapy	1.88	1.92	1.92	0.38	0.43	0.04	000
90875		N	Psychophysiological therapy	1.20	0.67	0.73	0.38	0.40	0.04	XXX
90876		N	Psychophysiological therapy	1.90	0.87	0.95	0.60	0.64	0.05	XXX
90880		A	Hypnotherapy	2.19	0.58	0.70	0.40	0.47	0.05	XXX
90885		B	Psy evaluation of records	0.97	0.31	0.32	0.31	0.32	0.02	XXX
90887		B	Consultation with family	1.48	0.78	0.79	0.47	0.49	0.04	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	0.10	0.11	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.39	1.43	0.30	0.30	0.06	000
90918		I	ESRD related services, month	11.16	5.98	6.02	4.89	5.21	0.36	XXX
90919		I	ESRD related services, month	8.53	3.93	3.95	3.39	3.54	0.29	XXX
90920		I	ESRD related services, month	7.26	3.52	3.59	2.99	3.19	0.23	XXX
90921		I	ESRD related services, month	4.46	2.20	2.26	2.09	2.18	0.14	XXX
90922		I	ESRD related services, day	0.37	0.20	0.20	0.16	0.18	0.01	XXX
90923		I	Esrd related services, day	0.28	0.13	0.13	0.11	0.12	0.01	XXX
90924		I	Esrd related services, day	0.24	0.11	0.11	0.10	0.10	0.01	XXX
90925		I	Esrd related services, day	0.15	0.07	0.07	0.07	0.07	0.01	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.53	0.57	0.04	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	0.77	0.82	0.07	000
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.55	0.58	0.04	000
90947		A	Dialysis, repeated eval	2.16	NA	NA	0.78	0.83	0.07	000
90997		A	Hemoperfusion	1.84	NA	NA	0.50	0.54	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	2.15	1.69	2.15	1.69	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.93	1.47	1.93	1.47	0.01	000
91000	26	A	Esophageal intubation	0.73	0.22	0.23	0.22	0.23	0.03	000
91010		A	Esophagus motility study	1.25	3.68	3.87	3.68	3.87	0.12	000
91010	TC	A	Esophagus motility study	0.00	3.13	3.34	3.13	3.34	0.06	000
91010	26	A	Esophagus motility study	1.25	0.55	0.52	0.55	0.52	0.06	000
91011		A	Esophagus motility study	1.50	5.45	5.40	5.45	5.40	0.13	000
91011	TC	A	Esophagus motility study	0.00	4.72	4.72	4.72	4.72	0.06	000
91011	26	A	Esophagus motility study	1.50	0.73	0.68	0.73	0.68	0.07	000
91012		A	Esophagus motility study	1.46	5.47	5.55	5.47	5.55	0.13	000
91012	TC	A	Esophagus motility study	0.00	4.79	4.91	4.79	4.91	0.07	000
91012	26	A	Esophagus motility study	1.46	0.68	0.64	0.68	0.64	0.06	000
91020		A	Gastric motility studies	1.44	4.89	4.80	4.89	4.80	0.13	000
91020	TC	A	Gastric motility studies	0.00	4.26	4.21	4.26	4.21	0.06	000
91020	26	A	Gastric motility studies	1.44	0.63	0.59	0.63	0.59	0.07	000
91022		A	Duodenal motility study	1.44	3.37	3.63	3.37	3.63	0.13	000
91022	TC	A	Duodenal motility study	0.00	2.67	2.98	2.67	2.98	0.06	000
91022	26	A	Duodenal motility study	1.44	0.69	0.65	0.69	0.65	0.07	000
91030		A	Acid perfusion of esophagus	0.91	3.00	2.86	3.00	2.86	0.06	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.55	2.45	2.55	2.45	0.02	000
91030	26	A	Acid perfusion of esophagus	0.91	0.44	0.41	0.44	0.41	0.04	000

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91034		A	Gastroesophageal reflux test	0.97	4.12	4.41	4.12	4.41	0.12	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.71	4.01	3.71	4.01	0.06	000
91034	26	A	Gastroesophageal reflux test	0.97	0.41	0.39	0.41	0.39	0.06	000
91035		A	G-esoph reflx tst w/electrod	1.59	11.44	11.29	11.44	11.29	0.12	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.73	10.62	10.73	10.62	0.06	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.71	0.67	0.71	0.67	0.06	000
91037		A	Esoph imped function test	0.97	3.46	3.33	3.46	3.33	0.12	000
91037	TC	A	Esoph imped function test	0.00	3.02	2.91	3.02	2.91	0.06	000
91037	26	A	Esoph imped function test	0.97	0.44	0.41	0.44	0.41	0.06	000
91038		A	Esoph imped funct test > 1h	1.10	2.81	2.67	2.81	2.67	0.12	000
91038	TC	A	Esoph imped funct test > 1h	0.00	2.31	2.19	2.31	2.19	0.06	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.50	0.48	0.50	0.48	0.06	000
91040		A	Esoph balloon distension tst	0.97	8.83	9.42	8.83	9.42	0.12	000
91040	TC	A	Esoph balloon distension tst	0.00	8.33	8.95	8.33	8.95	0.06	000
91040	26	A	Esoph balloon distension tst	0.97	0.50	0.46	0.50	0.46	0.06	000
91052		A	Gastric analysis test	0.79	2.58	2.55	2.58	2.55	0.05	000
91052	TC	A	Gastric analysis test	0.00	2.28	2.25	2.28	2.25	0.02	000
91052	26	A	Gastric analysis test	0.79	0.30	0.30	0.30	0.30	0.03	000
91055		A	Gastric intubation for smear	0.94	2.53	2.63	2.53	2.63	0.07	000
91055	TC	A	Gastric intubation for smear	0.00	2.24	2.35	2.24	2.35	0.02	000
91055	26	A	Gastric intubation for smear	0.94	0.29	0.28	0.29	0.28	0.05	000
91065		A	Breath hydrogen test	0.20	1.63	1.59	1.63	1.59	0.03	000
91065	TC	A	Breath hydrogen test	0.00	1.55	1.51	1.55	1.51	0.02	000
91065	26	A	Breath hydrogen test	0.20	0.08	0.08	0.08	0.08	0.01	000
91100		A	Pass intestine bleeding tube	1.08	2.11	2.28	0.27	0.27	0.07	000
91105		A	Gastric intubation treatment	0.37	1.69	1.79	0.07	0.07	0.03	000
91110		A	Gi tract capsule endoscopy	3.64	20.80	21.17	NA	NA	0.16	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	19.11	19.58	NA	NA	0.07	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.69	1.58	1.69	1.58	0.09	XXX
91111		A	Esophageal capsule endoscopy	1.00	18.77	18.77	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	18.32	18.32	NA	NA	0.02	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.45	0.45	0.45	0.45	0.03	XXX
91120		A	Rectal sensation test	0.97	9.19	9.65	9.19	9.65	0.11	XXX
91120	TC	A	Rectal sensation test	0.00	8.90	9.35	8.90	9.35	0.04	XXX
91120	26	A	Rectal sensation test	0.97	0.29	0.31	0.29	0.31	0.07	XXX
91122		A	Anal pressure record	1.77	4.10	4.35	4.10	4.35	0.21	000
91122	TC	A	Anal pressure record	0.00	3.52	3.77	3.52	3.77	0.08	000
91122	26	A	Anal pressure record	1.77	0.58	0.59	0.58	0.59	0.13	000
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	0.25	0.24	0.25	0.24	0.02	XXX

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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	0.32	0.30	0.32	0.30	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	0.94	0.95	0.26	0.28	0.02	XXX
92004		A	Eye exam, new patient	1.82	1.59	1.62	0.56	0.59	0.04	XXX
92012		A	Eye exam established pat	0.92	1.00	1.01	0.31	0.31	0.02	XXX
92014		A	Eye exam & treatment	1.42	1.39	1.39	0.47	0.47	0.03	XXX
92015		N	Refraction	0.38	0.13	0.47	0.12	0.13	0.01	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	0.87	0.92	0.07	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.34	0.40	0.03	XXX
92020		A	Special eye evaluation	0.37	0.25	0.27	0.13	0.14	0.01	XXX
92025		A	Corneal topography	0.35	0.49	0.49	0.49	0.49	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.37	0.37	0.37	0.37	0.01	XXX
92025	26	A	Corneal topography	0.35	0.12	0.12	0.12	0.12	0.01	XXX
92060		A	Special eye evaluation	0.69	0.78	0.76	NA	NA	0.03	XXX
92060	TC	A	Special eye evaluation	0.00	0.55	0.52	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.23	0.24	0.23	0.24	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	0.77	0.68	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.09	0.10	0.09	0.10	0.01	XXX
92070		A	Fitting of contact lens	0.70	0.91	0.95	0.23	0.25	0.02	XXX
92081		A	Visual field examination(s)	0.36	0.96	0.96	NA	NA	0.02	XXX
92081	TC	A	Visual field examination(s)	0.00	0.85	0.84	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.11	0.12	0.11	0.12	0.01	XXX
92082		A	Visual field examination(s)	0.44	1.33	1.31	NA	NA	0.02	XXX
92082	TC	A	Visual field examination(s)	0.00	1.19	1.15	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.14	0.15	0.14	0.15	0.01	XXX
92083		A	Visual field examination(s)	0.50	1.53	1.50	NA	NA	0.02	XXX
92083	TC	A	Visual field examination(s)	0.00	1.36	1.32	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.17	0.18	0.17	0.18	0.01	XXX
92100		A	Serial tonometry exam(s)	0.92	1.27	1.29	0.29	0.30	0.02	XXX
92120		A	Tonography & eye evaluation	0.81	0.98	1.00	0.25	0.27	0.02	XXX
92130		A	Water provocation tonography	0.81	1.17	1.20	0.27	0.29	0.02	XXX
92135		A	Ophth dx imaging post seg	0.35	0.80	0.80	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.68	0.67	NA	NA	0.01	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.12	0.13	0.12	0.13	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.43	1.49	NA	NA	0.08	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.24	1.28	NA	NA	0.07	XXX
92136	26	A	Ophthalmic biometry	0.54	0.20	0.21	0.20	0.21	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	0.91	0.93	0.15	0.17	0.01	XXX
92225		A	Special eye exam, initial	0.38	0.24	0.23	0.12	0.13	0.01	XXX

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92226		A	Special eye exam, subsequent	0.33	0.23	0.23	0.12	0.12	0.01	XXX
92230		A	Eye exam with photos	0.60	0.69	0.90	0.19	0.20	0.02	XXX
92235		A	Eye exam with photos	0.81	2.28	2.36	NA	NA	0.08	XXX
92235	TC	A	Eye exam with photos	0.00	1.99	2.05	NA	NA	0.06	XXX
92235	26	A	Eye exam with photos	0.81	0.29	0.31	0.29	0.31	0.02	XXX
92240		A	Icg angiography	1.10	4.42	4.85	NA	NA	0.09	XXX
92240	TC	A	Icg angiography	0.00	4.02	4.42	NA	NA	0.06	XXX
92240	26	A	Icg angiography	1.10	0.40	0.42	0.40	0.42	0.03	XXX
92250		A	Eye exam with photos	0.44	1.30	1.36	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.16	1.21	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.14	0.15	0.14	0.15	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	0.99	1.12	NA	NA	0.06	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.76	0.87	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	1.38	1.42	NA	NA	0.05	XXX
92270	TC	A	Electro-oculography	0.00	1.14	1.16	NA	NA	0.02	XXX
92270	26	A	Electro-oculography	0.81	0.24	0.26	0.24	0.26	0.03	XXX
92275		A	Electroretinography	1.01	2.46	2.33	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.10	1.96	NA	NA	0.02	XXX
92275	26	A	Electroretinography	1.01	0.36	0.38	0.36	0.38	0.03	XXX
92283		A	Color vision examination	0.17	1.01	0.97	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	0.96	0.91	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.05	0.06	0.05	0.06	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.10	1.30	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.03	1.23	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.06	0.07	0.06	0.07	0.01	XXX
92285		A	Eye photography	0.20	0.80	0.85	NA	NA	0.02	XXX
92285	TC	A	Eye photography	0.00	0.73	0.77	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.07	0.07	0.07	0.07	0.01	XXX
92286		A	Internal eye photography	0.66	2.10	2.34	NA	NA	0.04	XXX
92286	TC	A	Internal eye photography	0.00	1.88	2.10	NA	NA	0.02	XXX
92286	26	A	Internal eye photography	0.66	0.22	0.24	0.22	0.24	0.02	XXX
92287		A	Internal eye photography	0.81	1.92	2.04	0.28	0.29	0.02	XXX
92310		N	Contact lens fitting	1.17	1.27	1.23	0.37	0.39	0.04	XXX
92311		A	Contact lens fitting	1.08	1.29	1.24	0.31	0.32	0.03	XXX
92312		A	Contact lens fitting	1.26	1.48	1.38	0.34	0.38	0.03	XXX
92313		A	Contact lens fitting	0.92	1.42	1.33	0.31	0.30	0.02	XXX
92314		N	Prescription of contact lens	0.69	1.33	1.23	0.22	0.23	0.01	XXX
92315		A	Prescription of contact lens	0.45	1.30	1.19	0.13	0.14	0.01	XXX
92316		A	Prescription of contact lens	0.68	1.63	1.45	0.22	0.24	0.02	XXX
92317		A	Prescription of contact lens	0.45	1.36	1.25	0.12	0.13	0.01	XXX
92325		A	Modification of contact lens	0.00	0.84	0.73	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.74	0.96	NA	NA	0.06	XXX

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92340		N	Fitting of spectacles	0.37	0.52	0.57	0.12	0.12	0.01	XXX
92341		N	Fitting of spectacles	0.47	0.55	0.60	0.15	0.16	0.01	XXX
92342		N	Fitting of spectacles	0.53	0.57	0.62	0.17	0.18	0.01	XXX
92352		B	Special spectacles fitting	0.37	0.66	0.67	0.12	0.12	0.01	XXX
92353		B	Special spectacles fitting	0.50	0.70	0.71	0.16	0.17	0.02	XXX
92354		B	Special spectacles fitting	0.00	0.33	2.48	NA	NA	0.10	XXX
92355		B	Special spectacles fitting	0.00	0.52	1.48	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.28	0.45	NA	NA	0.05	XXX
92370		N	Repair & adjust spectacles	0.32	0.46	0.48	0.10	0.11	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.28	0.37	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	0.90	0.95	0.05	000
92504		A	Ear microscopy examination	0.18	0.60	0.57	0.06	0.07	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.49	3.27	0.27	0.30	0.03	XXX
92507		A	Speech/hearing therapy	0.52	1.21	1.18	0.15	0.17	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.56	0.55	0.09	0.10	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.12	3.17	0.67	0.70	0.03	000
92512		A	Nasal function studies	0.55	0.99	1.03	0.17	0.17	0.02	XXX
92516		A	Facial nerve function test	0.43	1.22	1.22	0.14	0.16	0.01	XXX
92520		A	Laryngeal function studies	0.75	0.95	0.84	0.24	0.27	0.03	XXX
92526		A	Oral function therapy	0.55	1.63	1.63	0.15	0.17	0.02	XXX
92541		A	Spontaneous nystagmus test	0.40	1.20	1.16	NA	NA	0.04	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	1.08	1.02	NA	NA	0.02	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.12	0.14	0.12	0.14	0.02	XXX
92542		A	Positional nystagmus test	0.33	1.36	1.31	NA	NA	0.03	XXX
92542	TC	A	Positional nystagmus test	0.00	1.26	1.19	NA	NA	0.02	XXX
92542	26	A	Positional nystagmus test	0.33	0.10	0.11	0.10	0.11	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.68	0.66	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.65	0.62	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	1.10	1.05	NA	NA	0.03	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	1.02	0.96	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	1.07	1.01	NA	NA	0.03	XXX
92545	TC	A	Oscillating tracking test	0.00	1.01	0.93	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	1.91	1.93	NA	NA	0.03	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.83	1.84	NA	NA	0.02	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.08	0.09	0.08	0.09	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.12	0.11	0.12	0.11	0.06	ZZZ
92548		A	Posturography	0.50	1.82	1.93	NA	NA	0.15	XXX
92548	TC	A	Posturography	0.00	1.67	1.75	NA	NA	0.13	XXX

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92548	26	A	Posturography	0.50	0.15	0.17	0.15	0.17	0.02	XXX
92551		N	Pure tone hearing test, air	0.00	0.29	0.29	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.61	0.57	NA	NA	0.04	XXX
92553		A	Audiometry, air & bone	0.00	0.77	0.74	NA	NA	0.06	XXX
92555		A	Speech threshold audiometry	0.00	0.41	0.41	NA	NA	0.04	XXX
92556		A	Speech audiometry, complete	0.00	0.65	0.63	NA	NA	0.06	XXX
92557		A	Comprehensive hearing test	0.60	0.29	0.52	0.20	0.45	0.12	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.73	0.73	NA	NA	0.06	XXX
92562		A	Loudness balance test	0.00	0.66	0.60	NA	NA	0.04	XXX
92563		A	Tone decay hearing test	0.00	0.58	0.53	NA	NA	0.04	XXX
92564		A	Sisi hearing test	0.00	0.51	0.50	NA	NA	0.05	XXX
92565		A	Stenger test, pure tone	0.00	0.29	0.32	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	0.15	0.04	XXX
92571		A	Filtered speech hearing test	0.00	0.44	0.42	NA	NA	0.04	XXX
92572		A	Staggered spondaic word test	0.00	0.60	0.47	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.18	0.96	NA	NA	0.02	XXX
92576		A	Synthetic sentence test	0.00	0.57	0.54	NA	NA	0.05	XXX
92577		A	Stenger test, speech	0.00	0.31	0.41	NA	NA	0.07	XXX
92579		A	Visual audiometry (vra)	0.70	0.35	0.44	0.23	0.36	0.06	XXX
92582		A	Conditioning play audiometry	0.00	1.20	1.08	NA	NA	0.06	XXX
92583		A	Select picture audiometry	0.00	0.83	0.85	NA	NA	0.08	XXX
92584		A	Electrocochleography	0.00	1.42	1.69	NA	NA	0.21	XXX
92585		A	Auditor evoke potent, compre	0.50	2.14	2.13	NA	NA	0.17	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.99	1.96	NA	NA	0.14	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.15	0.17	0.15	0.17	0.03	XXX
92586		A	Auditor evoke potent, limit	0.00	1.52	1.61	NA	NA	0.14	XXX
92587		A	Evoked auditory test	0.13	0.65	0.83	NA	NA	0.12	XXX
92587	TC	A	Evoked auditory test	0.00	0.61	0.79	NA	NA	0.11	XXX
92587	26	A	Evoked auditory test	0.13	0.04	0.04	0.04	0.04	0.01	XXX
92588		A	Evoked auditory test	0.36	1.14	1.26	NA	NA	0.14	XXX
92588	TC	A	Evoked auditory test	0.00	1.03	1.14	NA	NA	0.13	XXX
92588	26	A	Evoked auditory test	0.36	0.11	0.13	0.11	0.13	0.01	XXX
92596		A	Ear protector evaluation	0.00	1.02	0.91	NA	NA	0.06	XXX
92597		A	Oral speech device eval	0.86	1.99	1.92	0.28	0.32	0.03	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.25	1.82	0.75	1.44	0.07	XXX
92602		A	Reprogram cochlear implt < 7	1.30	0.88	1.26	0.42	0.92	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.19	1.43	0.74	1.09	0.07	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.78	0.92	0.41	0.65	0.07	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.61	4.23	NA	NA	0.05	XXX
92608		A	Ex for speech device rx addl	0.00	0.86	0.78	NA	NA	0.05	XXX
92609		A	Use of speech device service	0.00	2.46	2.24	NA	NA	0.04	XXX
92610		A	Evaluate swallowing function	0.00	1.69	2.13	NA	NA	0.08	XXX

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92611		A	Motion fluoroscopy/swallow	0.00	1.94	2.31	NA	NA	0.08	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.97	2.92	0.42	0.48	0.04	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.24	0.28	0.23	0.27	0.05	XXX
92614		A	Laryngoscopic sensory test	1.27	2.43	2.45	0.42	0.48	0.04	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.21	0.24	0.21	0.24	0.05	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.16	3.22	0.60	0.70	0.06	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.25	0.30	0.25	0.30	0.05	XXX
92620		A	Auditory function, 60 min	0.00	1.95	1.75	NA	NA	0.06	XXX
92621		A	Auditory function, + 15 min	0.00	0.44	0.39	NA	NA	0.06	ZZZ
92625		A	Tinnitus assessment	0.00	1.95	1.75	1.95	1.75	0.06	XXX
92626		A	Eval aud rehab status	0.00	2.01	2.06	NA	NA	0.06	XXX
92627		A	Eval aud status rehab add-on	0.00	0.46	0.48	0.46	0.48	0.02	ZZZ
92640		A	Aud brainstem implt programg	0.00	1.44	1.44	1.44	1.44	0.01	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	3.26	3.50	0.77	0.82	0.28	000
92953		A	Temporary external pacing	0.23	NA	NA	0.08	0.07	0.02	000
92960		A	Cardioversion electric, ext	2.25	4.37	4.87	1.45	1.38	0.07	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	2.46	2.37	0.29	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.42	1.33	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	1.76	1.64	0.23	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.61	1.50	0.21	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	3.83	3.58	0.50	000
92977		A	Dissolve clot, heart vessel	0.00	1.72	3.31	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	0.96	0.90	0.96	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	0.72	0.78	0.72	0.06	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	8.13	7.62	1.03	000
92981		A	Insert intracoronary stent	4.16	NA	NA	2.23	2.08	0.29	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	6.06	5.68	0.76	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.59	1.48	0.21	ZZZ
92986		A	Revision of aortic valve	22.70	NA	NA	15.24	14.40	1.51	090
92987		A	Revision of mitral valve	23.48	NA	NA	15.78	14.90	1.59	090
92990		A	Revision of pulmonary valve	18.12	NA	NA	11.91	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	6.69	6.26	0.84	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.74	1.63	0.10	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	5.28	5.17	0.40	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	2.96	2.77	0.28	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.35	0.39	0.35	0.39	0.03	XXX

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93005		A	Electrocardiogram, tracing	0.00	0.28	0.32	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	4.58	4.95	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	1.97	1.97	1.97	1.97	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	1.59	1.62	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	2.37	2.17	NA	NA	0.12	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.81	1.64	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	4.37	5.18	NA	NA	0.14	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.99	4.83	NA	NA	0.11	XXX
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	0.19	0.19	0.19	0.19	0.02	XXX
93041		A	Rhythm ECG, tracing	0.00	0.14	0.15	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	1.93	2.36	1.93	2.36	0.24	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.85	0.95	NA	NA	0.08	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	1.19	1.44	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
93230		A	ECG monitor/report, 24 hrs	0.52	1.75	2.29	1.75	2.29	0.26	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.71	0.92	NA	NA	0.11	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.34	1.56	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	0.77	2.45	0.77	2.45	0.28	XXX
93270		A	ECG recording	0.00	0.29	0.53	NA	NA	0.08	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.98	6.00	NA	NA	0.18	XXX
93272		A	Ecg/review, interpret only	0.52	0.22	0.21	0.22	0.21	0.02	XXX
93278		A	ECG/signal-averaged	0.25	0.63	0.78	NA	NA	0.12	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.52	0.68	NA	NA	0.11	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.10	0.10	0.01	XXX
93303		A	Echo transthoracic	1.30	4.72	4.63	NA	NA	0.27	XXX
93303	TC	A	Echo transthoracic	0.00	4.13	4.07	NA	NA	0.23	XXX
93303	26	A	Echo transthoracic	1.30	0.59	0.56	0.59	0.56	0.04	XXX
93304		A	Echo transthoracic	0.75	3.16	2.93	NA	NA	0.15	XXX
93304	TC	A	Echo transthoracic	0.00	2.85	2.62	NA	NA	0.13	XXX
93304	26	A	Echo transthoracic	0.75	0.31	0.30	0.31	0.30	0.02	XXX
93307		A	Echo exam of heart	0.92	3.74	3.86	NA	NA	0.26	XXX
93307	TC	A	Echo exam of heart	0.00	3.28	3.43	NA	NA	0.23	XXX
93307	26	A	Echo exam of heart	0.92	0.46	0.43	0.46	0.43	0.03	XXX

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93308		A	Echo exam of heart	0.53	2.63	2.51	NA	NA	0.15	XXX
93308	TC	A	Echo exam of heart	0.00	2.36	2.26	NA	NA	0.13	XXX
93308	26	A	Echo exam of heart	0.53	0.27	0.25	0.27	0.25	0.02	XXX
93312		A	Echo transesophageal	2.20	7.40	6.70	NA	NA	0.37	XXX
93312	TC	A	Echo transesophageal	0.00	6.42	5.77	NA	NA	0.29	XXX
93312	26	A	Echo transesophageal	2.20	0.98	0.93	0.98	0.93	0.08	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.12	0.14	0.06	XXX
93314		A	Echo transesophageal	1.25	7.13	6.42	NA	NA	0.33	XXX
93314	TC	A	Echo transesophageal	0.00	6.59	5.89	NA	NA	0.29	XXX
93314	26	A	Echo transesophageal	1.25	0.54	0.52	0.54	0.52	0.04	XXX
93315		C	Echo transesophageal	0.00	NA	NA	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	NA	NA	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.31	1.24	1.31	1.24	0.09	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.26	0.25	0.05	XXX
93317		C	Echo transesophageal	0.00	NA	NA	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	NA	NA	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	0.86	0.76	0.86	0.76	0.14	XXX
93320		A	Doppler echo exam, heart	0.38	1.68	1.72	1.68	1.72	0.13	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.49	1.55	1.49	1.55	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	0.61	0.75	0.61	0.75	0.09	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.54	0.68	0.54	0.68	0.08	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.07	0.07	0.07	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.67	1.24	0.67	1.24	0.22	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.63	1.20	0.63	1.20	0.21	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.03	0.03	0.01	ZZZ
93350		A	Echo transthoracic	1.48	5.10	4.41	NA	NA	0.18	XXX
93350	TC	A	Echo transthoracic	0.00	4.33	3.69	NA	NA	0.13	XXX
93350	26	A	Echo transthoracic	1.48	0.76	0.71	0.76	0.71	0.05	XXX
93501		A	Right heart catheterization	3.02	18.85	18.67	NA	NA	1.27	000
93501	TC	A	Right heart catheterization	0.00	17.28	17.20	NA	NA	1.06	000
93501	26	A	Right heart catheterization	3.02	1.57	1.47	1.57	1.47	0.21	000
93503		A	Insert/place heart catheter	2.91	NA	NA	NA	NA	0.20	000
93505		A	Biopsy of heart lining	4.37	20.89	16.59	NA	NA	0.46	000
93505	TC	A	Biopsy of heart lining	0.00	18.61	14.46	NA	NA	0.16	000
93505	26	A	Biopsy of heart lining	4.37	2.27	2.13	2.27	2.13	0.30	000
93508		A	Cath placement, angiography	4.09	28.98	25.42	NA	NA	0.93	000
93508	TC	A	Cath placement, angiography	0.00	26.81	23.27	NA	NA	0.65	000
93508	26	A	Cath placement, angiography	4.09	2.17	2.15	2.17	2.15	0.28	000
93510		A	Left heart catheterization	4.32	28.30	31.05	NA	NA	2.61	000
93510	TC	A	Left heart catheterization	0.00	26.02	28.79	NA	NA	2.31	000

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93510	26	A	Left heart catheterization	4.32	2.28	2.26	2.28	2.26	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	2.66	2.61	2.66	2.61	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	3.53	3.43	3.53	3.43	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	3.71	3.58	3.71	3.58	0.48	000
93526		A	Rt & Lt heart catheters	5.98	35.30	39.25	NA	NA	3.46	000
93526	TC	A	Rt & Lt heart catheters	0.00	32.13	36.17	NA	NA	3.04	000
93526	26	A	Rt & Lt heart catheters	5.98	3.17	3.08	3.17	3.08	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	3.84	3.71	3.84	3.71	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	3.98	4.00	3.98	4.00	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	2.56	2.49	2.56	2.49	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	1.98	1.97	1.98	1.97	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	3.80	3.75	3.80	3.75	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	4.37	4.34	4.37	4.34	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	3.03	2.98	3.03	2.98	0.47	000
93539		A	Injection, cardiac cath	0.40	2.47	1.89	0.21	0.20	0.01	000
93540		A	Injection, cardiac cath	0.43	8.61	6.50	0.23	0.22	0.01	000
93541		A	Injection for lung angiogram	0.29	0.16	0.14	0.16	0.14	0.01	000
93542		A	Injection for heart x-rays	0.29	5.18	3.91	0.15	0.14	0.01	000
93543		A	Injection for heart x-rays	0.29	2.62	1.99	0.16	0.15	0.01	000
93544		A	Injection for aortography	0.25	1.84	1.41	0.13	0.12	0.01	000
93545		A	Inject for coronary x-rays	0.40	5.86	4.44	0.21	0.20	0.01	000
93555		A	Imaging, cardiac cath	0.81	0.59	2.10	NA	NA	0.37	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.17	1.70	NA	NA	0.34	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.43	0.40	0.43	0.40	0.03	XXX

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93556		A	Imaging, cardiac cath	0.83	0.88	3.22	NA	NA	0.54	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.44	2.81	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	0.95	0.89	0.95	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	0.72	0.67	0.72	0.67	0.04	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	9.48	8.96	1.25	000
93581		A	Transcath closure of vsd	24.39	NA	NA	11.57	11.04	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	1.09	1.02	1.09	1.02	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	1.06	1.00	1.06	1.00	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	1.06	1.00	1.06	1.00	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	2.60	2.44	2.60	2.44	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	1.50	1.41	1.50	1.41	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	1.46	1.39	1.46	1.39	0.25	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	3.69	3.46	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	0.46	0.53	0.46	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	0.32	0.35	0.32	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

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93618	26	A	Heart rhythm pacing	4.25	2.29	2.14	2.29	2.14	0.30	000
93619		C	Electrophysiology evaluation	0.00	NA	NA	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	NA	NA	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	3.89	3.72	3.89	3.72	0.51	000
93620		C	Electrophysiology evaluation	0.00	NA	NA	0.00	0.00	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	NA	NA	0.00	0.00	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	6.07	5.77	6.07	5.77	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	1.10	1.03	1.10	1.03	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	1.57	1.48	1.57	1.48	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	1.49	1.40	1.49	1.40	0.20	ZZZ
93624		C	Electrophysiologic study	0.00	NA	NA	0.00	0.00	0.00	000
93624	TC	C	Electrophysiologic study	0.00	NA	NA	0.00	0.00	0.00	000
93624	26	A	Electrophysiologic study	4.80	2.53	2.45	2.53	2.45	0.33	000
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	2.57	2.63	2.57	2.63	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	1.82	1.70	1.82	1.70	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	3.10	2.91	3.10	2.91	0.41	000
93642		A	Electrophysiology evaluation	4.88	7.34	7.86	7.34	7.86	0.57	000
93642	TC	A	Electrophysiology evaluation	0.00	4.76	5.37	4.76	5.37	0.42	000
93642	26	A	Electrophysiology evaluation	4.88	2.58	2.49	2.58	2.49	0.15	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	5.77	5.44	0.73	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	8.51	7.97	1.13	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	9.27	8.68	1.23	000
93660		A	Tilt table evaluation	1.89	3.02	2.87	3.02	2.87	0.08	000
93660	TC	A	Tilt table evaluation	0.00	2.04	1.95	2.04	1.95	0.02	000
93660	26	A	Tilt table evaluation	1.89	0.98	0.92	0.98	0.92	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	1.46	1.38	1.46	1.38	0.09	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.48	0.48	NA	NA	0.01	XXX
93701		A	Bioimpedance, thoracic	0.17	0.70	0.77	NA	NA	0.02	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.64	0.71	NA	NA	0.01	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.06	0.06	0.06	0.06	0.01	XXX

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93720		A	Total body plethysmography	0.17	1.29	1.16	1.29	1.16	0.07	XXX
93721		A	Plethysmography tracing	0.00	1.14	1.03	NA	NA	0.06	XXX
93722		A	Plethysmography report	0.17	0.04	0.04	0.04	0.04	0.01	XXX
93724		A	Analyze pacemaker system	4.88	3.42	4.04	3.42	4.04	0.39	000
93724	TC	A	Analyze pacemaker system	0.00	0.90	1.67	0.90	1.67	0.24	000
93724	26	A	Analyze pacemaker system	4.88	2.51	2.37	2.51	2.37	0.15	000
93727		A	Analyze ilr system	0.52	0.64	0.53	0.64	0.53	0.02	XXX
93731		A	Analyze pacemaker system	0.45	0.79	0.76	NA	NA	0.05	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.55	0.53	NA	NA	0.04	XXX
93731	26	A	Analyze pacemaker system	0.45	0.24	0.22	0.24	0.22	0.01	XXX
93732		A	Analyze pacemaker system	0.92	1.15	1.08	NA	NA	0.07	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.67	0.63	NA	NA	0.04	XXX
93732	26	A	Analyze pacemaker system	0.92	0.48	0.45	0.48	0.45	0.03	XXX
93733		A	Telephone analy, pacemaker	0.17	0.92	0.89	NA	NA	0.07	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.85	0.82	NA	NA	0.06	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.08	0.08	0.08	0.08	0.01	XXX
93734		A	Analyze pacemaker system	0.38	0.70	0.65	NA	NA	0.03	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.50	0.46	NA	NA	0.02	XXX
93734	26	A	Analyze pacemaker system	0.38	0.20	0.18	0.20	0.18	0.01	XXX
93735		A	Analyze pacemaker system	0.74	0.96	0.90	NA	NA	0.06	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.57	0.54	NA	NA	0.04	XXX
93735	26	A	Analyze pacemaker system	0.74	0.39	0.36	0.39	0.36	0.02	XXX
93736		A	Telephonic analy, pacemaker	0.15	0.90	0.85	NA	NA	0.07	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.84	0.78	NA	NA	0.06	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.07	0.07	0.07	0.07	0.01	XXX
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
93741		A	Analyze ht pace device sngl	0.80	1.01	1.00	NA	NA	0.07	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.59	0.61	NA	NA	0.04	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.42	0.39	0.42	0.39	0.03	XXX
93742		A	Analyze ht pace device sngl	0.91	1.15	1.12	NA	NA	0.07	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.67	0.67	NA	NA	0.04	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.48	0.45	0.48	0.45	0.03	XXX
93743		A	Analyze ht pace device dual	1.03	1.19	1.17	NA	NA	0.07	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.64	0.67	NA	NA	0.04	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.55	0.51	0.55	0.51	0.03	XXX
93744		A	Analyze ht pace device dual	1.18	1.34	1.29	NA	NA	0.08	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.72	0.71	NA	NA	0.04	XXX
93744	26	A	Analyze ht pace device dual	1.18	0.63	0.59	0.63	0.59	0.04	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

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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	1.10	1.21	1.10	1.21	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.82	0.84	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.45	0.47	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.14	0.14	0.14	0.14	0.01	XXX
93797		A	Cardiac rehab	0.18	0.32	0.31	0.09	0.08	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.44	0.45	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
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.59	2.53	NA	NA	0.12	XXX
93875	TC	A	Extracranial study	0.00	2.52	2.45	NA	NA	0.11	XXX
93875	26	A	Extracranial study	0.22	0.07	0.07	0.07	0.07	0.01	XXX
93880		A	Extracranial study	0.60	6.20	6.05	NA	NA	0.39	XXX
93880	TC	A	Extracranial study	0.00	5.99	5.84	NA	NA	0.35	XXX
93880	26	A	Extracranial study	0.60	0.21	0.21	0.21	0.21	0.04	XXX
93882		A	Extracranial study	0.40	4.10	3.96	NA	NA	0.26	XXX
93882	TC	A	Extracranial study	0.00	3.99	3.84	NA	NA	0.22	XXX
93882	26	A	Extracranial study	0.40	0.11	0.12	0.11	0.12	0.04	XXX
93886		A	Intracranial study	0.94	7.10	7.02	NA	NA	0.45	XXX
93886	TC	A	Intracranial study	0.00	6.82	6.72	NA	NA	0.39	XXX
93886	26	A	Intracranial study	0.94	0.27	0.30	0.27	0.30	0.06	XXX
93888		A	Intracranial study	0.62	5.01	4.82	NA	NA	0.32	XXX
93888	TC	A	Intracranial study	0.00	4.81	4.61	NA	NA	0.27	XXX
93888	26	A	Intracranial study	0.62	0.20	0.21	0.20	0.21	0.05	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.27	5.93	NA	NA	0.45	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	5.99	5.62	NA	NA	0.39	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.29	0.32	0.29	0.32	0.06	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	6.92	6.48	NA	NA	0.45	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	6.60	6.13	NA	NA	0.39	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.31	0.35	0.31	0.35	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	6.97	6.49	NA	NA	0.45	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	6.64	6.12	NA	NA	0.39	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.33	0.36	0.33	0.36	0.06	XXX
93922		A	Extremity study	0.25	3.13	3.02	NA	NA	0.15	XXX
93922	TC	A	Extremity study	0.00	3.05	2.94	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	4.72	4.56	NA	NA	0.26	XXX
93923	TC	A	Extremity study	0.00	4.58	4.41	NA	NA	0.22	XXX
93923	26	A	Extremity study	0.45	0.14	0.14	0.14	0.14	0.04	XXX
93924		A	Extremity study	0.50	5.98	5.69	NA	NA	0.30	XXX
93924	TC	A	Extremity study	0.00	5.81	5.52	NA	NA	0.25	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.17	0.17	0.05	XXX

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93925		A	Lower extremity study	0.58	8.10	7.78	NA	NA	0.39	XXX
93925	TC	A	Lower extremity study	0.00	7.91	7.58	NA	NA	0.35	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.20	0.20	0.04	XXX
93926		A	Lower extremity study	0.39	5.18	4.90	NA	NA	0.27	XXX
93926	TC	A	Lower extremity study	0.00	5.06	4.78	NA	NA	0.23	XXX
93926	26	A	Lower extremity study	0.39	0.12	0.12	0.12	0.12	0.04	XXX
93930		A	Upper extremity study	0.46	6.26	6.04	NA	NA	0.41	XXX
93930	TC	A	Upper extremity study	0.00	6.11	5.89	NA	NA	0.37	XXX
93930	26	A	Upper extremity study	0.46	0.15	0.15	0.15	0.15	0.04	XXX
93931		A	Upper extremity study	0.31	4.22	4.04	NA	NA	0.27	XXX
93931	TC	A	Upper extremity study	0.00	4.12	3.94	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	3.03	2.97	NA	NA	0.14	XXX
93965	TC	A	Extremity study	0.00	2.92	2.86	NA	NA	0.12	XXX
93965	26	A	Extremity study	0.35	0.11	0.11	0.11	0.11	0.02	XXX
93970		A	Extremity study	0.68	6.26	6.01	NA	NA	0.46	XXX
93970	TC	A	Extremity study	0.00	6.04	5.79	NA	NA	0.40	XXX
93970	26	A	Extremity study	0.68	0.22	0.22	0.22	0.22	0.06	XXX
93971		A	Extremity study	0.45	4.10	3.98	NA	NA	0.30	XXX
93971	TC	A	Extremity study	0.00	3.95	3.83	NA	NA	0.27	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.15	0.15	0.03	XXX
93975		A	Vascular study	1.80	8.52	8.30	NA	NA	0.56	XXX
93975	TC	A	Vascular study	0.00	7.88	7.68	NA	NA	0.43	XXX
93975	26	A	Vascular study	1.80	0.64	0.63	0.64	0.63	0.13	XXX
93976		A	Vascular study	1.21	4.63	4.56	NA	NA	0.35	XXX
93976	TC	A	Vascular study	0.00	4.20	4.14	NA	NA	0.30	XXX
93976	26	A	Vascular study	1.21	0.43	0.43	0.43	0.43	0.05	XXX
93978		A	Vascular study	0.65	6.08	5.69	NA	NA	0.43	XXX
93978	TC	A	Vascular study	0.00	5.87	5.48	NA	NA	0.37	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.22	0.22	0.06	XXX
93979		A	Vascular study	0.44	4.21	3.96	NA	NA	0.27	XXX
93979	TC	A	Vascular study	0.00	4.06	3.81	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	3.68	3.48	NA	NA	0.42	XXX
93980	TC	A	Penile vascular study	0.00	3.21	3.02	NA	NA	0.34	XXX
93980	26	A	Penile vascular study	1.25	0.47	0.46	0.47	0.46	0.08	XXX
93981		A	Penile vascular study	0.44	2.88	2.88	NA	NA	0.33	XXX
93981	TC	A	Penile vascular study	0.00	2.73	2.73	NA	NA	0.31	XXX
93981	26	A	Penile vascular study	0.44	0.16	0.15	0.16	0.15	0.02	XXX
93982		R	Aneurysm pressure sens study	0.30	0.81	0.81	NA	NA	0.01	XXX
93990		A	Doppler flow testing	0.25	5.24	4.94	NA	NA	0.26	XXX
93990	TC	A	Doppler flow testing	0.00	5.18	4.86	NA	NA	0.23	XXX
93990	26	A	Doppler flow testing	0.25	0.06	0.07	0.06	0.07	0.03	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.35	0.34	0.09	XXX

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94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.31	0.31	0.06	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.23	0.23	0.04	XXX
94005		B	Home vent mgmt supervision	1.50	0.88	0.88	NA	NA	0.06	XXX
94010		A	Breathing capacity test	0.17	0.74	0.73	NA	NA	0.03	XXX
94010	TC	A	Breathing capacity test	0.00	0.70	0.68	NA	NA	0.02	XXX
94010	26	A	Breathing capacity test	0.17	0.04	0.05	0.04	0.05	0.01	XXX
94014		A	Patient recorded spirometry	0.52	0.81	0.80	0.81	0.80	0.03	XXX
94015		A	Patient recorded spirometry	0.00	0.67	0.65	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.14	0.14	0.14	0.14	0.02	XXX
94060		A	Evaluation of wheezing	0.31	1.32	1.26	1.32	1.26	0.07	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.24	1.18	1.24	1.18	0.06	XXX
94060	26	A	Evaluation of wheezing	0.31	0.07	0.08	0.07	0.08	0.01	XXX
94070		A	Evaluation of wheezing	0.60	1.01	0.96	NA	NA	0.13	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.85	0.80	NA	NA	0.10	XXX
94070	26	A	Evaluation of wheezing	0.60	0.15	0.16	0.15	0.16	0.03	XXX
94150		B	Vital capacity test	0.07	0.56	0.54	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.54	0.51	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.02	0.02	0.02	0.02	0.01	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.51	0.49	NA	NA	0.03	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.48	0.47	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	0.83	0.78	NA	NA	0.06	XXX
94240	TC	A	Residual lung capacity	0.00	0.76	0.72	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	0.52	0.55	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.49	0.52	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	0.76	0.72	NA	NA	0.05	XXX
94260	TC	A	Thoracic gas volume	0.00	0.73	0.68	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	0.64	0.67	NA	NA	0.05	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.57	0.60	NA	NA	0.04	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.96	0.90	NA	NA	0.07	XXX
94360	TC	A	Measure airflow resistance	0.00	0.90	0.83	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	0.61	0.64	NA	NA	0.03	XXX
94370	TC	A	Breath airway closing volume	0.00	0.55	0.57	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	0.72	0.69	NA	NA	0.03	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.65	0.62	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	1.04	0.99	NA	NA	0.09	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.94	0.89	NA	NA	0.06	XXX

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94400	26	A	CO2 breathing response curve	0.40	0.10	0.10	0.10	0.10	0.03	XXX
94450		A	Hypoxia response curve	0.40	1.00	0.96	NA	NA	0.04	XXX
94450	TC	A	Hypoxia response curve	0.00	0.91	0.87	NA	NA	0.02	XXX
94450	26	A	Hypoxia response curve	0.40	0.09	0.10	0.09	0.10	0.02	XXX
94452		A	Hast w/report	0.31	1.27	1.21	NA	NA	0.04	XXX
94452	TC	A	Hast w/report	0.00	1.20	1.13	NA	NA	0.02	XXX
94452	26	A	Hast w/report	0.31	0.07	0.07	0.07	0.07	0.02	XXX
94453		A	Hast w/oxygen titrate	0.40	1.68	1.64	NA	NA	0.04	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.58	1.53	NA	NA	0.02	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.10	0.10	0.10	0.10	0.02	XXX
94610		A	Surfactant admin thru tube	1.16	0.36	0.36	0.36	0.36	0.26	XXX
94620		A	Pulmonary stress test/simple	0.64	0.79	1.22	NA	NA	0.13	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.63	1.05	NA	NA	0.10	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.16	0.17	0.16	0.17	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.24	2.98	NA	NA	0.16	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.77	2.52	NA	NA	0.10	XXX
94621	26	A	Pulm stress test/complex	1.42	0.46	0.46	0.46	0.46	0.06	XXX
94640		A	Airway inhalation treatment	0.00	0.38	0.36	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	0.96	0.96	NA	NA	0.02	XXX
94645		A	Cbt, each addl hour	0.00	0.36	0.36	NA	NA	0.02	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.79	0.76	0.19	0.20	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.18	0.19	0.03	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.41	0.38	NA	NA	0.04	XXX
94667		A	Chest wall manipulation	0.00	0.54	0.54	NA	NA	0.05	XXX
94668		A	Chest wall manipulation	0.00	0.55	0.53	NA	NA	0.02	XXX
94680		A	Exhaled air analysis, o2	0.26	1.09	1.28	1.09	1.28	0.07	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.02	1.21	1.02	1.21	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	1.08	1.44	NA	NA	0.13	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	1.03	1.39	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	1.06	1.30	NA	NA	0.05	XXX
94690	TC	A	Exhaled air analysis	0.00	1.05	1.28	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	1.16	1.12	NA	NA	0.07	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.10	1.06	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	0.99	1.48	NA	NA	0.13	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.93	1.41	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	1.84	1.72	NA	NA	0.05	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.78	1.66	NA	NA	0.04	XXX
94750	26	A	Pulmonary compliance study	0.23	0.06	0.06	0.06	0.06	0.01	XXX

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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	0.82	0.73	NA	NA	0.10	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.83	0.81	NA	NA	0.08	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.79	0.77	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	0.31	0.31	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.54	0.54	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	0.10	0.11	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.31	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	0.17	0.19	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.24	0.97	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.73	0.64	0.73	0.64	0.02	XXX
95065		A	Nose allergy test	0.00	0.71	0.58	0.71	0.58	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.81	1.18	NA	NA	0.02	XXX
95071		A	Bronchial allergy tests	0.00	0.96	1.46	NA	NA	0.02	XXX
95075		A	Ingestion challenge test	0.95	0.70	0.73	0.28	0.30	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.23	0.27	NA	NA	0.02	XXX
95117		A	Immunotherapy injections	0.00	0.29	0.34	NA	NA	0.02	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	0.68	0.62	0.02	0.02	0.01	XXX
95147		A	Antigen therapy services	0.06	0.66	0.60	0.02	0.02	0.01	XXX
95148		A	Antigen therapy services	0.06	0.98	0.88	0.02	0.02	0.01	XXX
95149		A	Antigen therapy services	0.06	1.30	1.18	0.02	0.02	0.01	XXX
95165		A	Antigen therapy services	0.06	0.27	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	1.67	1.76	0.77	0.81	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	3.46	3.63	NA	NA	0.01	XXX

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95251		A	Gluc monitor, cont, phys i&r	0.85	0.23	0.22	0.23	0.22	0.02	XXX
95805		A	Multiple sleep latency test	1.88	6.95	9.55	NA	NA	0.43	XXX
95805	TC	A	Multiple sleep latency test	0.00	6.44	9.00	NA	NA	0.34	XXX
95805	26	A	Multiple sleep latency test	1.88	0.50	0.54	0.50	0.54	0.09	XXX
95806		A	Sleep study, unattended	1.66	4.01	3.84	NA	NA	0.39	XXX
95806	TC	A	Sleep study, unattended	0.00	3.54	3.36	NA	NA	0.31	XXX
95806	26	A	Sleep study, unattended	1.66	0.47	0.48	0.47	0.48	0.08	XXX
95807		A	Sleep study, attended	1.66	11.56	11.65	NA	NA	0.50	XXX
95807	TC	A	Sleep study, attended	0.00	11.14	11.20	NA	NA	0.42	XXX
95807	26	A	Sleep study, attended	1.66	0.42	0.45	0.42	0.45	0.08	XXX
95808		A	Polysomnography, 1-3	2.65	15.74	15.12	NA	NA	0.55	XXX
95808	TC	A	Polysomnography, 1-3	0.00	15.04	14.37	NA	NA	0.42	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.70	0.75	0.70	0.75	0.13	XXX
95810		A	Polysomnography, 4 or more	3.52	17.55	17.55	NA	NA	0.59	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.66	16.59	NA	NA	0.42	XXX
95810	26	A	Polysomnography, 4 or more	3.52	0.89	0.96	0.89	0.96	0.17	XXX
95811		A	Polysomnography w/cpap	3.79	19.54	19.47	NA	NA	0.61	XXX
95811	TC	A	Polysomnography w/cpap	0.00	18.59	18.44	NA	NA	0.43	XXX
95811	26	A	Polysomnography w/cpap	3.79	0.95	1.03	0.95	1.03	0.18	XXX
95812		A	Eeg, 41-60 minutes	1.08	5.87	5.41	NA	NA	0.17	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	5.57	5.08	NA	NA	0.11	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.30	0.34	0.30	0.34	0.06	XXX
95813		A	Eeg, over 1 hour	1.73	6.60	6.21	NA	NA	0.20	XXX
95813	TC	A	Eeg, over 1 hour	0.00	6.12	5.68	NA	NA	0.11	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.48	0.53	0.48	0.53	0.09	XXX
95816		A	Eeg, awake and drowsy	1.08	5.25	4.87	NA	NA	0.16	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	4.95	4.53	NA	NA	0.10	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.30	0.34	0.30	0.34	0.06	XXX
95819		A	Eeg, awake and asleep	1.08	6.11	5.33	NA	NA	0.16	XXX
95819	TC	A	Eeg, awake and asleep	0.00	5.81	4.99	NA	NA	0.10	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.30	0.34	0.30	0.34	0.06	XXX
95822		A	Eeg, coma or sleep only	1.08	5.48	5.26	NA	NA	0.19	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	5.18	4.92	NA	NA	0.13	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.30	0.34	0.30	0.34	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	0.20	0.23	0.20	0.23	0.04	XXX
95827		A	Eeg, all night recording	1.08	11.57	9.36	NA	NA	0.19	XXX
95827	TC	A	Eeg, all night recording	0.00	11.28	9.03	NA	NA	0.14	XXX
95827	26	A	Eeg, all night recording	1.08	0.30	0.33	0.30	0.33	0.05	XXX
95829		A	Surgery electrocorticogram	6.20	25.69	27.05	NA	NA	0.50	XXX
95829	TC	A	Surgery electrocorticogram	0.00	23.90	25.13	NA	NA	0.02	XXX
95829	26	A	Surgery electrocorticogram	6.20	1.79	1.92	1.79	1.92	0.48	XXX
95830		A	Insert electrodes for EEG	1.70	2.98	3.06	0.45	0.52	0.11	XXX

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95831		A	Limb muscle testing, manual	0.28	0.40	0.42	0.09	0.10	0.01	XXX
95832		A	Hand muscle testing, manual	0.29	0.37	0.36	0.10	0.10	0.02	XXX
95833		A	Body muscle testing, manual	0.47	0.45	0.48	0.12	0.15	0.02	XXX
95834		A	Body muscle testing, manual	0.60	0.49	0.52	0.15	0.18	0.03	XXX
95851		A	Range of motion measurements	0.16	0.26	0.28	0.04	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.23	0.24	0.04	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.58	0.59	0.16	0.18	0.02	XXX
95860		A	Muscle test, one limb	0.96	1.15	1.22	NA	NA	0.07	XXX
95860	TC	A	Muscle test, one limb	0.00	0.83	0.87	NA	NA	0.02	XXX
95860	26	A	Muscle test, one limb	0.96	0.31	0.34	0.31	0.34	0.05	XXX
95861		A	Muscle test, 2 limbs	1.54	1.65	1.59	NA	NA	0.13	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.15	1.04	NA	NA	0.06	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.50	0.55	0.50	0.55	0.07	XXX
95863		A	Muscle test, 3 limbs	1.87	1.90	1.86	NA	NA	0.15	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.34	1.24	NA	NA	0.06	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.56	0.62	0.56	0.62	0.09	XXX
95864		A	Muscle test, 4 limbs	1.99	2.12	2.26	NA	NA	0.21	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.52	1.59	NA	NA	0.12	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.60	0.67	0.60	0.67	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	0.91	0.85	NA	NA	0.03	XXX
95865	26	A	Muscle test, larynx	1.57	0.50	0.57	0.50	0.57	0.08	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.34	1.19	NA	NA	0.10	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	0.94	0.75	NA	NA	0.03	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.40	0.44	0.40	0.44	0.07	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.14	1.09	NA	NA	0.07	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.90	0.82	NA	NA	0.04	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.24	0.27	0.24	0.27	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.45	1.39	NA	NA	0.10	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.10	1.00	NA	NA	0.05	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.35	0.39	0.35	0.39	0.05	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.02	0.86	NA	NA	0.04	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.90	0.73	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	0.98	0.83	NA	NA	0.04	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.86	0.70	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	1.63	1.53	NA	NA	0.13	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.76	0.72	NA	NA	0.05	XXX
95872	26	A	Muscle test, one fiber	2.88	0.88	0.81	0.88	0.81	0.08	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.04	0.87	1.04	0.87	0.04	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	0.89	0.72	0.89	0.72	0.02	ZZZ

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95873	26	A	Guide nerv destr, elec stim	0.37	0.15	0.15	0.15	0.15	0.02	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	0.94	0.80	0.94	0.80	0.04	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	0.82	0.67	0.82	0.67	0.02	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.12	0.13	0.12	0.13	0.02	ZZZ
95875		A	Limb exercise test	1.10	1.31	1.35	NA	NA	0.11	XXX
95875	TC	A	Limb exercise test	0.00	1.00	0.99	NA	NA	0.06	XXX
95875	26	A	Limb exercise test	1.10	0.32	0.35	0.32	0.35	0.05	XXX
95900		A	Motor nerve conduction test	0.42	0.93	1.01	NA	NA	0.04	XXX
95900	TC	A	Motor nerve conduction test	0.00	0.79	0.86	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	1.02	1.07	NA	NA	0.05	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.85	0.87	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	0.86	0.92	NA	NA	0.04	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.76	0.80	NA	NA	0.02	XXX
95904	26	A	Sense nerve conduction test	0.34	0.10	0.12	0.10	0.12	0.02	XXX
95920		A	Intraop nerve test add-on	2.11	1.69	1.83	1.69	1.83	0.23	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.08	1.14	1.08	1.14	0.07	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.61	0.69	0.61	0.69	0.16	ZZZ
95921		A	Autonomic nerv function test	0.90	1.19	1.07	NA	NA	0.06	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.93	0.79	NA	NA	0.02	XXX
95921	26	A	Autonomic nerv function test	0.90	0.26	0.28	0.26	0.28	0.04	XXX
95922		A	Autonomic nerv function test	0.96	1.63	1.42	NA	NA	0.07	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.35	1.11	NA	NA	0.02	XXX
95922	26	A	Autonomic nerv function test	0.96	0.27	0.31	0.27	0.31	0.05	XXX
95923		A	Autonomic nerv function test	0.90	2.33	2.23	NA	NA	0.07	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.07	1.95	NA	NA	0.02	XXX
95923	26	A	Autonomic nerv function test	0.90	0.26	0.29	0.26	0.29	0.05	XXX
95925		A	Somatosensory testing	0.54	3.16	2.65	NA	NA	0.10	XXX
95925	TC	A	Somatosensory testing	0.00	3.01	2.48	NA	NA	0.06	XXX
95925	26	A	Somatosensory testing	0.54	0.15	0.17	0.15	0.17	0.04	XXX
95926		A	Somatosensory testing	0.54	3.08	2.60	NA	NA	0.09	XXX
95926	TC	A	Somatosensory testing	0.00	2.93	2.43	NA	NA	0.06	XXX
95926	26	A	Somatosensory testing	0.54	0.15	0.17	0.15	0.17	0.03	XXX
95927		A	Somatosensory testing	0.54	3.18	2.68	NA	NA	0.10	XXX
95927	TC	A	Somatosensory testing	0.00	3.02	2.49	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	3.82	3.62	NA	NA	0.09	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	3.40	3.15	NA	NA	0.03	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.42	0.48	0.42	0.48	0.06	XXX
95929		A	C motor evoked, lwr limbs	1.50	4.12	3.90	NA	NA	0.09	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	3.70	3.42	NA	NA	0.03	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.42	0.48	0.42	0.48	0.06	XXX
95930		A	Visual evoked potential test	0.35	2.61	2.52	NA	NA	0.03	XXX

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95930	TC	A	Visual evoked potential test	0.00	2.51	2.41	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.10	0.11	0.10	0.11	0.02	XXX
95933		A	Blink reflex test	0.59	1.11	1.09	NA	NA	0.10	XXX
95933	TC	A	Blink reflex test	0.00	0.93	0.90	NA	NA	0.06	XXX
95933	26	A	Blink reflex test	0.59	0.18	0.19	0.18	0.19	0.04	XXX
95934		A	H-reflex test	0.51	0.89	0.78	NA	NA	0.04	XXX
95934	TC	A	H-reflex test	0.00	0.73	0.60	NA	NA	0.02	XXX
95934	26	A	H-reflex test	0.51	0.16	0.17	0.16	0.17	0.02	XXX
95936		A	H-reflex test	0.55	0.60	0.56	NA	NA	0.05	XXX
95936	TC	A	H-reflex test	0.00	0.44	0.38	NA	NA	0.02	XXX
95936	26	A	H-reflex test	0.55	0.16	0.18	0.16	0.18	0.03	XXX
95937		A	Neuromuscular junction test	0.65	0.92	0.84	NA	NA	0.10	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.72	0.62	NA	NA	0.02	XXX
95937	26	A	Neuromuscular junction test	0.65	0.20	0.22	0.20	0.22	0.08	XXX
95950		A	Ambulatory eeg monitoring	1.51	4.91	4.67	NA	NA	0.51	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	4.49	4.19	NA	NA	0.43	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.42	0.48	0.42	0.48	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	1.66	1.89	1.66	1.89	0.32	XXX
95953		A	EEG monitoring/computer	3.30	7.17	7.29	NA	NA	0.60	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.25	6.28	NA	NA	0.43	XXX
95953	26	A	EEG monitoring/computer	3.30	0.92	1.01	0.92	1.01	0.17	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.14	4.16	NA	NA	0.19	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	3.76	3.62	NA	NA	0.06	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.38	0.55	0.38	0.55	0.13	XXX
95955		A	EEG during surgery	1.01	2.68	2.59	2.68	2.59	0.22	XXX
95955	TC	A	EEG during surgery	0.00	2.41	2.30	2.41	2.30	0.17	XXX
95955	26	A	EEG during surgery	1.01	0.27	0.29	0.27	0.29	0.05	XXX
95956		A	Eeg monitoring, cable/radio	3.08	16.23	16.04	NA	NA	0.59	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	15.38	15.08	NA	NA	0.43	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	0.85	0.96	0.85	0.96	0.16	XXX
95957		A	EEG digital analysis	1.98	5.83	5.01	NA	NA	0.23	XXX
95957	TC	A	EEG digital analysis	0.00	5.28	4.39	NA	NA	0.12	XXX
95957	26	A	EEG digital analysis	1.98	0.55	0.62	0.55	0.62	0.11	XXX
95958		A	EEG monitoring/function test	4.24	6.83	6.00	NA	NA	0.34	XXX
95958	TC	A	EEG monitoring/function test	0.00	5.61	4.65	NA	NA	0.13	XXX
95958	26	A	EEG monitoring/function test	4.24	1.22	1.35	1.22	1.35	0.21	XXX
95961		A	Electrode stimulation, brain	2.97	3.02	2.92	NA	NA	0.55	XXX
95961	TC	A	Electrode stimulation, brain	0.00	2.15	1.94	NA	NA	0.07	XXX
95961	26	A	Electrode stimulation, brain	2.97	0.87	0.98	0.87	0.98	0.48	XXX
95962		A	Electrode stim, brain add-on	3.21	2.16	2.29	2.16	2.29	0.39	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.27	1.28	1.27	1.28	0.07	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	0.89	1.01	0.89	1.01	0.32	ZZZ

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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	2.51	2.74	2.51	2.74	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	1.26	1.37	1.26	1.37	0.19	XXX
95967		C	Meg, evoked, each add ╞	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each add ╞	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each add ╞	3.49	1.08	1.10	1.08	1.10	0.16	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.91	0.90	0.13	0.13	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.73	0.72	0.26	0.25	0.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.13	1.15	0.43	0.45	0.14	XXX
95973		A	Analyze neurostim, complex	0.92	0.51	0.54	0.23	0.25	0.07	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.43	1.50	0.78	0.91	0.16	XXX
95975		A	Cranial neurostim, complex	1.70	0.72	0.77	0.47	0.53	0.12	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.83	1.86	1.01	1.08	0.18	XXX
95979		A	Analyz neurostim brain addon	1.64	0.72	0.76	0.46	0.52	0.08	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.24	0.24	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	0.19	0.19	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	1.63	1.60	NA	NA	0.06	XXX
95991		A	Spin/brain pump refil & main	0.77	1.63	1.60	0.18	0.18	0.06	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	0.45	0.47	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.54	0.57	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.11	0.12	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.08	0.09	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.70	0.76	0.70	0.76	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	1.25	1.25	1.25	1.25	0.17	XXX
96040		B	Genetic counseling, 30 min	0.00	1.15	1.15	NA	NA	0.01	XXX
96101		A	Psycho testing by psych/phys	1.86	0.36	0.43	0.34	0.41	0.05	XXX
96102		A	Psycho testing by technician	0.50	1.04	0.95	0.10	0.11	0.01	XXX
96103		A	Psycho testing admin by comp	0.51	0.95	0.77	0.11	0.12	0.02	XXX
96105		A	Assessment of aphasia	0.00	1.97	1.92	NA	NA	0.18	XXX
96110		A	Developmental test, lim	0.00	0.18	0.18	NA	NA	0.18	XXX
96111		A	Developmental test, extend	2.60	0.74	0.82	0.62	0.73	0.18	XXX
96116		A	Neurobehavioral status exam	1.86	0.53	0.61	0.41	0.46	0.18	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.85	0.98	0.34	0.41	0.18	XXX
96119		A	Neuropsych testing by tec	0.55	1.52	1.40	0.10	0.12	0.18	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.65	1.42	0.11	0.12	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	0.78	0.78	0.37	0.37	0.16	XXX
96150		A	Assess hlth/behave, init	0.50	0.10	0.12	0.09	0.11	0.01	XXX

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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	0.14	0.15	0.14	0.15	0.02	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.86	1.69	NA	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.77	0.83	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.59	1.80	0.23	0.23	0.03	000
96406		A	Chemo intralesional over 7	0.80	2.23	2.43	0.32	0.31	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.82	2.85	NA	NA	0.06	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.52	1.54	NA	NA	0.06	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	3.66	3.80	NA	NA	0.08	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.66	0.69	NA	NA	0.07	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	4.12	4.24	NA	NA	0.08	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.74	1.80	NA	NA	0.07	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.84	2.80	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.59	4.65	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	2.03	2.00	NA	NA	0.02	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.65	4.61	NA	NA	0.08	XXX
96440		A	Chemotherapy, intracavitary	2.37	16.26	14.24	1.04	1.09	0.17	000
96445		A	Chemotherapy, intracavitary	2.20	4.77	5.59	0.74	0.85	0.14	000
96450		A	Chemotherapy, into CNS	1.53	3.23	4.17	0.61	0.78	0.09	000
96521		A	Refill/maint, portable pump	0.21	3.17	3.32	NA	NA	0.06	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.81	2.77	NA	NA	0.06	XXX
96523		T	Irrig drug delivery device	0.04	0.65	0.66	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	2.51	2.95	0.34	0.42	0.07	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.73	3.29	NA	NA	0.04	XXX
96570		A	Photodynamic tx, 30 min	1.10	0.38	0.38	0.38	0.38	0.11	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.18	0.19	0.18	0.19	0.03	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.57	0.54	NA	NA	0.02	XXX
96902		B	Trichogram	0.41	0.15	0.16	0.13	0.14	0.01	XXX
96904		R	Whole body photography	0.00	1.82	1.82	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	2.00	1.75	NA	NA	0.04	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.56	2.24	NA	NA	0.05	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.55	3.08	NA	NA	0.10	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.56	3.30	0.56	0.56	0.02	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.37	3.18	0.51	0.52	0.03	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.58	4.31	1.02	0.92	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	0.65	0.68	NA	NA	0.05	XXX
97002		A	Pt re-evaluation	0.60	0.41	0.41	NA	NA	0.02	XXX
97003		A	Ot evaluation	1.20	0.76	0.79	NA	NA	0.06	XXX
97004		A	Ot re-evaluation	0.60	0.54	0.57	NA	NA	0.02	XXX

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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	0.17	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	0.08	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	NA	NA	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.32	0.30	NA	NA	0.02	XXX
97112		A	Neuromuscular reeducation	0.45	0.34	0.33	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	0.27	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	NA	NA	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	0.36	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.22	0.21	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.27	0.26	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.37	0.36	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.28	0.27	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.29	0.29	NA	NA	0.01	XXX
97597		A	Active wound care/20 cm or <	0.58	1.10	0.99	0.12	0.26	0.05	XXX
97598		A	Active wound care > 20 cm	0.80	1.27	1.15	0.17	0.32	0.05	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.40	0.39	0.11	0.14	0.02	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.42	0.40	0.13	0.15	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	0.27	0.28	NA	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.42	0.40	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.33	0.31	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	0.45	0.15	0.23	0.12	0.21	0.01	XXX
97803		A	Med nutrition, indiv, subseq	0.37	0.12	0.21	0.09	0.19	0.01	XXX
97804		A	Medical nutrition, group	0.25	0.08	0.10	.	0.05	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.33	0.34	0.19	0.20	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.20	0.22	0.16	0.17	0.03	ZZZ

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97813		N	Acupunct w/stimul 15 min	0.65	0.34	0.36	0.21	0.22	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.24	0.26	0.17	0.18	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.29	0.30	0.12	0.13	0.02	000
98926		A	Osteopathic manipulation	0.65	0.37	0.38	0.17	0.19	0.03	000
98927		A	Osteopathic manipulation	0.87	0.46	0.47	0.23	0.24	0.03	000
98928		A	Osteopathic manipulation	1.03	0.52	0.54	0.26	0.28	0.04	000
98929		A	Osteopathic manipulation	1.19	0.59	0.61	0.31	0.33	0.05	000
98940		A	Chiropractic manipulation	0.45	0.21	0.22	0.12	0.12	0.01	000
98941		A	Chiropractic manipulation	0.65	0.27	0.28	0.18	0.17	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	0.22	0.13	0.14	0.01	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.68	0.68	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.33	0.33	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.24	0.24	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.11	0.11	0.08	0.08	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.19	0.19	0.16	0.16	0.02	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.27	0.27	0.24	0.24	0.03	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.35	0.35	NA	NA	0.04	XXX
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	NA	NA	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	NA	NA	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	2.26	2.14	0.82	0.76	0.08	000
99173		N	Visual acuity screen	0.00	0.07	0.07	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.38	0.63	NA	NA	0.10	XXX
99183		A	Hyperbaric oxygen therapy	2.34	2.62	2.78	0.58	0.62	0.16	XXX
99185		A	Regional hypothermia	0.00	1.88	1.57	NA	NA	0.04	XXX
99186		A	Total body hypothermia	0.00	1.68	1.71	NA	NA	0.45	XXX
99195		A	Phlebotomy	0.00	2.49	1.98	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	0.56	0.54	0.16	0.16	0.03	XXX
99202		A	Office/outpatient visit, new	0.88	0.85	0.83	0.30	0.30	0.05	XXX
99203		A	Office/outpatient visit, new	1.34	1.12	1.12	0.43	0.44	0.09	XXX
99204		A	Office/outpatient visit, new	2.30	1.50	1.50	0.72	0.72	0.12	XXX
99205		A	Office/outpatient visit, new	3.00	1.80	1.79	0.91	0.92	0.15	XXX
99211		A	Office/outpatient visit, est	0.17	0.33	0.34	0.06	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.45	0.56	0.55	0.15	0.15	0.03	XXX
99213		A	Office/outpatient visit, est	0.92	0.77	0.75	0.29	0.27	0.03	XXX
99214		A	Office/outpatient visit, est	1.42	1.10	1.09	0.44	0.43	0.05	XXX
99215		A	Office/outpatient visit, est	2.00	1.40	1.38	0.62	0.63	0.08	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.50	0.51	0.06	XXX

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99218		A	Observation care	1.28	NA	NA	0.38	0.39	0.06	XXX
99219		A	Observation care	2.14	NA	NA	0.59	0.63	0.10	XXX
99220		A	Observation care	2.99	NA	NA	0.84	0.89	0.14	XXX
99221		A	Initial hospital care	1.88	NA	NA	0.54	0.52	0.07	XXX
99222		A	Initial hospital care	2.56	NA	NA	0.71	0.72	0.10	XXX
99223		A	Initial hospital care	3.78	NA	NA	1.07	1.06	0.13	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.24	0.24	0.03	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.42	0.41	0.04	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.59	0.58	0.06	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	0.79	0.82	0.13	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	0.99	1.03	0.16	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.21	1.27	0.19	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.49	0.51	0.05	XXX
99239		A	Hospital discharge day	1.90	NA	NA	0.67	0.69	0.07	XXX
99241		A	Office consultation	0.64	0.66	0.66	0.22	0.22	0.05	XXX
99242		A	Office consultation	1.34	1.09	1.07	0.48	0.48	0.10	XXX
99243		A	Office consultation	1.88	1.45	1.44	0.67	0.66	0.13	XXX
99244		A	Office consultation	3.02	1.94	1.91	1.08	1.04	0.16	XXX
99245		A	Office consultation	3.77	2.26	2.27	1.31	1.30	0.21	XXX
99251		A	Inpatient consultation	1.00	NA	NA	0.31	0.29	0.05	XXX
99252		A	Inpatient consultation	1.50	NA	NA	0.49	0.49	0.09	XXX
99253		A	Inpatient consultation	2.27	NA	NA	0.80	0.77	0.11	XXX
99254		A	Inpatient consultation	3.29	NA	NA	1.19	1.14	0.13	XXX
99255		A	Inpatient consultation	4.00	NA	NA	1.39	1.38	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	0.17	0.16	0.04	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.25	0.26	0.09	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.47	0.47	0.14	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.68	0.69	0.23	XXX
99289		A	Ped crit care transport	4.79	NA	NA	1.32	1.35	0.24	XXX
99290		A	Ped crit care transport addl	2.40	NA	NA	0.59	0.65	0.12	ZZZ
99291		A	Critical care, first hour	4.50	2.26	2.34	1.09	1.14	0.21	XXX
99292		A	Critical care, add'l 30 min	2.25	0.78	0.81	0.54	0.57	0.11	ZZZ
99293		A	Ped critical care, initial	15.98	NA	NA	4.19	4.33	1.12	XXX
99294		A	Ped critical care, subseq	7.99	NA	NA	2.04	2.13	0.45	XXX
99295		A	Neonate crit care, initial	18.46	NA	NA	4.04	4.38	1.16	XXX
99296		A	Neonate critical care subseq	7.99	NA	NA	2.01	2.15	0.32	XXX
99298		A	Ic for lbw infant < 1500 gm	2.75	NA	NA	0.80	0.83	0.17	XXX
99299		A	Ic, lbw infant 1500-2500 gm	2.50	NA	NA	0.62	0.68	0.16	XXX
99300		A	Ic, infant pbw 2501-5000 gm	2.40	NA	NA	0.62	0.67	0.15	XXX
99304		A	Nursing facility care, init	1.61	0.58	0.55	0.58	0.55	0.05	XXX
99305		A	Nursing facility care, init	2.30	0.75	0.72	0.75	0.72	0.07	XXX
99306		A	Nursing facility care, init	3.00	0.91	0.87	0.91	0.87	0.09	XXX
99307		A	Nursing fac care, subseq	0.76	0.31	0.30	0.31	0.30	0.03	XXX

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99308		A	Nursing fac care, subseq	1.16	0.48	0.47	0.48	0.47	0.04	XXX
99309		A	Nursing fac care, subseq	1.55	0.61	0.61	0.61	0.61	0.06	XXX
99310		A	Nursing fac care, subseq	2.35	0.87	0.85	0.87	0.85	0.08	XXX
99315		A	Nursing fac discharge day	1.13	0.41	0.42	0.41	0.42	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.51	0.53	0.51	0.53	0.06	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.57	0.55	0.57	0.55	0.05	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.43	0.45	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	0.83	0.85	NA	NA	0.10	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.03	1.07	NA	NA	0.13	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.17	1.24	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	0.60	0.59	NA	NA	0.06	XXX
99336		A	Domicil/r-home visit est pat	2.46	0.78	0.79	NA	NA	0.09	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.05	1.08	NA	NA	0.13	XXX
99339		B	Domicil/r-home care supervis	1.25	0.73	0.73	NA	NA	0.06	XXX
99340		B	Domicil/r-home care supervis	1.80	0.98	0.98	NA	NA	0.07	XXX
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	0.83	0.86	NA	NA	0.10	XXX
99344		A	Home visit, new patient	3.38	1.02	1.06	NA	NA	0.13	XXX
99345		A	Home visit, new patient	4.09	1.18	1.24	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	0.57	NA	NA	0.06	XXX
99349		A	Home visit, est patient	2.33	0.74	0.77	NA	NA	0.09	XXX
99350		A	Home visit, est patient	3.28	0.98	1.03	NA	NA	0.13	XXX
99354		A	Prolonged service, office	1.77	0.66	0.69	0.50	0.54	0.08	ZZZ
99355		A	Prolonged service, office	1.77	0.64	0.67	0.49	0.52	0.07	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.50	0.53	0.07	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.50	0.53	0.08	ZZZ
99358		B	Prolonged serv, w/o contact	2.10	0.70	0.70	0.70	0.70	0.09	ZZZ
99359		B	Prolonged serv, w/o contact	1.00	0.35	0.35	0.35	0.35	0.04	ZZZ
99360		X	Physician standby services	1.20	0.38	0.38	0.38	0.38	0.05	XXX
99363		B	Anticoag mgmt, init	1.65	1.57	1.57	0.53	0.53	0.07	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.47	0.47	0.20	0.20	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.28	0.28	0.26	0.26	0.06	XXX
99367		B	Team conf w/o pat by phys	1.10	0.35	0.35	0.35	0.35	0.05	XXX
99368		B	Team conf w/o pat by hc pro	0.72	0.23	0.23	0.23	0.23	0.03	XXX
99374		B	Home health care supervision	1.10	0.68	0.69	0.35	0.37	0.05	XXX
99375		I	Home health care supervision	1.73	0.95	1.10	0.55	0.80	0.07	XXX
99377		B	Hospice care supervision	1.10	0.68	0.69	0.35	0.37	0.05	XXX
99378		I	Hospice care supervision	1.73	0.95	1.20	0.55	0.90	0.07	XXX
99379		B	Nursing fac care supervision	1.10	0.68	0.69	0.35	0.37	0.04	XXX
99380		B	Nursing fac care supervision	1.73	0.95	0.96	0.55	0.58	0.06	XXX

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99381		N	Init pm e/m, new pat, inf	1.19	1.20	1.28	0.38	0.40	0.05	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.26	1.33	0.43	0.46	0.05	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.25	1.31	0.43	0.46	0.05	XXX
99384		N	Prev visit, new, age 12-17	1.53	1.30	1.37	0.49	0.51	0.06	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.30	1.37	0.49	0.51	0.06	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.41	1.50	0.60	0.63	0.07	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.57	1.65	0.66	0.69	0.07	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.04	1.03	0.33	0.34	0.04	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.09	1.09	0.38	0.40	0.05	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.08	1.08	0.38	0.40	0.05	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.14	1.14	0.43	0.46	0.05	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.14	1.15	0.43	0.46	0.05	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.20	1.21	0.49	0.51	0.06	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.37	1.37	0.55	0.58	0.06	XXX
99401		N	Preventive counseling, indiv	0.48	0.44	0.48	0.15	0.16	0.01	XXX
99402		N	Preventive counseling, indiv	0.98	0.60	0.67	0.31	0.33	0.02	XXX
99403		N	Preventive counseling, indiv	1.46	0.75	0.84	0.47	0.49	0.04	XXX
99404		N	Preventive counseling, indiv	1.95	0.91	1.01	0.62	0.66	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	0.14	0.01	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.25	0.25	0.21	0.21	0.01	XXX
99409		N	Audit/dast, over 30 min	1.30	0.46	0.46	0.41	0.41	0.03	XXX
99411		N	Preventive counseling, group	0.15	0.26	0.24	0.05	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.28	0.08	0.08	0.01	XXX
99420		N	Health risk assessment test	0.00	0.26	0.26	NA	NA	0.01	XXX
99431		A	Initial care, normal newborn	1.17	NA	NA	0.28	0.31	0.05	XXX
99432		A	Newborn care, not in hosp	1.26	1.22	1.15	0.40	0.40	0.07	XXX
99433		A	Normal newborn care/hospital	0.62	NA	NA	0.17	0.18	0.02	XXX
99435		A	Newborn discharge day hosp	1.50	NA	NA	0.49	0.52	0.06	XXX
99436		A	Attendance, birth	1.50	NA	NA	0.41	0.43	0.06	XXX
99440		A	Newborn resuscitation	2.93	NA	NA	0.93	0.93	0.12	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.11	0.11	0.08	0.08	0.02	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.19	0.19	0.16	0.16	0.02	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.27	0.27	0.24	0.24	0.03	XXX
99477		A	Init day hosp neonate care	7.00	1.98	1.98	1.98	1.98	0.32	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.49	0.50	NA	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.33	0.34	0.06	0.06	0.01	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.56	2.49	0.63	0.60	0.08	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.42	6.36	1.83	1.74	0.30	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.56	2.49	0.63	0.60	0.08	000
G0106		A	Colon CA screen;barium enema	0.99	5.02	4.41	NA	NA	0.17	XXX
G0106	TC	A	Colon CA screen;barium	0.00	4.66	4.06	NA	NA	0.13	XXX

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			enema							
			Colon CA screen;barium							
G0106	26	A	enema	0.99	0.36	0.35	0.36	0.35	0.04	XXX
G0108		A	Diab manage trn per indiv	0.00	0.59	0.65	NA	NA	0.01	XXX
G0109		A	Diab manage trn ind/group	0.00	0.31	0.35	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.75	0.74	NA	NA	0.01	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.68	0.64	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	5.02	4.41	NA	NA	0.17	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.66	4.06	NA	NA	0.13	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.36	0.35	0.36	0.35	0.04	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.42	6.36	1.83	1.74	0.30	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.56	2.49	0.63	0.60	0.08	000
G0122		N	Colon ca scrn; barium enema	0.99	6.49	5.52	NA	NA	0.18	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	6.18	5.19	NA	NA	0.13	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.32	0.33	0.32	0.33	0.05	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	0.38	0.35	0.04	0.05	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.19	0.15	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.55	0.63	NA	NA	0.06	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.49	0.57	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
G0166		A	Extrnl counterpulse, per tx	0.07	4.49	4.27	NA	NA	0.01	XXX
G0168		A	Wound closure by adhesive	0.45	1.59	1.68	0.21	0.21	0.03	000
G0179		A	MD recertification HHA PT	0.45	0.48	0.62	NA	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.56	0.74	NA	NA	0.03	XXX
G0181		A	Home health care supervision	1.73	0.81	0.98	NA	NA	0.07	XXX
G0182		A	Hospice care supervision	1.73	0.82	1.03	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	2.81	2.80	NA	NA	0.10	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.57	2.57	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	3.11	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
G0237		A	Therapeutic procd strg endur	0.00	0.21	0.28	NA	NA	0.02	XXX
G0238		A	Oth resp proc, indiv	0.00	0.23	0.30	NA	NA	0.02	XXX
G0239		A	Oth resp proc, group	0.00	0.31	0.31	NA	NA	0.02	XXX
G0245		R	Initial foot exam pt lops	0.88	0.85	0.83	0.30	0.30	0.04	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.56	0.55	0.15	0.15	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.68	0.64	0.16	0.17	0.02	ZZZ

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G0248		R	Demonstrate use home inr mon	0.00	3.31	4.15	NA	NA	0.01	XXX
G0249		R	Provide INR test mater/equip	0.00	3.36	3.51	NA	NA	0.01	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.08	0.08	NA	NA	0.01	XXX
G0252	26	N	PET imaging initial dx	1.50	0.48	0.48	0.48	0.48	0.04	XXX
G0268		A	Removal of impacted wax md	0.61	0.67	0.66	0.20	0.21	0.02	000
G0270		A	MNT subs tx for change dx	0.37	0.12	0.21	0.09	0.19	0.01	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.08	0.10	.	0.05	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.13	0.12	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.13	0.13	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.14	0.13	NA	NA	0.01	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	1.01	3.42	NA	NA	0.18	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.58	0.64	0.26	ZZZ
G0308		A	ESRD related svc 4+mo < 2yrs	12.74	5.63	6.37	5.63	6.37	0.42	XXX
G0309		A	ESRD related svc 2-3mo <2yrs	10.61	4.06	4.82	4.06	4.82	0.36	XXX
G0310		A	ESRD related svc 1 vst <2yrs	8.49	2.86	3.57	2.86	3.57	0.28	XXX
G0311		A	ESRD related svs 4+mo 2-11yr	9.73	3.70	3.96	3.70	3.96	0.34	XXX
G0312		A	ESRD relate svs 2-3 mo 2-11y	8.11	2.78	3.07	2.78	3.07	0.29	XXX
G0313		A	ESRD related svs 1 mon 2-11y	6.49	1.97	2.27	1.97	2.27	0.22	XXX
G0314		A	ESRD related svs 4+ mo 12-19	8.28	3.43	3.68	3.43	3.68	0.27	XXX
G0315		A	ESRD related svs 2-3mo/12-19	6.90	2.60	2.87	2.60	2.87	0.23	XXX
G0316		A	ESRD related svs 1vis/12-19y	5.52	1.74	2.04	1.74	2.04	0.17	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.09	2.24	2.40	2.24	2.40	0.17	XXX
G0318		A	ESRD related svs 2-3 mo 20+y	4.24	1.68	1.86	1.68	1.86	0.14	XXX
G0319		A	ESRD related svs 1visit 20+y	3.39	1.13	1.32	1.13	1.32	0.11	XXX
G0320		A	ESD related svs home undr 2	10.61	2.64	3.76	2.64	3.76	0.36	XXX
G0321		A	ESRDrelatedsvs home mo 2-11y	8.11	2.03	2.51	2.03	2.51	0.29	XXX
G0322		A	ESRD related svs hom mo12-19	6.90	1.76	2.24	1.76	2.24	0.23	XXX
G0323		A	ESRD related svs home mo 20+	4.24	1.13	1.45	1.13	1.45	0.14	XXX
G0324		A	ESRD relate svs home/dy <2yr	0.35	0.16	0.18	0.16	0.18	0.01	XXX
G0325		A	ESRD relate home/day/ 2-11yr	0.23	0.09	0.10	0.09	0.10	0.01	XXX
G0326		A	ESRD relate home/dy 12-19yr	0.27	0.10	0.11	0.10	0.11	0.01	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.06	0.06	0.06	0.06	0.01	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.15	0.15	NA	NA	0.01	XXX
G0337		X	Hospice evaluation preelecti	1.34	0.43	0.45	0.43	0.45	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	3.07	3.75	NA	NA	0.48	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	5.08	5.14	1.46	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	8.57	8.63	2.07	090
G0344		A	Initial preventive exam	1.34	1.12	1.12	0.43	0.44	0.10	XXX

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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	5.24	4.94	NA	NA	0.25	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.18	4.86	NA	NA	0.23	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.06	0.07	0.06	0.07	0.02	XXX
G0366		A	EKG for initial prevent exam	0.17	0.35	0.39	0.35	0.39	0.03	XXX
G0367		A	EKG tracing for initial prev	0.00	0.28	0.32	NA	NA	0.02	XXX
G0368		A	EKG interpret & report preve	0.17	0.07	0.07	0.07	0.07	0.01	XXX
G0372		A	MD service required for PMD	0.17	0.05	0.13	0.05	0.05	0.01	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.45	2.45	NA	NA	0.11	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	2.24	2.24	NA	NA	0.08	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.21	0.21	0.21	0.21	0.03	XXX
G0392		A	AV fistula or graft arterial	9.48	48.24	48.24	3.19	3.19	0.62	000
G0393		A	AV fistula or graft venous	6.03	37.72	37.72	2.25	2.25	0.34	000
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.19	0.19	0.15	0.15	0.01	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.34	0.34	0.29	0.29	0.03	XXX
G0398		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	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.44	0.14	0.18	0.14	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	0.02	0.09	0.02	0.09	0.01	XXX
G9044		A	Low vision rehabilate teache	0.10	0.03	0.08	0.03	0.08	0.01	XXX
Gxx14		A	Fllwup inpt telecnslt, lmtd	0.76	NA	NA	0.24	0.24	0.03	XXX
Gxx15		A	Fllwup inpt telecnslt, inter	1.39	NA	NA	0.42	0.41	0.04	XXX
Gxx16		A	Fllwup inpt telecnslt, cplx	2.00	NA	NA	0.59	0.58	0.06	XXX
Gxxx1		C	Sat biopsy prostate 1-20 spc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Gxxx2		C	Sat biopsy prostate 21-40	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Gxxx3		C	Sat biopsy prostate 41-60	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Gxxx4		C	Sat biopsy prostate: >60	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Gxxx5		A	CORF related svc 15min each	0.00	0.36	0.36	0.35	0.35	0.01	XXX
M0064		A	Visit for drug monitoring	0.37	0.92	0.77	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	0.30	0.34	NA	NA	0.03	XXX
Q0035	TC	A	Cardiokymography	0.00	0.25	0.29	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	0.76	0.74	0.10	0.11	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.48	0.44	0.48	0.44	0.01	XXX
Q3001		C	Brachytherapy Radioelements	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

[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:

[RESERVED FOR FINAL RULE]

ADDENDUM D: Proposed 2009 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2009 GAF
31140	06	San Mateo, CA	1.203
31140	05	San Francisco, CA	1.201
00803	01	Manhattan, NY	1.164
00803	02	NYC Suburbs/Long I., NY	1.163
31140	09	Santa Clara, CA	1.148
00805	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.133
31140	07	Oakland/Berkley, CA	1.130
14330	04	Queens, NY	1.130
31146	26	Anaheim/Santa Ana, CA	1.128
31146	17	Ventura, CA	1.121
00903	01	DC + MD/VA Suburbs	1.121
00590	04	Miami, FL	1.116
31146	18	Los Angeles, CA	1.112
31140	03	Marin/Napa/Solano, CA	1.112
00591	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
00805	99	Rest of New Jersey	1.082
00865	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.064
00833	01	Hawaii/Guam	1.056
00590	03	Fort Lauderdale, FL	1.051
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
00831	01	Alaska	1.035
00901	01	Baltimore/Surr. Cntys, MD	1.035
00803	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
00834	00	Nevada	1.016
04402	18	Houston, TX	1.016
00902	01	Delaware	1.014
31140	99	Rest of California*	1.012
31146	99	Rest of California*	1.012
00528	01	New Orleans, LA	1.010
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00952	12	East St. Louis, IL	0.990
00973	50	Virgin Islands	0.989
00590	99	Rest of Florida	0.987
00835	01	Portland, OR	0.987
31144	40	New Hampshire	0.986
04402	31	Austin, TX	0.986

Contractor	Locality	Locality name	2009 GAF
04402	15	Galveston, TX	0.986
04402	09	Brazoria, TX	0.985
00901	99	Rest of Maryland	0.984
04402	28	Fort Worth, TX	0.983
31142	03	Southern Maine	0.980
05302	02	Metropolitan Kansas City, MO	0.978
04102	01	Colorado	0.975
00883	00	Ohio	0.973
00836	99	Rest of Washington	0.970
05392	01	Metropolitan St Louis, MO	0.969
03102	00	Arizona	0.968
00953	99	Rest of Michigan	0.968
00865	99	Rest of Pennsylvania	0.967
00954	00	Minnesota	0.958
31145	50	Vermont	0.955
00904	00	Virginia	0.952
04402	20	Beaumont, TX	0.951
03502	09	Utah	0.948
00952	99	Rest of Illinois	0.943
00630	00	Indiana	0.941
04202	05	New Mexico	0.941
00801	99	Rest of New York	0.941
05535	00	North Carolina	0.938
00951	00	Wisconsin	0.936
04402	99	Rest of Texas	0.933
00511	99	Rest of Georgia	0.931
00835	99	Rest of Oregon	0.930
00528	99	Rest of Louisiana	0.927
00880	01	South Carolina	0.924
05440	35	Tennessee	0.924
00884	16	West Virginia	0.924
05202	00	Kansas	0.915
05202	04	Kansas	0.915
05130	00	Idaho	0.914
31142	99	Rest of Maine	0.913
00660	00	Kentucky	0.909
00510	00	Alabama	0.907
00512	00	Mississippi	0.907
03602	21	Wyoming	0.904
05102	00	Iowa	0.903
05402	00	Nebraska	0.901
04302	00	Oklahoma	0.901
05392	99	Rest of Missouri*	0.895
05302	99	Rest of Missouri*	0.895
03202	01	Montana	0.894

Contractor	Locality	Locality name	2009 GAF
00520	13	Arkansas	0.891
03402	02	South Dakota	0.888
03302	01	North Dakota	0.880
00973	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI)+(0.03865 * mp GPCI).
GAF values do not contain a 1.000 floor on physician work GPCI.
* Indicates multiple contractors.

ADDENDUM E: Proposed 2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality***

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	0.982	0.852	0.504
00831	01	Alaska	1.018	1.088	0.657
03102	00	Arizona	0.988	0.955	0.836
00520	13	Arkansas	0.961	0.845	0.454
31146	26	Anaheim/Santa Ana, CA	1.035	1.267	0.825
31146	18	Los Angeles, CA	1.042	1.223	0.818
31140	03	Marin/Napa/Solano, CA	1.035	1.263	0.439
31140	07	Oakland/Berkley, CA	1.054	1.284	0.432
31140	05	San Francisco, CA	1.060	1.439	0.421
31140	06	San Mateo, CA	1.073	1.431	0.401
31140	09	Santa Clara, CA	1.084	1.292	0.383
31146	17	Ventura, CA	1.028	1.263	0.779
31140	99	Rest of California*	1.008	1.056	0.558
31146	99	Rest of California*	1.008	1.056	0.558
04102	01	Colorado	0.986	0.990	0.652
00591	00	Connecticut	1.039	1.183	0.997
00903	01	DC + MD/VA Suburbs	1.048	1.216	1.050
00902	01	Delaware	1.012	1.044	0.690
00590	03	Fort Lauderdale, FL	0.989	1.016	2.288
00590	04	Miami, FL	1.001	1.067	3.221
00590	99	Rest of Florida	0.973	0.937	1.753
00511	01	Atlanta, GA	1.010	1.012	0.850
00511	99	Rest of Georgia	0.979	0.882	0.843
00833	01	Hawaii/Guam	0.998	1.159	0.676
05130	00	Idaho	0.967	0.882	0.555
00952	16	Chicago, IL	1.026	1.078	1.973
00952	12	East St. Louis, IL	0.989	0.917	1.824
00952	15	Suburban Chicago, IL	1.018	1.066	1.657
00952	99	Rest of Illinois	0.975	0.879	1.240
00630	00	Indiana	0.986	0.916	0.609
05102	00	Iowa	0.965	0.869	0.441
05202	00	Kansas	0.969	0.881	0.567
05202	04	Kansas	0.969	0.881	0.567
00660	00	Kentucky	0.969	0.859	0.663
00528	01	New Orleans, LA	0.986	1.042	0.972
00528	99	Rest of Louisiana	0.970	0.877	0.907
31142	03	Southern Maine	0.980	1.023	0.500
31142	99	Rest of Maine	0.962	0.891	0.500
00901	01	Baltimore/Surr. Cntys, MD	1.013	1.055	1.105
00901	99	Rest of Maryland	0.994	0.980	0.889
31143	01	Metropolitan Boston	1.030	1.289	0.777
31143	99	Rest of Massachusetts	1.008	1.104	0.777

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00953	01	Detroit, MI	1.037	1.038	1.939
00953	99	Rest of Michigan	0.998	0.921	1.101
00954	00	Minnesota	0.992	0.981	0.249
00512	00	Mississippi	0.959	0.853	0.822
05302	02	Metropolitan Kansas City, MO	0.990	0.943	1.208
05392	01	Metropolitan St Louis, MO	0.993	0.929	1.093
05392	99	Rest of Missouri*	0.949	0.820	1.014
05302	99	Rest of Missouri*	0.949	0.820	1.014
03202	01	Montana	0.950	0.846	0.685
05402	00	Nebraska	0.959	0.888	0.249
00834	00	Nevada	1.003	1.024	1.102
31144	40	New Hampshire	0.982	1.037	0.470
00805	01	Northern NJ	1.058	1.226	1.135
00805	99	Rest of New Jersey	1.043	1.124	1.135
04202	05	New Mexico	0.973	0.888	1.115
00803	01	Manhattan, NY	1.065	1.296	1.027
00803	02	NYC Suburbs/Long I., NY	1.052	1.287	1.256
00803	03	Poughkpsie/N NYC Suburbs, NY	1.015	1.075	0.836
14330	04	Queens, NY	1.033	1.237	1.241
00801	99	Rest of New York	0.997	0.919	0.432
05535	00	North Carolina	0.972	0.923	0.645
03302	01	North Dakota	0.947	0.843	0.394
00883	00	Ohio	0.993	0.925	1.253
04302	00	Oklahoma	0.964	0.849	0.638
00835	01	Portland, OR	1.003	1.013	0.480
00835	99	Rest of Oregon	0.968	0.925	0.480
00865	01	Metropolitan Philadelphia, PA	1.017	1.095	1.645
00865	99	Rest of Pennsylvania	0.993	0.923	1.099
00973	20	Puerto Rico	0.904	0.693	0.254
00524	01	Rhode Island	1.014	1.086	1.013
00880	01	South Carolina	0.975	0.904	0.454
03402	02	South Dakota	0.942	0.863	0.427
05440	35	Tennessee	0.978	0.887	0.618
04402	31	Austin, TX	0.991	0.981	0.986
04402	20	Beaumont, TX	0.984	0.874	1.369
04402	09	Brazoria, TX	1.020	0.920	1.244
04402	11	Dallas, TX	1.010	0.999	1.129
04402	28	Fort Worth, TX	0.998	0.951	1.129
04402	15	Galveston, TX	0.991	0.957	1.244
04402	18	Houston, TX	1.017	0.983	1.368
04402	99	Rest of Texas	0.968	0.878	1.083
03502	09	Utah	0.977	0.905	1.044
31145	50	Vermont	0.968	0.981	0.497
00904	00	Virginia	0.982	0.940	0.668
00973	50	Virgin Islands	0.997	0.976	1.026

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00836	02	Seattle (King Cnty), WA	1.015	1.083	0.718
00836	99	Rest of Washington	0.987	0.972	0.705
00884	16	West Virginia	0.973	0.826	1.376
00951	00	Wisconsin	0.988	0.919	0.416
03602	21	Wyoming	0.956	0.841	0.904

* Indicates multiple contractors.
** 2009 work GPCI does not reflect the 1.000 floor.
*** 2009 GPCIs are the second year of the update transition.

ADDENDUM F: Multiple Procedure Payment Reduction Effective 1/1/2009

CPT Code	Family
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

CPT Code	Family
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

CPT Code	Family
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: FY 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	0.8561
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	0.9360
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9201
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9207
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9820

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8589
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	1.0052
11020	Altoona, PA Blair County, PA	0.9010
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9439
11180	Ames, IA Story County, IA	1.0031
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2616
11300	Anderson, IN Madison County, IN	0.9262
11340	Anderson, SC Anderson County, SC	1.0119
11460	Ann Arbor, MI Washtenaw County, MI	1.1043
11500	Anniston-Oxford, AL Calhoun County, AL	0.8380
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9981
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC	0.9666

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0125
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0296
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2584

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Atlantic County, NJ	
12220	Auburn-Opelika, AL Lee County, AL	0.7977
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	1.0164
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0083
12540	Bakersfield, CA Kern County, CA	1.1848
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	1.0626
12620	Bangor, ME Penobscot County, ME	1.0757
12700	Barnstable Town, MA Barnstable County, MA	1.3339
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA	0.8615

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	
12980	Battle Creek, MI Calhoun County, MI	1.0701
13020	Bay City, MI Bay County, MI	0.9778
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8965
13380	Bellingham, WA Whatcom County, WA	1.2257
13460	Bend, OR Deschutes County, OR	1.2029
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.1153
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9310
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9066
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	0.9297
13900	Bismarck, ND	0.7558

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Burleigh County, ND Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8622
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9494
14060	Bloomington-Normal, IL McLean County, IL	0.9858
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9760
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2580
14500	Boulder, CO Boulder County, CO	1.0893
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8870
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0468
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1388
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3711

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9428
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.0363
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0084
15500	Burlington, NC Alamance County, NC	0.9237
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9785
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1667
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.1034
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9347
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9935
16180	Carson City, NV Carson City, NV	1.0709
16220	Casper, WY Natrona County, WY	1.0128
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9430

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9933
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8749
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9764
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	1.0143
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	1.0379
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9387
16940	Cheyenne, WY	0.9808

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1017
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.1522
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0235
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8774
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8469
	Bradley County, TN	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9763
17660	Coeur d'Alene, ID Kootenai County, ID	0.9857
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9882
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0564
17860	Columbia, MO Boone County, MO Howard County, MO	0.9029
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9446
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9241
18020	Columbus, IN Bartholomew County, IN	1.0290
18140	Columbus, OH	1.0468

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9092
18700	Corvallis, OR Benton County, OR	1.1952
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8264
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	1.0516
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9137
19180	Danville, IL Vermilion County, IL	0.9912
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8876
19340	Davenport-Moline-Rock Island, IA-IL	0.8919

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9731
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8250
19500	Decatur, IL Macon County, IL	0.8565
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9396
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	1.1438
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	1.0082
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0523

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7994
20100	Dover, DE Kent County, DE	1.0918
20220	Dubuque, IA Dubuque County, IA	0.8860
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0958
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0290
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0201
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1931
20940	El Centro, CA Imperial County, CA	0.9248
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.9014
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0108
21300	Elmira, NY Chemung County, NY	0.8720

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21340	El Paso, TX El Paso County, TX	0.9193
21500	Erie, PA Erie County, PA	0.9170
21660	Eugene-Springfield, OR Lane County, OR	1.1682
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9188
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1946
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.7397
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8634
22140	Farmington, NM San Juan County, NM	0.8513
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9876
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9485
22380	Flagstaff, AZ Coconino County, AZ	1.2417
22420	Flint, MI	1.2080

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Genesee County, MI	
22500	Florence, SC Darlington County, SC Florence County, SC	0.8641
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8299
22540	Fond du Lac, WI Fond du Lac County, WI	0.9826
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0433
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0517
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8138
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9272
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9702
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0266
23420	Fresno, CA Fresno County, CA	1.1642
23460	Gadsden, AL Etowah County, AL	0.8441

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9842
23580	Gainesville, GA Hall County, GA	0.9607
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9805
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8958
24140	Goldsboro, NC Wayne County, NC	0.9667
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7999
24300	Grand Junction, CO Mesa County, CO	1.0374
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9711
24500	Great Falls, MT Cascade County, MT	0.9288
24540	Greeley, CO Weld County, CO	1.0239
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0291
24660	Greensboro-High Point, NC Guilford County, NC	0.9528

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Randolph County, NC Rockingham County, NC	
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9990
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0369
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	0.9547
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9512
25260	Hanford-Corcoran, CA Kings County, CA	1.1493
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9677
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9404
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1704
25620	Hattiesburg, MS	0.7757

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Forrest County, MS Lamar County, MS Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9491
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9640
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9525
26180	Honolulu, HI Honolulu County, HI	1.2505
26300	Hot Springs, AR Garland County, AR	0.9635
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8203
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	1.0402
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH	0.9785

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Cabell County, WV Wayne County, WV	
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9603
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9601
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0491
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0028
27060	Ithaca, NY Tompkins County, NY	1.0165
27100	Jackson, MI Jackson County, MI	0.9843
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8531
27180	Jackson, TN Chester County, TN Madison County, TN	0.9012

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9519
27340	Jacksonville, NC Onslow County, NC	0.8646
27500	Janesville, WI Rock County, WI	1.0215
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.9279
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8420
27780	Johnstown, PA Cambria County, PA	0.8368
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8371
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9945
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.1421
28100	Kankakee-Bradley, IL Kankakee County, IL	1.2777
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS	1.0155

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0479
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9267
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8187
28740	Kingston, NY Ulster County, NY	0.9913
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8333
29020	Kokomo, IN	0.9885

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Howard County, IN Tipton County, IN	
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0317
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9654
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8842
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7989
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0964
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0338
29460	Lakeland-Winter Haven, FL Polk County, FL	0.9019
29540	Lancaster, PA Lancaster County, PA	0.9859
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0500
29700	Laredo, TX Webb County, TX	0.8845
29740	Las Cruces, NM Dona Ana County, NM	0.9440
29820	Las Vegas-Paradise, NV Clark County, NV	1.2663
29940	Lawrence, KS	0.8821

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Douglas County, KS	
30020	Lawton, OK Comanche County, OK	0.8682
30140	Lebanon, PA Lebanon County, PA	0.9468
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	1.0008
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9710
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9632
30620	Lima, OH Allen County, OH	0.9968
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0318
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9122
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9268
30980	Longview, TX Gregg County, TX Rusk County, TX	0.8851

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Upshur County, TX	
31020	Longview, WA Cowlitz County, WA	1.1851
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2874
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	0.9779
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9231
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9216
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0119
31460	Madera, CA	0.8394

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Madera County, CA	
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1596
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0953
31900	Mansfield, OH[1] Richland County, OH	0.9865
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.7397
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9560
32780	Medford, OR Jackson County, OR	1.0832
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	0.9762
32900	Merced, CA Merced County, CA	1.2945
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0393
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9669
33260	Midland, TX Midland County, TX	1.0390
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI	1.0658

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Ozaukee County, WI Washington County, WI Waukesha County, WI	
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	1.1790
33540	Missoula, MT Missoula County, MT	0.9488
33660	Mobile, AL Mobile County, AL	0.8310
33700	Modesto, CA Stanislaus County, CA	1.2825
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8353
33780	Monroe, MI Monroe County, MI	0.9338
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8610
34060	Morgantown, WV Monongalia County, WV	0.9017

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Preston County, WV	
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7669
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0883
34620	Muncie, IN Delaware County, IN	0.8975
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0630
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9139
34900	Napa, CA Napa County, CA	1.5353
34940	Naples-Marco Island, FL Collier County, FL	1.0228
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	1.0049
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3163
35084	Newark-Union, NJ-PA	1.2402

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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	1.2415
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	0.9795
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	1.3622
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9586
35980	Norwich-New London, CT New London County, CT	1.2000
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6749

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36100	Ocala, FL Marion County, FL	0.9000
36140	Ocean City, NJ Cape May County, NJ	1.2155
36220	Odessa, TX Ector County, TX	1.0017
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9678
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	0.9225
36500	Olympia, WA Thurston County, WA	1.2198
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	0.9996
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9639
36780	Oshkosh-Neenah, WI	1.0017

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Winnebago County, WI	
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.9182
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2560
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9867
37380	Palm Coast, FL Flagler County, FL	0.9476
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8840
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8318
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8566
37764	Peabody, MA Essex County, MA	1.1363
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8714
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9439
37964	Philadelphia, PA Bucks County, PA Chester County, PA	1.1626

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Delaware County, PA Montgomery County, PA Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0983
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8380
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9115
38340	Pittsfield, MA Berkshire County, MA	1.1044
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9879
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	1.0512
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR	1.2094

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0434
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1527
39140	Prescott, AZ Yavapai County, AZ	1.0807
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	1.1172
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9651
39380	Pueblo, CO Pueblo County, CO	0.9212
39460	Punta Gorda, FL Charlotte County, FL	0.9491
39540	Racine, WI Racine County, WI	0.9360
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0386
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0148

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39740	Reading, PA Berks County, PA	0.9772
39820	Redding, CA Shasta County, CA	1.4391
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0897
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9900
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2065
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA	0.9157

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Roanoke County, VA Roanoke City, VA Salem City, VA	
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1857
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9320
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0399
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	1.0496
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9548
40660	Rome, GA Floyd County, GA	0.9658
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4163
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9201
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1605
41100	St. George, UT	0.9539

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Washington County, UT	
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0960
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9521
41420	Salem, OR Marion County, OR Polk County, OR	1.1413
41500	Salinas, CA Monterey County, CA	1.5825
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9776
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT	0.9683

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Tooele County, UT	
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8980
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	0.9363
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2161
41780	Sandusky, OH Erie County, OH	0.9379
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6302
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.7397
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7083
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR	0.7397

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3168
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2662
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2603
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7346
42140	Santa Fe, NM Santa Fe County, NM	1.1218
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6348
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9676
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8788
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2430
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9746
43100	Sheboygan, WI Sheboygan County, WI	0.9432
43300	Sherman-Denison, TX Grayson County, TX	0.9542
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8926
43580	Sioux City, IA-NE-SD Woodbury County, IA	0.9426

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Dakota County, NE Dixon County, NE Union County, SD	
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9890
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0145
43900	Spartanburg, SC Spartanburg County, SC	0.9543
44060	Spokane, WA Spokane County, WA	1.1165
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9624
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0807
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8827
44220	Springfield, OH Clark County, OH	0.9262
44300	State College, PA Centre County, PA	0.9449
44700	Stockton, CA San Joaquin County, CA	1.2662
44940	Sumter, SC	0.8730

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sumter County, SC	
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0347
45104	Tacoma, WA Pierce County, WA	1.1887
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9478
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9349
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9604
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8611
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9944
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS	0.9258

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ Mercer County, NJ	1.1212
46060	Tucson, AZ Pima County, AZ	0.9758
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8944
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8913
46340	Tyler, TX Smith County, TX	0.9309
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8886
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8487
46700	Vallejo-Fairfield, CA Solano County, CA	1.5182
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8590
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0961

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9385
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0726
	Tulare County, CA	
47380	Waco, TX	0.9088
	McLennan County, TX	
47580	Warner Robins, GA	0.9491
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	1.0468
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1426
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8976
48140	Wausau, WI Marathon County, WI	1.0167
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8496
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.0091
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0324
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7397
48620	Wichita, KS	0.9589

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9339
48700	Williamsport, PA Lycoming County, PA	0.8560
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1310
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9610
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0363
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9533
49340	Worcester, MA Worcester County, MA	1.1456
49420	Yakima, WA Yakima County, WA	1.0519
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR	0.7397

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Yauco Municipio, PR	
49620	York-Hanover, PA York County, PA	1.0119
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9427
49700	Yuba City, CA	1.1610
49740	Yuma, AZ Yuma County, AZ	0.9813

ADDENDUM H: FY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.8022
2	Alaska	1.2581
3	Arizona	0.8938
4	Arkansas	0.7902
5	California	1.2938
6	Colorado	1.0098
7	Connecticut	1.1779
8	Delaware	1.0534
10	Florida	0.8992
11	Georgia	0.8046
12	Hawaii	1.1627
13	Idaho	0.8089
14	Illinois	0.8867
15	Indiana	0.8946
16	Iowa	0.9309
17	Kansas	0.8514
18	Kentucky	0.8239
19	Louisiana	0.7873
20	Maine	0.9140
21	Maryland	0.9393
22	Massachusetts[1]	1.2256
23	Michigan	0.9383
24	Minnesota	0.9579
25	Mississippi	0.8018
26	Missouri	0.8436
27	Montana	0.9155
28	Nebraska	0.9231
29	Nevada	0.9897
30	New Hampshire	1.0803
31	New Jersey[1]	------
32	New Mexico	0.9318
33	New York	0.8663

34	North Carolina	0.9068
35	North Dakota	0.7618
36	Ohio	0.9065
37	Oklahoma	0.8224
38	Oregon	1.0804
39	Pennsylvania	0.8845
40	Puerto Rico[1]	0.7397
41	Rhode Island[1]	------
42	South Carolina	0.9028
43	South Dakota	0.9096
44	Tennessee	0.8236
45	Texas	0.8347
46	Utah	0.8741
47	Vermont	1.0658
48	Virgin Islands	0.7397
49	Virginia	0.8311
50	Washington	1.0765
51	West Virginia	0.7933
52	Wisconsin	1.0006
53	Wyoming	0.9849

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2009. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2008.

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