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Department of Health and Human Services

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42 CFR Parts 409, 410, et al.

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 411, 413, 414, 415, 418, 423, 424, 482, 484, and 485

[CMS–1385–FC]

RIN 0938–AO65

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period addresses certain provisions of the Tax Relief and Health Care Act of 2006, as well as making other proposed changes to Medicare Part B payment policy. We are making these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule with comment period 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 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 renal dialysis services; performance standards for independent diagnostic testing facilities; expiration of the physician scarcity area (PSA) bonus payment; conforming and clarifying changes for comprehensive outpatient rehabilitation facilities (CORFs); a process for updating the drug compendia; physician self referral issues; beneficiary signature for ambulance transport services; durable medical equipment (DME) update; the chiropractic services demonstration; a Medicare economic index (MEI) data change; technical corrections; standards and requirements related to therapy services under Medicare Parts A and B; revisions to the ambulance fee schedule; the ambulance inflation factor for CY 2008; and amending the e-prescribing exemption for computer-generated facsimile transmissions. We are also finalizing the calendar year (CY) 2007 interim RVUs and are issuing interim RVUs for new and revised procedure codes for CY 2008.

As required by the statute, we are announcing that the physician fee schedule update for CY 2008 is −10.1 percent, the initial estimate for the sustainable growth rate for CY 2008 is −0.1 percent, and the conversion factor (CF) for CY 2008 is $34.0682.

DATES: *Effective Date:* The provisions of this final rule with comment period are effective January 1, 2008, except for the amendments to § 409.17 and § 409.23 which are effective July 1, 2008, and the amendments to § 423.160 which is effective January 1, 2009.

Comment Date: Comments will be considered if we receive them at one of the addresses provided below, no later than 5 p.m. e.s.t. on December 31, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1385–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By 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–1385–FC, P.O. Box 8020, Baltimore, MD 21244–8020.

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–1385–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 in advance to schedule your arrival with one of our staff members.

Room 445–G, Hubert H. Humphrey (HHH) Building, 200 Independence Avenue, SW., Washington, DC 20201; or 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 and comprehensive outpatient rehabilitation facilities.

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

Stephanie Monroe, (410) 786–6864 for issues related to the geographic practice cost index and malpractice RVUs.

Craig Dobyski, (410) 786–4584 for issues related to list of telehealth services.

Ken Marsalek, (410) 786–4502 for issues related to the DRA imaging cap.

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

Edmund Kasaitis (410) 786–0477 for issues related to the Competitive Acquisition Program (CAP) for part B drugs.

Anita Greenberg (410) 786–4601 for issues related to the clinical laboratory fee schedule.

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.

Kate Tillman (410) 786–9252 or Brijit Burton (410) 786–7364 for issues related to the drug compendia.

David Walczak (410) 786–4475 for issues related to reassignment and physician self-referral rules for diagnostic tests and beneficiary signature for ambulance transport.

Lisa Ohrin (410) 786–4565 or Joanne Sinsheimer (410) 786–4620 for issues related to physician self-referral rules.

Bob Kuhl (410) 786–4597 for issues related to the DME update.

Rachel Nelson (410) 786–1175 for issues related to the physician quality reporting system for CY 2008.

Maria Ciccanti (410) 786–3107 for issues related to the reporting of anemia quality indicators.

James Menas (410) 786–4507 for issues related to payment for physician pathology services.

Dorothy Shannon, (410) 786–3396 for issues related to the outpatient therapy caps.

Drew Morgan, (410) 786–2543 for issues related to the E-Prescribing Exemption for Computer Generated Facsimile Transmissions.

Roechel Kujawa (410) 786–9111 or Anne Tayloe (410) 786–4546 for issues related to the ambulance fee schedule.

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

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: Interim Relative Value Units (RVUs) for selected codes identified in Addendum C and the physician self-referral designated health services (DHS) procedures listed in Addendum I. You can assist us by referencing the file code [CMS–1385–FC] 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.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' 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.

This **Federal Register** document is also available from the **Federal Register** online database through Government Printing Office Access a service of the U.S. Government Printing Office. The Web site address is: *http://www.access.gpo.gov/nara/index.html.*

Information on the physician fee schedule can also be found on the CMS homepage. You can access this data by using the following directions:

1. Go to the following Web site: *http://www.cms.hhs.gov/PhysicianFeeSched/.*

2. Select ''PFS Federal Regulation Notices.''

To assist readers in referencing sections contained in this preamble, we are providing the following 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.* Information on the regulation's impact appears throughout the preamble and is not exclusively in section VI.

Table of Contents

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:

AAA Abdominal aortic aneurysm
AAP Average acquisition price
ACOTE Accreditation Council for Occupational Therapy Education
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AHFS–DI American Hospital Formulary Service—Drug Information
AHRQ Agency for Healthcare Research and Quality (HHS)
AIF Ambulance inflation factor
AMA American Medical Association
AMA–DE American Medical Association Drug Evaluations
AMP Average manufacturer price
AOTA American Occupational Therapy Association
APC Ambulatory payment classification
APTA American Physical Therapy Association
ASA American Society of Anesthesiologists
ASC Ambulatory surgical center
ASP Average sales price
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
BLS Bureau of Labor Statistics
BMD Bone mineral density
BMI Body mass index
BMM Bone mass measurement
BN Budget neutrality
BSA Body surface area
CAD Computer aided detection
CAH Critical access hospital
CAP Competitive acquisition program
CBSA Core-Based Statistical Area
CEM Cardiac event monitoring
CF Conversion factor
CFR Code of Federal Regulations
CMA California Medical Association
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CORF Comprehensive Outpatient Rehabilitation Facility
COTA Certified Occupational Therapy Assistant
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–D Cardiac resynchronization therapy defibrillator
CT Computed tomography
CTA Computed tomographic angiography
CY Calendar year
DEXA Dual energy x-ray absorptiometry
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DO Doctor of Osteopathy
DRA Deficit Reduction Act of 2005 (Pub. L. 109–432)
E/M Evaluation and management
ECI Employment cost index
EHR Electronic health record
EPC [Duke] Evidence-based Practice Centers
EPO Erythopoeitin
ESRD End stage renal disease
F&C Facts and Comparisons
FAW Furnish as written

FAX Facsimile
FDA Food and Drug Administration (HHS)
FMR Fair market rents
FQHC Federally qualified health center
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GII Global Insight, Inc.
GPO Group purchasing organization
GPCI Geographic practice cost index
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HHA Home health agency
HHS [Department of] Health and Human Services
HIT Health information technology
HMO Health maintenance organization
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
HUD [Department of] Housing and Urban Development
ICD Implantable cardioverter-defibrillator
ICF Intermediate care facilities
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IOTED International Occupational Therapy Eligibility Determination
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IV Intravenous
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JCAAI Joint Council of Allergy, Asthma, and Immunology
LPN Licensed practical nurse
MA Medicare Advantage
MA–PD Medicare Advantage Prescription Drug Plans
MD Medical doctor
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)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MNT Medical nutrition therapy
MP Malpractice
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
MSP Medicare Secondary Payer
MSVP Multi-specialty visit package
NBCOT National Board for Certification in Occupational Therapy, Inc.
NCCN National Comprehensive Cancer Network
NCPDP National Council for Prescription Drug Programs
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NEMC New England Medical Center
NISTA National Institute of Standards and Technology Act
NLA National limitation amount
NP Nurse practitioner
NPP Nonphysician practitioners
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
OPD Outpatient Department
OPPS Outpatient prospective payment system
OPT Outpatient physical therapy
OSCAR Online Survey and Certification and Reporting
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
PET Positron emission tomography
PFS Physician Fee Schedule
PLI Professional liability insurance
PPI Producer price index
PPS Prospective payment system
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PT Physical therapy
PT/INR Prothrombin time, international normalized ratio
RFA Regulatory Flexibility Act
RHC Rural health clinic
RIA Regulatory impact analysis
RN Registered nurse
RT 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
SLPs Speech—language pathologists
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
STS Society of Thoracic Surgeons
TA Technology Assessment
TC Technical Component
TENS Transcutaneous electric nerve stimulator
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
USP–DI United States Pharmacopoeia-Drug Information
WAC Wholesale acquisition cost
WAMP Widely available market price
Wet AMD Exudative age-related macular degeneration
WFOT World Federation of Occupational Therapists

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the 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 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 (HHS). 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 formula used to calculate payment 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. 103–32), 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 the 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 reexamine 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 to require 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 RVUs no less often than every 5 years. The first 5-Year Review of the physician work RVUs was effective in 1997, published on November 22, 1996 (61 FR 59489). The second 5-Year Review went into effect in 2002, published in the CY 2002 PFS final rule (66 FR 55246). The third 5-Year Review of physician work RVUs went into effect on January 1, 2007 and was published in the CY 2007 PFS final rule with comment period (71 FR 69624) (although we note that certain additional proposals relating to the third 5-Year Review are addressed in the CY 2008 PFS proposed rule and in this final rule with comment period).

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 malpractice 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 are applying 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 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.

Payments are converted to dollar amounts through the application of a CF, which is calculated by the Office of the Actuary (OACT) and is updated annually for inflation.

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

Payment = [(RVU work × budget neutrality adjuster × work GPCI) + (RVU PE × PE GPCI) + (MP RVU × MP GPCI)] × CF.

C. Most Recent Changes to the Fee Schedule

The CY 2007 PFS final rule with comment period (71 FR 69624) addressed certain provisions of the Deficit Reduction Act of 2005 (Pub. L. 109–432) (DRA) 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. This final rule with comment period also discussed GPCI changes; requests for additions to the list of telehealth services; payment for covered outpatient drugs and biologicals; payment for renal dialysis services; policies related to private contracts and opt-out; policies related to bone mass measurement (BMM) services, independent diagnostic testing facilities (IDTFs), the physician self-referral prohibition; laboratory billing for the technical component (TC) of physician pathology services; the clinical laboratory fee schedule; certification of advanced practice nurses; health information technology, the health care information transparency initiative; updated the list of certain services subject to the physician self-referral prohibitions, finalized ASP reporting requirements, and codified Medicare's longstanding policy that payment of bad debts associated with services paid under a fee schedule/charge-based system is not allowable.

We also finalized the CY 2006 interim RVUs and issued interim RVUs for new and revised procedure codes for CY 2007.

In addition, the CY 2007 PFS final rule with comment period included revisions to payment policies under the fee schedule for ambulance services and announced the ambulance inflation factor (AIF) update for CY 2007.

In accordance with section 1848(d)(1)(E)(i) of the Act, we also announced that the PFS update for CY 2007 is −5.0 percent, the initial estimate for the sustainable growth rate (SGR) for CY 2007 is 1.8 percent and the CF for CY 2007 is $35.9848. However, subsequent to publication of the CY 2007 PFS final rule with comment period, section 101(a) of Division B, Title I of the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006, amended section 1848(d) of the Act. [Division B of the Tax Relief and Health Care Act of 2006 is entitled Medicare and Other Health Provisions and its short title is the Medicare Improvements and Extension Act of 2006. Therefore, the law is hereinafter referred to as ''MIEA–TRHCA''.] As a result of this statutory change, the CF of $37.8975 was maintained for CY 2007.

II. Provisions of the Final Rule Related to the Physician Fee Schedule

In response to the CY 2008 PFS proposed rule (72 FR 38122), we received approximately 27,000 comments. We received comments from individual physicians, health care workers, professional associations and societies, and beneficiaries. The majority of the comments addressed the proposals related to anesthesia coding and the 5-Year Review, the physician self-referral provisions and the technical correction to § 410.32(a)(1) concerning an exception to the requirement that diagnostic services (including x-rays) must be ordered by the treating physician. To the extent that comments were outside the scope of the proposed rule, they are not addressed in this final rule with comment period.

RVU changes implemented through this final rule with comment are subject to the $20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act. After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIV. For the convenience of the reader, the headings for the policy issues correspond to the headings used in the CY 2008 PFS proposed rule (72 FR 38122). More detailed background information for each issue can be found in the CY 2008 PFS proposed rule.

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

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

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation required 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 furnish 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 Five-Year Review of Work RVUs Under the PFS and Proposed Changes to the PE Methodology 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 cardio-thoracic 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 Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for CY 2002 final rule (66 FR 55246, November 1, 2002) (hereinafter referred to as CY 2002 PFS final rule).) 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 expenses 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, the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period, (65 FR 25664, May 3, 2000).) 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, (November 7, 2003; 68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule).

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 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. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the maximum of either the clinical labor costs or the physician work RVUs. For calculation of the 2008 PE RVUs, we are using the 2006 procedure-specific utilization data crosswalked to 2007 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 cardio-thoracic 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).) 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), which may be furnished independently or by different providers. When services have TC, PC, and global components that can be billed separately, the payment for the global component equals the sum of the payment for the TC and PCs. 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, PC, and TCs for a service. (The direct PE RVUs for the TC and PCs 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 thereinafter), 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 a TC 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 PERVU/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 PERVU/direct percentage) + clinical PE RVU.*

(Note that 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 TC 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 components.

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 modifier:* Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.
- *Payment modifiers:* Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier.
- *Work RVUs:* The setup file contains the work RVUs from this final rule with comment period.

(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.

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

	Step	Source	Formula	99213	33533	71020	71020TC	7102026	93000	93005	93010
				Office visit, est non-facility	CABG, arterial, single facility	Chest x-ray non-facility	Chest x-ray non-facility	Chest x-ray non-facility	ECG, complete non-facility	ECG, tracing non-facility	ECG, report non-facility
(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	$7.60	$
(5) Direct adjustment (Dir Adj).	Steps 2–4	See footnote [1]		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)	$7.89	$45.89	$3.40	$3.40	$	$3.62	$3.62	$
(7) Adjusted supplies	Steps 2–4	=Sup * Dir Adj	=(2) * (5)	$1.77	$4.35	$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)	$9.77	$50.62	$10.25	$10.25	$	$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	0.8806	0.81	29.62	0.19	0.00 –	0.19	0.15	0.00	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	0.26	0.11	0.15
(22) Indirect Allocator (1st+2nd).	Step 8		=(19)+(21)	1.37	32.70	0.73	0.54	0.19	0.47	0.32	0.15
(23) Indirect Adjustment (Ind Adj).	Steps 9–11	See footnote [2]		0.362	0.362	0.362	0.362	0.362	0.362	0.362	0.362
(24) Adjusted Indirect Allocator.	Steps 9–11	=Ind Alloc * Ind Adj		0.50	11.84	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		0.968	0.942	1.054	1.054	1.054	1.280	1.280	1.280
(26) Adjusted Indirect	Step 17	= Adj. Ind Alloc * PCI	=(24) * (25)	0.48	11.15	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	12.64	0.58	0.51	0.07	0.35	0.28	0.07

[1] The direct adj = [current pe rvus * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3].
[2] The indirect adj = [current pe rvus * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10.

Comments Related to PE Methodology

Comment: Several commenters recommend that the unadjusted work RVUs be used in the allocation of the indirect PE RVUs.

Response: The decision to use the budget neutralized work RVUs in the calculation of indirect PEs appropriately maintains the current relationships between the work, PE, and professional liability payments. We also believe it is important to apply the revised, budget neutralized work RVUs consistently within the PFS framework. It would not be consistent to apply one set of work RVUs for work payments, but a different set for purposes of calculating indirect PEs. Therefore, we will base the calculation of both the work payments and the indirect PE payments on the adjusted work RVUs, and maintain the current overall relationships between work, PE, and professional liability. The PE RVUs in Addendum B and throughout the rest of this rule reflect this policy.

Comment: Several commenters commended CMS on the bottom up approach to calculating resource based PE RVUs. Commenters expressed gratitude for the transparency and straight forward nature of the revised methodology.

Response: We appreciate the support for the revised bottom up practice methodology and agree that the bottom up methodology is a more straight forward methodology then its predecessor.

Comment: Some commenters contend that the approach of basing PE calculations on the weighted average of all specialties furnishing a service is flawed and should be replaced with an approach that bases the specialty weighted factors upon specialties that represent 95 percent of the total utilization of each respective service.

Response: This issue was fully addressed in the comment and response section of the CY 2007 PFS final rule with comment period (71 FR 69641), and we did not make any further proposals relating to this policy in the CY 2008 PFS proposed rule. Thus, these comments are outside the scope of the CY 2008 PFS proposed rule.

Comment: One commenter stated that the use of direct PEs in the allocation of indirect PEs unfairly penalizes PC only billers that do not have any direct costs. Additionally, this commenter contends that the use of only the work RVU in the allocation of indirect PEs for this situation underestimates the indirect PEs for PC only billers.

Response: The resource-based PE methodology uses both the work RVU and the direct cost PE RVU in the allocation of indirect PEs. For PC only billers, which do not have any direct costs, indirect costs will only be allocated based upon the work RVUs. There is no provision within the current methodology to allocate the indirect PEs differently, and we made no proposals in the CY 2008 PFS proposed rule regarding this allocation. Additionally, we note that a review of comments on past regulations confirms that the physician community believes that the work RVUs ''over allocate'' the indirect PEs. Thus, there appear to be differing views regarding the effect of this allocation. We will continue to allocate the indirect PEs of PC only services on the work RVUs.

Comment: One commenter recommended that, for procedures that have supply costs in excess of 40 to 50 percent of total direct costs, all supply costs be passed through and exempt from the direct adjustment factor.

Response: The resource-based PE methodology converts the direct costs for a service, obtained from the direct cost database, into PE RVUs by comparing the service specific aggregate costs to the aggregate pool of costs available for expenditure on direct costs. Because the aggregate direct costs for all services contained in the direct cost database exceed the aggregate pool of available direct dollars, a direct cost adjustment must be applied to scale the database to the pool. Irrespective of the percentage of total direct costs for a specific service represented by supplies, this adjustment will still be applied. If this adjustment were not applied to certain services, the system would either not be budget neutral or RVUs for all other services would have to be reduced to offset these exemptions. We did not make any proposals relating to this adjustment. Moreover, we see no methodological reason to exempt any services regardless of the percentage of their direct costs represented by supplies from the adjustments that apply to all direct costs.

g. Discussion of Equipment Usage Percentage

In the CY 2008 PFS proposed rule (72 FR 38132), we included a discussion about our use of the equipment usage assumption of 50 percent, and stated that we continue to receive requests that we refine this usage percentage. Some groups and individuals state that this usage percentage should be in the range of 70 to 80 percent while others contend that the current utilization rate is too high at 50 percent and should be refined downward to a lower usage percentage.

If the equipment usage percentage is set too high, the result would be insufficient allowance at the service level for the practice costs associated with equipment. If the equipment usage percentage is set too low, the result would be an excessive allowance for the PE costs of equipment at the service level. Although we acknowledged the 50 percent across the board usage rate that we currently apply for all equipment does not capture the actual usage rates for all equipment, we indicated we do not believe that we have sufficient empirical evidence to justify an alternative proposal on this issue. Therefore, we requested that commenters submit information relating to alternative percentages and approaches that differentially classify equipment into mutually exclusive categories with category specific usage rate assumptions. In addition, we requested any empirical data that would assist us in these efforts.

h. Equipment Interest Rate

As part of our calculation of the PE equipment costs, we consider several factors, for example, the useful life of each piece of equipment and the typical interest that would be incurred in the purchase of the equipment. We updated the assigned useful life for all the equipment in our PE input database in the CY 2005 PFS final rule with comment period. However, we have used the same interest rate of 11 percent since the inception of the resource based PE methodology in 1999. There has been much discussion regarding whether this is still the appropriate interest rate to utilize in the calculation of the equipment costs. The majority of comments on the CY 2007 PFS final rule with comment period requested an interest rate of prime plus 2 percent while a small number of commenters requested an interest rate significantly lower than prime plus 2 percent.

In the CY 2008 PFS proposed rule (72 FR 38132), we discussed the basis for the current interest rate of 11 percent and indicated that, based on our analysis of the revised SBA interest rate data, we believe 11 percent continues to be an appropriate assumption; therefore, we stated would retain the interest rate used in the calculation of equipment costs at 11 percent.

Comments Concerning Equipment Usage and Interest Rate

Comment: Several commenters, including several specialty societies, MedPAC, and the AMA RUC offered recommendations regarding the 11 percent interest rate and the 50 percent utilization rate used to calculate the

price per minute for each piece of equipment. The recommendations received regarding the proposed 11 percent interest rate were generally favorable with the majority of commenters recommending that we monitor the interest rate annually to ensure that the appropriate percentage is utilized in the calculation of the equipment costs.

The commenters' recommendations about making adjustments to the 50 percent utilization rate varied. Certain commenters recommended we do nothing until stronger empirical evidence is available, while other commenters recommended a decrease in the utilization assumptions, and some commenters recommended an increase in the utilization assumption. The particular changes recommended in the utilization assumptions were, in most cases, directly related to a specific code. Virtually all comments received support an on going process of obtaining reliable empirical data to utilize in the calculation of equipment costs in the future.

Response: As discussed in detail in the CY 2007 PFS final rule with comment period (71 FR 69650), we agree with commenters that both the equipment interest rate and the equipment utilization rate should continue to be examined for accuracy. We are committed to working with all interested parties to define the most accurate utilization and interest rate information for equipment used in the provision of physicians' services. Since we did not propose a specific change, we will maintain the assumptions of a 50-percent equipment utilization rate and an 11-percent equipment interest rate in the calculation of the PE RVUs published in Addendum B of this final rule with comment period. We will continue to monitor the appropriateness of these assumptions, and evaluate whether changes should be proposed in light of the data available.

Comment: A few commenters recommended that the equipment utilization rate associated with preventive services be reduced since much of the equipment associated with preventive services is procedure specific and thus not utilized at as high a rate as other medical equipment.

Response: Similar to our response regarding the equipment utilization rate associated with the entire universe of medical equipment, we do not believe that we have any strong empirical evidence to suggest a change in the current equipment utilization rate associated with preventive services. We are committed to continue working with all interested parties to identify the most accurate utilization rate information for equipment used in the provision of physicians' services.

2. PE Proposals for CY 2008

a. Radiology Practice Expense Per Hour

The American College of Radiology (ACR) presented CMS with information regarding the PE/HR that was used in the PE methodology for radiology in the CY 2007 PFS final rule with comment period. ACR suggested that we change our methodology in a way that would weight the survey data to provide an alternative method of representing large and small practices. We agreed to take their approach to our contractor, the Lewin Group, for further analysis. (We note that the Lewin Group, in its initial analysis of the ACR survey data, had also raised concerns about the representation of small high cost entities in the ACR survey data.) The Lewin Group reviewed ACR's approach and concluded that weighting the ACR survey by practice size more appropriately accounts for the small high cost entities in the final PE/HR. After reviewing both the ACR inquiry and the Lewin response, we also agreed that ACR's approach more appropriately identifies the PE/HR for radiology.

For these reasons, we proposed to revise the PE/HR associated with radiology using the survey data weighted by practice size and included this revised PE/HR in Table 2 of the CY 2008 PFS proposed rule which identified the PE/HR for all specialties.

Comment: Several commenters, including the AMA's RUC, expressed concern over the proposed increase in the PE/HR for radiology whereby the PE/HR associated with this specialty would be developed based upon a revised practice size weighting methodology. Commenters believed that it is inappropriate to refine the current weighting methodology because: (1) This weighting methodology was not done for all specialties; and (2) some specialties requested to survey their memberships after the deadline to submit supplemental survey data and were denied this opportunity by CMS. Several other commenters commended CMS on their ability to review this potential problem and offer a timely resolution to the affected specialty.

Response: The American College of Radiology approached CMS with questions regarding the weighting methodology that were used in the development of their PE/HR. Specifically, ACR believed that small high cost practices that primarily furnish professional only services were severely underrepresented in the published PE/HR. Therefore, we forwarded ACR's concerns to our contractor for further review. Upon review of ACR's concerns, our contractor concluded that their initial PE/HR recommendation to CMS was not fully representative of these smaller high cost practices. For this reason, our contractor recommended a revised weighting approach that would fairly represent these small high cost practices. We agree with both the ACR and our contractor and will finalize our proposal to use the revised PE/HR for radiology.

Additionally, we do not believe that these revisions to the PE/HR for radiology constitute a submission of data after the deadline. No new data were submitted. Rather, we view this as a revision to the weighting methodology in order to address a unique situation.

Comment: Several commenters recommended that all pain management services be crosswalked to the interventional pain management specialty as opposed to using the actual data which currently report the anesthesiology specialty furnishing a significant portion of the pain management services. According to the comments received, anesthesiology is listed as the primary specialty on many pain management services and since the PE/HR associated with anesthesiology is lower than interventional pain management, pain management services are being inappropriately valued.

Response: Physicians self-designate their respective specialty for purposes of Medicare enrollment. If commenters believe that physicians are incorrectly self-designating their specialty as anesthesiology when it would be more appropriate for them to designate interventional pain management, commenters should work with their respective specialty organizations to ensure physicians appropriately designate the correct specialty. If the specialty of a certain percentage of the physicians furnishing the pain management service is actually anesthesiology, we believe that weighting the various PE/HR for all specialties that furnish these services, as we currently do, is the appropriate methodology to establish the final PE/HR for pain management services.

Comment: One commenter recommends that only the PE/HR associated with ophthalmology be used in the establishment of RVUs for CPT code 66984, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or*

phacoemulsification). The commenter contends that the 14 percent of the utilization that is associated with optometry is in error as optometrist would only be involved in the post-operative care of these patients and not the surgical procedure.

Response: Although we did not make any proposals in the CY 2008 PFS proposed rule regarding this issue, we agree that, generally, optometrists will not be involved in the surgical procedure. As stated by the commenter, and supported by the utilization data, there are a significant number of services for which optometrists are involved in the post-operative care of CPT code 66984. The resource-based PE methodology appropriately adjusts for those services identified with modifier 55 (post-operative care only). Since there are PEs associated with the post-operative care of CPT code 66984, and since we adjust the utilization for those services that are identified as the post-operative care only of CPT code 66984, we believe the current methodology appropriately reflects the correct weighted specialty mix associated with this service.

Comment: One commenter recommended that the PE/HR for CPT codes 22862, *Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace,* and 22865, *Removal of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace,* be crosswalked to orthopedic surgery as opposed to the all physician PE/HR. The commenter contended this is similar to the crosswalk change from all physicians to orthopedic surgery that was reflected in the PE methodology in the proposed rule for CPT code 22857, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace.*

Response: CPT codes 22862 and 22865 were new for CY 2007 and absent specific information with respect to the specialty performing the services, we had crosswalked these codes to the all physician PE/HR. We agree with the commenter that these codes are of a similar nature to CPT code 22857. They are part of the same orthopedic family of codes and should be treated consistently when applying the PE methodology. Therefore, we will assign the orthopedic surgery PE/HR to CPT codes 22862 and 22865 as opposed to the all physician PE/HR.

Comment: Several commenters conveyed support for the Physician Practice Information Survey which is currently being administered throughout the nation and encouraged CMS to use this practice cost information to update the current PE/HR data that is being utilized in the development of resourced-based PE RVUs.

Response: The Physician Practice Information Survey is a practice cost survey that is being conducted by the AMA with support from various specialty societies and CMS. We look forward to analyzing the results of the AMA data collection efforts for possible inclusion in the resource-based PE methodology in future rulemaking cycles.

b. RUC Recommendations for Direct PE Inputs and Other PE Input Issues

In the CY 2008 PFS proposed rule (72 FR 38133), we proposed the following concerning direct PE inputs.

(i) RUC Recommendations

In 2004, the AMA's Relative Value Update Committee (RUC) established a new committee, the Practice Expense Review Committee (PERC), to assist the RUC in recommending direct PE inputs (clinical staff, supplies, and equipment) for new and existing CPT codes, a process that was previously accomplished by the Practice Expense Advisory Committee (PEAC).

The PERC reviewed the PE inputs for nearly 300 existing codes at its meetings held in February 2007 and April 2007. (A list of these reviewed codes can be found in Addendum C of the CY 2008 PFS proposed rule.)

In the CY 2007 PFS final rule with comment period, we addressed several issues concerning direct PE inputs and encouraged specialty societies to pursue further review of these inputs through the RUC/PERC process. The following discussions summarize the PERC recommendations regarding these issues:

Cardiac Catheterization Procedures

As discussed in the CY 2008 PFS proposed rule, the PERC considered recommendations for new or updated PE inputs for the family of CPT codes 93501 through 93556 for cardiac catheterization. The American College of Cardiology (ACC), in cooperation with the Society of Cardiac Angiography and Interventions (SCA&I) and the Cardiovascular Outpatient Center Alliance (COCA), developed PE inputs for the nonfacility setting for 13 of the 28 CPT codes in this family.

We proposed to accept the PERC recommendations for the direct PE inputs for the nonfacility setting for the CPT codes 93501, 93505, 93508, 93510, 93526, 93539, 93540, 93542, 93543, 93544, 93545, 93555, and 93556.

In addition, we proposed that the PE for the following CPT codes will not be valued or applicable to the nonfacility setting: 93503, 93511, 93514, 93524, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93561, 93562, 93571, and 93572.

Comment: We received comments from the ACC and the SCA&I thanking us for our consideration of the PERC recommendations for 13 CPT codes for cardiac catheterization procedures performed in the nonfacility setting and for accepting their request not to establish nonfacility PE RVUs for the remaining 15 procedures in the cardiac catheterization family.

Response: We appreciate the commenters' support and have accepted the PERC recommendations for the 13 cardiac catheterization procedures and have changed our PE database to reflect the PE inputs. For the 15 remaining codes, we will finalize the proposal and attach the ''NA'' indicator to them.

Comment: We received comments from COCA, a national organization representing nonfacility medical cardiology practices that conducted a ''Direct Cost Study'' purporting to demonstrate that the major problem with the 2006 RUC estimates of direct PE costs for nonfacility outpatient cardiac catheterization was an inadequate list of direct patient care activities. In addition, COCA contends that the total RUC estimates of clinical labor time were so low as to lack credibility. The commenter contends that a significant amount of the data from its Direct Cost Study were not incorporated into the PE recommendations that were jointly prepared and presented at the April 2007 RUC meeting with ACC and SCA&I for the cardiac catheterization procedures. In addition to the inadequate clinical labor inputs, the commenter believes that the RUC process does not allow for the inclusion of safety devices, such as crash carts, as direct PE inputs because these are not used in the typical case; rather, these are considered indirect PE. COCA has requested that we review the data from the Direct Cost Study and revise the current proposed PE RVUs for these procedures to values that reflect more appropriately the direct and indirect costs of providing these services. As an alternative solution, COCA asks that we tie reimbursement for these services to a reasonable percentage of the hospital APC.

We also heard from many cardiology practices that provide cardiac catheterizations in the nonfacility

setting. They had similar comments and indicated their support for COCA's request that we review the cost study data and revise the PE RVUs to more appropriately value the cardiac catheterization procedures when performed in the nonfacility setting.

Response: While we understand COCA's and the other commenters' concerns about the decrease in the PE RVUs for the cardiac catheterization procedures, we want to clarify that the PE inputs for these procedures were fully considered by the RUC process. The RUC has identified standard descriptions of clinical staff activities that the specialty societies follow as they prepare their recommendations for direct PE inputs believed to be typical to a service and the RUC has established standard values for some of these clinical activities. The RUC does not deviate from accepted standard unless the specialty society presents compelling evidence to substantiate that the variance is typical to the practice for each procedure. In the past, the RUC has recommended, and we agreed, that the crash cart would be included as equipment necessary to perform the services of cardiopulmonary resuscitation, CPT 92950, but is not necessary to perform other services, even though many physicians have purchased and maintain crash carts as part of their medical practices. Since the crash cart is only specified as required for use in CPT 92950, it is considered as indirect PE for all other procedures. We note that COCA's request in the alternative to make payment for these procedures based on a percentage of the OPPS APC is not feasible. The PFS and the OPPS APC payment amounts are determined by different payment methodologies that are specified in the statute. We rely on the RUC process to assist us in establishing the typical PE inputs that are necessary to provide physician services. This is because the specialty-developed PE recommendations that are presented to the RUC are all subject to the same multi-specialty scrutiny. We agree with the PERC's direct PE recommendations for the 13 cardiac catheterization codes in the nonfacility setting and we will accept the RUC PE recommendations for these 13 procedures. However, we are sympathetic to the concerns raised by COCA and echoed by other commenters about the extent to which the data from the Direct Cost Study were considered in the RUC process and we ask that the RUC provide another opportunity for the review of the direct PE inputs for these cardiac catheterization procedures to ensure that the data from the COCA Direct Cost Study is afforded appropriate and adequate consideration.

Obstetric/Gynecologic PE

As discussed in the CY 2008 PFS proposed rule, we agreed with the PERC recommendation to add a non-sterile sheet (drape) 40 in by 60 in (supply code SB006) priced at $0.222 to the pelvic exam pack resulting in the new price of $1.172. This change affected 236 CPT codes for obstetric/gynecologic services containing the pelvic exam pack. We also proposed to accept the PERC recommendations to standardize the equipment used in post-operative visits to include both a power table and fiberoptic light in the PE database for 70 obstetric/gynecologic codes.

Comment: We received a comment from the society representing gynecologic oncologists commending us for making the above changes to the pelvic exam pack and for standardizing the equipment used in follow-up visits. The society believes these changes enable gynecologic oncologists to account for the additional costs incurred in their practice specialty.

Response: We appreciate the specialty society's comments and we will adopt the PERC recommended inputs as proposed.

Dual Energy X-Ray Absorptiometry (DEXA)

The PERC recommended revisions to the direct PE inputs for CPT codes 77080, 77081, and 77082 to comply with established PERC standards, and more appropriately reflect the resources used to furnish these services. We agreed with these PERC recommendations.

Comment: We received several comments thanking us for accepting the RUC's PE recommendations for the DEXA codes. We also received comments from several device manufacturers and specialty societies representing gynecologists, endocrinologists, rheumatologists, and radiologists informing us that the PE recommendations passed by the RUC, which we had proposed to accept in the proposed rule, contained a mistake as to the correct DEXA equipment that is typically used to perform the procedure represented by CPT code 77080. The RUC's PE recommendations listed the DEXA equipment as that using a ''pencil beam'' technology, priced at $41,000. However, the correct DEXA equipment used for CPT 77080 uses the ''fan-beam'' technology and is priced at $85,000.

Response: We were sympathetic to the concerns expressed by the commenters about the listing of the incorrect DEXA equipment, and we worked with the RUC staff to arrange for this equipment error to be reconsidered by the RUC at its September 2007 meeting. The RUC agreed to the specialty society's recommended change in the DXA equipment for CPT 77080. We agree with the recommendations from the specialty societies and the RUC and we have corrected our PE database to reflect that the fan-beam DEXA equipment is typically used for CPT 77080. In addition, a price of $3,000, with documentation, was presented for the spinal phantom used in this procedure. We have also accepted this price and have changed the PE database accordingly.

Comment: We received many comments expressing concerns about the cuts to the PE RVUs for these DEXA services. These commenters believe the cuts are a result of the new PE methodology and may result in access problems for patients because physicians will no longer be able to afford to provide these services in the office setting. One commenter asked us to identify and make available to the public the inputs used to derive the indirect PE RVUs.

Response: We are aware that the PE RVUs for these DEXA services were negatively impacted by the change in the PE methodology, as were those for many other services in which the previous PE RVUs were not based on the PE resources used to furnish the service. Because the new PE methodology now utilizes these resources, it is important to make certain that the PE direct inputs actually reflect the typical resources that are used to provide each service. The methodology for determining the indirect PE RVUs, including a description of each step in the calculation, is detailed earlier in this section. We share the commenters concerns about beneficiary access to DEXA services and will continue to monitor this issue.

Computer-Aided Detection (CAD) Codes

The specialty society for radiological services reviewed the direct inputs for CPT codes 77051 and 77052 and recommended that no changes to the PE inputs were needed. The PERC concurred with this decision and we are in agreement.

Comment: We received a comment from the society representing radiologists conveying their appreciation for accepting the unchanged direct PE inputs for CAD services.

Response: We appreciate the commenter's support and will maintain the PE inputs as proposed.

Nuclear Medicine Services

The specialty society representing nuclear medicine and the PERC recommended that the direct PE inputs for 2 CPT codes contained CPEP inputs and needed to be updated to agree with 2004 PEAC-approved inputs. However, in reviewing the PE database, we discovered that there were 4 other related codes which also had CPEP inputs which should be updated. We made the appropriate adjustments to substitute the PEAC inputs for the CPEP for CPT codes 78600, 78607, 78206, 78647, 78803 and 78807.

The specialty society also noted that for 7 CPT codes, revision of x-ray related supplies was required, including the number of x-ray films, developer solution, and film jackets. The PERC forwarded these recommendations and we made the appropriate changes to the PE database for the following CPT codes: 78600, 78601, 78605, 78606, 78607, 78610 and 78615.

Comment: The specialty society representing nuclear medicine expressed appreciation for acceptance of their recommended inputs and indicated it will continue to monitor the nuclear medicine codes and provide inputs and refinements as necessary and appropriate.

Response: We appreciate the specialty society's comments and we will adopt the PERC recommended inputs as proposed.

Transcatheter Placement of Stent(s)

At the request of the specialty societies representing radiology and interventional radiology, the PERC considered and approved direct PE inputs for the nonfacility setting for 3 CPT codes, 37205, 37206, and 75960, for transcatheter placement of stent(s). Among the supplies, a ''vascular stent deployment system'', valued at $1,645, was noted by the society as the typical stent used for CPT codes 37205 and 37206 requiring 2 such stents for the placement in the initial vessel and 1 stent for each subsequent vessel, respectively. We reviewed a published clinical research study that was forwarded by the specialty society. The study indicated that 1 stent was typical for the procedure of CPT code 37205. As discussed in the CY 2008 PFS proposed rule (72 FR 38134), absent any further verification from the specialty, we included only 1 stent in the PE database for this code.

Comment: Commenters, representing specialty societies for radiology, interventional radiology and vascular surgery appreciated the proposal assigning direct PE inputs for the nonfacility setting for these three CPT codes. However, these commenters expressed concern that the number of stents had been reduced. One commenter agreed that two stents may not be typical but requested guidance on how the cost of the additional stent could be billed; another of the commenters asked that we reconsider this decision or at a minimum include the ''average'' of 1.5 stents. One of the commenters also noted that several studies clearly establish that these peripheral stent services are safely performed in the nonfacility environment, with nearly all of the procedures in the studies resulting in short observation stays, typically of less than 4 hours.

Response: Based on a review of the literature and other information provided by the commenters we will revise the PE database for CPT code 37205 to reflect 1.5 stents.

Comment: Two commenters, representing manufacturers, expressly urged us to consider the safety issues surrounding the proposal to value these procedures in the nonfacility setting and believe that this conflicts with the decision to exclude these procedures from the ambulatory surgical center (ASC) list. One of these commenters acknowledged that, while we have no specific policy to identify which procedures can be safely performed in a physician's office, we do have some safety standards for ASCs. The commenter requested that the ASC standards be extended to the physician office. This commenter also referenced studies that demonstrate complications can be associated with these procedures, and suggested that these risks need to be addressed by appropriate safety or quality standards.

Response: We appreciate the commenters' viewpoint. However, as the commenters acknowledged, we have no established policy to designate procedures that can be ''safely'' performed in the physician office setting. The purpose of the PFS is to establish proper payment for procedures furnished by physicians and other health professionals. Several medical specialty societies recommended the valuation of these services in the nonfacility setting, which suggests to us that these procedures are being furnished in nonfacility settings on a regular basis. These societies provided the recommended PE inputs involved in furnishing the typical service in a nonfacility setting, and these inputs were reviewed, accepted and recommended by the RUC. We also note that, as indicated in the previous comment, one commenter provided literature from studies to support that these services are safely performed in the nonfacility environment. Because it appears these procedures are being furnished regularly in nonfacility settings, we believe it is appropriate to value them for payment in those settings. Therefore, we will value these procedures in the nonfacility setting as proposed.

Comment: One commenter noted that payment for CPT code 75960, the supervision and interpretation service associated with the 2 CPT codes discussed above for the transcatheter placement of stent(s), is still shown as carrier-priced in the Addendum of the proposed rule.

Response: We regret the error. The Addendum and PFS database have been corrected to reflect the appropriate RVUs.

(ii) Remote Cardiac Event Monitoring

In the CY 2007 PFS final rule with comment period, direct PE inputs for remote cardiac event monitoring (CEM) services represented by CPT codes 93012, 93225, 93226, 93231, 93232, 93270, 93271, 93733, and 93736 were revised on an interim basis to reflect the unique circumstances surrounding the provision of these services. Unlike most physicians' services, CEM services are furnished primarily by specialized IDTFs that, due to the nature of CEM services, must operate on a 24/7 basis. The specialty group representing suppliers that furnish CEM services believes that these services require additional direct PE inputs, such as telephone line charges associated with trans-telephonic transmissions and fees associated with providing Web access for storage and transmission of clinical information to the patient's physician. We continue to work with the specialty group regarding the specific direct PE inputs, as well as the components for the indirect PE allocation, based on surveys conducted by the specialty group. To clarify and further the results of our discussions with and information provided by, the specialty group, we requested comments in the CY 2008 PFS proposed rule on the appropriateness of the above-mentioned direct PE inputs. In addition, we invited comments on any additional direct inputs and components of the indirect PE allocations which would be appropriate for these services, along with supporting documentation to justify their inclusion for PE purposes.

Comment: We received comments from medical societies, provider organizations and a device manufacturer thanking us for working with these organizations to develop direct PE for

these services that do not fit the typical physician service model. Several comments supported the specific PE proposals supplied by the specialty group representing providers that furnish CEM services, and urged us to adopt them. A medical society representing cardiologists requested to work with us and the remote CEM provider groups to gather and review any additional necessary data prior to adoption of additional direct PE inputs.

The CEM provider group specifically proposed that we add telephone transmission costs to the direct PE inputs for CPT codes for CEM, 93012 and 93271 and the CPT codes for pacemaker monitoring, 93733, and 93736. The group also identified expenses for Web-based storage, maintenance and access to clinical information to be allocated to the CEM and pacemaker monitoring CPT codes, as well as the holter monitoring CPT codes 93226 and 93232. In addition to these supply PE recommendations, the CEM provider group proposed equipment time-in-use increases for the holter monitors, cardiac event monitors and for INR monitors (which are discussed later in this section).

Response: We carefully reviewed the information supplied by all of the commenters and believe that it would be valuable for the commenters to work together, including the cardiology specialty society, before we establish further direct PE inputs for these cardiac monitoring services. In addition, we would like to make the CEM providers aware that it appears the assignment we made in CY 2007 of 43,200 time-in-use minutes for the looping CEM monitor used in CPT code 93271 (typically used for a 30-day period) pays back the cost of this CEM monitor, that is valued at $995, in less than 5 months, even though the CEM monitor has an established 4-year useful life. As we discuss later in the Prothrombin Time, International Normalized Ratio (PT/INR) section, we believe that the time-in-use assigned to any one device should not exceed its useful life. We will review this time-in-use assignment for CEM monitors during our CY 2009 rulemaking.

(iii) Prothrombin Time, International Normalized Ratio (PTI/NR)

As discussed in the CY 2008 PFS proposed rule, based on comments received and subsequent discussions with entities that furnish these PT/INR services, we adjusted the time in use for the home monitor equipment for G0249 *Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting pwiof [prothrombin] test results to physician; per four tests* to 1440 minutes to reflect that the monitor is dedicated for use 24 hours a day and unavailable for others receiving this service. We invited comments on this change, as well as comments on any additional direct inputs which would be appropriate to this service, along with supporting documentation to justify their inclusion for PE purposes.

Comment: We received comments from specialty societies, provider groups, and individuals expressing their appreciation of our attempt to correct the problem concerning the application of PE methodology for the PT/INR service, but noted their concern that changing the INR home monitor time-in-use minutes from 32 to 1440 does not have a rational basis nor does it provide for an adequate recoupment of the cost of the device. These commenters requested that we assign a more realistic figure to capture the 28-day period that the patient is required to use the monitor. One commenter noted that using the current 1440 minutes, it would take 11.7 years to recoup the $2000 price of the equipment which has an assigned life of 4 years. The commenters suggested several alternative methodologies to calculate the time-in-use for the INR monitor. One method suggests multiplying the 1-day time, 1440 minutes, by 4, which represents the number of tests conducted in the 28-day period, to equal 5,760 minutes. This method would take 3 years to get back the $2000 value of the INR monitor. Another proposal suggests multiplying the 1-day 1440 minutes by 28 days which is the actual time the patient has the equipment. This method yields 40,300 minutes and the commenter admittedly states this method greatly overestimates the value of the INR monitor because it would take just 5 months to recoup the $2000 price. One commenter suggested that we simply amortize the price of the equipment, $2,000, over the useful life of 4 years. Another commenter's suggestion uses the annual minutes figure of 150,000 that we use in our formula for deriving per minute equipment costs, and divides it by 28 (days) to arrive at 5,753 minutes. This method recoups the INR monitor price in 3 years.

Other commenters voiced concerns about the valuation of the INR home monitor and offered alternatives to capture the cost of the device. One commenter suggested that we treat the cost of the INR home monitor as a one-time upfront cost and include this price in HCPCS code G0248 that is used to report the demonstration of the INR monitor to the patient, at the initial use. Another commenter recommended that the INR home monitor be removed from the PE for both G0248 and G0249 and be considered under the DME benefit.

Response: We understand the concerns expressed by the commenters and appreciate their suggested alternatives that we could use to more appropriately cover the costs of the INR home monitor. Further, we agree that the 1440 minutes we assigned for CY 2007 seems too low considering that the patient uses the INR home monitor for 28 days, not just one. After reviewing all of the suggested alternatives, we eliminated the two proposals asking us to change the mechanism of payment for the INR home monitor. We, therefore, considered the various suggestions for establishing a more appropriate time-in-use value for the INR home monitor. We believe the proposal that best reflects the policy we use to determine the time-in-use for equipment items where the actual minutes-in-use exceed the assigned useful life is the commenter's suggestion to amortize the $2000 INR monitor over its 4-year life. Using this method, 4,315 minutes is the necessary time-in-use figure to recover the purchase price of the equipment in 4 years. We will replace the 1440 minutes assigned for CY 2007 with 4,315 minutes as the time-in-use for the INR home monitor and will change the PE database accordingly.

(iv) Positron Emission Tomography (PET) Codes Clinical Labor Time

We received comments from the specialty society representing nuclear medicine regarding a discrepancy in the clinical labor time for CPT codes 78811, 78812, and 78813 which are PET codes for tumor imaging. The specialty noted that the clinical labor time indicated in the PE database differs by 7 minutes from the time that was previously recommended by the PERC in April 2004. We agreed with the specialty society that the PE database labor inputs for these 3 PET codes are incorrect and we made the appropriate adjustments to the PE database.

Comment: The specialty society representing nuclear medicine expressed appreciation for acceptance of its recommended inputs and indicated it will continue to monitor the nuclear medicine codes and provide inputs and refinements as necessary and appropriate.

Response: We thank the specialty society for reviewing the direct inputs for their related procedures in the PE

database that we post as a download with each proposed and final rule on our Web site (*www.cms.hhs.gov/PhysicianFeeSchedule/PFSFRN*). We will adopt the recommended inputs as proposed.

(v) Nuclear Medicine PE Supplies

The specialty society representing nuclear medicine commented that the PE database currently contains supply items that are inappropriate for certain procedures and provided the information to make the corrections. For respiratory imaging procedures represented by CPT codes 78587, 78591, 78593, 78594, 78630, 78660, 78291, and 78195, the specialty society noted specific IV supply items to be deleted from procedures where they are not required. For a thyroid imaging procedure represented by CPT code 78020, x-ray supply items were recommended for deletion. In addition, the society recommended adding supply items for respiratory imaging procedures, including nose clips, masks, and nebulizer kits, as appropriate, to CPT codes 78584, 78585, 78591, 78593, 78594, 78586, 78587, 78588, and 78596. For a kidney function study represented by CPT code 78725, injection supply items were noted as missing and the specialty society requested that these be added. We proposed to accept these direct PE input corrections and revised our PE database accordingly.

Comment: The specialty society voiced its gratitude for the acceptance of their recommended inputs.

Response: We thank the specialty society for its interest in assuring the accuracy of the PE inputs in the procedures provided by their members. We will adopt the PERC recommended inputs as proposed.

(vi) Arthroscopic Procedure Nonfacility Inputs

In the CY 2008 PFS proposed rule (72 FR 38135), we included a discussion about the establishment of nonfacility direct PE inputs for the arthroscopic procedures represented by CPT codes 29805, 29830, 29840, 29870, and 29900. Absent specific recommendations from the RUC and because some physicians are already performing these procedures in the office setting, we specifically requested comments regarding the appropriateness of establishing nonfacility PE inputs for these arthroscopic procedures when they are provided in the office setting. We also invited comments as to the specific direct PE inputs, following the RUC approved standardized format, that are typical in the provision of each above listed arthroscopic procedure furnished in the physician's office. We indicated we will review these comments to determine whether or not it is appropriate to propose on an interim basis PE inputs for these codes in the nonfacility setting in our final rule.

Comment: We received comments from the specialty society representing orthopedic surgeons in opposition to the establishment of nonfacility PE for the arthroscopic procedures because they believe these procedures are not safely performed in the office setting. The specialty society indicated that one of these codes, CPT 29900, *Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy,* was surveyed by the RUC in April 2001 and, at that time, the RUC recommended this service only as a facility-based procedure. The RUC supported the AAOS concerns and recommended that the PE RVUs for the nonfacility setting remain designated as ''NA.'' The specialty society believes that if the arthroscopic procedures were valued in the nonfacility setting, untrained physicians may begin to perform them and, as a result, patients will face significant risks. The specialty society believes that only credentialed physicians should perform these procedures and that this process can only be ensured in the facility-based setting. The specialty society also asserts the facility-based setting is the safest setting for these procedures because it affords the physician more clinical options for dealing with any complications that may arise. In addition, if the procedure is furnished in the nonfacility setting, there would be no way to address any treatable lesion that is found and a patient would need to be seen in the facility setting to undergo a second procedure.

Because the specialty society's position was established by an expert panel, the society states that it will reconsider its position if evidence is presented establishing the safety and efficacy of these procedures in the office setting and if a method is established to ensure that only qualified physicians perform these procedures in the office setting.

We also received comments from orthopedic practices and individual physicians—the majority of which indicated they are members of the orthopedic specialty society—all stating that they are currently performing these procedures in the nonfacility setting. These comments requested that we establish PE inputs for the arthroscopic procedures because this would allow patients greater access to these services in more convenient settings and, because it would establish payment that would more fairly compensate them for the resources they use to provide these services in the office location. A product manufacturer supported the views of the physicians who requested the establishment of nonfacility PE for the nonfacility setting.

These physicians note that the safety of the in-office procedures is well documented in the literature, and provided us with citations of articles going back to the mid-1990s. We also received suggested PE inputs including clinical labor, supplies and equipment that are typically used when these procedures are provided in the nonfacility setting.

Response: We appreciate the concern expressed by the commenters opposing the establishment of PE for the office setting and are sympathetic to those supporting the assignment of PE for these codes. We are also dismayed that the parties involved on each side of this issue have not been able to resolve these issues to date. We have decided that the most prudent course of action is to defer proposing nonfacility inputs for these arthroscopic procedures in this final rule. We are hopeful that the specialty society and its physician colleagues who provide these services in the nonfacility setting will be able to discuss the issues of mutual concern regarding the safety of performing these procedures in the office setting. We are hopeful that this issue can be resolved and that the physicians performing these services in the nonfacility setting will be given the opportunity to have a multi-specialty review by the RUC. We are aware that this decision to refer this issue back to the specialty society and the RUC postpones the establishment of nonfacility PE values for these procedures until CY 2009, at the soonest, and that a review by the RUC process is not guaranteed. However, given the apparent level of dissension within the specialty, we believe that the specialty society, its physician colleagues, and the RUC should first be given an opportunity to resolve these important issues.

(vii) Nonfacility Inputs for CPT Code 52327

As discussed in the CY 2008 PFS proposed rule we indicated that the society representing urologists requested that we remove all of the nonfacility PE inputs for CPT code 52327, *Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material.* The specialty society reasoned that the nonfacility PE value is inappropriate since the procedure is never performed in the physician office;

it is specific to the pediatric population; and, as such, is always performed with general anesthesia. We agreed with the specialty society that this procedure is incorrectly valued for the nonfacility setting and proposed to accept its recommendation to remove the nonfacility direct PE inputs, revising the PE database accordingly.

Comment: The specialty society thanked us for accepting its recommendation to remove the nonfacility PE for this procedure. However, the society indicated that a review of the PE database on our Web site indicated that these inputs were still included and suggested that they be deleted.

Response: We appreciate the commenter's attention to detail and have removed the PE inputs from the PE database.

(viii) Maxillofacial Prosthetics

We have been working with the society representing maxillofacial prosthetists since 2005 to establish nonfacility direct inputs for the prosthetic services represented by the CPT code series, 21076 through 21087. The current PE database reflects the labor, supplies, and equipment needed to perform each procedure. However, we do not have pricing information and documentation for many supply items. The society provided information and documentation for equipment prices, but because specific time-in-use information was not provided, we developed time in use in 2006 for each equipment item in each procedure. For CY 2007, these equipment inputs were utilized under the new PE methodology to calculate the nonfacility PE RVUs for these procedures. Although we have asked the specialty society to provide the supply pricing information and time in use data for each equipment item for each procedure, we have not received the requested information to date. Consequently, unless such information is provided, the PE database will continue to have no prices associated with these supplies. Therefore, in the CY 2008 PFS proposed rule, we proposed to cap the time in use for each equipment item at 25 minutes until specific information is received regarding the actual time in use. Tables listing the needed information for were included in the proposed rule.

Comment: The specialty society representing the maxillofacial prosthetists supplied us with some of the requested information. The society provided us with the time-in-use data for every piece of equipment for each of the procedures in the CPT code series 21076 through 21087. The specialty also provided prices for the supply items used in this code series; however, it did not provide any documentation to support these prices.

Response: We appreciate the information provided by the specialty, especially that in relation to the equipment time-in-use. The recommended equipment times were compared with the total clinical labor time for each procedure and times that were greater were reduced to equal the labor time, in accordance with our usual allocation policy. Capping the equipment time-in-use to match the labor time affected 4 pieces of equipment in every procedure including: the dental chair, ceiling light, air compressor, and delivery unit. For 3 of these codes, the time-in-use for a 5th piece of equipment, the washout and curing unit, was also capped. We will accept the specialty's equipment time-in-use information, with the aforementioned variances, and have changed the PE database accordingly.

We regret that documentation for the supply prices was not forwarded. We did, however, receive a catalog documented pricing for articulating paper/ribbon that was submitted by a different specialty in reference to another CPT code, and have entered this price in the PE database for 8 of the 10 codes in this family, as appropriate. The specialty is reminded that our policy for accepting prices for supplies or equipment in the PE database requires the submission of acceptable documentation, the definition of which is specified below the table that appeared in the proposed rule listing the outstanding prices for supply items needing documentation. We will continue to work with the specialty as it collects and forwards this important information.

(ix) Requests for Increases in Supply Prices

We received a request from the specialty society for obstetrics and gynecology to increase the price of supply item (kit, hysteroscopic tubal implant for sterilization) for CPT code 58565, *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants* for this code which was created for CY 2005. This hysteroscopic implant kit is priced at $980 and the specialty is now requesting a price of $1,245, providing an invoice for documentation. The specialty reports that the higher price is attributed to a manufacturer change in design and materials, and submitted the manufacturer's documents supporting these changes that were used to secure FDA approval. Therefore, we proposed to accept the new price of $1,245 for the hysteroscopic implant kit due to the changes made in the modified model.

Comment: We did not receive comments on this proposal.

Response: We will finalize our proposed price of $1,245 for the hysteroscopic implant kit and will amend our PE database, as appropriate.

(x) Supply and Equipment Items Needing Specialty Input

We have identified certain supply and equipment items for which we were unable to verify the pricing information (see Table 2: Supply Items Needing Specialty Input for Pricing and Table 3: Equipment Items Needing Specialty Input for Pricing). In our CY 2008 PFS proposed rule, we listed both supply and equipment items for which pricing documentation was needed from the medical specialty societies and, for many of these items, we received sufficient documentation containing specific descriptors and pricing information in the form of catalog listings, vendor Web pages, invoices, and manufacturer quotes. We have accepted the documented prices for many of these items and these prices are reflected in the PE RVUs in Addendum B of this final rule with comment period. For the items listed in Tables 2 and 3, we are requesting that commenters provide pricing information on items in these tables along with acceptable documentation, as noted in the footnote to each table, to support recommended prices. For supplies or equipment that have previously appeared on this list, and for which we received no or inadequate documentation, we proposed to delete these items unless we receive adequate information to support current pricing by the conclusion of the comment period for this proposed rule.

In Tables 4 and 5, we have listed new supplies and equipment from the new CPT codes for CY 2008 that are discussed elsewhere in this final rule with comment period. These items have been added to the PE database and, where priced, are reflected in the PE RVUs in Addendum B.

TABLE 2.—SUPPLY ITEMS NEEDING SPECIALTY INPUT FOR PRICING

Code	2006/7 Description	Unit	Unit price	Primary associated specialties	Associated *CPT code(s)	Prior item status on table	Commenter response and CMS action	2008 item status refer to note(s)
SC088 ..	Fistula needle, dialysis, 17g.	Item ...	.....	Dermatology	36522	Yes	Documentation received. Revised description per specialty's comments. Price accepted at $1.62.	C
	Gas, argon, cryoablation.	.....	.....	Urology, Radiology, Interventional Radiology.	50395	No	New Item	A, E
	Gas, helium, cryoablation.	.....	.....	Urology, Radiology, Interventional Radiology.	50395	No	New Item	A, E
SD140 ..	Pressure bag	item	8.925	Cardiology	93501, 93508, 93510, 93526.	Yes	Documentation received. Price accepted at $19.00.	C
SL119 ..	Sealant spray	oz	.....	Radiation Oncology ...	77333	Yes	No comments received.	B
SD213 ..	Tubing, sterile, nonvented (fluid administration).	item	1.99	Cardiology	93501, 93508, 93510, 93526.	Yes	Documentation received. Price accepted at $0.949.	C
	Stent, vascular, deployment system.	Kit	$1,645	Radiology, Interventional Radiology.	37205, 37206	Yes	Documentation received. Price retained at $1,645.	C
	Catheter, Kumpe	Item ...	.....	Radiology, Interventional Radiology.	50385, 50386	No	New item	A, E
	Disposable aspirating syringe.	.....	.....	Oral and Maxillofacial Surgery.	21073	No	New item	A, E
	Guidewire, angle tip (Terumo), 180 cm[1].	.....	.....	Radiology, Interventional Radiology.	50385, 50386	No	New item	A, E
	Snare, Nitinol (Amplatz).	Item ...	.....	Radiology, Interventional Radiology.	50385, 50386	No	New item	A, E

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Note: Acceptable documentation includes—Detailed description (including system components), source, and current pricing information, such as copies of catalog pages, hard copy from specific Web pages, invoices, and quotes (letter format okay) from manufacturer, vendors or distributors. Unacceptable documentation includes—phone numbers and addresses of manufacturer, vendors or distributors, Web site links without pricing information, etc.

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

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

Note C: Submitted price accepted.

Note D: Deleted per comment or CMS.

Note E: 2007/8 price retained on an interim basis. Forward acceptable documentation promptly.

TABLE 3.—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING AND PROPOSED DELETIONS

Code	2006/7 Description	2007/8 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status on table	Commenter response and CMS action	2008 Item status refer to note(s)
EQ269 ...	Ambulatory blood pressure monitor.	3000	Cardiology	93784, 93786, 93788.	Yes	Documentation provided. Price accepted is $1525 (Did not accept $395 warranty cost.).	C
	Camera mount—floor	2300	Dermatology	96904	Yes	Specialty to submit, asap.	A, E
	Cross slide attachment.	500	Dermatology	96904	Yes	Specialty to submit, asap.	A, E
	Dermal imaging software.	4500	Dermatology	96904	Yes	Documentation provided. Price accepted at $4500.	C
	Dermoscopy attachments.	650	Dermatology	96904	Yes	Documentation provided. Price accepted at $650 (average of the cost of the two items provided).	C

TABLE 3.—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING AND PROPOSED DELETIONS—Continued

Code	2006/7 Description	2007/8 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status on table	Commenter response and CMS action	2008 Item status refer to note(s)
EQ008 ...	ECG signal averaging system w-P waves and late potentials software.	8,250	Cardiology, IM	93278	Yes	Documentation provided. Revised description to better describe system. Price accepted at 17,900.	A, E
	Instrument, microdissection.	.....	Pathology	88380	No	New Item	A, E
	Lens, macro, 35–70mm.	.....	Dermatology	96904	Yes	Deleted item as price is less than $500 per documentation received.	D
	Plasma pheresis machine.	37,900	Radiology, Dermatology.	36481, G0341	Yes	Revised description based on comments received that light source was not part of item. Documentation requested.	B
ED039 ...	Psychology Testing Equipment.	.....	Psychology	96101, 96102	Yes	Specialty to submit, asap.	B
ER070 ...	Portal imaging system (w/PC work station and software).	377,319	Radiation oncology	77421	Yes	Documentation provided. Price accepted at $489,940 (average of the cost of the two items provided).	C
	Strobe, 400 watts (Studio) (2).	1500	Dermatology	96904	Yes	Documentation requested.	B
	Cryosurgery system (for tumor ablation)[1].	.....	Urology, Radiology, Interventional Radiology.	50593	No	New item	A, E

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Note: Acceptable documentation includes—Detailed description (including system components), source, and current pricing information, such as copies of catalog pages, hard copy from specific Web pages, invoices, and quotes (letter format okay) from manufacturer, vendors or distributors. Unacceptable documentation includes—phone numbers and addresses of manufacturer, vendors or distributors, Web site links without pricing information, etc.

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

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

Note C: Submitted price accepted.

Note D: Deleted per comment or CMS.

Note E: 2007/8 price, where specified, retained on an interim basis. Forward acceptable documentation promptly.

TABLE 4.—PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR CY 2008

Equip code	Supply description	Unit	Unit price	*CPT code(s) associated with item	Supply category
NA	Blade, sharp pointed surgical	item	0.73	88381	Cutters, closures.
NA	Buffer, lysis	ml	0.46	88381	Lab.
NA	Caps, Capsure Macro LCM	ml	4.54	88380	Lab.
NA	Catheter, balloon, lacrimal	item	306	68816	Accessory.
NA	Catheter, Kumpe [1]	item	.....	50385, 50386	Accessory.
NA	Disposable aspirating syringe [1]	.....	.....	21073	
NA	Ethanol, 95%	ml	0.0033	88380, 88381	Lab.
NA	Fee, image analysis	item	18	99174	Office supply.
NA	Gas, argon, cryoablation	.....	.....	50593	Accessory.
	Gas, helium, cryoablation	.....	.....	50593	Accessory.
NA	Gastrostomy. Low profile replacement button (Mic-Key)	item	5	43760	Accessory.
NA	Gastrostomy. Stoma measuring device (Mic-Key)	item	10	43760	Accessory.
NA	Glycerol, 3%	ml	0.001	88380, 88381	Lab.
NA	Guidewire, angle tip (Terumo), 180 cm [1]	item	.....	50385, 50386	Accessory.
NA	IV infusion set, Sof-set (Minimed)	item	11.50	90769, 90771	Hypodermic, IV.
NA	Methylene blue stain	ml	0.178	88380	Lab.
NA	Probe, cryoablation, renal	item	1175	50593	Accessory.
NA	Rnase-free water	ml	0.85	88381	Lab.
NA	Slide, microscope, sterile	item	1	88380, 88381	Lab.
NA	Snare, Nitinol (Amplatz) [1]	item	.....	50385, 50386	Accessory.
NA	Swab, patient prep, 1.5 ml (chloraprep)	item	1.04	36592	Pharmacy, NonRx.

TABLE 4.—PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR CY 2008—Continued

Equip code	Supply description	Unit	Unit price	*CPT code(s) associated with item	Supply category
NA	Tube, jejunsostomy	item	195	49441, 49446, 49451 and 49452.	Accessory.

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

TABLE 5.—PRACTICE EXPENSE EQUIPMENT ITEM ADDITIONS FOR CY 2008

Equip code	Equipment description	Life	Unit price	*CPT code(s) associated with item	Equipment category
NA	Cryosurgery system (for tumor ablation) [1]	10	.....	50593	Other Equipment.
NA	Cardiac coil, 1.5T 8-channel (MR)	5	35400	7557, 7558 and 75559.	Imaging Equipment.
	Instrument, Microdissection	7	.....	88381	Laboratory.
NA	Pressure sensor, wireless (for implanted AAA sac sensor)	5	25000	93982	Documentation.
NA	Camera, ocular photoscreening, w-laptop and software	5	7000	99174	Documentation.

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

(xi) Additional PE Issues Raised By Commenters

Comment: One commenter recommends that the direct inputs associated with all fee schedule services be made available to the public.

Response: Since the inception of resource based PEs, all direct input data has been made available to the public on the CMS Web page. The direct inputs associated with this final rule with comment period are also available to the public at the following Web site under CMS–1385–IFC: *http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage*.

Comment: Several commenters recommend that we reprice supply items over $200 in the PE direct input database annually. Additionally, commenters also requested that we establish individual J codes for these high cost supplies. Alternatively, several other commenters expressed concerns over this recommendation stating that utilization guidelines must be set up that would trigger repricing or an undue burden would be placed upon those specialties using these high cost supplies.

Response: Using an individual HCPCS code for each of these supplies would be difficult as there are multiple manufacturers, with multiple prices, associated with the majority of these codes. Having multiple manufacturers, and thus multiple prices, also makes it difficult to reprice these supplies within the PE methodology, which is why we continue to work with the AMA RUC to establish direct cost input data. Additionally, all direct inputs need to be budget neutralized within the PE methodology. Removing these high cost supplies from the standard PE methodology would unfairly advantage procedures that contain these supplies as they would not be subject to the same budget neutrality adjustments as would other supplies. Finally, we agree with those commenters that state that any annual repricing of these supplies would place undue burden on specific physician groups. For these reasons, we will continue to price these high cost supplies within the standard PE methodology.

Comment: A few comments were received that recommended that desktop computers be included as a direct PE cost.

Response: The direct PE database includes desktop computers with monitor when this computer is identified as being dedicated to a specific procedure. The costs associated with computers that are used for non-clinical purposes assigned to a specific procedure, for example, used for administrative procedures, are more appropriately captured in the indirect cost category.

Comment: One commenter representing home care physicians requested that travel time and other inherent costs related to mobile medical services such as vehicle operation and mobile communication should be accounted for in the PE calculation.

Response: To the extent that travel time is necessary to furnish physician services outside of the office setting, these expenses are not considered direct costs under the PE methodology. Although the mobile communication devices are not specifically included as direct PE inputs, 12 minutes of clinical labor time is assigned for each of the home visit E/M services, 6 minutes in the pre-time period and 6 minutes in the post time period. Phone calls are standardized at 3 minutes each for purposes of the direct PE inputs and would be included as part of this clinical labor time.

Comment: One commenter stated that adjustments need to be made to the PE database for certain dialysis codes and requested that for G0393 and G0392 an angioplasty balloon be added to the PE database and that for CPT code 36870 the PE database should be revised to include an angiographic room and a power table.

Response: The balloon catheters are reflected in the PE database, as supply number SD152, and the angiographic room and an exam table are included in the equipment for CPT code 36870.

Comment: Commenters expressed concern about the level of reimbursement for intrathecal pump management services for chronic pain patients and believe that the refill kit is not accounted for in the PE. In addition, commenters expressed concern that reimbursement did not cover the leasing costs for the equipment.

Response: We reviewed the PE database and have verified that a refill kit, priced at $28, is included as a supply in CPT codes 95990 and 95991. In our PE database, equipment costs are assigned based on the purchase price for each piece of equipment, regardless of whether the equipment is owned, rented or leased.

Comment: A manufacturer expressed concern that the PE RVUs for intranasal administration of vaccines (CPT codes 90467/8 and 90473/4) are inappropriately low and should be equalized to the injectable immunization administration PE RVUs.

The commenter stated that when the codes were reevaluated in 2004 there was not enough experience in the office to fully understand the time associated with providing an intranasal vaccine. The commenter stated that specialty organizations have indicated that this issue is worth reexamining and indicated that they had been encouraged to communicate with the RUC in support of equalizing payment for the codes.

Response: We appreciate the commenter's concerns about the disparity in the PE RVUs for the intranasal and injectable immunization administration procedures. To the extent that these concerns relate to the direct PE inputs, we would encourage the commenter to work with the specialty organizations to determine if it is appropriate to bring these codes forward for further RUC review.

Comment: One commenter requested that we publish the RUC approved RVUs for all noncovered and carrier priced services, particularly for the positron emission tomography (PET) and PET/CT procedures.

Response: We have made it our policy to publish work and PE RVUs for services in instances where the information has been forwarded to us, with a few exceptions. One exception to this policy is for carrier priced codes. Our rationale for this policy is simply that any published values for carrier-priced codes would be in direct contradiction of our intentions with respect to this designation. As we state in Addendum A, a ''C'' status indicator means that carriers price this code establishing RVUs and payment amounts without direct guidance from CMS. Because the commenter did not provide us with information about specific noncovered services that do not have published RVUs, we are not able to address this particular aspect of the comment.

Comment: Commenters representing radiation oncologists expressed concern about the significant PE reductions in CPT code 77336 for continuing medical physics consults. The commenters noted this code was last reviewed by the PEAC in 2002 and the practice standard has changed significantly. Commenters recommended that the direct PE inputs for this code be reviewed and refined so that accurate PE data is reflected for this code.

Response: While we appreciate that the commenters expressed their concerns to us regarding a change in the practice standards for the services of CPT code 77336 which they believe results in the need to change the direct PE inputs, we believe that the appropriate course of action for the commenters is to work together with the RUC affiliated specialty society in order to determine if these concerns can be appropriately addressed by the RUC.

Comment: We received comments from individuals and associations with concerns about the new bottom-up PE methodology and the resulting effect of decreases in the PE RVUs for various services including, but not limited to the following: chemotherapy administration, endovenous ablation procedures, brachytherapy treatments, 3-D imaging services, and procedures for photopheresis and plasma pheresis.

Response: As we noted earlier in this section, we are aware that the PE RVUs for some services were negatively impacted by the change in our PE methodology. However, we will reiterate here that it is our policy to make certain, to the maximum extent possible, that the direct PE inputs used in the PE RVU calculation actually reflect the typical resources used to provide each service. To the extent that the current PE RVUs are lower than those determined under our previous methodology, the difference is likely attributable to a previous PE RVU that was based on charges that overvalued the service. Because the current methodology uses the direct PE inputs that are inherent and typical to each procedure, the resulting PE RVUs more accurately reflect the resources that are used to provide the service.

Comment: One commenter explained that, in the CY 2004 PFS final rule, we decided to set the values for the monthly ESRD-related services for home dialysis patients (for example, G0323) at the same rate as the monthly ESRD related services with 2 or 3 visits per month (for example, HCPCS code G0318) to provide an incentive for the increase use of home dialysis (as authorized under 1881(b)(3)(B) of the Act). The commenter notes that the current payment rate for ESRD related services, with 2 or 3 face-to-face visits per month is higher than ESRD related services for home dialysis patients, (due to a difference in PE). As such, the commenter is concerned that the differential in payment rates mitigates the incentives that we previously attempted to establish. The commenter suggested that incentives for using home dialysis should be strengthened by using a consistent PE value for MCP codes G0323 and G0318. However, the commenter prefers that we establish a new payment rate for the monthly management of home dialysis patients based on the weighted average of the MCP for patients who dialyze in a dialysis center or other outpatient facility.

Response: We appreciate the suggestions regarding our payment policy for the monthly management of home dialysis patients. We intend to consider the commenters suggestions as we continue to evaluate payment rates for the monthly management of patients on home dialysis.

Note: We received comments regarding certain items and services that are not germane to the PE RVUs or other components of the PFS. These issues include comments regarding: revisions to the definition of pre-service work and time for certain global services; inadequate pricing of HCPCS code A4562 for pessaries, requests for payment adjustments for certain services under PFS to approximate payment amounts for these services established under OPPS and ASCs, inadequate payment for pharmacy costs and nursing services for drug administration codes, and concerns about the reduction of PE RVUs in the nonfacility setting due to the changes in the PE methodology along with requests to freeze payment amounts at the level of the CY 2006 transitional PE RVUs. Because these comments are outside the scope of the issues raised in the CY 2008 PFS proposed rule, we will not respond to these issues in this final rule with comment period.

B. Geographic Practice Cost Indices (GPCIs)

We are required by section 1848(e)(1)(A) and (C) of the Act to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities; and to review and, if necessary, adjust the GPCIs at least every 3 years. In the CY 2008 PFS proposed rule, we published the proposed GPCIs for CY 2008 in Addendum E, noting that the proposed GPCIs do not reflect the 1.000 floor that was in place during CY 2006 and CY 2007. This floor expires as of January 1, 2008 in accordance with section 102 of the MIEA–TRHCA.

In developing a GPCI, section 1848(e)(1)(A)(i) and (ii) of the Act require that the PE and malpractice (MP) GPCIs reflect the full relative cost difference while section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one quarter of the relative cost differences. Section 1848(e)(1)(C) of the Act 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. All GPCIs are developed through a comparison to a national average for each component, and the RVUs for different services uniformly weight each component.

1. GPCI Update

A detailed description of the methodology used to develop and update the GPCIs can be found in the CY 2004 PFS proposed rule (68 FR 49039, August 15, 2003). There are three components of the GPCIs (physician work, PE, and MP) and each relies on its own data source.

a. Physician Work

The physician work GPCI is developed using the median hourly earnings from the 2000 Census of workers in six professional specialty occupation categories which we use as a proxy for physician wages and calculate to reflect one quarter of the relative cost differences. Physician wages are not included in the occupation categories because Medicare payments are a key determinant of physicians' earnings; therefore, including physician wages in the physician work GPCI would, in effect, make the index dependent upon Medicare payments. The physician work GPCI was updated in 2001, 2003, and 2005 using data from the 2000 Census; the proposed CY 2008 physician work GPCI is also based on the 2000 Census data. Because all updates since 2001 have relied on the 2000 Census data, the changes observed in the physician work GPCI in the update years are due to minor changes in utilization and budget neutrality factors; for CY 2008, Addendum E shows that there have been small changes in the physician work GPCI. Section 102 of the MIEA–TRHCA required application of a 1.000 floor on the work GPCI in payment localities where the work GPCI was less than 1.000. This provision expires on December 31, 2007. The CY 2008 proposed physician work GPCI reflects the removal of this floor.

b. Practice Expense

The PE GPCI is developed from three data sources:

(i) *Employee Wages:* We use 2000 Census median hourly earnings of four occupation categories. The physician work GPCI was updated in 2001, 2003, and 2005 using data from the 2000 Census.

(ii) *Office Rents:* We use residential apartment rental data produced annually by the Department of Housing and Urban Development (HUD) as a proxy for physician office rents. In 2001, 2003, and 2005, we used rents in the HUD 40th percentile. For CY 2008, we have calculated the GPCI using rents in the 50th percentile for the physician office rent proxy. We proposed to use the 50th percentile because although HUD generally allows payment for subsidized housing up to the 40th percentile, in some areas it allows payment up to the 50th percentile. We made this change to reflect the trend toward higher rents across the country.

Fair Market Rents (FMRs) are gross rent estimates including rent and utilities. HUD calculates the FMRs annually using: (1) Decennial Census data; (2) American Housing Surveys conducted by the Census Bureau for HUD to enable HUD to develop revisions between Census years; and (3) random digit dial surveys to enable HUD to develop gross rent change factors. The American Housing Surveys cover 11 areas annually, rotating among the 44 largest metropolitan areas. The random digit dial component surveys 60 FMR areas annually.

The FMR is set as a percentile point in the distribution of rents for standard housing occupied by people who moved within the previous 15 months. The current FMR definition is the 40th percentile rent (the amount below which 40 percent of units are rented). Each year, the 50th percentile rent is also calculated by HUD and available through the HUDUSER Web site.

In 2000, HUD changed its FMR policy to increase access to housing for families receiving Section 8 rent subsidy vouchers (65 FR 58870). To do so, HUD increased FMRs from the 40th percentile to the 50th percentile in areas where subsidized families were highly concentrated in certain census tracts, given evidence that affordable housing was not well distributed. Only metropolitan areas with more than 100 census tracts are considered for possible increase to the 50th percentile rent. FMRs can be moved from 40th to 50th percentile or back from 50th to 40th percentile.

In the case of the office rent index for the PE GPCI, FMRs have been used to capture geographic differences in rental costs, in the absence of a consistent commercial rent index that covers all metropolitan and nonmetropolitan areas in the U.S. It has been used as a measure of the ''average rent'' in a market. However, since 2000, the FMRs have been a mixture of the 40th percentile and 50th percentile rents. FMR areas move between the two cutoffs. For example, in California, 9 counties had FMRs set at the 50th percentile in 2004. In 2007, only 2 of these 9 counties were still at the 50th percentile level for the FMR, out of 4 total counties at the 50th percentile level.

As described above in this section (and as detailed in 65 FR 58870), the criteria for setting the FMR at the 40th or 50th percentile are based on concentrations of subsidized households. There is no reason to assume that commercial rents would follow the same patterns.

Therefore, we believe the 50th percentile, or median, rents calculated by HUD will be a more consistent, fair measure of geographic differences for the purpose of proxying for commercial rents.

Rent data produce the most significant changes because they are based on annual changes in HUD rents, and therefore, are more volatile than the wage (Census) data. While it has been suggested that we explore sources of commercial rental data for use in the GPCI, we do not believe there is a national data source better than the HUD data.

(iii) *Equipment and Supplies:* We assume that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. As mentioned in previous updates, some price differences may exist, but we believe these differences are more likely to be based on volume discounts rather than on geographic market differences. Equipment and supplies are factored into the GPCIs with a component index of 1.000.

c. Malpractice

The MP GPCI is calculated based on insurer rate filings of premium data for a $1 million to $3 million mature ''claims made'' policy along with premium or surcharge data for mandatory patient compensation funds (PCFs). The MP GPCI is the most volatile of the GPCIs. This GPCI was updated in 2001 and 2003 as scheduled with the physician work and PE GPCIs; but, there was an unscheduled update of the MP GPCI in 2004 (68 FR 49043) to reflect increases in MP premiums nationwide. The proposed CY 2008 MP update reflects the most recent premium data available. The physician work and PE GPCIs are being updated at the same time.

We received the following comments about our proposed GPCIs:

Comment: We received several comments expressing the concern that San Benito County in California was placed in the wrong payment locality.

Response: In 2003, the U.S. Census Bureau moved San Benito County from the Rest of State Census category and placed it in the San Jose MSA. Our data and methodology do not accommodate mid-decennial changes in Census data, and therefore, our 2008 update reflects that San Benito County remains in the Rest of California payment locality.

Comment: We received several comments about the PE GPCI for Santa Clara County, California. In the proposed rule, the PE GPCI was lower for Santa Clara than it has been in previous years and commenters were concerned about why this happened.

Response: We recognize that there was a decrease in the proposed Santa Clara County PE GPCI. We have studied this issue including examining both the source data and the methodology for obtaining the PE GPCI in case there was a mistake in the proposed values. However, a close examination of the data showed that the GPCI is accurate and reflects a decrease in the value of HUD rentals in Santa Clara County.

Comment: One commenter suggested that a GPCI adjustment should not be applied to physician work, or that the physician work GPCI should be 1.000 for all localities.

Response: We are required to apply a GPCI adjustment to physician work in accordance with section 1848(e) of the Act. Therefore, we will continue to apply the physician work GPCI.

Comment: We received several comments suggesting that the PE GPCI is inaccurate due to our continued use of HUD rental data as a proxy for medical office space.

Response: Because Medicare is a national program, we believe it is important to use the best data that is available on a nationwide basis. We believe the HUD rental data is the most comprehensive and valid indicator of the national real estate rental market that is available. Additionally, as we stated most recently in the CY 2007 PFS final rule with comment period (71 FR 69656), we believe the HUD rental data remains the best data source to fulfill our requirements that the data be available for all areas, be updated annually, and retain consistency area-to-area and year-to-year. In the past, we have had both the GAO and the Research Triangle Institute examine available data sources for use in the PE GPCI, and both have found that available commercial data sets either have insufficient coverage nationally or are developed by suspect methodology. Therefore, we continue to believe the HUD rental data is the best nationally available data source to use as a proxy for physician office rents.

Comment: We received several comments suggesting that the GPCIs of Hawaii/Guam and Alaska need to be adjusted to accommodate the higher costs of transportation of supplies and equipment to these localities.

Response: The GPCIs are a proxy for costs associated with providing services to beneficiaries, not costs associated with living in a particular place. However, we will consider these comments as we evaluate possible changes to our methodology.

Comment: We received comments from the Medicare Payment Advisory Commission (MedPAC) suggesting an alternative method for calculating the PE GPCI. This alternative PE GPCI method excludes cost measures for equipment and supplies.

Response: We appreciate MedPAC suggesting an alternative method. We intend to evaluate the suggested change to the PE GPCI methodology and will propose any changes in future rulemaking.

We will finalize the GPCIs shown in Addendum E. The GPCI values shown represent the first year of the two-year GPCI update transition and have been budget neutralized to ensure that nationwide total RVUs are not impacted by changes in locality GPCIs. Specifically, this is done by applying a weight that is derived from the difference between payments using the ''old'' GPCIs and the ''new'' GPCIs to the proposed GPCIs that insures that total payments would not be different. As we indicated above in this section, there is no 1.000 floor on the physician work GPCI in 2008. The GAFs are shown in Addendum D.

2. Payment Localities

a. Background

The Medicare statute requires that PFS payments be adjusted for certain differences in the relative costs among areas. The statute requires an adjustment which reflects differences among areas for the relative costs of the mix of goods and services comprising PEs (other than Malpractice expenses) compared to the national average. The statute also requires adjustment for the relative costs of MP expenses among areas compared to the national average. Finally, the statute requires adjustment for one quarter of the difference between the relative value of physicians' work effort among areas and the national average of such work effort.

The physician work component represents 52.466 percent of the national average fee schedule payment amount. Thus, the statutory requirement for geographic adjustment of only one-quarter of the differences in the physician work component means that, on average, only 13.117 percentage points of physician work are geographically-adjusted, and, on average 39.349 percentage points of the physician work component are not adjusted and represent a national fee schedule amount.

In addition, the PE component represents 43.669 percent of the national average fee schedule payment amount. PEs are comprised of nonphysician employee compensation, office expenses (including rent), medical equipment, drugs and supplies, and other expenses. As explained above in this section, we do not make a geographic adjustment relating to medical equipment, drugs, and supplies because there is a national market for these items. Thus, only the categories of nonphysician employee compensation and rents are geographically adjusted. These categories represent, on average, 30.862 percentage points of the total PE, and 12.807 percentage points of PEs are not geographically-adjusted.

In total, more than half (52.156 percent) of the average PFS amount is a national payment that is the same in all areas of the country; that is, 52.156 percent of the average fee is not geographically-adjusted.

There are two additional points about the geographic indices that are important to note. First, as described above in this section, the data used to measure cost differences among localities are proxies for physician work, employee compensation and office rents. That is, wage data for various categories of employees are used to proxy the actual wages of physician employees. Second, the data used for such proxies are based on actual Census data only for a limited number of counties. The geographic adjustment factors (GAFs) for more than 90 percent of counties are developed using proxies based on larger geographic areas (for example, data for all rural areas in a State are combined and used to proxy the values for each rural county in a State). This aggregation is necessary for areas where country level data are not available. Thus, the underlying data are proxies for actual costs, and the resulting GPCIs do not measure perfectly the cost differences among localities.

Currently, there are 89 Medicare physician payment localities to which GPCIs are applied. The payment locality structure under the PFS was established in 1996 and took effect January 1, 1997. The development of this structure is described in detail in both the CY 1997 PFS proposed (61 FR 34615) and final rules (61 FR 59494).

b. Revision of Payment Localities

Over time, changing demographics and local economic conditions may lead to increased variations in practice costs within payment locality boundaries. We are concerned about the potential impact of these variations and have

been studying this issue and potential alternatives for a number of years. However, because changes to the GPCIs must be applied in a budget neutral manner (and under the current locality system, budget neutrality results in aggregate payments within each State remaining the same), there are significant redistributive effects to any change. Therefore, we are also concerned about the potential impact of locality revisions.

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.

The California Medical Association (CMA) suggested that we use our demonstration authority to adopt an alternative locality configuration and avoid certain redistributive effects, but such an approach was not feasible (as discussed in the CY 2005 PFS final rule with comment period (70 FR 70151)). In the CY 2006 PFS proposed rule (70 FR 45784), we proposed to remove two counties from the ''Rest of California'' payment locality and create a new payment locality for each county. These two counties were the ones with the largest difference between the county and locality GAFs. However, there was much more opposition than support for this proposal, in large part because of its negative effect on payments for the counties that would have remained in the ''Rest of California'' locality. For example, the CMA commented on this proposal stating, ''a nationwide legislative solution that would provide additional funding * * * is the only solution we are supporting at this time.'' We did not finalize the proposal and described our reasons in the CY 2006 PFS final rule with comment period (70 FR 70151).

As indicated previously, we recognize that changing demographics and local economic conditions may lead to increased variations in practice costs within payment locality boundaries. We are concerned about the potential impact of these variations.

In considering potential changes in payment localities, we believe it is important to evaluate both the potential impact of intralocality practice cost variations and the redistributive impacts that would result from any revisions to the localities. We also indicated that we are concerned about the considerable administrative issues in making locality changes, particularly if such changes involve a transition, and if they occur when new GPCI data are being phased-in. As we noted in the response to the June 2007 General Accountability Office report on localities (GAO–07–466), changing localities requires reprogramming systems and extensive provider education, both of which are expensive and burdensome administrative activities that can last for a significant period of time. We receive claims for payment that cross calendar years and carriers must maintain payment files for the 2 different years.

In the proposed rule we solicited comments on three possible locality reconfigurations. We indicated that because of the importance of striking an appropriate balance between intralocality variations and redistributive impacts with any such locality revisions, we wanted to be cautious and evaluate the impacts in California before considering applying the policy more broadly in the future.

The three options from the proposed rule are described as follows:

Option 1: Using the existing locality structure, apply a rule whereby if a county GAF is more than 5 percent greater than the GAF for the locality in which the county resides it would be removed from the current locality. A separate locality would be established for each county that is removed. Based on the new fully phased-in GPCI data (that is, for CY 2009), application of this approach in California would remove three counties (Santa Cruz, Monterey, and Sonoma) from the Rest of California payment locality and Marin county from the Marin/Napa/Solano payment locality and create separate payment localities for each of these four counties.

This approach focuses on counties for which there is the biggest difference between the county GAF and the locality GAF.

This proposal is similar to the policy we previously proposed in the CY 2006 PFS proposed rule (70 FR 45784) but did not adopt to address the counties with GAFs that are most different from their current locality designation. Implementation of this option would lead to an increase in payment of 7.6 percent for Santa Cruz County (and average increase of 5 percent for the other counties involved) and a decrease in payment of 4.3 percent for Napa and Solano Counties.

Option 2: This approach is similar to option 1, but the new localities would be structured differently. We would use the same 5 percent threshold methodology but instead of creating four new localities in which each county becomes its own new locality, the three counties that are removed from the Rest of California locality would become one new locality. Marin County would still be removed from the Marin/Napa/Solano locality to become its own locality. Application of this approach would remove three counties (Santa Cruz, Sonoma, and Monterey) from the Rest of California payment locality, and Marin County from the existing Marin/Napa/Solano payment locality. This approach groups together counties from the Rest of California locality that have the greatest difference between the county and locality GAF. (This option would lead to an increase of 6 percent for the new 3-county payment locality.) These counties have similar cost structures and grouping them together into one new locality is consistent with our goal of homogeneous resource costs within a locality.

Option 3: Apply a methodology similar to that used in the 1997 locality revisions (61 FR 59495), but applied at the county level rather than the ''existing locality'' level. That is, we sorted the counties by descending GAFs and compared the highest county to the second highest. If the difference is less than 5 percent, the counties were included in the same locality. The third highest is then compared to the highest county GAF. This process continues until a county has a GAF difference 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 approach would group counties within a State into localities based on similarity of GAFs even if the counties were not geographically contiguous.

This organizes payment localities based on costs, which would reduce the number of payment localities in California from 9 to 6 localities. This option alleviates the greatest variations in cost between counties in California. This proposal is unique in that the new localities are not contiguous. Currently, all localities encompass adjacent geographic areas.

The impacts associated with this option are significant. Depending on the tier, changes could reflect increases of as much as 7.6 percent or decreases of as much as 7.3 percent.

We received numerous comments on these options as discussed below:

We received similar comments from a number of individuals, State and local medical societies, and organizations, including the California Medical Association, on several significant issues and are addressing these together:

Comment: Santa Cruz County should be removed from the Rest of California payment locality due to its higher costs.

Response: We recognize that Santa Cruz County has higher costs than other

counties within the Rest of California locality, and the methodologies we presented in each of the options would result in Santa Cruz County being removed from the Rest of California payment locality.

Comment: Many commenters were concerned about the description of the methodology used for Options 1 and 2. Specifically, these comments directed us to adopt a methodology suggested by the California Medical Association. The methodology compares the highest GAF county to the weighted average (GAF) of the remaining counties of the locality.

Response: To clarify, the methodology we used identified counties where the county GAF was at least 5 percent higher than the GAF of the locality and then we either left that county as a payment locality itself or joined it with other counties into a payment locality. In Option 1, each of these counties became a separate locality; in Option 2, we combined several of these counties into a single payment locality. This approach is not the ''iterative methodology'' that some commenters suggested we should follow. We recognize that there are alternative methodologies that can be used to consider reconfigurations to locality structures. We will consider the suggestions of the commenters in the future.

Comment: There were concerns that combining several counties into a single payment locality in Option 2 was arbitrary and led to lower payments for these counties.

Response: As we stated in the proposed rule, there are trade-offs involved in making any changes to localities, and we recognize the importance of trying to achieve a reasonable balance among competing priorities. One of our goals was to keep the number of payment localities manageable. Although we recognize that there are effects on each of the individual counties, combining counties with very similar costs was a reasonable way to meet this goal.

Comment: Numerous commenters from California recommended that we implement Option 3 but suggested that we erred in describing the methodology used in the development of Table 9 of the proposed rule and recommended that if we implement it, we should use their suggested methodology. Commenters suggested that we really meant to insert a hierarchical approach and discussed how these are both acceptable ways to accomplish the restructuring of the counties. Other State societies expressed interest in this option as long as we use the alternative methodology suggested by the California commenters.

Response: In Option 3 in the proposed rule, we ranked the counties by GAF from highest to lowest. We then combined into a new payment locality the county with the highest GAF and the other counties that have a GAF within 5 percent of the highest GAF county. Then, we found the county with the highest GAF among the remaining counties. We combined that county and all the counties that have a GAF within 5 percent of the new highest GAF county into a payment locality. We continued this method until all counties were included in a locality. As previously mentioned, there are multiple approaches to reconfiguring the localities that result in similar outcomes. We will further study the suggestions provided by the commenters.

Comment: We received a number of comments requesting that we provide a wide variety of data, at the county level, from numerous sources covering the years 1999 through 2006.

Response: We believe we provided commenters sufficient information to fairly evaluate our proposals. We note that many of these requests involved county level data. There is very little county level data available nationwide. Most of our data sources are collected at the MSA or Consolidated MSA, or Non-Metropolitan Area level, and our methodology was designed to be used to develop GPCIs within a payment locality analysis, not a county level analysis. We do our best to provide requestors with sources for publicly available data and to provide any other data that is requested of CMS. However, we often simply do not have data available at other than the locality level.

Comment: Several commenters are concerned that the data used to develop the latest GPCI update are out of date or inaccurate.

Response: We used the most up-to-date data available for the GPCIs used in the calculation of the proposed options. Descriptions of the data sources we use can be found in previous regulations (69 FR 66261) but we will reiterate them here. For the physician work GPCI, we use data files from the latest decennial census (currently 2000) supplied to CMS by the Census Bureau. These data are available to any individual or group interested in obtaining them from the Census Bureau. Data for the rental portion of the PE GPCI update come from HUD rental files, and these data are available online to anyone wishing to obtain them. Wage data for the PE GPCI come from the 2000 Census files which are available from the Census Bureau. Data for the malpractice GPCI come from premium data that are filed by companies writing Professional Liability Insurance in each state. These filings are provided, upon request by our contractor, to CMS by each State Department of Insurance. Our latest update covers premium data for 2004, 2005 and 2006.

Comment: We received comments from certain physicians in Ohio requesting that we examine Ohio for a possible change in the current Statewide payment locality.

Response: We are currently examining alternatives to the current locality structure. As a part of our study we will revisit Statewide localities to determine if revisions are appropriate.

Comment: We received a number of comments from ambulance suppliers throughout the mid-West requesting that we make no changes that would have a negative impact on the GPCIs in rural areas. Other commenters expressed similar concerns about the impact of locality changes on rural physicians and beneficiaries.

Response: The vulnerability of rural areas to decreases in relative payments as a result of locality revisions is an issue that is of considerable concern to us and something we take very seriously. However, as previously noted we must find an acceptable balance between the multiple competing concerns when making changes in localities in order to best meet the needs of the entire program and this generally cannot be done without having any impact on rural areas.

Comment: MedPAC provided comments outlining two possible mechanisms for developing changes in the payment localities of the States. These methods are similar but differ in that one method begins at the locality level and the other starts with MSA level data. MedPAC also suggests that we determine whether those States that are currently single payment localities wish to remain single payment localities.

Response: As always, we value the input of MedPAC and we intend to analyze their suggested methods carefully as we discuss possible national policy changes.

Comment: Comments regarding changes in the payment localities in California were universally accompanied with a belief that we should implement these changes, without decreasing payments to any counties.

Response: We understand the desire to avoid the negative impact implementing any of these options might have on certain areas. However,

the statute requires that geographic adjustments be established based upon an index of costs that is tied to national averages. As a result, when the average increases in one locality because of the addition of a higher cost county, the average in the locality that previously contained the higher cost county will necessarily decrease. Any changes in localities will necessarily produce changes in the underlying GPCIs, and we have no authority to assign or retain GPCIs that do not represent the actual values for a locality.

Comment: Many commenters suggested that we consider a national solution to payment locality structure problems, not focus on a single state.

Response: Our proposals attempted to address locality issues in an area of the country where the incongruity of certain GAFs within localities is particularly evident. In addition, these issues have been brought to our attention regularly over the past several years, and the California Medical Association has demonstrated its desire and willingness to work with us to develop ideas for resolving them. We viewed these proposals relating only to California as a starting point and, as we indicated in the proposed rule, we would consider applying any changes to additional States in the future.

Decision: We appreciate the thoughtful comments we received in response to the three options we included in the proposed rule. As mentioned above, we recognize that changing the locality structure is a complex undertaking and there are competing concerns, including budget neutrality that results in payments in certain areas decreasing whenever payments in other areas are increased, that must be carefully balanced to achieve the most appropriate results. Historically, to help us find the best balance in a particular state, we have looked to State medical societies to work with us to provide leadership and support on preferred approaches to locality reconfiguration in that particular State.

The comments we received from California physicians, including the California Medical Association's indication that it does not support any of the options, and interested parties from other States have convinced us that this issue requires further study and analysis. Therefore, we will not be finalizing any of the three proposed options in this rule. Commenters have suggested some other methodologies that we find worthy of further exploration, including the use of Metropolitan Statistical Areas (MSAs). We do not necessarily believe that the county is the appropriate geographic unit on which we should be focusing for locality revisions. Commenters also made strong arguments for why any locality reconfiguration should be done on a nationwide basis and not just one State at a time. Therefore, we intend to conduct a thorough analysis of approaches to reconfiguring localities and will address this issue again in future rulemaking.

C. Malpractice RVUs (TC/PC Issue)

In the CY 2008 PFS proposed rule (72 FR 38142), we included a discussion about the radiology codes for which the technical component malpractice RVUs are higher than the professional component malpractice RVUs. In the past, several organizations have requested that we examine these codes and make changes to this assignment of malpractice RVUs. We asked for information about how we could address this issue and obtain data on malpractice costs associated with these radiology codes.

We received the following comments on this issue.

Comment: The Professional Liability Insurance (PLI) workgroup of the AMA/Specialty Society RVU update committee (RUC) supported by several other organizations recommended that we reduce the PLI technical component for these codes to zero. They suggest that there are no identifiable separate costs for professional liability for technical components. They also recommend that the PLI RVUs be redistributed across all physicians' services. The RUC is concerned that the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) cap on the TC payment for imaging services will remove an estimated $200 million from the Part B pool (as a result of the exemption of the reduced expenditures from the budget neutrality requirement at section 1848(c)(2)(B)(v)). The RUC believes that making the recommended changes will keep money that would be lost due to the DRA cap in the Part B pool. The RUC wants CMS to implement this change immediately and consider other changes to the PLI RVU assignment later.

Response: In the CY 2008 PFS proposed rule, we explained that these codes had not been reviewed due to a lack of suitable data on the cost of PLI for technical staff or imaging centers. The RUC believes that no such data are available because there are no identifiable separate costs. At this point in time, we are not able to evaluate whether sufficient data exists or to make a judgment on the RUC's assertion that such data are not available because there are no identifiable costs. We will continue to explore possible sources of information about these costs. We made no proposal regarding malpractice RVU assignment and we are still considering possible changes. If we identify in the future what we believe is a more appropriate way to pay for these services, we will propose changes through notice and comment rulemaking.

Comment: Some commenters stated that the malpractice RVUs in the technical component should not be zero. These commenters suggested that we either ''flip'' the malpractice RVU assignment between the professional and technical components or make them equal.

Response: As we stated in the CY 2008 PFS proposed rule, we do not believe it would be appropriate to ''flip'' the PC and TC RVU values because the professional part of the MP RVUs has undergone a resource based review, is derived from actual data, and is consistent with the resource based methodology for PFS payments. Further, we will not simply equalize the PC and TC RVU values because at this time we have no data to demonstrate that the malpractice costs for the technical portion of these services are the same as the professional portion. We will continue to study this issue and will propose any changes in future rulemaking.

Comment: We received several comments recommending that we make the PLI RVUs resource based for all codes and that we should continue to collect and analyze appropriate malpractice premium data before making changes to the RVU assignment.

Response: We will continue to solicit, collect, and analyze appropriate data on this subject. Once we have sufficient information, we will be better able to make a determination as to what, if any, changes should be made, and we will propose any changes in future rulemaking.

D. Medicare Telehealth Services

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

As discussed in the CY 2008 PFS proposed rule (72 FR 38143), 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 CY 2003 PFS final rule with comment period (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 office and other outpatient visits, consultation, 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 furnished under the monthly capitation payment (MCP) with two to three visits per month and four or more visits per month (although we require at least one visit a month, in person ''hands on'', by a physician, Certified Nurse Specialist, NP, or PA to examine the vascular access site); and individual medical nutrition therapy.

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 2006 are considered for the CY 2008 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/*.

We received the following requests for additional approved services in CY 2006: (1) Subsequent hospital care (as represented by HCPCS codes 99231 through 99233); (2) neurobehavioral status exam (HCPCS code 96116); and (3) neuropsychological testing (HCPCS codes 96118 through 96120).

After reviewing the public requests, we proposed to add neurobehavioral status exam as described by HCPCS code 96116 to the list of Medicare telehealth services in the CY 2008 PFS proposed rule. We also proposed to revise § 410.78 and § 414.65 to include neurobehavioral status exam as a Medicare telehealth service. We did not propose to add subsequent hospital care or neuropsychological testing but requested comments as to how we could determine when subsequent hospital care is actually a follow-up inpatient consultation and specific information on neuropsychological testing. For further information on our proposals, see the CY 2008 PFS proposed rule (72 FR 38143).

Subsequent Hospital Care

The following is a summary of the comments we received regarding subsequent hospital care.

Comment: We received two comments regarding the conditions (or requirements) we could apply to subsequent hospital care so that subsequent hospital care reflects a follow-up inpatient consultation. One commenter suggested that follow-up inpatient consultation should be approved as a telehealth service only if the initial inpatient consultation was performed via telehealth. The commenter does not believe we should approve a follow-up inpatient consultation for telehealth if the initial inpatient consultation was furnished in-person (because it might lead to a reduction in follow-up consultations furnished face-to-face). The commenter also agreed with our proposal not to approve subsequent hospital care for telehealth. Another commenter noted that follow-up inpatient consultation was previously on the list of Medicare telehealth services and asserts that the AMA's deletion of follow-up inpatient consultation (as described by CPT codes 99261 through 99263) created the need to approve the addition of subsequent hospital care to the list of Medicare telehealth services when used for follow-up inpatient consultation care. The commenter suggested that we create a special modifier to report follow-up inpatient consultation via telehealth.

Response: We appreciate the comments on the conditions (or requirements) we could apply to subsequent hospital care so that subsequent hospital care reflects a follow-up inpatient consultation. We intend to consider the suggestions raised by the commenters as we continue to evaluate whether subsequent hospital care should be approved for telehealth when it is used to furnish a follow-up inpatient consultation. With regard to the commenter who suggested the creation of a special modifier, we will assess whether it would be appropriate to use a modifier(s) to identify when a subsequent hospital care service is actually a follow-up inpatient consultation.

Comment: One commenter who supports approving subsequent hospital care for telehealth explained that recruiting specialists to North and South Dakota is difficult and that telehealth has helped hospital inpatients in these States to obtain access to various types of specialty care including pulmonology, endocrinology, pediatric gastroenterology, pediatric cardiology, and infectious disease specialties. The commenter also mentioned that inpatient consultations are frequently provided by infectious disease specialists for patients in the intensive care unit (ICU) and explained that once the patient has made progress and is moved from the ICU, the infectious disease specialist at the distant site continues to ''follow'' the patient until the patient is discharged from the hospital. The commenter recognized that access to on-going specialty care for outpatients is important but believes that obtaining access to specialty subsequent inpatient ''follow-up'' care is even more critical. Commenters submitted a comparative study between subsequent hospital care furnished as a telehealth service and furnished in-person.

Response: As discussed in the CY 2008 PFS proposed rule, given the potential acuity level of the patient in the hospital setting, we believe that many services furnished within the scope of the subsequent hospital service codes are not similar to the current telehealth services. As such, we indicated that subsequent hospital care is a category 2 service (which requires sufficient comparative analyses before approving it for telehealth). The commenters did submit one comparative analysis between subsequent hospital care furnished as a telehealth service and subsequent hospital care furnished in-person. However, the study submitted involved only continuing specialist care (for one specialty), not continuing inpatient care by the primary attending physician. In

addition, the sample size was extremely small. Thus, the study findings are not generalizable.

As such, we continue to have concerns about using a telecommunications system as a substitute for the on-going, day-to-day (in-person) evaluation and management of a hospital inpatient and believe further study is necessary. In the absence of sufficient, well-designed comparison studies showing that the use of a telecommunications system is an adequate substitute for the in-person delivery of subsequent hospital care, we are not adding subsequent hospital care to the list of Medicare telehealth services. As discussed above in this response, we will work with the industry organizations and groups to learn more about hospital care as a telehealth service when it is used for follow-up inpatient consultations.

Comment: One commenter (who submitted the request to approve subsequent hospital care for telehealth) stated that the original request to add subsequent hospital care to the list of Medicare telehealth services was a request to ''re-establish'' subsequent inpatient visits (as a Medicare telehealth service). The commenter described two scenarios in which subsequent hospital care could be furnished as a telehealth service. The first scenario would involve a specialty physician who furnishes an inpatient consultation as a telehealth service (as requested by the attending physician). The second scenario involves an attending or admitting physician who furnishes initial hospital care in-person (not as telehealth) and provides subsequent hospital care as a telehealth service. The commenter believes that access to telehealth care is better than not having access to any care and that studies have shown that telehealth care provides better clinical outcomes than no care at all. Additionally, the commenter asserts that tertiary care trauma surgeons, neurologists (for initial and follow-up stroke evaluation), psychiatrists (for initial assessment and prescriptive safety orders), infectious disease physicians, and cardiologists can be made available through telehealth when these specialties are not available on-site. The commenter believes that not approving subsequent hospital care for telehealth will severely hinder access to specialty care in the inpatient hospital setting and will lead to grave consequences for patients when no specialists are available on-site (at the hospital).

Response: We agree that telehealth services may help provide greater access to specialty care, and therefore, better clinical outcomes where a shortage of medical professionals exist (or in situations when no care is available). As discussed in the CY 2008 PFS proposed rule, we are considering approving subsequent hospital care for telehealth when it is used for follow-up inpatient consultation. We believe that permitting follow-up inpatient consultations via telehealth will help provide greater access to specialty care in the inpatient hospital setting.

Additionally, we note that, contrary to the commenter's assertion, subsequent inpatient hospital visits were not previously on the list of Medicare telehealth services. As mentioned by a previous commenter, the AMA deleted the codes for follow-up inpatient consultation (as described by CPT codes 99261 through 99263). Effective January 1, 2006, these CPT codes no longer exist and were removed from the PFS, and a conforming change was made to the list of Medicare telehealth services. Prior to January 1, 2006, the physician (or practitioner) at the distant site could have used these CPT codes to bill for follow-up inpatient consultations as a telehealth service. However, subsequent inpatient hospital visits were not on the list of Medicare telehealth services.

Comment: One commenter cited the concerns we raised in the proposed rule regarding the acuity level of a hospital inpatient and the use of a telecommunications system to furnish on going evaluation and management services in the inpatient hospital setting. The commenter believes that patients in the emergency department typically have a higher acuity level, are in a more precarious physical state (as compared to a hospital inpatient) and may not have a diagnosis. The commenter explains that hospitalized patients have already been seen and admitted by a physician on site and have at least a preliminary diagnosis. Despite the higher acuity level of a patient in the emergency department, the commenter asserts that we reimburse for telehealth care in the emergency department (but not for inpatients).

Additionally, the commenter discussed various scenarios involving the examination of acute stroke patients via telehealth in the emergency room and ICU. For example, the commenter provided a summary of a study that tested whether the use of an audio and video multimedia telecommunications system is a feasible and reliable means for delivering emergency stroke care (using the National Institute of Health Stroke Scale). This study concluded that ''remote examination of acute stroke patients with a computer based telesupport system is feasible and reliable when applied in the emergency room''. The commenter also explained how telehealth is being used to provide 24 hour access to acute stroke care expertise for a number of hospitals in Massachusetts and that similar programs are being established throughout the United States, Canada, the United Kingdom, Scandinavia, and other parts of the world. The commenter also provided a discussion of a study that examined the fiscal impact of providing telehealth consultation (for acutely ill and injured children in the ICU) on rural hospitals. The study found that as a result of greater access to pediatric consultations, savings are realized from a reduction in patient transfers (to larger hospitals) and increased revenue for rural hospitals.

Response: We appreciate the information the commenter has submitted on the remote evaluation of stroke patients and pediatric telehealth consultations in the emergency department or ICU. We intend to consider this information as we evaluate whether to approve subsequent hospital care for telehealth when it is used for follow up inpatient consultation. We would also mention that the nature of the comment indicates a misconception that we pay for emergency department services as a telehealth service. We note that only outpatient consultations (not visits) are approved as a Medicare telehealth service for a patient in the emergency department. If guidance or advice is needed in the emergency department (for example, for acute stroke care), an outpatient consultation may be requested from an appropriate source and may be furnished as a telehealth service. However, emergency department services (as described by CPT codes 99281 through 99285) are not on the list of Medicare telehealth services.

Comment: One commenter mentioned that we previously approved the psychiatric diagnostic interview examination and subsequent ESRD related visits furnished under the monthly capitation payment (MCP) for telehealth without comparative analyses and data showing patient satisfaction (which implies that subsequent hospital care could be approved for telehealth on the same basis). The commenter also cited the proposed regulatory impact analysis for telehealth stating that previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures.

Response: In approving the psychiatric diagnostic interview examination for telehealth, we considered this service to be comparable

to an initial office visit, or consultation service, which are currently Medicare telehealth services. Likewise, we considered the outpatient dialysis visits furnished under the MCP (except for one visit to examine the vascular access site) to be comparable to office and other outpatient visits currently on the list of Medicare telehealth services. Therefore, we considered these services to be category 1, and therefore, we were able to review and approve them for telehealth without reviewing additional research studies to support their approval. However, as discussed above in this section, because of the potential acuity of a hospital inpatient, we were not able to conclude that the entire scope of services described by the subsequent hospital care codes is similar to the existing list of telehealth services (for example, an office visit, office psychology service, or consultation). Therefore, we considered subsequent hospital care to be a category 2 service (which requires sufficient comparative analyses before approving for telehealth).

For more information on the addition of the psychiatric diagnostic interview examination see the CY 2003 PFS proposed rule (67 FR 43863). For more information on the addition of ESRD-related visits furnished under the MCP, see the CY 2005 PFS proposed rule (69 FR 47511).

Neurobehavioral Status Exam

Comment: Several commenters expressed support for our proposal to add the neurobehavioral status exam to the list of Medicare telehealth services. Commenters agreed that because the neurobehavioral status exam is primarily a clinical interview (similar to the psychiatric diagnostic interview which is currently a Medicare telehealth service), it is logical and consistent to approve this service for telehealth.

Response: We agree with the commenters. As discussed in the proposed rule, the neurobehavioral status exam is furnished by a physician or psychologist and includes an initial assessment and evaluation of mental status for a psychiatric patient. In this regard, we believe the neurobehavioral status exam is similar to psychiatric diagnostic interview examination (which is currently approved as a Medicare telehealth service).

Comment: One commenter who supported our proposal to approve the neurobehavioral status exam for telehealth, stated that HCPCS code 96116 is a new code that replaced HCPCS code 96115 (the predecessor to HCPCS code 96116) in the 2006 CPT compendia. The commenter believes that neurobehavioral status exam (as described by HCPCS code 96115) was previously on the list of Medicare telehealth services and considers our proposal to add neurobehavioral status exam (as described by CPT code 96116) to be a restoration of the neurobehavioral status exam as a telehealth service.

Response: The commenter's assertion that our proposal to add the neurobehavioral status exam to the list of Medicare telehealth services is a restoration of the neurobehavioral status exam as a telehealth service is not correct. The neurobehavioral status exam (as previously described by CPT code 96115) was not on the list of Medicare telehealth services. The proposed addition of neurobehavioral status exam is a new proposal.

Comment: One commenter stated that the neurobehavioral status exam appears to require that the service be provided face to face (in person). Therefore, the commenter requested us to clarify that face to face services may qualify as telehealth services.

Response: As discussed in the CY 2005 PFS final rule with comment period, only services that traditionally require a face-to-face (in-person) physician or practitioner encounter are candidates for the list of Medicare telehealth services. Services not requiring a face-to-face encounter with the patient that may be furnished through the use of a telecommunications system are already covered under Medicare. For more information see the CY 2005 PFS final rule (69 FR 66278).

Neuropsychological Testing

Comment: We received conflicting comments regarding neuropsychological testing. For example, one commenter agreed with the requestor that neuropsychological testing furnished via telehealth is not significantly different from being furnished in-person (especially when administered by a computer). Additionally, the commenter stated that existing telehealth services for psychiatric patients include office visits, consultation, and office psychiatry. The commenter believes that the patient-provider dynamics of these services would not appear to be so significantly different from those for neuropsychological testing as to justify not approving the services for telehealth. The commenter also believes that testing dynamics, such as the patient being blindfolded or having numbers assigned to his or her fingers, could be easily reproduced with the help of someone at the originating site.

The same commenter also provided a discussion of the importance of early detection of dementia through neuropsychological testing. The commenter included a letter from the Armed Forces Epidemiological Board about brain injury in military service members with recommendations on handling these injuries. The commenter stated that although the Epidemiological Board addressed military patients, the principles of its findings apply to civilian assessment and treatment of brain injuries; that is, appropriate testing at earlier stages of brain injury or disease is likely to elicit a more accurate patient profile, leading to more targeted interventions and better patient outcomes.

In addition, the commenter stated that the administration of neuropsychological testing may be more difficult for some patients than others; however, this is true in both the in-person and telehealth setting. The commenter believes that if the patient requires immediate in-person assistance, a telepresenter could be used to facilitate the testing and that the determination of patient suitability for testing should be up to the physician or practitioner at the distant site. Two commenters agreed that a telepresenter could assist the physician or psychologist at the distant site with the testing and that the physician or psychologist should determine which patients (and tests) are appropriate for telehealth.

Another commenter who provides neuropsychological testing via telehealth explained that many standardized neuropsychological tests are available (literally hundreds) to the physician or psychologist (or technician) and that tests vary widely in terms of administrative procedure and the level of interaction between the patient and practitioner responsible for administering the test. The commenter believes that many tests could be effectively administered via telehealth and that it is not appropriate for us to issue a ''global denial'' of neuropsychological testing. For example, the commenter believes that neuropsychological testing administered via a computer should be approved for telehealth and that testing administered by a physician, psychologist, or qualified technician should be re-evaluated. The commenter also explained that an RN is often used as a telepresenter to assist the neuropsychologist or technician with testing. When testing cannot be administered in a ''standardized fashion'' via telehealth, a qualified technician could be present on-site with the patient to assist a psychologist who

furnishes the test at the distant site. However, the commenter believes that some testing measures may not be appropriate for telehealth. The commenter estimated that ''fewer than 35 percent of the hundreds of available measures do not lend themselves to standardized administration via telehealth''. The commenter also cited the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct and stated these guidelines would prohibit administration of certain individual tests via telehealth.

Other commenters believe that further study is necessary. The commenters urged us to seek additional information concerning the provision of neuropsychological testing before making a determination about these services for telehealth. One commenter believes that neuropsychological testing should be considered for telehealth approval stating, ''however it is unclear whether the technology has advanced far enough to allow all neuropsychological testing to be provided via telehealth without compromising the quality of care''. Additionally, the commenter stated that more time is needed to assess how neuropsychological testing could be provided via telehealth and listed the following issues that need further consideration:

- The variety of disorders and diagnoses appropriate via telehealth;
- The physical assistance that patients may need to complete tests; and
- The impact of face-to-face interactions with a psychologist or trained psychological technician during testing on the interpretation of test results.

Response: We appreciate the comments regarding the use of an interactive audio and video telecommunications system in furnishing neuropsychological testing services. Based on the comments received, we believe that further study is necessary before making a determination about neuropsychological testing for telehealth. As discussed above in this section, we received conflicting comments as to whether the administration of a neuropsychological test could be furnished adequately when the practitioner who is responsible for administering the test is not physically present with the patient.

For example, some commenters believe that neuropsychological testing furnished via telehealth is not significantly different than when furnished in-person and that a telepresenter could be used to assist the physician or psychologist at the distant site if necessary. Other commenters believed that further study is necessary before approving neuropsychological testing for telehealth. One commenter believed that it is unclear whether the use of a telecommunications system for administering neuropsychological testing would compromise quality of care and listed specific issues that need greater exploration. Even a commenter who supports approving neuropsychological testing for telehealth indicated that many neuropsychological testing measures would not be appropriate for telehealth. As such, we continue to have concerns about using an interactive audio and video telecommunications system as a substitute for the face-to-face (in-person) requirements of neuropsychological testing.

Comment: Two commenters believe that sufficient empirical evidence exists to support the approval of neuropsychological testing for telehealth. The commenters submitted summaries of two comparative analyses between neuropsychological testing furnished via an interactive audio and video telecommunications system and neuropsychological testing furnished in-person.

Response: As discussed above in this section, we believe that further study is necessary before approving neuropsychological testing for telehealth. Although the commenters did submit comparative analyses, in one of the studies cited, the same psychologist furnished neuropsychological testing in both conditions (face-to-face and via telehealth). In another study cited, study participants without neuropsychological or psychiatric disturbance were tested. Additionally, the studies cited had extremely small samples. As such, we believe it would be difficult to generalize any findings to a broader population.

Comment: One commenter questioned whether the regulatory impact analysis for telehealth was intended to provide a rationale to make reductions in Medicare payment for telehealth services in the future. The commenter urged us to continue to fund a wide variety of telehealth services.

Response: The regulatory impact analysis was not intended to be used as a rationale for making reductions in Medicare payment for telehealth services. The intent of the regulatory impact analysis on telehealth was to illustrate that the proposed addition of neurobehavioral status exam to the list of Medicare telehealth services should not have a significant budgetary impact on the Medicare program. For more information on our regulatory impact analysis for the proposed addition of neurobehavioral status exam to the list of Medicare telehealth services, see the CY 2008 PFS proposed rule (72 FR 38216).

Comment: One commenter stated that neuropsychological testing is ancillary to a neurobehavioral status exam and that neuropsychological testing would have little additional budgetary impact (beyond the impact of adding neurobehavioral status exam). To support this assertion, the commenter cited our proposed regulatory impact analysis on the addition of neurobehavioral status exam (as described by CPT code 96116).

Response: As discussed above in this section, we believe that further study is necessary before approving neuropsychological testing for telehealth.

Comment: A few commenters requested that we approve additional services for telehealth (for example, standardized performance testing as described by CPT code 96125).

Response: Requests for additions (including any supporting data analyses) should be submitted through our process for adding services and must be received by December 31 of each calendar year to be considered for the next proposed rule. For more information on how to submit a request for addition, please visit our Web site at *http://www.cms.hhs.gov/telehealth.*

Results of Evaluation of Comments

We are adding the neurobehavioral status exam as represented by HCPCS code 96116 to the list of Medicare telehealth services. Additionally, we are revising § 410.78 and § 414.65 to include neurobehavioral status exam as a Medicare telehealth service.

As discussed above, only services that traditionally require a face-to-face (in person) physician or practitioner encounter are candidates for the list of Medicare telehealth services. Services not requiring a face-to-face encounter with the patient that may be furnished through the use of a telecommunications system are already covered under Medicare. As discussed in chapter 15, section 30 of the Medicare Benefit Policy Manual, payment may be made for physicians' services delivered via a telecommunications system for services that do not require a face-to-face patient encounter. The interpretation of an x-ray, electrocardiogram, electroencephalogram and tissue samples are listed as examples of these services.

After further review of the requested services for addition, neuropsychological testing administered by a computer (as described by HCPCS code 96120) is not a candidate for the list of Medicare telehealth services. Neuropsychological testing administered by a computer (HCPCS code 96120) does not require a face-to-face (in person) encounter between the patient and the physician or psychologist (or qualified technician) responsible for the administration and interpretation of the test results (for example, the patient is interfacing with the computer, not a physician or psychologist). As such, a telecommunications system may be used to facilitate neuropsychological testing administered by a computer (as described by HCPCS code 96120); for example, Web-based computer neuropsychological testing, and/or transmission of neuropsychological test results to an interpreting physician or psychologist via telecommunications system.

E. Specific Coding Issues Related to the PFS

1. Reduction in the Technical Component (TC) for Imaging Services Under the PFS to the Outpatient Department (OPD)

Effective January 1, 2007, section 5102(b)(1) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) amended section 1848 of the Act to require that, for imaging services, if—''(i) The technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule* * * without application of the geographic adjustment factor * * *, exceeds (ii) The Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services* * * for such service for such year, determined without regard to geographic adjustment * * *, the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor [under the PFS], for the fee schedule amount for such technical component for such year.''

As required by the statute, for imaging services (described in this section) furnished on or after January 1, 2007, we cap the TC of the PFS payment amount for the year (prior to geographic adjustment) by the Outpatient Prospective Payment System (OPPS) payment amount for the service (prior to geographic adjustment). We then apply the PFS geographic adjustment to the capped payment amount.

Section 5102(b)(1) of the DRA defines imaging services as ''imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including PET), magnetic resonance imaging (MRI),computed tomography (CT), and fluoroscopy, but excluding diagnostic and screening mammography.''

To apply section 5102(b) of the DRA, we needed to determine the CPT and alpha-numeric HCPCS codes that fall within the scope of ''imaging services'' defined by the DRA provision. In the CY 2008 PFS proposed rule, we explain in detail the process we used for establishing the list of codes that fall within the scope of this DRA provision. We also stated that upon further review, we have determined that certain ophthalmologic procedures meet the DRA definition of imaging procedures, but were not included in the original list of imaging services subject to the OPPS cap. Therefore, we proposed to add the following procedures to the list of procedures subject to the OPPS cap, effective January 1, 2008:

- 92135, *Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report.*
- 92235, *Fluorscein angioscopy (includes multiframe imaging) with interpretation and report.*
- 92240, *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report.*
- 92250, *Fundus photography with interpretation and report.*
- 92285, *External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography).*
- 92286, *Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count.*

A complete list of CPT codes that identify imaging services as defined by the DRA OPPS cap provision, amended to include these ophthalmologic procedures, was also published in Addendum F of the CY 2008 PFS proposed rule (72 FR 38369 through 38372). Payment for an individual service on this list will only be capped if the PFS TC payment amount exceeds the OPPS payment amount.

Comment: Several commenters indicated that none of the six ophthalmologic CPT codes proposed for addition to the list of procedures subject to the OPPS cap meet the statutory definition of imaging under the DRA, that is, none of the procedures codes fall under the categories of x-rays, ultrasound, MRI, PET, CT or fluoroscopy. Specifically, they noted that CPT code 92250 utilizes a wide angle camera used primarily for detecting retinopathy in diabetics. Likewise, CPT codes 92235, 92240, and 92285 are all photos, using photographic equipment, or an angioscope. The commenters concluded that the Congress did not intend for any service that uses a camera or microscope, takes photographs, and produces negatives to be included in the DRA definition of imaging services.

Another commenter indicated that CPT codes 92250 and 92285 do not meet our criterion for including a procedure under the DRA provision, that is, services that provide visual information regarding areas of the body that are not normally visible, thereby assisting in the diagnosis or treatment of injury. The commenter noted that the subject procedures take traditional pictures of parts of the eye that are normally visualized with the naked eye. One commenter noted that the six CPT codes have not experienced dramatic increases in utilization, but rather, utilization has remained stable or decreased.

Response: The DRA provision describes imaging services broadly as ''imaging and computer-assisted imaging services,'' and does not provide for the type of distinctions the commenters suggested. While it specifically includes certain imaging modalities (x-ray, ultrasound, MRI, PET, CT, and fluoroscopy), it does not exclude other imaging modalities. In fact, the DRA provision excludes only one imaging service, that is, diagnostic and screening mammography. Concerning CPT codes 92250 and 92285, we believe the images generated by these services may include information that requires the use of photographic or imaging equipment and is not normally visible by the unaided human eye. Finally, the description of imaging services to which the DRA provision applies is not limited to procedures that have experienced dramatic increases in utilization. We believe the six procedures meet the DRA definition of imagining services and are similar to other procedures already subject to the DRA provision. Therefore, we will include these CPT codes on the list of procedures subject to the OPPS cap. (**Note:** This list of procedures is published in Addendum F of this final rule with comment period.)

Comment: Many comments requested clarification of the application of the OPPS cap when there is no OPPS payment for comparison; where the code is bundled under OPPS; or where

the OPPS payment includes items (for example, contrast agents or radiopharmaceuticals) that are paid separately under the PFS.

Response: Where there is no OPPS payment for a procedure or where the OPPS for a procedure is bundled, there is no OPPS amount for the comparison with the PFS payment. Therefore, it is infeasible to apply an OPPS cap. The codes will remain on the list of codes subject to the OPPS cap, but will not be affected by the cap. Where the OPPS payment includes packaged services or items that are paid separately under the PFS, we can and do apply an OPPS cap. The physician can continue to bill separately for such services or items when furnished in a place of service, for example, a physician's office, where the item is paid separately.

2. Application of Multiple Procedure Reduction for Mohs Micrographic Surgery (CPT Codes 17311 Through 17315)

Under the multiple procedure payment reduction policy, reimbursement for subsequent surgical procedures performed during the same operative session by the same physician is reduced by 50 percent. The Mohs surgery codes have been exempt from the multiple procedure payment reduction rules since the inception of the PFS (56 FR 59602, November 25, 1991).

The CPT Editorial Panel reviewed all of the codes on the list of codes exempt from the multiple procedure payment reduction (the ''−51 modifier exempt list'') to identify which codes should be exempt from the multiple procedure payment reduction rules. Based on the revisions to the code descriptors and a clearer understanding regarding the technical elements of the procedure, in CY 2007, the CPT Editorial Panel removed the Mohs procedure from the −51 modifier exempt list. The codes for Mohs surgery were revised to take into account the different level of physician work intensity involved based on anatomic site. The RVUs associated with the codes for each anatomic location were recommended by the RUC, as they are for other procedures, after a thorough discussion by the RUC of all aspects of the service. Work RVUs were developed for each Mohs surgery base code based on an assumption that each code is performed separately. Because the work RVUs for these services do not take into account the efficiencies that occur when multiple procedures are performed in one session, we do not believe that these codes should continue to be exempt from the multiple procedure payment reduction. Therefore, we proposed to eliminate the modifier 51 exemption and apply the multiple procedure payment reduction rules to these codes.

Comment: We received comments supporting our proposal and expressing the belief that our proposal is fair and consistent with our multiple procedure payment policies already affecting a wide range of procedures with codes in the Surgery/Integumentary System of CPT. Many commenters opposed our proposal to eliminate the modifier −51 exemption and apply the multiple procedure payment reduction to these codes. These commenters believed that eliminating these codes from the modifier −51 exempt list would negatively impact Medicare beneficiaries'' access to timely and quality care, and could lead to increases in pathology charges and increase the amount spent on multiple facility fees, thereby raising the overall cost of treating an individual with skin cancer. In addition to these concerns, many of the commenters do not believe we have sufficient justification to make the change, and suggest that this is an arbitrary decision. Further, the commenters asserted that the AMA–RUC and CPT decisions were in error and should not be followed.

Response: We verified with the CPT Editorial Panel that the application of the modifier −51 exempt status indicator, and subsequently, the inclusion of this series of codes (CPT codes 17311 through 17315) in Appendix E, Summary of CPT Codes Exempt from Modifier −51, of the 2008 CPT codebook would not be carried forward with the new series of codes created in 2007. The CPT panel confirmed with us that the exclusion of these codes from Appendix E was not an error. The AMA RUC reviewed and valued the new and existing codes for Mohs surgery. Upon completion of a thorough review and discussion of the Mohs codes, the RUC valued these codes with the full understanding these codes were removed from the modifier −51 exempt list and would be subject to the multiple procedure payment reduction as well.

We believe the CPT Editorial Panel and the Mohs workgroup on the CPT Editorial Panel gave considerable time, effort and discussion in the creation of the new and existing codes for Mohs surgery. We also believe the AMA-RUC carefully reviewed the rationale and deliberations which lead to the creation of new Mohs surgery codes. In addition, we believe the specialty society had ample time and opportunity to express its point of view to both the CPT Panel and the AMA-RUC. As a result of the revisions to these codes and their respective valuation, we do not believe they should continue to be treated differently from other codes in the Surgery/Integumentary System section of the CPT book and see no reason not to accept the recommendations provided by the CPT Panel and AMA-RUC. Therefore, we are finalizing our proposal to eliminate the modifier –51 exemption and apply the multiple surgery procedure payment reduction rules to these codes.

3. Payment for Intravenous Immune Globulin (IVIG) Add-On Code for Preadmission Related Services

Intravenous immune globulin (IVIG) is a unique product derived from blood plasma. This drug is paid for under the ASP methodology and the administration of this drug is reported using the first hour and second hour infusion codes for therapeutic, prophylactic and diagnostic services under CPT.

We recognize the importance of IVIG to patients who require it and are concerned about reports of problems with IVIG access and availability. We have initiated several actions in response to concerns about the supply of IVIG.

In July 2007, we implemented new codes for reporting IVIG for liquid non-lyophilized IVIG.

In CY 2006 and 2007, we established payment, through the creation of a special G-code, G0332, for preadministration services furnished in connection with the procurement of IVIG in the physician's office. This code is designed to compensate physicians for the extra resources required to be expended due to market conditions to locate and obtain the appropriate IVIG products and to schedule patient infusions.

Comment: We received several comments regarding our proposal to continue in CY 2008 the preadministration payment under the PFS for patients treated with IVIG in a physician's office.

The majority commenters supported our proposal and recommended that it be finalized, and recommended that this policy be made permanent. Commenters stated that if this code and payment are not made permanent, we would need to present a convincing evidence to terminate this payment. Commenters indicated that without continuation of the add on payment, access problems for Medicare beneficiaries in need of IVIG would be more severe.

Many commenters indicated problems with the ASP payment methodology for IVIG stating that IVIG is a unique

product for which market conditions are unlike all other drugs paid under ASP. Other commenters remarked that the addition of the four new billing codes for liquid IVIG adopted in July 2007 should improve market conditions and beneficiary access to IVIG. Some commenters asked that we consider making the liquid IVIG codes permanent J-codes. A few commenters asked that CMS consider establishing an add on payment for IVIG similar to the add on payment for clotting factor.

Two commenters indicated that Addendum B did not include the G-code for preadministration services and recommended that the code be included in Addendum B for the final rule.

Response: Comments regarding the ASP pricing methodology for IVIG, the adoption of new drug codes for liquid IVIG in CY 2007, and the consideration of an add-on payment for IVIG similar to the add-on payment for blood clotting factor are beyond the scope of our proposal which focuses on payment for a service under the PFS. We will consider these comments in context of any proposed policies for drug payments made as part of the CY 2009 PFS proposed rule.

In terms of the preadministration service for IVIG, we will continue the CY 2007 payment policy for code G0332 through CY 2008. We will carefully consider all relevant information including the conditions of the IVIG drug market during CY 2008 when we address whether it would be appropriate to continue the payment policy as part of the CY 2009 PFS.

We appreciate the commenters alerting us that G0332 was omitted from Addendum B in the proposed rule and we will ensure that this code is listed in Addendum B of this final rule with comment period.

Therefore, we are finalizing the proposal to continue to recognize payment for preadministration services for IVIG furnished to patients in a physician's office in CY 2008. Payment for this service will be made based on the PE RVUs previously established for this service in CY 2007. Payment for preadminstration services for IVIG furnished to hospital outpatients is paid under the outpatient PPS (OPPS) and is addressed as part of that final rule.

4. Reporting of Cardiac Rehabilitation Services

For CY 2008, we proposed to assign a status indicator of ''I'' (invalid for Medicare purposes, Medicare recognizes another code for the billing of this service) to the current CPT codes for cardiac rehabilitation services, CPT codes 93797, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)*, and 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* and proposed to establish two new Level II HCPCS codes that we believe are more appropriate for specifically reporting cardiac rehabilitation services under the PFS. The proposed HCPCS codes are: GXXX1, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour)*, and GXXX2, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour)*. We also proposed to crosswalk the current RVUs associated with CPT codes 93797 and 93798 to HCPCS Codes Gxxx1 and Gxxx1.

Comment: Many commenters, including physicians and providers of cardiac rehabilitation services, were generally supportive of the proposal for the specific G-codes. Commenters believed that this proposed coding change would allow for more appropriate coding and payment for cardiac rehabilitation services in those cases where intensive programs provide multiple sessions each day. In addition, commenters requested that we explicitly state that multiple sessions of cardiac rehabilitation can be paid for the same date of service when modifier 59 is reported. They also requested that we crosswalk the payments for both of the proposed G-codes to the higher cost CPT code 93798 to ensure that the full range of modalities provided in certain intensive cardiac rehabilitation programs are available.

Several of these commenters also requested that we provide additional guidance related to reporting of the cardiac rehabilitation G-codes, such as: (1) Explaining that it is likely to be reasonable and necessary to cover 72 cardiac rehab sessions when multiple sessions are provided in one day; (2) encouraging contractors to factor the ''proven results'' of a program into coverage decisions and that 72 sessions should be ''presumptively covered'' when they are furnished by a certain intensive cardiac rehabilitation program; and (3) providing further clarification and expansion of nutritional counseling by registered dieticians, indicating that they could independently bill for nutritional counseling within cardiac rehabilitation programs using the medical nutrition therapy codes because the NCD does not specifically mention these services.

Alternatively, a few commenters, including physician specialty groups, questioned the need for the proposed G-codes, indicating that no new data would be gained by a coding shift that changes a unit from a session to an hour. Commenters also suggested that we work with the AMA to address the issue of whether it would be appropriate to modify the CPT definition for this code from a per session to per hour basis.

Many commenters also expressed concern that the use of the term ''physician services'' and ''MD services'' in the G-code descriptors could be misinterpreted by Medicare contractors as requiring a physician to directly deliver the care or be in attendance during each service episode and requested that the code descriptor be revised.

Response: We are aware of several intensive cardiac rehabilitation programs that provide multiple sessions in a day, lasting several hours total. The NCD for cardiac rehabilitation currently states that cardiac rehabilitation programs are covered for certain categories of patients and that the programs must be comprehensive. To be comprehensive the programs must include a medical evaluation, a program to modify cardiac risk factors (for example, nutritional counseling), prescribed exercise, education, and counseling. The NCD does not distinguish between different approaches to the delivery of cardiac rehabilitation services, whether the more common practice of two sessions per week or the more intensive programs of several sessions per day. In order to allow for flexibility and tailoring of cardiac rehabilitation programs based on patient needs, we have not been prescriptive regarding the precise amount of time that must be spent on each component of the program. Regarding intensity, we expect the intensity of cardiac rehabilitation programs to vary by patient and by program.

We believe it is important that our payment policy provides appropriate payment for cardiac rehabilitation services. In order to minimize the administrative burden to physicians and providers, but permit accurate reporting and payment for cardiac rehabilitation programs that provide more than one session per day, we believe that continuing the use of CPT codes 93797 and 93798 and allowing physicians and providers to bill more than one session per day under some circumstances would be the most appropriate course. Therefore, based upon the comments received and upon further review of this issue, for CY 2008, we will allow physicians and providers to report more than one unit for a date of service if

more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day.

With respect to commenters' concerns about the use of the term ''physician services'' in the proposed G-code descriptors, we note that the descriptors for these codes were proposed to be parallel to the descriptors of the CPT codes for cardiac rehabilitation sessions which contain the term ''physician services'' in their descriptors. We are not aware that physicians and providers have problems with Medicare contractors'' interpretation of the CPT code descriptors.

After consideration of all public comments received, we are not finalizing our proposal to establish two new G-codes for reporting cardiac rehabilitation services. Instead, we will continue to use the CPT codes 93797 and 93798 to report cardiac rehabilitation services under the CY 2008 PFS.

We will provide further guidance on coding and payment instructions for the cardiac rehabilitation services codes through program instructions.

We will not provide the additional coverage-related guidance requested by some commenters, such as the presumptive coverage and independent billing for registered dieticians. These recommendations effectively request changes to the NCD, and therefore, are outside of the scope of this final rule with comment period.

F. Part B Drug Payment

1. Average Sales Price (ASP) Issues

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this 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 January 2006, the drug coverage available to Medicare beneficiaries expanded with the implementation of Medicare Part D. The Medicare Part D program does not change Medicare Part B drug coverage.

In this section, we discuss changes and issues related to the determination of the payment amounts for covered Part B drugs and furnishing blood clotting factor. This section also discusses changes to how manufacturers calculate and report ASP data to us.

a. ASP Payment

Section 303(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) (MMA) amended Title XVIII of the Act by adding section 1847A. This section revised the payment methodology for the vast majority of drugs and biologicals not paid on a cost or prospective payment basis furnished on or after January 1, 2005. The ASP reporting requirements are set forth in section 1927(b) of the Act. Manufacturers must submit ASP data by 11-digit National Drug Code (NDC) to us quarterly. The manufacturers' submissions are due to us not later than 30 days after the last day of each calendar quarter. 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 update the Part B drug payment amounts quarterly based on the data we receive. In this section of the preamble, we discuss certain aspects of the calculation of manufacturers' ASP data, issues related to bundled price concessions, and other Part B drug payment issues.

Further information on manufacturers' submission of ASP data for Medicare Part B drugs and biologicals is contained in prior rulemaking documents and other guidance accessible on the CMS Web page at (*http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*). Specifically refer to the April 6, 2004 ASP interim final rule with comment period (IFC) (69 FR 17935) and the CY 2007 PFS final rule with comment period (71 FR 69624), which finalized the ASP calculation and reporting requirements of the April 6, 2004 IFC, and the Frequently Asked Questions available on the CMS Web page.

b. Bundled Price Concessions

In the CY 2007 PFS proposed rule and final rule with comment period, we solicited and responded to comments regarding the issue of how to allocate price concessions across drugs that are sold under bundling arrangements for purposes of calculating the ASP. We did not establish a specific methodology that manufacturers must use for the treatment of bundled price concessions for purposes of the ASP calculation in the CY 2007 PFS final rule with comment period. In the absence of specific guidance, we maintained existing guidance that manufacturers may make reasonable assumptions in their calculation of ASP, consistent with the general requirements and the intent of the Act, Federal regulations, and their customary business practices. We also indicated that we would be closely monitoring this issue and may provide more specific guidance in the future if we determine it is warranted.

As stated in the CY 2008 PFS proposed rule (72 FR 38150), in its January 2007 Report to Congress, ''Impact of Changes in Medicare Payments for Part B Drugs,'' the MedPAC discussed the issue of allocation of bundled price concessions for purposes of calculating the ASP, noting that ''some manufacturers offer provider discounts for one of their products contingent on purchases of one or more other products.'' This report discusses two approaches for allocating bundled price concessions.

According to MedPAC, one option would be to require manufacturers to allocate bundled discounts in proportion to the sales of each drug sold under the bundled arrangement. For example, Drug A and Drug B are sold under a bundled arrangement and have a combined bundled discount equal to $200,000 on total sales of $1 million. If Drug A has sales of $600,000, the manufacturer would allocate 60 percent of the bundled discount to that drug when calculating ASP. Forty percent of the bundled discount would be allocated to Drug B. MedPAC states that this approach would parallel bundling requirements under Medicaid and would be simpler to administer. However, MedPAC notes that this method might not capture contingent discounts.

The other approach discussed by MedPAC would be to require manufacturers to allocate bundled discounts to reflect the contingencies in the contract. That is, manufacturers would allocate any additional (or increased) discount to the sales of the drug (or drugs) that the discount is meant to increase. This approach would result in an ASP that more accurately reflects the transaction price of drugs when a discount for one drug or drugs is contingent in whole or in part on the purchase of another drug. For example, if a greater discount on the purchase price of Drug A is contingent on the

purchase (or purchases) of Drug B, this additional discount would be allocated to sales of Drug B in the calculation of ASP.

In its discussion of bundling, MedPAC states that the goal should be to ensure that ASP reflects the average transaction price for drugs. To that end, MedPAC recommends that the Secretary clarify the ASP reporting requirements for bundled products to ensure that ASP calculations allocate discounts to reflect the transaction price for each drug. Further, MedPAC states that we should ensure that the reporting requirements for allocating discounts are clear and that they can be implemented by manufacturers in a timely fashion.

In the CY 2008 PFS proposed rule (71 FR 77176), we also discussed the Medicaid Program: Prescription Drugs proposed rule published in the December 22, 2006 **Federal Register** (hereinafter referred to as the December 22, 2006 proposed rule) concerning the calculation of manufacturers' average manufacturer price (AMP). In the December 22, 2006 proposed rule, we proposed that discounts associated with a bundled sale would be allocated proportionately according to the dollar value of the units of each drug sold under the bundled arrangement. For bundled sales where multiple drugs are discounted, the aggregate value of all the discounts would be proportionately allocated across all of the drugs in the bundle. For AMP purposes, a bundled sale would mean an arrangement regardless of physical packaging under which the rebate, discount, or other price concession is conditioned upon the purchase of the same drug or drugs of different types (that is, at the nine-digit NDC level) or some other performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary), or where the resulting discounts or other price concessions are greater than those which would have been available had the bundled drugs been purchased separately or outside of the bundled arrangement. In the December 22, 2006 proposed rule, we further proposed that the AMP should be adjusted for bundled sales by determining the total value of all the discounts on all drugs in the bundle and allocating those discounts proportionately to the respective AMP calculations. The aggregate discount is allocated proportionately to the dollar value of the units of each drug sold under the bundled arrangement. Where discounts are offered on multiple products in a bundle, the aggregated value of all of the discounts should be proportionately allocated across all of the drugs in the bundle. We received many comments on the many aspects of the December 22, 2006 proposed rule. However, the review of those comments and development of the final AMP calculation policies and rule were not complete at the time the CY 2008 PFS proposed rule was developed.

In light of MedPAC's recommendation that we clarify the ASP reporting requirements for bundled products and our discussion of bundled price concessions in the CY 2007 PFS rulemaking, we stated in the CY 2008 PFS proposed rule that we believe specific guidance in the ASP context is warranted to provide for greater consistency in ASP reporting across manufacturers and to enhance the accuracy of the ASP payment system. We stated that we found MedPAC's suggestion not to defer further guidance in this area compelling with respect to the potential that manufacturers may make differing assumptions in the absence of specific guidance on how to allocate bundled price concessions in the context of ASP. In addition, we stated that we believe it is appropriate at this time to establish a specified method for treating bundled price concessions in the calculation of ASP that is consistent with the treatment of such discounts for purposes of the AMP calculation, and that appropriate consistencies across the calculations of ASP and AMP will result in a lower potential for error and more accurate calculations of both prices.

As we noted in the CY 2008 PFS proposed rule, although ASP and AMP serve similar, but not identical, purposes, differences between these calculations provide a rationale for, and in some instances may require, minor differences between the final policies adopted in Medicaid and Medicare regulations. We believe any differences would be necessary to clarify certain aspects of a consistent approach for treatment of bundling, and would not result in significant policy differences on how bundling is addressed in the context of AMP and in the context of ASP.

Therefore, for purposes of calculating the ASP (beginning with the reporting period for the first calendar quarter of 2008 and thereafter), we proposed that the manufacturer must allocate the total value of all price concessions proportionately according to the dollar value of the units of each drug sold under a bundled arrangement to ensure that the ASP is adjusted for bundled arrangements as defined at proposed § 414.802. For a bundled arrangement, where multiple drugs are discounted, the aggregate value of all the discounts would be proportionately allocated across all of the drugs sold under the bundled arrangement. We proposed that a bundled arrangement, for ASP purposes, would mean an arrangement, regardless of physical packaging under which the rebate, discount, or other price concession is conditioned upon the purchase of the same drug or biological or other drugs or biologicals or some other performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary, purchasing patterns, prior purchases), or where the resulting discounts or other price concessions are greater than those that would have been available had the drugs or biologicals sold under the bundled arrangement been purchased separately or outside of the bundled arrangement. We proposed to specify at proposed § 414.804(a)(2)(iii) that all price concessions on drugs sold under a bundled arrangement must be allocated proportionately to the dollar value of the units of each drug sold under the bundled arrangement.

In the CY 2008 PFS proposed rule, we also stated our intention to remain consistent, as appropriate, with the final policy adopted in the Medicaid Program: Prescription Drugs final rule with comment period published in the July 17, 2007 **Federal Register** (72 FR 39142) (hereinafter referred to as the July 17, 2007 final rule with comment period), which was still under development at that time. We stated that the Medicaid policies on bundled sales may ultimately differ from our discussion of the topic in the CY 2008 PFS proposed rule as a result of the final policy adopted in the July 17, 2007 final rule with comment period and that our policies for ASP in this final rule with comment period may reflect the final Medicaid policy on bundled sales, but only to the extent that it is appropriate for ASP and the public has had the opportunity to comment on how the final Medicaid policy for bundled sales, if appropriately adopted for ASP purposes, would effect the calculation of ASP. The final Medicaid policy on bundled sales adopted in the July 17, 2007 final rule with comment period was consistent with the discussion of this issue in the December 22, 2006 proposed rule with certain clarifications.

Comment: We received many comments on this issue. Most of these commenters noted that our proposal for the treatment of bundled price concessions in the ASP context was similar to the language finalized in the July 17, 2007 final rule with comment period. In general, most of the

commenters supported an appropriately consistent approach for the treatment of bundled price concessions within both the AMP and ASP calculations. However, several commenters indicated that they were still reviewing the July 17, 2007 final rule with comment period and believe additional time may be needed to better understand how the proposed Medicare bundled arrangement definition is to be applied. Several commenters had questions about how the proposed bundling policies may apply to certain contracting arrangements, and because of these questions, recommended that we cease or delay implementation of our proposed method for treatment of bundled price concessions for purposes of ASP.

Response: Based on comments recommending a delay and to better understand the concerns stated by the commenters, we are not finalizing the regulatory language changes we proposed in the CY 2008 PFS proposed rule at this time. Although we are not establishing a specific methodology that manufacturers must use for the treatment of bundled price concessions for purposes of calculating ASP at this time, we are clarifying that, in the absence of specific guidance, manufacturers may make reasonable assumptions in their calculation of ASP, consistent with the general requirements and the intent of the Act, Federal regulations, and their customary business practices. In making reasonable assumptions for purposes of calculating ASP, one method manufacturers could use is to reallocate price concessions that are conditioned upon other purchases or a performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary) so that the total value of all such price concessions are allocated proportionately according to the dollar value of the units of each drug sold. However, manufacturers may have other methods they could use to report bundled price concessions, so long as manufacturers apply reasonable assumptions consistent with the general requirements and the intent of the Act, Federal regulations, and their customary business practices. Manufacturers' reasonable assumptions consistent with our requirements, guidance and manufacturer's customary business practices remain an important aspect of ASP reporting. These assumptions should be submitted along with the ASP data and the signed certification form.

Recognizing that the treatment of bundled price concessions in the ASP calculation has implications for the integrity of the ASP payment methodology, we will continue to monitor this issue, will consider the comments on this issue, and may provide more specific guidance in the future through rulemaking or through program instruction or other guidance (consistent with our authority under section 1847A(c)(5)(C) of the Act) if we determine it is warranted. As we continue to review these issues, we want to be sure we are aware of concerns from all stakeholders, and thus we encourage the public to provide additional information or concerns to us on this issue as they may arise.

c. Clotting Factor Furnishing Fee

Section 303(e)(1) of the MMA added section 1842(o)(5) of the Act which requires the Secretary, beginning in CY 2005, to pay a furnishing fee in an amount the Secretary determines to be appropriate to hemophilia treatment centers and homecare companies for the items and services associated with the furnishing of blood clotting factor. Section 1842(o)(5)(C) of the Act specifies that the furnishing fee for clotting factor for CY 2006 and subsequent years will be equal to the fee for the previous year increased by the percentage increase in the consumer price index (CPI) for medical care for the 12 month period ending with June of the previous year.

The furnishing fee for CY 2007 is $0.152 per unit clotting factor. The percent increase in the CPI for medical care for the 12-month period ending in June 2007 is 4.0 percent. Consequently, the furnishing fee will be $0.158 per unit of clotting factor for CY 2008. While the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits.

In the CY 2008 PFS proposed rule, we proposed to announce the annual update of the blood clotting factor furnishing fee, as specified in section 1842(o)(5)(C) of the Act, by issuing program instructions and postings on the CMS Web site in lieu of including a discussion of this issue in PFS rulemaking for CY 2009, and thereafter, until such time as the update methodology may be modified. We made our proposal because the update is statutorily determined, is based on an index not affected by administrative discretion or public comment, is based on the percentage increase in the CPI for medical care for the 12-month period ending with June of the previous year, and is not released by the Bureau of Labor Statistics until after our proposed rule is published.

As stated in the CY 2008 proposed rule, we believe that including a discussion of the furnishing fee update in annual rulemaking does not provide an advantage over other means of announcing this information, so long as the current statutory update methodology continues in effect. We believe that the public's need for information and adequate notice regarding the updated furnishing fee can be better met by issuing program instructions which will eliminate the discussion of the furnishing fee update annually in rulemaking. In addition, by communicating the updated furnishing fee in program instruction, the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure can be announced more timely than when included as part of the PFS final rulemaking process.

Comment: We received comments in support of our proposal to announce the update furnishing fee via program instructions beginning in CY 2009, and to continue updating the furnishing fee according to the consumer price index for medical care. Comments supported the continued use of our proposed approach until such time as the methodology is changed.

Response: After consideration of the public comments, beginning for CY 2009, we will announce the updated blood clotting factor furnishing fee via program instructions and via a Web posting. In addition, we may include the updated blood clotting factor furnishing fee in the annual PFS final rules to promote broader dissemination of the announcement.

d. Widely Available Market Prices (WAMP) and AMP Threshold

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 widely available market price (WAMP) for these drugs and biologicals (if any); and
- The 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 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 is specified in the statute as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold 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 and CY 2007, 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 2008, we proposed to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its comparison of both the WAMP and the AMP. Furthermore, information on how recent changes to the calculation of the AMP may affect the comparison of AMP to ASP is not available at this time. Since we do not have data that suggest another level is more appropriate at this time, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2008.

As we noted in the CY 2007 PFS final rule with comment period (71 FR 69680), we understand that there are complicated operational issues associated with potential payment substitutions and 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.

Comment: We received several comments regarding our proposal to maintain the threshold at 5 percent. Most commenters supported maintaining this threshold. One commenter suggested increasing the threshold but did not specify a percentage to which it should be increased. Another commenter suggested increasing the threshold for AMP to 10 percent while maintaining the 5 percent threshold for WAMP.

Response: We recognize the public's concern regarding the establishment of an appropriate threshold for making price substitutions. We disagree with the commenter who recommended different thresholds for WAMP comparisons and for AMP comparisons because of current operational difficulties associated with maintaining and communicating different thresholds. At the current time, we also believe that maintaining two thresholds lessens stakeholders' ability to accurately predict the potential risk for price adjustments. After considering public comments on this issue, and as required by statute, we are finalizing our proposal to establish the WAMP/AMP threshold at 5 percent for CY 2008.

Comment: We received many comments suggesting that caution be exercised in the determination of price substitutions and that we develop a formal process and criteria to be used to determine when substitutions are necessary. Commenters also recommended that we assure adequate notice is provided prior to making a price substitution. Several commenters indicated recent policy changes made to the Medicaid AMP calculation could impact the accuracy of the comparisons between AMP and ASP and stated that these changes should be carefully studied and considered before implementing any pricing changes.

Additionally, several commenters opposed any price substitutions for certain classes of providers or for certain specific drugs. The commenters noted that certain classes of providers may be subject to different cost structures making wholesale substitution of prices impractical. Some commenters asserted that certain drugs experience unique market forces that may be adversely affected by pricing substitutions.

Response: We understand that complex operational issues, both within CMS and externally could impact potential payment rate substitutions. We acknowledge the recent changes to the AMP regulations and are studying such changes carefully. Furthermore, we recognize the variety of providers and the marketplace forces that impact drug pricing decisions under ASP. Therefore, we will proceed cautiously 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 substitution.

e. Other Issues

Comment: A few commenters noted that we did not discuss the payment for separately billable ESRD drugs in the CY 2008 PFS proposed rule. These commenters supported continuation of the current policy of basing the payment on the ASP+6 percent.

Response: We did not propose any policy changes to the approach that we currently use to pay for separately billed ESRD drugs. Therefore, for CY 2008 payment for separately billable drugs furnished by ESRD facilities will continue at ASP+6 percent in accordance with section 1847A of the Act.

Comment: Several commenters noted that the billing and payment codes recently established for liquid IVIG to implement separate payment under section 1847A(b)(4) of the Act should improve beneficiary access to these products.

Response: We thank the commenters for communicating their support.

Comment: We received a few comments expressing concern that, because ASP based payment limit updates lag time by at least 2 calendar quarters, increases in market prices may not be reflected in a drug's payment limit for at least 6 months after a pricing adjustment. One commenter suggested that current technology should enable CMS to decrease the lag time from 6 months to 2 to 3 months.

Response: By statute, the ASP based payment allowances are determined on a quarterly basis and are based on ASPs reported by manufacturers quarterly. Manufacturers must report to us no later than 30 days after the close of the calendar quarter. There is a necessary time frame after the close of a calendar quarter for manufacturers to calculate and submit the ASP data to CMS, for CMS to prepare and issue the payment rates, and for the claims processing contractors to implement the updated payment files. We implement these new payment limits through program instructions or otherwise at the first opportunity after we received the data, which is the calendar quarter after receipt.

Comment: One commenter suggested that we modify the formula we use to calculate the payment amounts based on manufacturers' ASP data so that the formula is volume weighted as suggested by the OIG.

Response: We discussed our formula for determining the payment amounts based on manufacturers' ASP data in the CY 2006 PFS final rule (70 FR 70217). As we stated in the CY 2006 PFS final rule, in establishing the formula used to calculate the payment amounts based on manufacturers' ASP data, we considered various approaches, including the alternative suggested by this commenter. If appropriate, we may consider revising the methodology in the future. We did not propose to change our current formula, and are not

implementing changes to our formula at this time.

Comment: We received a few requests to increase the pharmacy supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs for CY 2008 to reflect actual supplying costs. We also received comments expressing concerns that primarily because of the labor intensive Medicare Part B claims processing services provided by specialty transplant pharmacies, the current supplying fee payment for immunosuppressive drugs is substantially lower than reported actual supplying costs. One commenter requested that we eliminate the two-tiered pharmacy supplying fee for prescriptions filled within a 30-day period.

Response: We are committed to assuring that our claims systems process claims as timely and accurately as possible and that their payment methodologies result in the determination of accurate payment amounts. We recognize the operational complexities under which certain providers operate and strive to develop systems and processes to minimize such complexities. We appreciate the comments that were provided and may consider the issue in future rulemaking if appropriate. Since we did not propose a change to these rates for CY 2008, they will continue to be in effect in CY 2008. We received several other comments on the use and potential impacts of the ASP payment methodology and other issues related to Part B drugs that are also outside the scope of this rulemaking and will not be addressed in this final rule with comment. These topics include the following:

- Requests for billing codes for specific products;
- Whether alternative payment methodologies or exceptions to the ASP based payment should be considered;
- Variation in local coverage and payment policies, including use of least costly alternative policies and invoice pricing for compounded drugs;
- Excluding prompt pay discounts from the calculation of ASP; and
- Whether coverage under Part B should be expanded to include certain vaccines.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA required the implementation of a CAP for certain Medicare Part B drugs and biologicals not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (published in the March 4, 2005 **Federal Register**; hereinafter referred to as the March 4, 2005 proposed rule) and interim final rule with comment period (published in the July 6, 2005 **Federal Register**; hereinafter referred to as the July 6, 2005 IFC) (70 FR 10746 and 70 FR 39022, respectively). Certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70116). We specified a single CAP drug category to include a defined list of drugs furnished incident to a physician's service.

In this final rule with comment period, we discuss the impact of provisions in section 108 of the MIEA–TRHCA on administrative and operational aspects of the CAP. Topics include the implementation of a post-payment review process and the corresponding changes to claims processing procedures, and changes to other operational aspects of the CAP. This final rule with comment period implements conforming changes to the CAP regulations to reflect these provisions that made changes to the payment process of the CAP for Part B Drugs.

When the CAP program began on July 1, 2006, physicians were given a choice between obtaining these drugs from vendors selected through a competitive bidding process and approved by CMS, or directly purchasing these drugs and being paid under the ASP system. In this final rule with comment period, we discuss areas related to transporting CAP drugs and the administrative burden of the CAP submitted in response to the July 6, 2005 IFC. In addition, we are finalizing portions of the July 6, 2005 IFC that were not finalized in the CY 2006 PFS final rule with comment period and responding to the other timely comments we received on the July 6, 2005 IFC that we have not responded to previously.

a. MMA Operational Provisions

Prior to the enactment of the MIEA–TRHCA, section 1847B(a)(3)(A) of the Act set forth specific requirements that have a direct impact on the administrative and operational parameters for instituting a CAP. This section of the statute required the following:

(1) Approved CAP vendors bill the Medicare program for the drug or biological supplied, and collect any applicable deductibles and coinsurance from the Medicare beneficiary. (For purposes of the preamble, the term ''approved CAP vendor'' means the term ''contractor'' as referred to in the statute.)

(2) Any applicable deductible and coinsurance may not be collected unless the drug was administered to the beneficiary. (For purposes of the preamble, the term ''drug'' refers to drugs and biologicals furnished under the CAP, unless the context specifies otherwise.)

(3) Medicare can make payments only to the approved CAP vendor, and these payments are conditioned upon the administration of the drug.

Section 108 of the MIEA–TRHCA amended this third element.

b. MIEA–TRHCA

Section 108 of the MIEA–TRHCA made changes to the CAP payment methodology. Section 108(a)(1) of the MIEA–TRHCA amended section 1847B(a)(3)(A)(iii) of the Act by adding new language that requires that payment for drugs and biologicals be made upon receipt of a claim for a drug or biological supplied for administration to a beneficiary. This statutory change took effect on April 1, 2007.

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 shall recoup, offset, or collect any overpayments determined by the Secretary under this process.

Section 108(b) of the MIEA–TRHCA states that nothing in this section shall be construed as requiring the conduct of any additional competition under section 1847B(b)(1) of the Act; or requiring an additional physician election process.

Section 108(c) of the MIEA–TRHCA states that the amendments of this section apply to payments for drugs and biologicals supplied: (1) On or after April 1, 2007; and (2) on or after July 1, 2006 and before April 1, 2007, for claims that are unpaid as of April 1, 2007.

Comment: Some commenters suggested that any changes to the CAP be made only after the expiration of the current vendor contract. The commenters stated that implementation of changes before the next vendor contract would be unfair to bidders who chose not to participate in the CAP because of previously issued guidance. The commenters cited the CAP statutory reference about waiving the FAR in order to promote competition. The commenters believe that such changes would inappropriately favor the single

existing vendor, and therefore, hurt competition.

Response: We do not have the authority to delay implementing the claims processing changes required by the MIEA–TRHCA, which were effective April 1, 2007. Although some of our changes were not expressly required by the statute, we believe these conforming changes are necessary to allow the program to function in a manner that is consistent with, and required by, the statutory changes. Further, because the CAP is a new payment program, change that is consistent with operational experience and improves efficiency for participants is to be expected. Finally, we disagree that the FAR affects our ability to make changes in the program while the current contract is in force. Because these changes do not modify an approved CAP vendor's responsibilities under its contract with us, we do not believe the FAR is implicated.

Further, as we have discussed in prior rulemaking, the CAP statute authorizes the waiver of provisions of the FAR (other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate) as necessary for the efficient implementation of Section 1847B of the Act, in order to promote competition.

We have discussed our approach to conforming to the confidentiality provisions in the July 6, 2005 IFC (70 FR 39077), and we intend to comply with this approach during future vendor bidding periods. In implementing the CAP, we have waived all of the FAR except for the confidentiality and the conflict of interest provisions to promote competition and the efficient implementation of the program. We made the decision to waive the FAR (other than the provisions on confidentiality and conflict of interest) in order to increase the pool of qualified vendors available to participate in the program. It is our understanding that compliance with the FAR is not normally required of the companies that make up the pool of potential CAP vendors. It is also not required of other Medicare suppliers. We waived these provisions in order to structure CAP bidding in a manner consistent with established vendor bidding practices.

The FAR's confidentiality provisions, as well as the conflict of interest standards and requirements found in FAR subsection 9.5, apply to approved CAP vendors and applicants. All other provisions of the FAR have been waived for purposes of the CAP. However, we have used certain provisions of the FAR for guidance in implementing the CAP, and we may from time to time used other FAR provisions as a guide, even though they have been waived. For example, as we discussed in the July 6, 2005 IFC (70 FR 39063), we look to the provisions of the FAR to guide our assessment of bidder's financial solvency.

However, even if the FAR were implicated, we believe these changes promote competition because they make the program a more attractive option for physicians, which will provide physicians who compete among one another a more meaningful choice between the CAP and the ASP methodology. We further believe the changes we are implementing here are designed to improve the flexibility and administrative ease of the CAP. Therefore, we will proceed with implementing the provisions we are finalizing as indicated in this final rule with comment period.

c. CAP Claims Processing

In the July 6, 2005 IFC (70 FR 39042), we initially implemented a claims processing system that enables selected approved CAP vendors to bill the Medicare program directly, and to bill the Medicare beneficiary and his or her third party payer after verification that the physician has administered the drug. When a participating CAP physician elects to join the program, he or she must agree to obtain all drugs on the CAP drug list from the approved CAP vendor, with only a few exceptions. For example in furnish as written (FAW) situations (that is, where a beneficiary needs a particular formulation of a drug not available from the approved CAP vendor) the participating CAP physician would be allowed to obtain that drug outside of the CAP. In the case of Medicare Secondary Payer (MSP) (that is, where a Medicare beneficiary may have another payer primary to Medicare), the participating CAP physicians must obtain physician administered drugs from entities approved by the primary plan and bill the primary payer. Detailed MSP instructions have been issued by CMS that allow the physician to bill under the ASP methodology for the portion of the drug not covered by the primary payer in this situation.

Prior to the MIEA–TRHCA, the claims processing procedures for the approved CAP vendor and the participating CAP physician were as follows:

- Once a shipment is received from the approved CAP vendor, the participating CAP physician stores the drug until the date of drug administration.
- When the drug is administered to the beneficiary, the participating CAP physician places the prescription order number for each drug administered on the claim form submitted to his or her regular Part B carrier.

Similarly, when the approved CAP vendor bills Medicare for the drug it shipped to the participating CAP physician, it places the relevant prescription order number on the claim form submitted to the designated carrier. The use of the prescription order number on both the participating CAP physician's claim and the approved CAP vendor's claim is intended to indicate drug administration to the beneficiary. The participating CAP physician's claim and the approved CAP vendor's claim are matched in the Medicare claims processing system so that drug administration can be verified and payment to the approved CAP vendor can be made.

d. Required Changes to CAP Claims Processing

As originally implemented, the claims matching process described above in this section was completed before payment was made. However, as of April 1, 2007, section 108 of the MIEA–TRHCA requires payment to be made to the CAP vendor for claims upon receipt. The statute also requires us to establish a post-payment review process to assure that payment is made for a drug only if the drug has been administered to a beneficiary. We are authorized under the statute to recoup, offset, or collect any overpayments by the Secretary. We are also authorized to conduct post-payment review using statistical sampling and to implement the post-payment review process by program instruction or otherwise. We implemented the necessary changes to our claims processing system and initiated the post-payment review process on April 1, 2007 via instructions to the CAP-designated claims processing contractor and Questions and Answers posted on the CMS competitive bidding Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage*.

Under the post-payment review process, the CAP-designated carrier will use the CMS claims processing system to look for a match between the CAP prescription order number on the participating CAP physician's claim and the same prescription order number on the approved CAP vendor's claim to track drug administration on a dose by dose basis. If the CAP-designated carrier is able to find a match between the two claims, the carrier makes a determination that the beneficiary did receive the drug being billed for by the CAP physician. The participating CAP

physician claim may also contain information on any determination of medical necessity and coverage made by the local carrier.

We will also use statistical sampling under the post-payment review process to determine whether drugs were medically necessary. All Medicare claims are subject to medical necessity determinations; however, under the changes required by the MIEA–TRHCA, CAP claims may not all have a chance to be reviewed for medical necessity before they are paid. Therefore, the post-payment review includes both verification of drug administration and a medical necessity review of a statistically valid sample of CAP claims. In conducting the post-payment review, we will continue to monitor for fraud, waste, and abuse. All CAP claims will remain eligible for review for medical necessity and verification of drug administration. We anticipate that the post-payment review process will provide us with additional opportunities to monitor for the appropriate payment of drugs furnished under this program.

To conduct post-payment review of claims, we may also ask for documentation of administration from the approved CAP vendor and for medical records from the participating CAP physician for any claim that is identified for review. While it is standard practice for CMS to require Medicare providers to submit medical records as part of claims review, we reserve the right to also specifically request any other records that verify the administration of a CAP drug. Furthermore, we want to make it very clear to the participating CAP physician that when electing to join the program that the physician may be asked to supply medical records for post-payment review. Therefore, in the CY 2008 PFS proposed rule (72 FR 38153), we proposed to revise § 414.908(a)(3)(xi) and the physician election agreement form to clarify that medical records and certain other information may be requested from the CAP physician during the post-payment review process.

The procedures used to verify valid claims and ensure proper payment for drugs supplied under the CAP are based on established post-payment review processes used in other parts of the Medicare program. The request for medical records as part of the claims payment process during CAP post-payment review is intended to work in conjunction with Item 12 on the Health Insurance Claim Form CMS–1500 which, when signed by a beneficiary, authorizes the release of ''any medical information necessary to process a claim.''

When a claim is selected for review we notify the approved CAP vendor and request its records to verify administration. We also notify the approved CAP vendor that we will be requesting medical records from the participating CAP physician. If the medical record is not received within 30 days, the claim is denied because we will not have sufficient information to verify drug administration and medical necessity.

This review process is similar to those used elsewhere in the Medicare program such as clinical laboratory payment review or payment of radiology services.

As we specified in the July 6, 2005 IFC (70 FR 39038), the local carrier's medical review policies and coverage determinations will continue to apply in the CAP. Under our previous claims processing methodology, the local carrier made the coverage determination on the drug ordered by the participating CAP physician and furnished by the approved CAP vendor as part of the claim matching process prior to payment of the approved CAP vendor's claim. Under the new methodology, the drug claim will be paid upon receipt unless the local carrier has already made a coverage or medical necessity determination on the drug, and the match has already occurred showing that the drug claim should be denied.

As part of the post-payment review process, the CAP-designated carrier checks the CMS central claims processing system to determine whether the local carrier has made a coverage or medical necessity determination on the CAP drug indicated on the participating CAP physician's drug administration claim. If a coverage determination has been made, the CAP-designated carrier reflects the local carrier's decision in its post-payment review of the claim. If the local carrier has not reviewed the drug administration portion of the participating CAP physician's claim as of the date that the designated carrier processes the approved CAP vendor's drug claim, the CAP-designated carrier uses the local carrier's coverage determination policies when conducting medical review of the claim.

Comment: One commenter stated that we had exceeded the scope of the statute because we were planning to conduct a medical necessity review on CAP drug claims that were selected for review as part of the statistical sample.

Another commenter recommended that we make detailed description of the claims sampling process available for public comment and asked that we design the process consistent with the Medicare Program Integrity Manual. The commenter also asked for more detail on the information necessary to include in the medical record to ensure that the participating CAP physician has appropriately documented the medical necessity of the drug administered.

One commenter questioned whether we needed to obtain additional information from the CAP participating physician on claims selected for post pay review based on the statistical sample and stated that the information contained on the claim form should be sufficient to verify administration.

Another commenter questioned why we were changing the CAP claims processing methodology to pay most claims upon receipt and to verify administration on a post pay basis. The commenter asked whether we would allow for extenuating circumstances if the medical record was not supplied by the participating CAP physician within the 30-day time period for situations such as bankruptcy, litigation, or closure of the practice.

Response: As stated in the CY 2008 PFS proposed rule (72 FR 38153), we were required to make changes to the CAP claims processing methodology because section 108 of the MIEA–TRHCA amended section 1847B(a)(3)(A)(iii) of the Act by adding new language that requires the payment for drugs and biologicals upon receipt of a claim for a drug or biological supplied for administration to a beneficiary. This change in the law was effective on April 1, 2007. 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 overpayment determined by the Secretary under this process. We implemented the necessary changes to our claims processing system and initiated the post-payment review process on April 1, 2007, via instructions to the CAP-designated claims processing contractor and Questions and Answers posted the CMS competitive bidding Web site at *http://www.cmsm.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage.* In the CY 2008 PFS proposed rule, we described the changes we had made to our claims processing system and proposed conforming changes to our regulations for additional items not covered by the MIEA–TRHCA. Because the MIEA–TRHCA gave us authority to

implement its provisions by program instructions or otherwise by April 1, 2007, the necessary changes have already been made to our claims processing system and the post-pay review process had been implemented. The post-payment review process includes verification of drug administration and a medical necessity review of a statistically-valid sample of CAP claims. This process was designed in conformance with the Medicare Program Integrity Manual and in consultation with CMS statistical sampling experts, consistent with our authority to establish these procedures by program instruction or otherwise. For additional information on the requirements of the Program Integrity Manual see *http://www.cms.hhs.gov/manuals/downloads/pim83co2pdf.*

All Medicare claims are subject to medical necessity determinations; however, under the changes required by the MIEA–TRHCA, there may not be sufficient time for all CAP claims to be reviewed for medical necessity before they are paid. Prior to paying the approved CAP vendor's claim, the designated carrier will check the claims processing system to determine whether the participating CAP physician has submitted the claim for the administration of the drug. If the physician has submitted the claim and the local carrier has made a determination that the drug is not payable because of a coverage or medical necessity denial, the drug claim will be denied by the designated carrier. However, if no determination has been made on the physician's claim, the designated carrier will pay the approved CAP vendor's claims for the drug under the MIEA–TRHCA, and the claim will be subject to statistical sampling on a post-pay basis. If the claim is selected for review, verification of drug administration and a medical necessity review will be conducted. As part of this process, the designated carrier will check the system to see whether the local carrier had denied the claim as not medically necessary. If a denial has been made, the designated carrier will deny the approved CAP vendor's claim on medical necessity grounds. The designated carrier will use the local carrier's policies when conducting the review.

Medical necessity review is always conducted based on medical records obtained from the physician and will be conducted in an effort to look behind the information on the claim form. As specified in chapter 3 of the Medicare Program Integrity Manual, standard data elements for post-pay medical review include signature requirements, diagnosis requirements, and documentation of orders for testing. The carrier may also specify additional information it will review to document that coverage and medical necessity requirements have been met. Under the current CAP post-pay review process, the designated carrier requests that all records be supplied by the physician within 30 days but allows for a limited amount of time beyond that period before the service will be considered not to have been administered. Participating CAP physicians are encouraged to send any information they can provide to the designated carrier within the timeframes provided. If the physician is unable to provide all of the requested information in a timely manner to the carrier, he or she may contact the carrier to determine if the contractor will grant an extension. There is also a provision in the Medicare Program Integrity Manual that allows contractors to grant additional time in the event of a natural disaster. As we indicated in the CY 2008 PFS proposed rule, it is standard practice for Medicare providers to be required to submit medical records to assist in claims review. Therefore, we are finalizing our proposal to revise § 414.908(a)(3)(xi) and the physician election agreement to make it very clear to the CAP participating physician that they may be asked to provide medical records for post-payment review in the CAP.

e. Provisions for Collection of Beneficiary Coinsurance

In the CY 2006 PFS final rule with comment period, we specified at § 414.914(h)(1) that subsequent to receipt of final payment by Medicare, or the verification of drug administration by the participating CAP physician, the approved CAP vendor must bill any applicable supplemental insurance policies. If a balance remains after the supplemental insurer pays its share of the bill, or if there is no supplemental insurance, the approved CAP vendor may bill the beneficiary for the balance. In prior practice, a match in the claims system between the participating CAP physician's drug administration claim and the approved CAP vendor's drug claim and the subsequent payment by Medicare was used to indicate that the beneficiary received the drug. We also allowed voluntary information exchanges between the approved CAP vendor and the participating CAP physician's office to verify CAP drug administration. Additionally, we note that under the CAP regulations, the participating CAP physician has a responsibility to notify the approved CAP vendor when a drug is not administered or a smaller amount was administered than was originally ordered.

Because section 108 of the MIEA–TRHCA requires the payment of CAP claims upon receipt, payment of a claim by Medicare may occur before administration of the drug has been verified. However, section 1847B(a)(3)(A)(ii) of the Act, which states that deductible and coinsurance shall not be collected unless the drug or biological is administered, remains unchanged. Thus, because we have interpreted this provision as requiring verification of administration prior to the collection of applicable cost sharing amounts, the requirement for verification of administration similarly remains unchanged. However, because of the statutory change of section 108(a)(1) of the MIEA–TRHCA and its resulting impact on our claims processing methodology, the claims processing system no longer provides a way for CMS to verify administration on the approved CAP vendor's behalf before the approved CAP vendor collects coinsurance from the beneficiary or the supplemental insurer. Verification of CAP drug administration is also conducted in the post-payment review process. The approved CAP vendor is expected to make information available to verify administration for post-payment review as necessary.

We believe that an approved CAP vendor can verify whether a CAP drug was administered in a variety of ways. For example, an approved CAP vendor may enter into a voluntary agreement with a participating CAP physician to exchange such information as described in the CY 2006 PFS final rule with comment period (70 FR 70251). However, if a participating CAP physician is unwilling to enter into a voluntary agreement to verify administration, the approved CAP vendor may verify that the drug was administered by contacting the participating CAP physician's office to request verbal confirmation. In such an instance, the approved CAP vendor is expected to document the verbal confirmation of CAP drug administration, the identities of individuals who exchanged the information, and the date and time that the information was obtained. In addition to verifying administration through contact with the physician's office, we also suggest that the approved CAP vendor place a statement on beneficiaries' bills informing the individual of the statutory requirement and suggesting that the beneficiary contact the participating CAP physician to verify that he or she received the dose

of the drug for which he or she are being billed prior to paying any cost sharing amount.

For the reasons described above in this section, we believe that the verification of CAP drug administration remains a required element of the CAP; therefore, in the CY 2008 PFS proposed rule (72 FR 38155), we proposed to add § 414.906(a)(6) by specifying that all of the following elements are required to document the verification of CAP drug administration:

- Beneficiary's name.
- Health insurance number.
- Expected date of administration.
- Actual date of administration.
- Identity of the participating CAP physician.
- Prescription order number.
- Identity of the individuals who supply and receive the information.
- Dosage supplied.
- Dosage administered.

In the CY 2008 PFS proposed rule, these data elements were actually proposed in § 414.914 (72 FR 38226). We believe that the drug administration verification requirements best fit in § 414.914 since CAP vendors must collect this information as part of their terms of contract. Therefore, we are finalizing § 414.914 to include these provisions.

Also, as a result of changes mandated by section 108(a)(1) of the MIEA–TRHCA, we proposed to revise new § 414.914(i)(1) to remove the reference to ''final payment by Medicare'' and revise this language to state, ''payment by Medicare.'' The original language was written to indicate that an approved CAP vendor could not bill a beneficiary's supplemental insurer for applicable amounts of cost sharing until the CAP drug claim had matched the corresponding physician's drug administration claim. Under the post-payment review process, the final payment would not occur until a statistical review of the claims was complete, a process that may take several months. Removing the word final from this section of the regulation will clarify that the approved CAP vendor may bill the supplemental insurer immediately after the designated CAP carrier makes the initial payment on a CAP drug claim. Under our current regulations, the approved CAP vendor may also bill the beneficiary if drug administration is verified by the participating CAP physician. This provision remains unchanged.

Under the revised CAP claims payment process, the approved CAP vendor will bill Medicare for the CAP drug that has been provided. In most cases Medicare will pay the claim upon receipt. If the beneficiary has a supplemental insurance policy, and the supplemental insurer has a crossover agreement with Medicare, the claim automatically will cross over to the supplemental insurer for payment. The supplemental insurer will pay its share. Upon receipt of payment from the supplemental insurer, the approved CAP vendor may bill the beneficiary for any residual amount. For beneficiaries who do not have a supplemental insurance policy, the approved CAP vendor may bill the beneficiary after payment by Medicare.

However, in either case, the approved CAP vendor may not collect any coinsurance owed from the beneficiary or his or her supplemental insurer unless it has verified that the drug was administered. If the approved CAP vendor believes that the drug was administered but later learns that it was not, the approved CAP vendor must refund any coinsurance collected to the beneficiary and his or her supplemental insurer, as applicable. In addition, in § 414.914(i)(2), we proposed that the approved CAP vendor must promptly refund any payment made by CMS if the vendor has been paid for drugs that were not administered. We also proposed to interpret the word ''promptly'' to mean 2 weeks. Thus, the approved CAP vendor would have 2 weeks from the date it was notified that it had been paid for a drug that had not been administered to refund to the designated carrier any payment for the claim and refund any cost sharing collected to the beneficiary or his or her supplemental insurer.

Comment: We received few comments on our proposal for provisions for collection of beneficiary coinsurance. One commenter was concerned about the administrative burden placed on the participating CAP physician if the approved CAP vendor calls the physician's office to verify that a drug was administered. Another commenter agreed with our proposal to require that the approved CAP vendor refund any cost sharing collected in error promptly to the beneficiary and or his or her supplemental insurance provider. The commenter also suggested that we require the approved CAP vendor to pay a penalty above the amount owed if it does not refund the cost sharing amount within the 2 week time frame.

Response: Physicians and their staff are the best source of information for drug verification since they have direct contact with the beneficiary. We have structured the process for verification of CAP drug administration in the least burdensome way possible for the participating CAP physician that would still provide us with information to comply with the statutory mandate to assure that payment is made for a CAP drug only if it has been administered to a beneficiary.

Physicians have flexibility in how verification for drug administration occurs. The physician is free to enter into a voluntary agreement with the approved CAP vendor to verify drug administration and to specify the manner in which he or she would like the verification to occur. Alternatively, if the physician chooses not to enter into such an agreement and does not notify the vendor that a dose of a CAP drug has been administered, the approved CAP vendor will contact the physician to verify administration before collecting coinsurance from the beneficiary.

We believe that the degree of flexibility built into this procedure for drug administration verification minimizes the burden for participating CAP physicians within the confines of our statutory obligation to assure that payment is made for a CAP drug only if it has been administered to a beneficiary. Therefore, we are finalizing our proposal to add new § 414.914(h)(1) as described above in this section.

We are also finalizing our proposal to revise new § 414.914(i)(1) to remove the reference to ''final payment by Medicare'' and revise this language to state, ''payment by Medicare.'' Under the post-payment review process, the final payment will not occur until a statistical review of the claims was complete, a process that may take several months. Removing the word final from this section of the regulation will clarify that the approved CAP vendor may bill the supplemental insurer immediately after the designated CAP carrier makes the initial payment on a CAP drug claim. Under our current regulations, the approved CAP vendor may also bill the beneficiary if drug administration is verified by the participating CAP physician. This provision remains unchanged.

Under the revised CAP claims payment process, the approved CAP vendor will bill Medicare for the CAP drug that has been provided. In most cases Medicare will pay the claim upon receipt. If the beneficiary has a supplemental insurance policy, and the supplemental insurer has a crossover agreement with Medicare, the claim automatically will cross over to the supplemental insurer for payment. The supplemental insurer will pay its share. Upon receipt of payment from the supplemental insurer the approved CAP vendor may bill the beneficiary for any residual amount. For beneficiaries who

do not have a supplemental insurance policy, the approved CAP vendor may bill the beneficiary after payment by Medicare.

However, in either case, the approved CAP vendor may not collect any coinsurance owed from the beneficiary or his or her supplemental insurer unless it has verified that the drug was administered. If the approved CAP vendor believes that the drug was administered but later learns that it was not, the approved CAP vendor must refund any coinsurance collected to the beneficiary and his or her supplemental insurer, as applicable.

In addition, we are finalizing § 414.914(i)(2), so that the approved CAP vendor must promptly refund any payment made my CMS if the vendor has been paid for drugs that were not administered. We are implementing our proposal to interpret the term ''promptly'' to mean 2 weeks so that the approved CAP vendor would have 2 weeks from the date that they were notified that they had been paid for a drug that had not been administered to the beneficiary to refund any payment for the claim made to the designated carrier and refund any cost sharing collected to the beneficiary and his or her supplemental insurer. We are not implementing a penalty if the refund of any cost sharing collected in error exceeds the two week time frame because section 1847B of the Act does not provide for such a remedy.

f. Approved CAP Vendor Appeals for Denied Drug Claims

In the March 4, 2005 proposed rule (70 FR 10757 through 10758) and the July 6, 2005 IFC (70 FR 39054 through 39057), we discussed the development of the CAP dispute resolution process and the limited applicability of the traditional Medicare fee for service appeals process to an approved CAP vendor's dispute of CAP drugs claims that are denied by the CAP-designated carrier. We stated that the approved CAP vendor could file appeals as a Medicare supplier consistent with the rules at 42 CFR part 405, subpart I. For the purposes of the appeals regulations at Part 405, Subpart I, we indicated that a local carrier's initial determination of the participating CAP physician's drug administration claim was an initial determination regarding payment of the approved CAP vendor's drug claim. Thus, the approved CAP vendor was to be considered a party to any redetermination of the drug administration claim by the local carrier. In addition, the approved CAP vendor would be considered a party to an initial determination on the claim for payment for the drug product that the approved CAP vendor filed with the CAP-designated carrier.

We also specified that appeals of either initial determination would be filed with the local carrier. We stated that the local carrier, rather than the designated carrier, possessed all information necessary to adjudicate an appeal in this situation. Such information included local coverage decisions, medical necessity determinations, and information regarding payment of drug administration claims. A dispute resolution process was set forth in § 414.916.

Under our initial implementation of the provision that authorized CAP, this alternative approach provided party status to the approved CAP vendor on the participating CAP physician's drug administration claim. This was necessary because an approved CAP vendor was not permitted to receive payment for a CAP drug until the corresponding drug administration claim was submitted by a participating CAP physician. Payment for the approved CAP vendor's claim was authorized when the participating CAP physician's claim and the approved CAP vendor's claim were matched in the system.

However, changes to the claims processing requirements and the addition of a post-payment review process required by section 108(a)(2) of the MIEA–TRHCA (discussed above in this section) eliminate the approved CAP vendor's dependency on a participating CAP physician's filing of a drug administration claim in order to receive payment for a CAP drug. Accordingly, the approved CAP vendor no longer needs party status on the drug administration claim submitted by the participating CAP physician. Instead, under the MIEA–TRHCA, the approved CAP vendor's drug claim may be paid by the CAP-designated carrier once it is received. This determination made on the claim constitutes an initial determination as defined in § 405.924. The approved CAP vendor is considered a party to this initial determination and may request a redetermination and subsequent appeals consistent with the process established under 42 CFR part 405, subpart I.

The changes to CAP claims processing in this final rule with comment period that conform to the MIEA–TRHCA result in two scenarios that create appeals rights for the approved CAP vendor with respect to their drug product claim: (1) Prepayment denials of the approved CAP vendor's claim made by the CAP-designated carrier (based on information from the local carrier that the payment for the drug should be denied as excluded or non-covered); and (2) post-payment denials by the CAP-designated carrier based on the post-payment review process established under the MIEA–TRHCA.

Therefore, as proposed in the CY 2008 PFS proposed rule (72 FR 38156), we are making the following clarifications regarding the CAP appeals process for an approved CAP vendor's denied drug claims:

- For prepayment denials, the approved CAP vendor, as a supplier, has a direct right to appeal the initial determination made by the designated carrier on its drug product claim. The local carrier will conduct the redetermination on prepayment denials. It is the most appropriate entity to review prepayment denials since it is most familiar with the relevant coverage policies for that jurisdiction. We acknowledge that this process differs from a traditional fee-for-service appeal since the redetermination will not be conducted by the contractor that issued the initial determination.
- For the post-payment review process, an initial determination will be considered re-opened if the CAP-designated carrier selects the drug claim for review. If the CAP-designated carrier cannot verify administration or cannot determine that the drug is covered or medically reasonable and necessary, the CAP-designated carrier will issue a revised determination to deny coverage of the drug product claim. The CAP-designated carrier will then determine whether an overpayment exists, and if so, will recover the overpayment. As a supplier, the approved CAP vendor would then have the right to request a redetermination of the revised coverage determination, and the overpayment assessment. The CAP-designated carrier will process the redetermination.

We received no comments on this topic; therefore, we are finalizing the proposed conforming changes to the CAP appeals process as described herein.

g. Definition of Exigent Circumstances

Sections 1847B(a)(1)(A)(ii) and 1847B(a)(5)(A)(ii) of the Act require that each physician be given the opportunity annually to elect to obtain drugs and biologicals through the CAP and to select an approved CAP vendor. Section 1847B(a)(5)(A)(i) of the Act allows for selection of another approved CAP vendor more frequently than annually in exigent circumstances as defined by CMS.

In the CY 2005 PFS final rule with comment period (70 FR 70258), we

stated that participating CAP physicians would have the option of changing approved CAP vendors or opting out of the CAP program on an annual basis. We also provided the circumstances, as specified in § 414.908(a)(2), under which a participating CAP physician may choose a different approved CAP vendor mid-year or opt-out of the CAP. These circumstances are: (1) If the selected approved CAP vendor ceases to participate in the CAP; (2) if the participating CAP physician leaves the group practice that had selected the approved CAP vendor; (3) if the participating CAP physician relocates to another competitive acquisition area (if multiple CAP competitive areas are developed) or, (4) for other exigent circumstances defined by CMS.

We also identified a separate exigent circumstance relating to instances in which an approved CAP vendor declines to ship CAP drugs (when the conditions of new § 414.914(i) are met) in § 414.908(a)(5). We noted that in these cases, a physician may opt-out of his or her drug category, and because there is currently only one drug category for the CAP, then the participating CAP physician would be allowed to opt-out of the CAP altogether (70 FR 39081).

The CAP became operational on July 1, 2006. At that time, we believed that most issues raised by participating CAP physicians would relate to quality and service, which could be resolved through the approved CAP vendor's grievance process and the dispute resolution process conducted by the designated carrier. However, since then, we have been contacted by a few participating CAP physicians who have requested termination of their election agreement because they misunderstood the CAP program or determined that it was not a viable option for their practice.

These instances demonstrate that a practice might wish to leave the program for other business reasons that are unrelated to the approved CAP vendor's performance. However, we continue to believe that opportunities for leaving the CAP outside the annual election process should be limited because the CAP was designed as a program in which physicians would make an annual decision to participate, as consistent with sections 1847B(a)(1)(A)(ii) and 1847B(a)(5)(A) of the Act.

Therefore, in the CY 2008 PFS proposed rule (72 FR 38156), we proposed to define an additional exigent circumstance for opting out of the CAP. We proposed that within 30 days of the effective date of the election agreement, the participating CAP physician may submit a written request to terminate his or her participation in the CAP. The request would be sent to the designated carrier under the dispute resolution process, and the designated carrier would determine within 1 business day whether the request was related to the service provided by the approved CAP vendor. If so, the designated carrier would refer the participating CAP physician to his or her approved CAP vendor's grievance process to further determine whether any appropriate and reasonable steps could be taken to resolve the identified issue.

We proposed that the approved CAP vendor would have 2 business days to respond to the participating CAP physician's concern, consistent with § 414.914(f)(5). If the approved CAP vendor is unable to identify a solution for resolving the issue that is consistent with the CAP statute, regulations, contracts and guidance, and that is acceptable to the physician, then the participating CAP physician would be referred back to the designated carrier for assistance under the dispute resolution process. We also proposed that the participating CAP physician's request would be handled under the dispute resolution process because protocols and defined time frames have already been developed for handling participating CAP physician and approved CAP vendor complaints in this set of procedures.

We proposed that if the designated carrier does not believe that the participating CAP physician's request is related to an issue that could be resolved by the approved CAP vendor, then the designated carrier would conduct an investigation and attempt to resolve any issues identified in the physician's request to terminate his or her CAP election agreement. If the designated carrier is unable to resolve the situation to the physician's satisfaction within 2 business days, then it can either make a recommendation to CMS that the physician be permitted to terminate his or her CAP election agreement, or request a 2-day extension to continue examining the issue. We stated that we believed that 4 business days would be sufficient to conclude this process because it would give the designated carrier time to gather information from other affected parties, such as the participating CAP physician's local carrier, but still prepare a speedy summary of the issues involved in the physician's request.

Under our proposal, after the 2-day or 4-day period, as applicable, the designated carrier would forward its recommendation and the physician's request to CMS. We would then review the recommendation and make a final decision within 2 business days from the date that we received the request.

We proposed that if the participating CAP physician demonstrated that remaining in the CAP was a significant burden, then we would allow that physician to terminate his or her participation in the program. We would inform the designated carrier of our decision, which the designated carrier would then communicate to the participating CAP physician in writing. As part of this process, the physician's termination date for his or her CAP election agreement would be determined and communicated to all parties involved, including the physician's local carrier.

Conversely, if we did not believe that the physician demonstrated that CAP participation constituted a significant burden, then we would not allow the physician to terminate his or her CAP contract. Subsequently, we would inform the physician of our decision in writing via the designated carrier. We would also include a recommendation for corrective action.

In the CY 2008 PFS proposed rule, we also proposed that, even if we agreed to terminate the participating CAP physician's CAP election agreement, the physician would still be required to continue to cooperate in any post-payment review and appeal of claims for drugs that the approved CAP vendor had already provided and been paid for. The physician would also have to make arrangements with the approved CAP vendor for the return of any unused drugs that had not been administered to the beneficiary prior to the effective date of the physician's termination from the CAP. If the approved CAP vendor had billed CMS for drugs that had not yet been administered to a beneficiary, then the vendor would be required to correct the claim and return any overpayment.

Comment: We received several comments that supported defining an additional exigent circumstance for leaving the CAP because of a burden on the practice. Several commenters addressed the timeframe for leaving the CAP. Of these comments, all supported a 30-day timeframe, though several encouraged a longer window. Commenters who encouraged a longer time period believe that 30 days was insufficient time to determine the suitability of the CAP for their practice.

While most commenters agreed that a demonstration of burden should be required, one commenter stated that allowing physicians to opt-out for any reason would be desirable. One commenter suggested that physicians should be allowed to opt-out of the CAP

at any time for any reason. Several commenters asked that the opt-out process be simplified. Another commenter requested that the process for determining whether to grant a physician's request to leave the CAP be outlined.

Response: Based on the comments, we are revising our proposal to make it more flexible. While we recognize the concerns raised by commenters who recommended that we allow physicians to leave the CAP for any reason at any time, we continue to believe that there should be limits on a participating CAP physician's ability to leave the CAP. The CAP statute contemplates an annual election process. Our proposal to allow a 30-day period for opting out because of a burden is based on our authority to specify ''exigent circumstances,'' and we do not believe it would be appropriate to allow physicians to opt-out under this process without some exigency that makes termination of CAP participation necessary. However, in recognition of these comments, and because we agree that participating CAP physicians should have a sufficient opportunity to assess the suitability of the CAP for their practice, we are making the following changes to the opt-out process.

First, we note that we intend to take a broad view of what would constitute a burden to the practice resulting in an ''exigent circumstance.'' We believe that a broad view is appropriate because there may be many reasons why a participating CAP physician may find CAP participation more burdensome than he or she expected, and we do not wish at this time to place a limit on what those reasons may be. As we gain experience with this process, we may in a future rulemaking specify a list of ''exigent circumstances'' or prescribe more specific standards for what constitutes an ''exigent circumstance'' for purposes of the opt-out process; however, for now we will assess requests on a case-by-case basis under the process described in this preamble and set forth in the regulations at § 414.908.

In response to comments seeking greater flexibility in the process and a longer window in which to assess the CAP's suitability for the physician's practice, we are implementing a two-tiered process that would both expand the initial time frame for requesting to opt-out of the CAP and would allow for requests to opt-out at any time based on a change in circumstances that was not previously known to the participating CAP physician. We believe that such a process, which we outline below, strikes a balance between providing participating CAP physicians with flexibility to opt-out of the CAP when participation is burdensome, while still placing appropriate limits on a physician's ability to leave the CAP outside the annual election process.

Thus, under the two-tiered process we are finalizing in this rule, we are changing to 60 days the initial period during which a physician can request termination of his or her CAP participation agreement as a result of exigent circumstances. We agree with commenters that allowing physicians more time to determine whether the CAP is suitable for their practices is advisable. We believe that an initial 60-day period will allow the participating CAP physician time to make a more complete assessment of the CAP's suitability. Although certain burdens will be likely to be apparent immediately, the first 30 days may be a period with a steep learning curve for the practice as it adapts to the CAP drug ordering process, and the first 30 days may involve working out any ''start up'' issues within the practice or with the approved CAP vendor. For this reason, the first 30 days may not be a fully representative time period during which to assess ongoing CAP participation. We believe an additional 30 days of CAP participation would be sufficient to identify, in the vast majority of cases, whether participation will constitute a burden to the practice.

Under this process, therefore, if a participating CAP physician's election agreement was effective on January 1, 2008, then he or she would have until March 1, 2008, to request to terminate participation in the program if CAP participation results in a burden to the practice. In addition, based on the concerns raised by commenters, we will allow physicians to leave the CAP at any time after the first 60 days if they can show that a change in circumstances that was not known to the practice *previously* results in a burden to the practice. As noted above, we believe that in the vast majority of cases participating CAP physicians will be able to identify a burden, if any, within the first 60 days. However, we also recognize that issues may arise during the course of the year that would result in an ''exigent circumstance,'' but that were not known to the participating CAP physician during the first 60 days of CAP participation. In such instances, we agree with commenters that physicians should have a longer window to request an opt-out.

For purposes of the two-tiered process, then, examples of burdens that we would expect a practice could identify within the first 60 days may include difficulties with CAP billing or drug ordering requirements, or documentation that the practice's initial understanding of these requirements was based on inaccurate information provided by a third party. Examples of burdens that might arise after the initial 60 days could include a change in practice personnel, patient population, computer systems, or vendor behavior that makes it harder to participate in the program. Where an opt-out request is submitted after the initial 60 days, we will require the participating CAP physician to demonstrate the request is based on information that he or she did not have within the first 60 days.

All requests to terminate participation, whether within the first 60 days or thereafter, would be submitted to the CAP-designated carrier and processed under the dispute resolution process. The request would need to document the physician's burden. Upon completion of the process outlined in proposed § 414.917, we would make the decision about whether the participating CAP physician's participation in the CAP will be terminated.

If the physician has not demonstrated that CAP participation represents a burden for his or her practice—either during the first 60 days or, if thereafter, as a result of a change in circumstances that was not known to the practice previously, then we would not allow the physician to terminate his or her participation in CAP because, as noted above, we continue to believe that a participating CAP physician's ability to opt-out of the CAP under this process should be limited to ''exigent circumstances,'' as contemplated by the statute and our regulations.

We would inform the physician of our decision in writing via the designated carrier. We would also include a recommendation for corrective action, if appropriate. For example, if the reason that the CAP participating physician wanted to leave the program was that the approved CAP vendor was not delivering drugs timely, the designated carrier would investigate the situation. If it found that the approved CAP vendor was complying with our regulations on drug delivery at § 414.914(f) and § 414.902 but that the participating CAP physician was not ordering drugs consistent with the vendor's procedures, then the CAP-designated carrier could educate the physician about the proper drug ordering procedures and facilitate a discussion between the approved CAP vendor and the participating CAP physician about how the physician could order drugs in a way that met the

needs of his or her practice and the drug ordering requirements of the CAP vendor. The CAP-designated carrier would document the result of that discussion in writing. The participating CAP physician would have the right to request a reconsideration of our decision as specified in § 414.916(c). We are revising § 414.916(c) to clarify that the physician reconsideration process would apply to reconsiderations of our decision on whether the participating CAP physician may opt-out of the CAP.

Based on our experience with the program, we continue to believe that handling all requests to terminate CAP election under the dispute resolution process is reasonable and straightforward. We further believe the use of our pre-existing process will not create unnecessary delays in processing opt-out requests, particularly in light of the short time frames we have specified for responding to opt-out requests. Moreover, we believe the dispute resolution process is sufficiently detailed that it provides an ample description of how a physician's request to terminate CAP participation will be assessed.

Physicians will still be required to return unused CAP drugs and to complete any required CAP claims processing activities as described in proposed § 414.917. The notification to a physician will also include the end date of CAP participation in order to facilitate an orderly and efficient changeover between the CAP and ASP payment systems.

Therefore, we are finalizing § 414.908 and § 414.917 as proposed, subject to the changes described in this section. (We are making an additional technical change to § 414.908 to consolidate the ''additional opt-out'' provision, currently set forth at § 414.908(a)(5), with the other opt-out provisions at § 414.908(a)(2). We believe this nonsubstantive change will improve the clarity of the regulations.) Finally, we also are finalizing § 414.916(c) as amended as described in this section.

h. Transporting CAP Drugs

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, 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.

As stated in § 414.906(a)(4), we implemented the CAP with a restriction that CAP drugs be shipped directly to the location where they will be administered. However, we were aware that physicians may desire to administer drugs in alternative settings, especially in a home. We sought comment on how this could be accommodated under the CAP in a way that addresses the concerns about product integrity and damage to the approved CAP vendors' property expressed by the potential vendors.

Several comments submitted in response to the July 6, 2005 IFC suggested either narrowing 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. It would allow practices with satellite operations that are not open every business day to receive shipments of CAP drugs at another practice location and then to administer the drugs in the satellite office.

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.

These comments and our experience with the CAP thus far have caused us to consider revising our policy. Therefore, in the CY 2008 PFS proposed rule (72 FR 38157), we requested comments on the potential feasibility of narrowing 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 practice locations listed on a physician's CAP election agreement form. Additionally, we also solicited comments on the following areas that we could use in the 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 the agreement should be documented in writing, and whether it is necessary to create any restrictions on which CAP drugs could be transported.

We stated that we were not making a specific proposal at this time but that we would use any information received to structure a future proposal in the event we made one.

Comment: Several commenters 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 be certain that appropriate safeguards would be in place 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 a physician's certification or discretion were satisfactory.

Response: We are sympathetic to the concerns expressed by the commenters and expect to issue a proposal in the CY 2009 PFS proposed rule that would allow the transportation of CAP drugs from one physician practice location in certain circumstances. We further expect that our proposal would propose to permit transport of CAP subject to voluntary agreements between the approved CAP vendor and the participating CAP physician that complied with all applicable State and Federal laws and regulations and product liability requirements. We welcome comments on how to structure such a proposal.

i. Alternatives to the CAP Prescription Order Number

In the July 6, 2005 IFC (70 FR 39043 and 39049), we responded to several comments regarding the administrative burden that the CAP ordering and claims payment process imposes upon participating CAP physicians; specifically, activities associated with using and tracking the prescription order number were mentioned. We received additional comments on this issue in response to the IFC as well.

After the close of the comment period, we also received an inquiry from the current approved CAP vendor about the potential length of the CAP prescription order number and whether it could present a burden to participating CAP physicians. A 30-byte field is currently available on the electronic claim form for prescription numbers; however, it is not necessary for the prescription order number to be 30 bytes long. Typically, 15 or fewer total characters have been used by the approved CAP vendor.

The requirements for developing the CAP prescription order number are as follows: The first 9 characters are the approved CAP vendor's ID and the HCPCS code of the drug that is being billed; the approved CAP vendor sets the remaining characters. The assigned CAP prescription order number is captured in Loop 2410, REF02 (REF01=XZ) of the ANSI 4010A1 electronic claims transaction. This segment of the electronic claims transaction is part of a specific data format that Medicare claims must adhere to in order to meet national electronic standards for the automated transfer of certain health care data as mandated by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA).

Each prescription order number is unique to a dose of a CAP drug that is being shipped for administration to a particular beneficiary. The prescription order number is generated by the approved CAP vendor and, as stated in the July 6, 2005 IFC (70 FR 39042), each dose of a CAP drug is required to have a separate prescription order number. After the drug is administered, the participating CAP physician's drug administration claim is submitted with a no-pay line containing the prescription order number. The approved CAP vendor's claim for the CAP drug also contains the prescription order number.

When the CAP was implemented, the prescription order number was used in the claims matching process to facilitate accurate payment of the approved CAP vendor. Prior to payment, this system paired an approved CAP vendor's drug claim to a participating CAP physician's drug administration claim using the prescription order number. A matching prescription order number between these two claims indicated that the drug had been administered.

Since the CAP began, the claims process has changed because of statutory changes. Section 108(a)(2) of the MIEA–TRHCA requires us to make payment upon receipt of an approved CAP vendor's drug claim and then to conduct a post-payment review of claims. As stated in the MIEA–TRHCA, the post-payment review process is intended to ''assure that payment is made only for a drug or biological * * * if the drug or biological has been administered to a beneficiary.''

Under this new process, the prescription order number still plays a pivotal role. Prior to the payment of the approved CAP vendor's drug claim, the CAP-designated carrier uses the prescription order number to check the claims processing system to ascertain whether the local carrier has adjudicated the drug administration claim. If the local carrier has done so, then the CAP-designated carrier will look to see whether the local carrier has determined that the CAP drug administered by the participating CAP physician is covered and is medically necessary. The local carrier's decision determines whether the CAP-designated carrier will pay the approved CAP vendor's drug claim. If the participating CAP physician's local carrier has not made a determination on the physician's claim and the CAP drug claim, then the designated carrier will pay the approved CAP vendor's claim upon receipt and use the CAP prescription order number to help verify drug administration on a post-payment basis.

The prescription order number is also still used in other CAP processes. Each dose of a CAP drug that is shipped by the approved CAP vendor is tracked using the prescription order number. Moreover, the prescription order number is particularly useful in certain situations such as those that involve recurring cyclic drug treatment regimens. In these cases, the prescription order number minimizes the possibility of confusion by serving as a unique differentiating factor between highly similar drug claims. Also, the prescription order number is valuable during instances in which the anticipated day of service submitted by the participating CAP physician differs from the actual date of drug administration. In these situations, the prescription order number would clarify confusion stemming from discrepancies in dates. Overall, we believe that the prescription order number remains an appropriate and necessary tool to track the administration of a specific dose of a drug and for the accurate execution of the post-payment review process.

Although we believe that the use of the prescription order number is necessary to facilitate accurate review of CAP claims, we are aware that it may be considered an inconvenience by some potential participating CAP physicians and approved CAP vendors. Therefore, in the CY 2008 PFS proposed rule (72 FR 38158), we requested comments on alternative methods to accurately track the administration of specific doses of drugs in order to meet the requirements stated in section 108(a)(2) of the MIEA–TRHCA. These comments could then be used in the development of a proposal for future rulemaking.

Comment: We received a few comments on this issue. One commenter suggested that the CAP-designated carrier should simply match vendor and physician claims but did not provide any details about how that could be accomplished without the prescription order number. Another commenter stated that the CAP prescription order number was no longer needed to verify drug administration and should be eliminated. Instead they recommended that we should rely on the approved e-CAP vendor's verification of drug administration and the physician's records of drug administrations.

Response: While the records of participating CAP physicians and the CAP vendor are currently used in the post pay review process, the CAP prescription order number plays an important role in that it enables the designated carrier to identify the exact doses of a drug that was administered and provides a link between the approved CAP vendor's claim and the participating CAP physician's claim that is not available otherwise.

We do not believe the suggestions that we have received thus far would allow us to discontinue the use of the prescription order number. The prescription order number allows us to better ''assure that payment is made only for a drug or biological * * * if the drug or biological has been administered to a beneficiary'' since it tracks the administration of a specific dose of a drug, which allows CMS to match the vendor and the physician claim in the post pay review process. However, we would appreciate receiving other suggestions that would allow drug administration verification on a dose specific basis. Since we did not make a specific proposal about this

issue, we will not make any changes at this time to the requirement that the CAP prescription order number be supplied by the approved CAP vendor and included on claims from both the participating CAP physician and the approved CAP vendor.

j. Prefilled Syringes

In the July 6, 2005 IFC (70 FR 39061), we described public comments which stated that participating CAP physicians could not vouch for the quality of products that were opened by an approved CAP vendor for repackaging, for mixing the drug with other drugs or injectable fluids (admixture), or for removing a part of the contents to supply the exact dose for a beneficiary. Several commenters recommended that approved CAP vendors deliver their products in the same form in which they are received from the manufacturer, without opening packaging or containers, mixing or reconstituting vials, or repackaging. Specifically, the commenters were concerned about the capabilities of individuals who mix the drug, as well as shipping conditions, storage, and stability.

We responded by stating that the CAP is not intended to require approved CAP vendors to perform pharmacy admixture services (for example, to furnish reconstituted or otherwise mixed drugs repackaged in IV bags, syringes, or other containers that are ready to be administered to a patient) when furnishing CAP drugs. Admixture services for injectable drugs require specialized staff, training, and equipment, and these services are subject to standards such as United States Pharmacopoeia Chapter 797, Pharmaceutical Compounding—Sterile Preparations. These requirements have significant impact on drug shipping, storage, and stability requirements, as well as system cost and complexity. As stated in § 414.906(a)(4), the approved CAP vendor must deliver ''CAP drugs directly to the participating CAP physician in unopened vials or other original containers as supplied by the manufacturer or from a distributor that has acquired the products directly from the manufacturer.''

Since issuing the July 6, 2005 IFC, we have become aware that bevacizumab (Avastin®) is being used for the treatment of exudative age-related macular degeneration (wet AMD) in very small doses. Although this is an off label use, it is gaining acceptance among ophthalmologists who treat wet AMD, and this use has been the subject of several carriers' local coverage determinations. Bevacizumab is considerably less expensive than certain other drugs used in the treatment of wet AMD.

The smallest commercially-available package of bevacizumab is a 100mg single use vial, while a dose used to treat wet AMD is approximately 1mg. Some local carriers who have issued coverage instructions for the use of bevacizumab in the treatment of wet AMD allow physicians to obtain these small doses of drug from a pharmacy that is capable of preparing sterile products. We expect to issue instructions that will allow participating CAP physicians to use the furnish as written option, as appropriate, and to obtain small doses of bevacizumab outside of the CAP in prefilled syringes if their local carrier's coverage determinations allow such a practice and if it is consistent with applicable laws and regulations. We believe that this approach will minimize the waste associated with using a 100mg single use vial for the treatment of wet AMD and will increase the flexibility for participating CAP physicians by making an alternative quantity of this drug available to participating CAP physicians whose carriers have applicable policies.

However, this option is not available in all areas. Therefore, we stated that we are considering reassessing our policy on the use of prefilled syringes to determine whether it would be feasible to make the option of using prefilled syringes supplied by an approved CAP vendor available to all physicians who participate in the CAP, rather than requiring physicians to go outside the CAP in order to obtain CAP drugs in prefilled syringes. In the CY 2008 PFS proposed rule (72 FR 38159), we requested comments on whether allowing approved CAP vendors to repackage CAP drugs in certain situations may be beneficial to beneficiaries, the program, and to the physicians who participate in it.

In considering whether to propose a change to our regulations in the future, we also solicited comments on:

- Whether approved CAP vendors are likely to be pharmacies or have access to pharmacy services with trained personnel and facilities for the small scale preparation of sterile drug products in response to a specific prescription order for a specific patient;
- Whether an approved CAP vendor should be given an opportunity to supply bevacizumab under the CAP if it is repackaged in a patient-specific dose consistent with applicable state laws and regulations upon request from a participating CAP physician;
- Whether this sort of activity should be restricted to bevacizumab, or possibly phased-in for other CAP drugs. If we were to apply this sort of policy to other CAP drugs, we would also have to determine how phasing-in might occur, which drugs it should apply to and whether the preparation of admixtures (including the preparation of sterile syringes, minibags, and mixing of drugs and solutions intended for intravenous administration) should be allowed as well;
- How this sort of service could be limited to participating CAP physicians who voluntarily agree to use it, and whether such an agreement should be made in writing between the approved CAP vendor and the participating CAP physician;
- How such a program could be structured so that the service and staff engaged in providing the service would be required to meet all applicable laws (including Stark, Anti-kickback, and State pharmacy laws), as well as regulations for the preparation of sterile products, (including standards for product integrity and sterility);
- Whether the cost of preparing such product would be included in the CAP vendor's bid price; and
- Whether any other important elements should be evaluated if we consider changing CAP policy on prefilled syringes in the future.

Comment: We received several comments on these issues. Overall, responses were generally equally divided among those who supported prefilled syringes, those who advocated a cautious approach, and those who opposed the practice.

Those who opposed making prefilled syringes available through the CAP cited stability and sterility concerns. Those commenters also raised concerns about whether the CAP vendor's preparation of a particular drug product for an off-label use by participating CAP physicians would violate existing drug law because of the potential scale of an approved CAP vendor's activities and because the drug was being prepared for use in a manner other than as described in its FDA-approved labeling. Several commenters urged that caution be used in developing changes to the aspects of the CAP that are discussed above in this section, but many of these commenters were not completely opposed to the preparation of prefilled syringes by approved CAP vendors.

Several commenters were quite supportive of using prefilled syringes. One commenter stated that pharmacy preparation of prefilled syringes was regarded as a ''convenient and safe practice'' and would avoid both waste

and some of the risk associated with transferring sterile products. Another commenter also recommended that a mechanism to pay for the preparation and waste associated with the process be established.

There was a general point of agreement between commenters who urged a cautious approach and those who agreed with the concept of prefilled syringes. These commenters agreed that that additional flexibility or enhancements to the CAP would be welcome provided that they did not affect beneficiary safety and were consistent with applicable laws, regulations, product stability, and product integrity requirements.

Response: We appreciate the comments on prefilled syringes and we will consider whether to develop a proposal that is consistent with applicable laws, regulations, product stability, and product integrity concerns in future rulemaking. Because we did not propose a change to our current regulations on the use of prefilled syringes in the CAP, they remain unchanged for the present time. We may make a proposal in the future.

k. Contractual Provisions

Section 1847B of the Act is generally silent on the subject of disputes surrounding the delivery of drugs and the denial of drug claims. However, section 1847B(b)(2)(A)(ii)(II) of the Act states that a grievance process is a quality and service requirement expected of approved CAP vendors. In the July 6, 2005 IFC (70 FR 39055 through 39058), we described the process for the resolution of approved CAP vendors' claims denials and the resolution of participating CAP physicians' drug quality and service complaints. We encouraged participating CAP physicians, beneficiaries, approved CAP vendors, and the designated carrier 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.

Suspension and termination from the CAP were the only remedies described under the CAP dispute resolution processes. Having gained some experience with the CAP, we believe that having an intermediate level of remedy for less serious but persistent problems is desirable in order to bridge the gap between taking no action and suspension or termination of an approved CAP vendor.

We believe that additional contractual obligations, such as additional reporting requirements, could be useful, particularly if they provide an opportunity for the approved CAP vendor to come into compliance using objective goals and a set timeline. Therefore, in the CY 2008 PFS proposed rule (72 FR 38160), we requested comments on what types of potential contractual provisions could be used to encourage approved CAP vendors to comply with CAP requirements for less serious violations, such as missing reporting deadlines, or participation in inappropriate promotional strategies. We also requested comments on the following:

- The type of contractual provisions that would be suitable. For example, requests for specific or targeted reporting and monitoring activities in response to specific violations.
- Whether an approved CAP vendor's code of conduct could be used to address these types of less serious situations and how that could be accomplished; and
- Whether the CAP physician election agreement should be revised to include provisions to address participating CAP physicians' noncompliance with CAP rules or the CAP election agreement.

Comment: One commenter agreed with the use of contractual provisions, including additional reporting requirements, as an intermediate form of remedy in response to a CAP vendor's noncompliance with CAP requirements. The commenter also noted that a vendor code of conduct would be useful.

Response: We plan to develop a proposal for additional provisions that could be added to the CAP contract. These provisions would be used to encourage approved CAP vendors to comply with CAP requirements. We will propose such provisions in a future rulemaking period.

l. Finalizing Remaining Provisions of the July 6, 2005 Interim Final Rule with Comment Period

In this PFS final rule with comment, we are finalizing the portions of the July 6, 2005 IFC that were not finalized in previous rulemaking. We are also responding to other timely comments we received on the July 6, 2005 IFC that we have not responded to previously.

Comments that we will be addressing in this rule include the following:

- The use of e-prescribing in CAP.
- Updating CAP prices and data reporting.
- The application of Comprehensive Error Rate Testing (CERT) to CAP claims.
- The 14-day participating CAP physician billing requirement.
- The impact of CAP participation on clinical research.
- Licensure requirements for CAP pharmacies and distributors.
- Community mental health centers and participation in the CAP.
- Administrative and financial burden of CAP participation for physicians.

We have addressed drug transportation previously in this section of this final rule with comment period.

Basis and Scope (§ 414.900)

These provisions provide that the regulations in this subpart implement sections 1847A and 1847B of the Act. We received no comments on these provisions and we are finalizing the corresponding regulatory text at § 414.900 in its entirety.

Definitions (§ 414.902)

Section 414.902 lists the definitions used in 42 CFR Subpart K. We did not receive any comments about the revisions to this section that we made in the July 6, 2005 IFC (70 FR 39093). At this time, we are finalizing the regulatory text at § 414.902 as it currently reads.

Competitive Acquisition Program as the Basis for Payment (§ 414.906)

Section 414.906 specifies how payment for CAP drugs is determined, including vendor responsibilities for billing, shipment and delivery; computation of the payment amount; substitution of CAP drugs and resupply of a participating CAP physician's drug inventory.

i. 2005 Comments

In the July 6, 2005 IFC (70 FR 39074), we discussed the methodology used to update CAP drug prices during the bidding process. We responded to comments that suggested that single price updates for CAP drugs should be tied to changes in ASP prices. We stated that we did not believe that there had been enough experience with the ASP payment methodology to update the bids based on growth in the ASP. We also solicited comments on this method of updating single drug prices to the payment year in order to develop and refine the CAP in the future.

(a) Updating CAP Prices and Data Submission

Comment: We received comments about updating CAP drug prices more frequently than annually. One commenter suggested that we should consider quarterly data submissions and

pricing updates even during the phase in period in order to produce greater savings in instances where vendors' overall costs for CAP drugs were declining, while providing greater protection for vendors in instances where vendors were experiencing cost increases. Another commenter encouraged us to compare CAP prices to ASP prices using the most recent data available and to account for manufacturer price adjustments in a timely manner.

Response: In the July 6, 2005 IFC (70 FR 39076), we stated, ''when the administrative mechanisms of the CAP are operational and vendors have more experience under the program, we will consider whether more frequent reporting (of reasonable net acquisition costs) would be appropriate.'' Section 414.914 requires that the CAP contract must provide for the disclosure of the approved CAP vendor's reasonable, net acquisition costs for a specified period of time, not to exceed quarterly and provide for appropriate adjustments as described in § 414.906(c)(1). This section describes the computation of an annual update to the payment amount and allows updates more often than annually but no more often than quarterly in any of the following cases: introduction of new drugs; expiration of a drug patent or availability of a generic drug; material shortages that result in a significant price increase for the drug; and withdrawal of a drug from the market. Also, the CAP payment amount is limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category, and limited by the payment amount established under section 1847A of the Act for each other drug for which the approved CAP vendor submits a bid. It is not clear how the commenter is proposing that we account for changes in manufacturer's price adjustments in a more timely manner. Because the CAP has been operational for 15 months, we are still gaining experience with the reporting and update mechanisms already in place. At present, we believe these processes are sufficient to address the needs of the CAP; however, as the program grows, we may consider other options, including more frequent price updates.

(b) Impact of CAP on Clinical Research

Comment: Some commenters stated that they were concerned that CAP participation would conflict with the Medicare National Coverage Decision (NCD) on Clinical Trials. Since the NCD enables Medicare to reimburse physicians for the current standard of care drugs that are administered to beneficiaries in the control group of clinical trial protocols, commenters were concerned that physicians would not be able to enroll Medicare beneficiaries in clinical trials if drugs required in the protocol were not on the CAP drug list. In addition, some commenters expressed their concern that there was a lack of built in oversight in CAP to ensure that vendors would buy drugs directly from a manufacturer or wholesaler. The commenters were concerned that this could result in the acquisition of counterfeit product, and that as a result, such products could infiltrate clinical trials and compromise the results of cancer clinical research that a CAP physician might be participating in.

Response: As a result of an executive memorandum issued by the President of the United States in June 2000, we instituted the NCD in September 2000 as explained in our ''September 2000 Program Memorandum'' on clinical trials available at *http://www.cms.hhs.gov/ClinicalTrialPolicies/*. The NCD stipulates that Medicare will provide payment for routine costs associated with qualifying clinical trials and for items or services needed to treat complications arising from participation in such trials. The NCD was revised in July 2007 as outlined in CAG–00071R, the ''Decision Memorandum for the Clinical Trial Policy,'' which may be found at *https://www.cms.hhs.gov/mcd*. More information about the National Coverage Decision on Clinical Trials can be found on the CMS Web site at *http://www.cms.hhs.gov/ClinicalTrialPolicies/* and through a Medicare Learning Network article at *http://www.cms.hhs.gov/MLNMattersArticles/*.

We are very aware of the importance of clinical trial research in the treatment of cancer, and we do not believe that CAP participation has imposed any undue hardships on participating CAP physicians or their Medicare patients who engage in such activities. Participating CAP physicians do not have to buy and bill for the medications they receive from the approved CAP vendor. The vendor is responsible for billing the designated carrier and the beneficiary. Thus, if the standard of care drug needed for the control group of a research protocol is on the CAP drug list, the participating CAP physician may order the medication from the approved CAP vendor. This should not affect the participating CAP physician's ability to enroll Medicare patients in clinical trials. Moreover, participating CAP physicians may still purchase and bill for medications that are not on the CAP drug list through the ASP system, which would allow them to obtain the non-CAP drugs required in a research protocol. If a particular NDC for a drug is not on the CAP drug list but is part of the research protocol, a participating CAP physician may buy the medication on their own and bill for it via the ''furnish as written'' provision, which allows the physician to bill for the drug under the ASP methodology in that instance, even though it is on the CAP drug list.

Though we have had no reports that CAP physicians have been prevented from engaging in clinical trial research because of their CAP participation, we are mindful that this could be an issue because of the way some studies are structured. In the event that we receive comments that demonstrate that this has become a problem in the future, we will address the issues accordingly and possibly propose mechanisms to facilitate participation in clinical trial research and the CAP.

We would also like to reemphasize that CAP is a voluntary program. If physicians do not believe that the ''furnish as written'' option and the CAP drug list are sufficient to meet their clinical research needs, then they may decline to join the CAP and continue to purchase and bill for medication under the ASP system.

We also are cognizant of the importance of preserving drug quality and integrity in the CAP and have structured the program accordingly. The importance of drug quality and oversight are recognized in both the vendor bidding process and in the CAP dispute resolution process administered by the designated carrier. We have discussed our concern for maintaining CAP drug quality in the program as a whole on several occasions, most recently in the CY 2006 PFS final rule with comment period (70 FR 70244). Section 1847B of the Act and § 414.908(b) delineate several requirements that vendors must meet in order to be selected to participate in the CAP, including an ability to ensure product integrity, at least 3 years experience in furnishing Part B Injectable drugs, and acquisition of all CAP drugs directly from the manufacturer or from the distributor that has acquired the products directly from the manufacturers. After an entity has been awarded a contract, we work closely with the CAP-designated carrier and the approved CAP vendor to monitor and respond to any concerns that are raised by participating CAP physicians under the dispute resolution process.

We have not received any complaints regarding CAP drug quality and integrity. If such an event were to occur, it would be investigated and resolved promptly so that patient health and safety would not be jeopardized. In light of all of these requirements and protections, we do not believe that research and CAP participation are incompatible.

At this time, we are finalizing the remaining provisions of this section.

Competitive Acquisition Program (§ 414.908)

This section specifies the process for a physician to select an approved CAP vendor. It also details the responsibilities of a participating CAP physician, such as including the specific information required on the prescription order, notifying the CAP vendor about changes in drug administration, and adhering to the timeframe for submission of claims.

Moreover, § 414.908 delineates the process for selecting approved CAP vendors. It also outlines additional factors that are considered both during and after the vendor selection process such as exclusion of entities from participation in Medicare or other Federal health care programs under section 1128 of the Act.

i. 2005 Comments

(a) Physician Administrative and Financial Burden

Comment: We received several comments from individual physicians and physician groups expressing their concern that CAP could place a significant burden on physicians. Some commenters stated that the requirement to maintain a separate inventory of CAP drugs will increase physicians' administrative burden and costs. Others indicated that physicians would have no incentive to participate in the CAP unless these extra administrative costs could be reimbursed. One commenter indicated that the program was impractical and economically unfeasible.

Response: In the July 6, 2005 IFC (70 FR 39049), we discussed the issue of administrative burden. Although we agree that a physician may have to make some adjustments in his or her practice in order to comply with the requirements of the CAP, we believe that the relief from the financial burden of purchasing drugs and billing Medicare for them will be a substantial benefit for many physicians. We do not believe that the clerical and inventory resources associated with participation in the CAP exceed the clerical and inventory resources associated with buying and billing drugs under the ASP system. A physician is free to design his or her practice in a way that minimizes the extent of changes necessary to comply with the CAP requirements. For example, an electronic inventory of CAP drugs is required, but separate drug storage is not; it is a suggested option if such a procedure makes it easier on the physician's practice to track the CAP drugs. We recognize that although a physician's staff or their software vendor may need to make system changes to bill using the CAP format and to accommodate the CAP modifiers and prescription numbers, these initial changes would be a one-time occurrence.

In the ASP system, the payment for clerical and inventory resources associated with buying and billing for drugs is bundled into the drug administration payment under the physician fee schedule. We have adopted this same logic in the CAP and believe that the drug administration payment is sufficient to cover any associated expenses of participating in the CAP.

If a physician perceives that CAP participation would be more burdensome than the ASP system, then he or she is under no obligation to join the CAP because it is a voluntary program. Additionally, as described in other parts of this rule, participating CAP physicians may also petition to terminate their CAP election due to exigent circumstances through the dispute resolution process in the event that they find the participation in the program becomes a burden.

Comment: One commenter expressed disappointment that community mental health centers (CMHCs) cannot elect to participate in the CAP.

Response: As noted in the July 6, 2005 IFC (70 FR 39030), CMHCs can not elect to participate in the CAP for provision of Part B drugs. The CAP statute is clear that only physicians may elect to have section 1847B of the Act apply in lieu of the ASP payment methodology.

(b) E-Prescribing

Comment: One commenter recommended that CAP vendors should be capable of accepting and submitting e-prescribing transactions in accordance with the final e-prescribing standards issued for Medicare Part D. The commenter reasoned that vendor compliance would not be an undue hardship because vendors already will have a fairly rigorous technical infrastructure in place.

Response: Section 101 of the MMA amended title XVIII of the Act to establish a voluntary prescription drug benefit program. The MMA electronic prescription program provisions found in section 1860D–4(e) of the Act apply to the electronic transmission of prescription and certain prescription-related information for Medicare Part D drugs for Part D eligible individuals. The Part D e-prescribing requirements do not apply to the electronic transmission of prescriptions and prescription related information for Part B drugs unless those prescriptions are written for Part D eligible persons and the prescribed drug is a Part D drug. Prescription Drug Plan (PDP) sponsors Medicare Advantage (MA) organizations offering Medicare Advantage-Prescription Drug Plans (MA–PD) are required to establish electronic prescription drug programs to provide for electronic transmittal of certain information to the prescribing provider and dispensing pharmacy and pharmacist. Prescribers and dispensers of Part D drugs are not required to write prescriptions electronically, but those that do so would be required to comply with any applicable final e-prescribing standards that are in effect when they conduct electronic prescription transactions, or seek or transmit prescription information or certain other related information electronically.

We responded to a comment on whether participating physicians would be required to incorporate e-prescribing technologies into the CAP in the July 6, 2005 IFC (70 FR 39039). At that time, we stated that we would monitor the development of the program to see if some aspects of it could be adapted to the CAP. Since publication of the IFC, we have adopted three foundation standards (70 FR 67568), recognized six initial standards in a Request for Applications (RFA) (Available through *http://www.grants.nih.gov/grants/guide/rfa-files/FRA-HS-06-001.htm)*, and conducted a pilot program in 2006 to test the six initial standards and their ability to interoperate with the foundation standards. More information about the MMA e-prescribing program and the outcome of the pilots can be found on the CMS Web site at *http://www.cms.hhs.gov/EPrescribing/*. The MMA requires the adoption of additional standards by the Secretary by April 1, 2008. We will continue to track the development of the e-prescribing program to see whether it would be appropriate to incorporate some of the program's elements into the CAP at a later date.

(c) The Comprehensive Error Rate Testing (CERT) Program and CAP Claims

The purpose of the CERT program is to monitor and report the accuracy of Medicare fee for service payments. In the July 6, 2005 IFC (70 FR 39038), we discussed CERT and how it would apply to CAP claims. While we anticipated that CERT would apply to CAP, the process had not been determined at that point. We received no additional comments on this issue and have implemented CERT review of CAP claims since publication of the July 6, 2005 IFC. CAP claims paid by the designated carrier may be selected for review in a manner consistent with other claims the carrier processes.

(d) 14-Day Billing Requirement

In the July 6, 2006 IFC (70 FR 39050), we summarized and responded to comments about the 14-day requirement for physicians to file claims for CAP drug administration. Although a number of commenters considered the time period to be too brief and were opposed to it, we decided to implement the 14-day requirement at § 414.908(a)(3)(x) because the approved CAP vendor's payment for drugs furnished under the CAP depended on a match between the vendor's drug claim and the physician's drug administration claim. Implementation of the post-payment review as mandated by section 108 of the MIEA–TRHCA has superseded our original implementation of CAP claims processing procedures, which had required a pre-payment claims matching process for CAP drug claims, and the 14-day billing requirement was not finalized in previous rules (70 FR 70260).

Comment: In 2006 several commenters asked us to allow at least 30 days or more for physicians to submit CAP drug administration claims. During this comment period, we also received several comments stating that the 14-day requirement be withdrawn because changes to the claims processing system made it unnecessary and such an action would encourage physician participation in the CAP.

Response: Our 14-day standard was based on a review of Medicare claims that showed approximately 75 percent of part B drug and drug administration claims were submitted within 14 days of the date of service. It was initially implemented as a means of facilitating the CAP claims matching process that was in effect prior to the implementation of the post-payment review process as mandated by section 108 of the MIEA TRHCA. As the commenters indicated, a 14-day requirement is less than is allowed under claim submission requirements used in other parts of the program.

We agree that the claims processing changes required by Section 108 of MIEA–TRHCA have altered the role of the claims submission standard. However, we do not believe that it has eliminated the need for a claims-matching process under the CAP. Under the new payment process that resulted from the MIEA–TRHCA, the CAP-designated carrier also conducts a pre-payment review in which it checks for any local carrier decisions about medical necessity prior to paying for drug claims submitted by the approved CAP vendor. Retaining a claims submission requirement for participating CAP physician drug administration claims may prevent the agency from paying for drugs that have been denied on a medical necessity basis by the local carrier because when the local carrier reviews the physician's claim it makes a determination on whether the CAP drug that was administered was medically necessary. We are not eliminating the requirement for prompt billing altogether, as requested by commenters, because it will continue to facilitate a quicker determination that the drug can be administered.

However, we acknowledge that a somewhat longer claims submission standard would not adversely affect the post-payment review process because it still would allow for a relatively quick match between the claim for a particular dose of a CAP drug and the claim for its administration. Also, separate analyses of previous claims submission data and CAP drug claims lead us to conclude that the overwhelming majority of participating CAP drug administration claims are submitted within 30 days of the date of service. We further believe that, in light of the comments, increasing the 14-day claims submission requirement would make the CAP more appealing to physicians and provide them with greater claims submission flexibility.

Therefore, we are increasing the requirement for timely CAP drug administration claim submission from 14 days to 30 days. We are finalizing the requirements at § 414.908 to include this revision.

ii. Regulatory Text

At this time, we are finalizing § 414.908 as amended to reflect the changes discussed in this final rule with comment period.

The Bidding Process (§ 414.910)

This section outlines the specific criteria for the submission of a bidding price for a CAP drug, and specifies what costs should be included in the bid price. We received no comments on this provision and are now finalizing the regulatory text for § 414.910.

Conflicts of Interest (§ 414.912)

Section 414.912 states conflict of interest requirements and standards that vendor applicants and approved CAP vendors must meet in order to participate in CAP. We received no comments on this provision, and therefore, are finalizing § 414.912.

Terms of Contract (§ 414.914)

Section 414.914 outlines the contract provisions between CMS and the approved CAP vendor such as contract length and termination, and specific requirements that the approved CAP vendor must comply with.

i. 2005 Comments

(a) Licensure Requirements for Cap Pharmacies and Distributors

Comment: Some commenters requested clarification on the types of licenses that are required of CAP vendors. A few commenters also asked us to specify whether a CAP vendor will be operating as a pharmacy or as a wholesale distributor since licensing requirements and regulatory laws for these two types of entities can vary by state, and since pharmacies and distributors are two different models.

Response: As specified in § 414.914, approved CAP vendors and their subcontractors must meet applicable licensure requirements in each State in which it supplies drugs under the CAP. This includes appropriate licensure in States that the CAP vendor ships drug to even though the vendor does not maintain a physical establishment in these States. In the July 6, 2005 IFC (70 FR 39066), we stated that a vendor, its subcontractor, or both must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, a vendor under the CAP would be required to be licensed as a pharmacy, as well as a distributor if a State requires it. It is the CAP vendor's responsibility to determine which State and national requirements it must adhere to. Based on our experience with the CAP, we are not persuaded by the comments that any changes to this policy are necessary at this time.

ii. Regulatory Text

We finalized portions of § 414.914 in the CY 2006 PFS final rule with

comment period (70 FR 70333) and are now finalizing the remainder of the regulatory text.

Dispute Resolution for Vendors and Beneficiaries (§ 414.916)

This section discusses the steps, timeframes, and requirements of the dispute resolution process that are available to an approved CAP vendor and beneficiaries to address the issue of denied CAP drug claims. It also describes the protocol that physicians would utilize to appeal the suspension of their CAP contract.

We did not receive any comment on this comments on this provision in response to the CY 2006 PFS proposed rule. However, a revision to this section will be made in light of the exigent circumstance discussion in section (g) of this section of the preamble. We are revising § 414.916(c) to clarify that the physician reconsideration process would apply to reconsiderations of our decision on whether the participating CAP physician may opt out of the CAP. We are finalizing § 414.916 at this time.

Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract (§ 414.917)

This section discusses the steps and timeframes of the process available to participating CAP physicians for the resolution of quality or service issues concerning an approved CAP vendor.

We did not receive any comments on this section during the comment period for the July 6, 2005 IFC. Comments that we received on this section during the comment period for the CY 2008 PFS proposed rule are discussed above in this section. We are now finalizing the regulatory text for this section as described in this final rule with comment period.

Assignment (§ 414.918)

Section 414.918 specifies that payment for a competitively biddable drug may be made only on an assignment related basis. We received no comments on this provision and are now finalizing § 414.918.

Judicial Review (§ 414.920)

Section 414.920 outlines the areas under the CAP that are not subject to administrative or judicial review. We received no comments on this provision and are now finalizing this section.

m. Brief Summary of Comments We Are Not Addressing

In response to the FY 2007 IPPS final rule with comment period (71 FR 47870), we received a comment related to the payment rate for intravenous immunoglobulin (IVIG) therapy in Medicare. We will not be addressing this comment since it is outside the scope of both the CY 2008 PFS proposed rule and the FY 2007 IPPS final rule with comment period. In addition, in response to the CY 2007 PFS proposed rule, one commenter recommended that we implement continuous open enrollment in the CAP and eliminate the requirement for annual physician election, and specify who are the appropriate people to sign the CAP election form. We are not addressing these comments because it is outside the scope of the proposed rule.

G. Issues Related to the Clinical Laboratory Fee Schedule

1. Date of Service for the Technical Component of Physician Pathology Services (§ 414.510)

In the CY 2007 PFS final rule with comment period (72 FR 69787), we added § 414.510 for the date of service of a clinical diagnostic laboratory test that uses a stored specimen.

When we added § 414.510, we indicated the provision applies to clinical diagnostic laboratory tests. For outpatients, clinical diagnostic laboratory tests are paid under the Medicare Part B clinical laboratory fee schedule. Upon further review, we believe the provision should also apply to the technical component (TC) of physician pathology services. In practice, the collection date for both clinical laboratory services and the TC of physician pathology services is similar. Therefore, we believe § 414.510 should apply to both types of services. This will improve claims processing and adjudication in relation to the clarity of dates of service, accuracy of payment, and detection of duplicate services. For outpatients, the TC of physician pathology services can be paid under the Physician Fee Schedule (PFS) or the hospital Outpatient prospective payment system (OPPS). As a result, for § 414.510, in the CY 2008 PFS proposed rule (72 FR 38160), we proposed to revise the section heading and introductory sentence to specify that the provision applies to both clinical laboratory and pathology specimens. We also proposed revising § 415.130(d) to include a reference to § 414.510.

Comment: Some commenters supported our proposal to revise the section heading and introductory sentence for § 414.510 to specify that the provision applies to both clinical laboratory and pathology specimens. (We also proposed revising § 415.130(d) to include a reference to § 414.510.) One commenter asked that we clarify whether the provision applies to pathology tests where the technical component and the professional component (PC) are performed by the same lab and billed globally.

Response: Concerning one line global billing, we would like to point out that the TC and the PC of a laboratory test should be on separate line items on the same claim when two different dates of service are involved, even when both services are performed by the same independent laboratory. One line global billing is not appropriate in this instance. Program instructions on this issue will be forthcoming.

Comment: One commenter requested revisions to our regulations to specify that if the clinical laboratory test specimen is collected outside the hospital by nonhospital personnel, the beneficiary qualifies as a nonhospital patient.

Response: We do recognize that the determination of whether the beneficiary qualifies as an inpatient, outpatient, or nonpatient is important for payment purposes. However, we do not agree that the laboratory date of service regulation should be amended to address the employment arrangements of the personnel performing the specimen collection. Furthermore, this comment is outside the scope of our proposal to broaden the clinical laboratory date of service rules we adopted last year.

We continue to believe the date of service should relate to clear calendar dates for the specimen collection and day of discharge from the hospital if the specimen was collected while the patient was undergoing a hospital procedure.

We are implementing our proposed regulation at § 414.510 on the date of service of the TC of the physician pathology service.

2. New Clinical Diagnostic Laboratory Test (§ 414.508)

a. Background

In the CY 2007 PFS final rule with comment period (71 FR 69701), we adopted a new subpart G under part 414 that implemented section 942(b) of the MMA requiring that we establish procedures for determining the basis for, and amount of payment for any clinical diagnostic laboratory test for which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (''new tests'').

Under § 414.508, we use one of two bases for payment to establish a payment amount for a new test. Under § 414.508(a), the first basis, called

''crosswalking,'' is used if a new test is determined to be comparable to an existing test, multiple existing test codes, or a portion of an existing test code. If we use crosswalking, we assign to the new test code the local fee schedule amount and national limitation amount (NLA) of the existing test code or codes. If we crosswalk to multiple existing test codes, we determine the local fee schedule amount and NLA based on a blend of payment amounts for the existing test codes. The second basis for payment is ''gapfilling.'' Under § 414.508(b), we use gapfilling when no comparable existing test is available. We instruct each Medicare carrier or MAC to determine a carrier-specific amount for use in the 1st year that the new code is effective. The sources of information that these carriers or MACs examine in determining carrier-specific amounts include:

- Charges for the test and routine discounts to charges;
- Resources required to perform the test;
- Payment amounts determined by other payers; and
- Charges, payment amounts, and resources required for other tests that may be comparable (although not similar enough to justify crosswalking) or otherwise relevant.

After the first year, the carrier-specific amounts are used to calculate the NLA for subsequent years. Under § 414.508(b)(2), the test code is paid at the NLA, rather than the lesser of the NLA and the carrier-specific amounts.

We instruct our carriers or MACs to use the gapfill method through program instruction, which lists the specific new test code and the timeframes to establish carrier-specific amounts. During the first year a new test code is paid using the gapfill method, contractors are required to establish carrier-specific amounts on or before March 31. Contractors may revise their payment amounts, if necessary, on or before September 1. In this manner, a carrier or MAC may revise its carrier-specific amount based on additional information during the 1st year.

In the CY 2007 PFS final rule with comment period (71 FR 69702), we also described the timeframes for determining the amount of and basis for payment for new tests. The codes to be included in the upcoming year's fee schedule (effective January 1) are available as early as May. We then list the new clinical laboratory test codes on our Web site, usually in June, along with registration information for the public meeting.

The public meeting is held no sooner than 30 days after we announce the meeting in the **Federal Register**. The public meeting is typically held in July. In September, we post our proposed determination of the basis for payment for each new code and seek public comment on these proposed determinations of the basis for payment. The updated clinical laboratory fee schedule is prepared in October for release to our contractors during the first week in November so that the updated clinical laboratory fee schedule is ready to pay claims effective January 1 of the following calendar year.

We received comments in response to the CY 2007 PFS proposed rule concerning information to be presented during the public meeting process. In responding to these comments in the CY 2007 PFS final rule, we stated that we did not believe that opportunities for information gathering on new tests have been fully utilized within the public meeting process. Payment recommendations from the public have sometimes lacked charge, cost, and clinically-detailed information for the new clinical laboratory tests. We also stated that when soliciting public input for the meeting we would recommend that all participants in the public meeting consultation process strive for transparency and try to provide as much supporting information as possible to assist us in evaluating their recommendations.

In addition, in the CY 2007 PFS final rule with comment period, in response to comments suggesting that the method used by contractors to determine their price for gapfilled tests should be more specific, we indicated that we would engage in discussions with our carrier contractors and laboratory industry representatives to explore their experiences with the gapfill process. We also agreed to host a forum to listen to suggestions from the public and said that we expected to solicit comments on a potential reconsideration process in a future rulemaking.

As explained in the CY 2008 PFS proposed rule, we discussed these issues with our contractors. We also solicited comments on the gapfill process in the July 16, 2007 clinical laboratory public meeting.

Discussions with our contractors and other interested parties revealed that the length of time we allow for a contractor to establish a carrier-specific amount may sometimes be insufficient for obtaining additional sources and data on a new test. However, our contractors and other interested parties were also concerned that if procedures and determinations were permitted to extend over too long a time frame, the uncertainty of the final payment amount would be detrimental for laboratories, practitioners, and patients for incorporating new technology tests and improving patient care. In the CY 2008 PFS proposed rule, we also encouraged the public to submit written comments on gapfilling and said that we would respond to them to the extent they related to a proposal in the rule.

In the CY 2008 PFS proposed rule, we proposed a reconsideration process for determining the basis for and amount of payment for any new test for which a new or substantially revised HCPCS code is assigned on or after January 1, 2008. This proposed change attempted to balance additional opportunities for public input against the necessity for establishing final fees for new clinical laboratory test codes.

Section 1833(h)(8)(A) of the Act provides broad authority to develop through regulation procedures for the method for determining the basis for and amount of payment for new tests. We believe that we have authority under section 1833(h)(8)(A) of the Act to establish procedures under which we may reconsider the basis for and amount of payment for a new test. Furthermore, under section 1833(h)(8)(D) of the Act, the Secretary may convene such other public meetings to receive public comments on payment amounts for new tests as the Secretary deems appropriate.

We note that, under both section 1833(h)(8)(B)(v) of the Act and § 414.506(d)(2), the Secretary must make available to the public a list of ''final determinations.'' We do not believe that these provisions preclude us from reconsidering our final determinations. It is not unusual for us to provide for discretionary reopening or reconsideration of final agency action. It is not unusual for us to provide for discretionary reopening or reconsideration of final agency action. For example, under § 405.1885, we may reopen a final agency determination regarding payment to a provider of services.

Comment: Commenters were supportive of our proposal to add § 414.509 concerning a reconsideration process for new lab test payment determinations. Generally, commenters believed that in contrast to several other payment systems, which have been significantly revised in the last several years, the procedures for operating the clinical laboratory fee schedule have remained relatively static. They further commented that the implementation of a reconsideration process would be a significant step in helping assure reasonable pricing decisions for new

tests, and they commended us for our actions in this regard.

Response: We appreciate the support for our proposal for a reconsideration process for new lab test payment determinations. We believe this additional opportunity to revisit payment determinations for clinical laboratory test codes will foster accurate payment levels for new tests. We will discuss specific suggestions for revisions to § 414.509 below in this section.

b. Basis for Payment

Under our existing procedures for determining the basis for payment of a new test, either to crosswalk or gapfill, we receive comments on the appropriate basis for payment for a new test both at the public meeting in July and after we announce our proposed determinations in September. In November, we post our determination on the basis for payment for the new test on the CMS Web site. This determination of the basis for payment is final, except in the case of a gapfilled test for which we later determine that gapfilling is not appropriate under § 414.508(b)(3).

In the CY 2008 PFS proposed rule, we proposed to create a reconsideration process for determinations of the basis, either crosswalking or gapfilling, for payment of a new clinical diagnostic laboratory test. Consistent with our existing process, we would make a determination using the information gathered from the public meeting process and post a determination of the basis for payment, either to crosswalk or gapfill, on the CMS Web site, likely in September. We would accept written comments asking for a reconsideration on this basis determination for 30 days after we posted the determination on the CMS Web site. If a commenter recommended that we switch from gapfilling to crosswalking for a new code, the commenter would also have the opportunity to recommend the code or codes to which to crosswalk the new test code. Under § 414.508, claims would be paid using this basis to calculate fees beginning January 1.

After considering the comments received and the information from the public meeting, we would post our decision on our Web site as to whether we elect to reconsider our determination of the basis for payment. If we elect to reconsider the basis for payment (that is, whether to crosswalk or gapfill a test), we would post our determination as to whether we would change the basis for payment on the CMS Web site. Our decision regarding the basis for payment would be final and not subject to further reconsideration.

If we change our prior determination of the basis for payment, the new determination would be effective on January 1. We would not reopen or otherwise reprocess claims with dates of service prior to the effective date of the revised determination.

We note that, under our proposed reconsideration processes (for both the basis for payment and amount of payment) we would make two separate decisions. First, we would decide whether to reconsider our prior determination. If we elect to reconsider our prior determination, we would then determine whether we should change our prior determination.

Comment: One commenter suggested that the agenda for the public meeting should announce a list of requests received by CMS to reconsider the basis for and amount of payment for a new clinical laboratory test, and the agenda should invite comment, either written or orally, on the requests. The commenter stated that in this way, we will receive views on the validity of the requests for reconsideration. Another commenter indicated that more than one public meeting per year should be hosted by CMS to discuss comments under the reconsideration process, as well as the payment determination process.

Response: We are receptive to suggestions on providing information about the public meeting agenda. We do not believe a revision to the regulatory text at subpart of § 414.509(a) is required in order to disseminate information on our meetings. We publish a public meeting notice in the **Federal Register** to announce the meeting. The notice includes many details about the purpose and registration process for the meeting and also refers to additional Web site information for the meeting. If we receive a request to reconsider the basis of payment for a new test within the 60-day window after we post our basis of payment on the CMS Web site, the requestor could also request to present his or her comment orally at the next clinical laboratory public meeting. We can include this information in the meeting agenda that will be posted on the CMS Web site. Members of the public who are interested in addressing a particular reconsideration request at the laboratory public meeting can let us know of their interest in doing so after they review the reconsideration requests that will be addressed at the laboratory public meeting. In addition, we will accept written comments on the reconsideration request after the public meeting. We will accept written comments during the same time period we set for accepting other comments after the clinical laboratory public meeting—usually 2 weeks. We note that, if the party that submitted the reconsideration request does not choose to present at the public meeting, members of the public may not comment on the reconsideration request and we will not accept written comments.

However, hosting more than one public meeting per year is a timing issue which is limited by the constraints of the process. Currently, there is a limited amount of time between the receipt of the new test codes for the upcoming year and the deadline to issue them via CMS instruction; therefore, we cannot accommodate two public meetings in a year. As a result, we are finalizing § 414.509(a) with revisions to specify that other commenters may speak about reconsideration requests on the laboratory public meeting agenda and that we will accept written comments on reconsideration requests addressed at the public meeting.

c. Amount of Payment

i. Crosswalking

Under our existing procedures, commenters recommend the code or codes to which to crosswalk a new clinical laboratory test both at the public meeting in July and during the comment period after we issue our proposed determination in September. We consider the appropriate basis for payment and the amount of payment at the same time. Therefore, commenters that recommend crosswalking as the basis for payment for a new test also make recommendations concerning the code or codes to which to crosswalk the new test. In November, we post the code or codes to which we will crosswalk the test and the payment amount for the test on the CMS Web site. This determination is final.

In the CY 2008 PFS proposed rule (72 FR 38162), we proposed to create a reconsideration process under which we may reevaluate the code or codes and their corresponding fees to which we crosswalk a new test's fees. We would accept reconsideration requests and written comments on the crosswalked code or codes and the resulting amount of payment for the new code for 60 days after we posted the determination on the CMS Web site, sometime in November. In addition, we proposed that a commenter who had submitted a written comment within the 60-day comment period would also be given the opportunity to present its comment at the public meeting. After considering the comments received and the

information of the public meeting, we would post our decision as to whether we had elected to reconsider our determination of the crosswalked code or codes and the resulting amount of payment on the CMS Web site. If we elect to reconsider the amount of payment and had determined that we should revise the amount of payment, we would post a new determination of the code or codes to which we would crosswalk the test on the CMS Web site. We proposed that, after we posted our determination of the code or codes to which the test would be crosswalked on the CMS Web site, we would pay claims on the basis of this determination beginning January 1. Our decision regarding the amount of payment would be final and not subject to further reconsideration.

If we change our prior determination of the amount of payment, the new determination would be effective January 1. We would not reopen or otherwise reprocess claims with dates of service prior to the effective date of the revised determination.

As discussed in section II.G.2.b., we may also change the basis for payment for a new test as the result of reconsideration. If we change the basis for payment from gapfilling to crosswalking, we would also determine the code or codes to which we would crosswalk the test. Because we believe it is important to establish final payment amounts within a reasonable amount of time, we also proposed that these determinations of crosswalked payment amounts would not be subject to reconsideration.

Comment: Some commenters indicated that § 414.509(b)(1) should establish payment amounts at the national limitation amount (NLA) of the tests to which the new tests are crosswalked. The NLA should replace carrier-specific amounts below the NLA for new tests. The commenters believe that if the amount of payment is lower than the NLA in a carrier's geographic area, patient access to a new test will be limited in the geographic area.

Response: In the CY 2008 PFS proposed rule, we did not make policy proposals regarding the level of payment for crosswalked tests. Rather, our policy proposals were limited to the reconsideration process. Accordingly, we believe that this comment is outside of the scope of this rulemaking

Comment: One commenter suggested that a similar reconsideration process should also be available for existing laboratory tests. The commenter pointed out that the payment amounts determined for certain laboratory tests by one or another Medicare carrier or MAC now differ from the payment amounts determined for these same tests by other Medicare contractors and from the corresponding NLA.

Response: Section 1833(h)(1) of the Act sets forth the calculation of the payment amounts for test codes included on the clinical laboratory fee schedule to be the lower of the charge submitted, the carrier-specific amount, or the NLA. We believe changes to payment amounts for tests that are not ''new tests'' under section 1833(h)(8)(A) of the Act would require a statutory change.

Comment: One commenter recommended that CMS clarify how fee schedule amounts below the NLA will be adjusted as carriers are phased out and their functions are moved to MACs.

Response: This comment is outside the scope of our proposal. If necessary we may address this comment in a future program memorandum.

We are finalizing § 414.509(b)(1). Consistent with the revisions we made to § 414.509(a), we are revising § 414.509(b)(1) to provide that other commenters may speak about reconsideration requests on the lab public meeting agenda and that we will accept written comments on reconsideration requests addressed at the public meeting.

ii. Gapfilling

As discussed in this preamble and in accordance with § 414.508(b), after we determine that gapfilling will be the basis for payment for a new clinical diagnostic laboratory test, we instruct our carriers or MACs to determine carrier-specific gapfill amounts by April 1 and finalize carrier-specific amounts by September 30. We include the determinations of carrier-specific amounts and the NLA for the new test code in the clinical laboratory fee schedule the following November when we post our payment determinations on the CMS Web site. Except in the case of a gapfilled test for which we determine that gapfilling was not appropriate under § 414.508(b)(3), these determinations are final.

We proposed to provide for a reconsideration process for gapfilled payment amounts. Under this process, by April 30, we would post the carrier-specific amounts on the CMS Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp.*

Interested parties would submit written comments to CMS (which we would provide to the carriers for their consideration) on the carrier-specific amounts within 60 days from the date of posting the carrier-specific amounts.

In the CY 2008 PFS proposed rule, we stated that carriers or MACs would finalize carrier-specific amounts by September 30 and that we would set the NLA at the median of the carrier-specific amounts, and we would post the carrier-specific amounts and the NLA on our Web site. In addition, we stated that the public would have 60 days to submit a reconsideration request.

We also proposed that if we elect to act on the reconsideration request to reconsider the carrier-specific amounts and decide to revise our prior determination, we would adjust the NLA based on comments received. We would post the revised NLA on the CMS Web site and payment for the test would be made at the NLA beginning January 1. This determination would be final and not subject to further reconsideration.

In addition we proposed that, if we change the basis of payment from crosswalking to gapfilling as the result of a reconsideration, the new gapfilled payment amount would be subject to reconsideration under proposed § 414.509(b)(2). Unlike a crosswalked test, the payment amount for a gapfilled test is not established when we determine the basis for payment because it takes approximately 9 months for our contractors to establish carrier-specific amounts. Thus providing for reconsideration of gapfilled payment amounts would not lengthen the period of time it would take to determine a final payment amount.

We proposed to amend § 414.508(b)(3) to provide that § 414.508(b)(3) applies to new tests for which a new or substantially revised HCPCS code assigned on or before December 31, 2007. We proposed that the more comprehensive reconsideration procedures would apply to new or substantially revised HCPCS codes assigned after December 31, 2007.

Comment: One commenter suggested that we should accept comments after the carrier-specific amounts become final, which is currently on September 30.

Response: We appreciate this commenter's input. We have decided to revise the reconsideration process that we proposed. Under the final policy we are adopting in this final rule with comment period, we will post interim determinations of carrier-specific amounts on the CMS Web site in April and, for 60 days, we will accept written comments that we will share with our carriers and MACs. However, we will not accept reconsideration requests on the interim carrier-specific amounts. In September, we will post final carrier-

specific amounts on the CMS Web site. Interested parties may request reconsideration of the final carrier-specific amounts within 30 days of when we post the final carrier-specific amounts on the CMS Web site. Based on the written reconsideration requests received, we would evaluate whether we should reconsider the carrier-specific amounts and NLA.

If we elect to reconsider the carrier-specific amounts and the NLA, we will process the request for reconsideration between the end of the 30-day comment period and the deadline for dissemination of the information to the Medicare carriers or MACs via CMS instruction so that we can finalize our determinations prior to January 1. A request for reconsideration can be denied or reconsidered for a different payment amount.

If we elect not to reconsider the carrier-specific amounts and the NLA, we will post the carrier-specific amounts and NLA on the CMS Web site on or before January 1. These amounts would be based on the carrier-specific amounts and NLA we had posted in September. Payment for the test would be made at the NLA on January 1. This determination would be final and not subject to further reconsideration.

In addition, after the final test codes and payment amounts are effective on January 1, there is no reconsideration process that occurs after that date.

Comment: One commenter suggested that CMS provide a rationale for either accepting or declining a reconsideration after it is received and for deciding whether to change a prior determination.

Response: We do not plan to post a rationale for our decision to accept or decline a reconsideration request. This is consistent with our policy in other areas of the Medicare program when we make a decision about whether to reopen a previous decision.

Comment: One commenter suggested that we should convene an expert advisory committee, broadly representative of the laboratory industry, to advise CMS on pricing along with standardizing the sources and quality of charge and cost data.

Response: The purpose of the Clinical Laboratory public meeting is to convene industry experts and entertain comments, both orally and in writing, as well as any charge and cost data that is available from the industry. In fact, we specifically asked, via public notice, those in the clinical laboratory industry to provide charge and cost data related to the agenda items at the annual public meeting. We welcome any related information that industry representatives would like to provide via the public meeting forum and during the associated comment period.

Comment: There were specific concerns raised by commenters regarding varying payment amounts set by carriers when the gapfilling basis is utilized to determine payment amounts for a new test code. These commenters recommended that we establish formal procedures for carriers or MACs to apply when establishing payment amounts, including a formal appeals process. The commenters stated the payment amounts should be calculated using information on the following factors, resources needed to perform the test, staff expertise, time needed to perform the test and the test's potential value. In addition, the commenters suggested we should publish the gapfill payment amounts determined by carriers or MACs and an explanation of the payment amounts.

Response: Although we appreciate the comments on the establishment of payment amounts for new clinical laboratory test codes using the gapfill basis and the suggested improvements to the way we set rates, these comments are outside the scope of this rulemaking. In the CY 2008 PFS proposed rule, we proposed policies and requested comment regarding our proposed reconsideration process. We made no policy proposals with respect to the methodology our contractors use to establish gapfilled payment amounts. However, in the interest of transparency we will instruct carriers or MACs to provide a rationale for their final carrier-specific amounts, which we will post on our Web site.

Comment: One commenter suggested that we should establish a temporary NLA based on the carrier-specific amounts posted on April 30 within the first year of the gapfill process.

Response: We appreciate the commenter's suggestion; however, we are concerned that establishing a temporary NLA within a 3 month time period is not possible due to our substantial program requirements each year. Currently, clinical laboratory fee schedule payment rates are established on a calendar year basis. During the year preceding each January 1, an extensive multi-step process is in place in order to bring those payment rates to fruition. Currently, that process does not allow for additional ratesetting procedures.

d. Jurisdiction for Reconsideration Decisions

In the CY 2008 PFS proposed rule (72 FR 38163), we proposed that jurisdiction for reconsideration would rest exclusively with the Secretary. A decision whether to reconsider a determination would be committed to the discretion of the Secretary. Accordingly, a refusal to reconsider an initial determination would not be subject to administrative or judicial review. We recognize that parties dissatisfied with an initial determination as to the amount of payment for a particular claim for laboratory services may appeal the initial determination under part 405, subpart I of our regulations. Under our proposal, a party could challenge under part 405, subpart I a determination regarding the amount of payment for a new test—regardless of whether the amount of payment was established as the result of a reconsideration—but a party could not challenge a decision not to reconsider.

Comment: One commenter stated that comments should be allowed on the final payment determination amounts.

Response: This comment appears to request an extension of the reconsideration process or a change in the jurisdiction as proposed in § 414.509. The commenter did not provide additional information on the circumstances that would warrant an extension of the reconsideration process. Also, the comment did not specify the length of time for an extension or procedures for an extension or change of jurisdiction. We believe § 414.506 through § 414.509 permit adequate opportunities for public participation in the process of establishing a payment amount and requesting a reconsideration. More than 2 years can elapse if all steps of these reconsideration procedures are necessary for the establishment of the basis and payment for a new test code. We do not agree that revisions to § 414.509(d) are warranted.

3. Technical Revisions

We also proposed technical revisions to § 414.502, § 414.506, and § 414.508. Under section 1833(h)(8)(A) of the Act, the term ''new tests'' is defined as any clinical diagnostic laboratory test for which a new or substantially revised HCPCS code is assigned on or after January 1, 2005. However, our regulations do not define the term ''new test.'' Therefore, we proposed to define the term ''new test'' under § 414.502 using the statutory definition. In addition, under § 414.506 and § 414.508, we proposed to replace references to ''new clinical diagnostic laboratory test that is assigned a new or substantially revised code on or after January 1, 2005'' with references to ''new test.''

Response: We received one supportive comment on this subpart,

and we appreciate the positive input received on our technical revisions. Therefore, we are finalizing the technical revisions as proposed.

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

In the CY 2008 PFS proposed rule (72 FR 38163), we outlined the proposed updates to the case mix adjusted composite rate payment system established under section 1881(b)(12) of the Act, added by section 623 of the MMA. These included updates to the drug add-on component of the composite rate system, as well as the wage index values used to adjust the labor component of the composite rate.

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

- A growth update to the drug add-on adjustment to the composite rates for 2008 required by section 1881(b)(12)(F) of the Act.
- An update to the wage index adjustments to reflect the latest hospital wage data, including a reduction to the wage index floor and a revised budget neutrality adjustment to the wage index for 2008.

We received approximately 7 comments on these proposed changes which are discussed in detail below in this section.

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

Section 623(d) of the MMA added section 1881(b)(12)(B)(ii) of the Act which required the establishment of 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.

Comment: Two commenters supported our continued use of ASP+6 percent to pay for separately billable ESRD drugs.

Response: Although these comments are outside the scope of the proposed rule, we appreciate the support of our previous decision to pay for separately billable ESRD drugs at ASP+6 percent.

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

The CY 2007 drug add-on adjustment to the composite rate is 14.9 percent. The drug add-on adjustment for 2007 incorporates an inflation adjustment of 0.5 percent. This computation is explained in detail in the CY 2007 PFS final rule with comment period (71 FR 69682 through 69684). We note that the drug add-on adjustment of 15.1 percent that was published in the CY 2007 PFS final rule with comment period did not account for the 1.6 percent update to the composite rate portion of the basic case-mix adjustment payment system that was subsequently enacted by the MIEA–TRHCA, effective April 1, 2007. Since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, the drug add-on percentage was decreased to account for the higher composite payment rate resulting in a 14.9 percent add-on adjustment beginning April 1, 2007. This adjustment was necessary to ensure that the total drug add-on dollars remain constant.

(a) Estimating Growth in Expenditures for Drugs and Biologicals for CY 2008

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established a 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.

For CY 2008, we proposed to continue using this methodology to update the drug add-on adjustment, using expenditure data from CY 2005 and CY 2006 to estimate the growth in per patient utilization of drugs. However, we also proposed using only drug expenditure data from independent ESRD facilities because we were unable to determine utilization change in hospital-based dialysis facilities due to the changes in payment methodology for these types of dialysis facilities from CY 2005 to CY 2006. In 2005, payments to hospital-based facilities were based on cost (or a percentage of charges), whereas payments to those facilities in 2006 were based on ASP pricing. Because of the cost payment methodology, the ''drug unit'' fields on the 2005 hospital-based ESRD facility bills were not used for payment purposes, and therefore, the data may not have been accurately reported on those bills. As such, we were unable to accurately isolate the per unit payment differential for hospital-based ESRD facility drug expenditures between 2005 (cost payments) and 2006 (ASP payments) for purposes of estimating the residual utilization change between years. We proposed imputing the same utilization growth for hospital-based ESRD facilities as estimated for independent ESRD facilities.

Comment: One comment urged us to reevaluate the data and methodology used to estimate utilization changes. The comment was specifically concerned about the timeliness of the data and that the exclusion of hospital-based drug data may significantly skew the accuracy of the utilization growth calculation. However, the comment did not suggest an alternative methodology.

Response: The data from CY 2005 and CY 2006 represent the most up to date and latest full years of data available. Contrary to the commenter's suggestion, as we indicated in the CY 2008 PFS proposed rule, including hospital-based data in the computation would have resulted in a negative utilization growth. Therefore, we opted to exclude those data to avoid penalizing ESRD facilities because of the problems with the hospital-based ESRD facility drug data. We believe our approach provides the most reasonable result given the available data.

Comment: One comment suggested that we adopt an index that would account for both price and utilization such as the National Health Expenditures (NHE) index. This would avoid the data issues associated with estimating utilization growth.

Response: We do not believe that the NHE projections would be the best proxy for growth in ESRD drug expenditures. The NHE projections are based on the economic, demographic and Medicare spending projections contained in the Medicare Trustees Report as opposed to an independent forecast of economic assumptions, such as the Global Insights projections of the PPI for prescription drugs that are used in our Medicare market basket forecasts to update many of our payment systems. The NHE projection modeling approach is at an aggregate level and does not capture the nuances of both labor and economic markets as accurately as does the specific PPI forecast. We believe that, despite some of the limitations in the data, estimating utilization growth

from reported ESRD claims data provides the most accurate measure of actual ESRD facility drug utilization.

Comment: One comment suggested that the PPI may not result in an accurate assessment of prices for ESRD drugs and that there are other available indices that would provide more accurate data on ESRD drugs. In addition, they stated that should we choose to move forward with the PPI, the most up to date PPI forecast should be used.

Response: We do not know of any better price index than the PPI for measuring price growth for ESRD drugs. However, we welcome any suggestion the industry may have on an alternative price index suitable for measuring price growth of ESRD drugs. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of our market baskets. The current projection of the PPI for prescription drugs is based on the 2007 second quarter forecast using historical data through the first quarter of 2007, the most current data available at this time.

Comment: One comment recommended that a mechanism be established to provide for a forecasting error adjustment of prior estimates.

Response: While we appreciate the concern related to the accuracy of an update based on proxy measures for price and the proposed utilization computations, the very nature of estimating future expenditures under a prospective payment system requires that those estimates are based on the best historical data available. As such, we believe we have met our obligation under the statute in estimating growth in ESRD drug expenditures for CY 2008. Moreover, forecast error adjustments are rarely made in our prospective payment systems.

(b) Estimating Growth in Per Patient Drug Utilization

To isolate and project the growth in per patient utilization of ESRD drugs for CY 2008, we removed the enrollment and price growth components from the historical data and considered the residual to be utilization growth. As discussed previously, we proposed to use independent ESRD facility drug expenditure data from CY 2005 and CY 2006 to estimate per patient utilization growth for CY 2008.

We first estimated total drug expenditures. For the CY 2008 PFS proposed rule (72 FR 38165), we used the final CY 2005 ESRD facility claims data and the latest available CY 2006 ESRD facility claims data, updated through December 31, 2006. That is, for CY 2006 we used claims that were received, processed, paid, and passed to the National Claims History File as of December 31, 2006. For this final rule with comment period, we are using more updated CY 2006 claims with dates of service for the same time period. This updated CY 2006 data file includes all claims that were received, processed, paid, and passed to the National Claims History File as of June 30, 2007 for CY 2006.

For the CY 2008 PFS proposed rule, we adjusted the December 2006 file to reflect our estimate of what total drug expenditures would be using the final June 30, 2007 bill file for CY 2006. The net adjustment we applied to the CY 2006 claims data was an increase of 12 percent to the December 2006 claims file. For this final rule with comment period, we are using the CY 2006 claims file as of June 30, 2007, which represents the final claims file for that year. To calculate the proposed per patient utilization growth, we removed the enrollment component by using the growth in enrollment data between 2005 and 2006. This was approximately 3 percent. To remove the price effect, we calculated the weighted difference between 2005 average acquisition price (AAP) and 2006 ASP pricing for the original top ten drugs for which we had average acquisition prices. We weighted the differences by the 2006 independent ESRD facility drug expenditure data. This process led to an overall 3 percent reduction in price between 2005 and 2006 (72 FR 38165 through 38166).

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 3 percent ($1.00 - 0.03 = 0.97$) into the total drug expenditure change between 2005 and 2006 of -0.2 percent ($1.00 - 0.00 = 1.00$). The result is a proposed utilization growth factor equal to 1.00 ($1.00/1.03 * 0.97 = 1.00$).

Since we observed no growth in per patient utilization of drugs between 2005 and 2006, we proposed no projected growth in per patient utilization for all ESRD facilities for CY 2008.

c. Applying the Proposed Growth Update to the Drug Add-On Adjustment

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

For CY 2008, we proposed to update the per treatment drug add-on amount of $19.64 established in CY 2007 by converting the update into an adjustment factor as specified in section 1881(b)(12)(F) of the Act.

(i) Update to the Drug Add-On Adjustment

In the CY 2008 PFS proposed rule (72 FR 38166), we estimated no growth in per patient utilization of ESRD drugs for CY 2008. Using the projected growth of the CY 2008 PPI for prescription drugs of 3.66 percent, we projected that the combined growth in per patient utilization and pricing for CY 2008 would result in an update equal to the PPI growth, or 3.66 percent ($1.0 * 1.0366 = 1.0366$). This proposed update factor was applied to the CY 2007 per treatment drug add-on amount of $19.64 (reflecting a 14.9 percent adjustment in CY 2007), resulting in a proposed weighted average increase to the composite rate of $0.72 for CY 2008 or a 0.5 percent increase in the drug add-on percentage. Thus, the total proposed drug add-on adjustment to the composite rate for CY 2008, including the growth update was 15.5 percent ($1.149 * 1.005 = 1.155$).

In addition, we proposed to continue to use this method to estimate the growth update to the drug add-on component of the case mix adjusted payment system until we have at least 3 years worth of ASP-based historical drug expenditure data that could be used to conduct a trend analysis to estimate the growth in drug expenditures. Given the time lag in the availability of ASP drug expenditure data, we expect that the earliest we could consider using trend analysis to update the drug add-on adjustment would be 2010. We intend to reevaluate our methodology for estimating the growth update at that time.

Comment: One comment suggested that we should work with the kidney care community as we consider a CY 2010 transition to trend analysis using ASP-based historical data. The comment expressed concern that using actual historical ESRD drug expenditure data reflecting ASP pricing could adversely affect ESRD facilities due to changes in ASP pricing for EPO and Procrit.

Response: Once we begin using trend analysis to update the drug add-on adjustment, we will provide details of that methodology in future rulemaking.

(ii) Final Growth Update to the Drug Add-On Adjustment for 2008

Similar to the proposed rule, we estimated no growth in per patient utilization of ESRD drugs for CY 2008. To remove the price effect, we used 2006 weights for each of the top ten ESRD drugs billed by independent ESRD facilities. These weights are shown in Table 6.

TABLE 6.—CY 2006 DRUG WEIGHTS FOR INDEPENDENT FACILITIES

Independent drugs	2006 weights (percent)
EPO	75.2
Paricalcitol	11.6
Sodium_ferric_glut	2.9
Iron_sucrose	5.7
Levocarnitine	0.3
Doxercalciferol	3.1
Calcitriol	0.1
Iron_dextran	0.0
Vancomycin	0.1
Alteplase	0.9

We removed the enrollment and price effects from the independent ESRD facility expenditure data to determine 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 3 percent (1.00 − 0.03 = 0.97) into the total drug expenditure change between 2005 and 2006 of −0.1 percent (1.00 − 0.00 = 1.00). The result is a utilization growth factor equal to 1.00 (1.00/1.03 * 0.97) = 1.00.

Using the latest projected growth of the CY 2008 PPI for prescription drugs of 3.5 percent, we project that the combined growth in per patient utilization and pricing of ESRD drugs for CY 2008 would result in an update equal to the PPI growth or 3.5 percent (1.00 * 1.035 = 1.035). This update factor was applied to the CY 2007 average per treatment drug add-on amount of $19.64 (reflecting a 14.9 percent adjustment for CY 2007), resulting in a weighted average increase to the composite rate of $0.69 for CY 2008 or a 0.5 percent increase in the drug add-on percentage for CY 2008. Thus, the total drug add-on adjustment to the composite rate for CY 2008, including the growth update is 15.5 percent (1.149 * 1.005 = 1.155).

2. Update to the Geographic Adjustment to the Composite Rates

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

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

In the CY 2008 PFS proposed rule (72 FR 38166), we clarified 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 data used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

(b) Updated Wage Index Values

In the CY 2006 PFS final rule with comment period (70 FR 70167), we described that methodology for calculating the CY 2006 wage index values and stated that we intend to update the ESRD wage index values annually. Current wage index values for CY 2007 were developed from FY 2003 wage and employment data obtained from the Medicare hospital cost reports. The ESRD wage index values are calculated without regard to geographic reclassifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix.

We proposed to use the same methodology for CY 2008 (72 FR 38167), with the exception that FY 2004 hospital data will be used to develop the CY 2008 ESRD wage index values. For a detailed description of the development of the CY 2008 wage index values based on FY 2004 hospital data, see the FY 2008 IPPS final rule entitled ''Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates'' (72 FR 47320). Section G of the preamble to that final 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 2008 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Comment: One commenter expressed concern in regard to our use of acute care hospital wage data in the calculation of the wage index stating that the cost for hospital based facilities and ambulatory centers varies greatly. The commenter urged us to locate an alternative data source that reflects information directly tied to ESRD facilities.

Response: At the present time, data that is specific to independent dialysis facilities is not available upon which to base the wage index. As described in the CY 2007 PFS final rule with comment period (71 FR 69685), given the similarity of the labor market for professional, technical, and nursing staff between hospitals and ESRD facilities, we believe our use of hospital wage and employment data obtained from the Medicare cost reports to develop the ESRD wage index is appropriate. In addition, several of our major prospective payment systems (PPS) utilize the same wage index (for example, Skilled Nursing Home PPS, Inpatient Psychiatric Facility PPS, Inpatient Rehabilitation Facility PPS, Home Health PPS, and Hospice PPS.)

(i) Third 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 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) will be a blend of its old MSA-based wage-adjusted payment rate and its new CBSA-based wage-adjusted payment rate for the transition year involved. In addition, beginning in CY 2006 we provided a gradual reduction in the wage index floor. We indicated that we would reassess the need for a wage index floor for CY 2008. In the CY 2008 PFS proposed rule (72 FR 38167), we proposed a further reduction in the wage index floor. 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 and the applicable wage index floor is as follows:

- In CY 2006, the first year of the transition, we implemented a 75/25 blend. The wage index floor was reduced from 0.9000 to 0.8500.
- In CY 2007, the second year of the transition, we implemented a 50/50 blend. The wage index floor was reduced from 0.8500 to 0.8000.
- For CY 2008, consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), we are implementing a 25/75 blend between an ESRD facility's MSA based composite

rate, and its CY 2008 CBSA-based rate reflecting its revised wage index values. In addition, we proposed to continue the wage index floor, but to further reduce it from 0.8000 to 0.7500.

An example of how the wage-adjusted composite rates would be blended during CY 2008 and the additional subsequent transition year follows.

Example: An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of $135.00 per treatment in CY 2007. Using CBSA-based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value would be $145.00. During the remaining 2 years of the 4-year transition period to the new CBSA-based wage index values, this facility's blended rate through 2009 would be calculated as follows:

CY 2008 = 0.25 × $135.00 + 0.75 × $145.00 = $142.50

CY 2009 = 0 × $135.00 + 1.0 × $145.00 = $145.00

We note that this hypothetical example assumes that the calculated wage-adjusted composite rate of $145.00 for CY 2008 does not change in CY 2009. In actuality, the wage-adjusted composite rate for CY 2009 would change because of annual revisions to the wage index. However, the example serves only to demonstrate the effect on the composite rate of the CBSA-based wage index values which will be phased in during the remaining 2 years of the transition period. As noted above in this section, the 4-year transition period will expire and in CY 2009 and forward, we will be using CBSA-based wage index values.

Comment: Several commenters expressed concern in regard to our proposal to decrease the wage index floor from 0.80 to 0.75. In addition, one commenter indicated that a defunct licensing board in Puerto Rico has inhibited licensing of dialysis technicians for a long period of time. As a result, registered nurses are the only group of licensed professional qualified to furnish dialysis within this area.

In addition, a commenter believes that decreasing the floor will make it difficult to recruit and retain qualified personnel in areas affected by the removal of the floor. The commenter also identified the recent transition to the ASP drug pricing methodology and increases in operating expense as factors that have compounded the impact of any further drop in the wage index floor.

Response: As described in the CY 2007 PFS final rule with comment period (71 FR 69686 through 69687), the proposed wage index floor was substantially higher than the actual wage index values for urban locales in Puerto Rico, without application of any floor and prior to the application of the BN adjustment. Specifically, the proposed wage index floor was 0.80 whereas the actual wage index values ranged from 0.3241 to 0.4893. Similarly, the proposed wage index floor for CY 2008 is 0.75 whereas the actual wage index values for urban locales in Puerto Rico range from 0.3064 to 0.4729. Therefore, we believe that the CY 2008 wage index floor of 0.75 compared to actual wage levels is an appropriate level and the new floor would not impede the ability of ESRD facilities to recruit and retain staff.

(ii) Wage Index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there is 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 both CY 2006 and CY 2007, we calculated the ESRD wage index values for those areas as follows:

- For rural Massachusetts, because we had not determined a reasonable proxy for rural data in Massachusetts, we used the FY 2005 wage index value for rural Massachusetts.
- For rural Puerto Rico, the situation is similar to rural Massachusetts. However, since all geographic areas in Puerto Rico were subject to the wage index floor in CY 2006 and CY 2007, 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 and CY 2007 wage index value for Hinesville, GA (CBSA 25980) based on the average wage index value for all urban areas within the State of Georgia.

In the CY 2008 PFS proposed rule (72 FR 38168), we proposed an alternative methodology for establishing a wage index value for rural Massachusetts. Since we have used the same wage index value for two years with no updates, we believed it was appropriate to establish a methodology that uses reasonable proxy data for rural areas (including rural Massachusetts) and also permits annual updates to the wage index value based on that proxy data. Therefore, in cases where there is a rural area without hospital wage data, we proposed to use the average wage index values from all contiguous CBSAs to represent a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpret 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. Under the proposed methodology, the wage index values for the counties of Barnstable (CBSA 12700, Barnstable Town, MA—(1.2539)) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI-MA—(1.0783)) are averaged, resulting in a proposed imputed wage index value of 1.1665 for rural Massachusetts for CY 2008.

For rural Puerto Rico, we proposed to continue to apply the wage index floor in CY 2008. Since all areas in Puerto Rico that have a wage index are eligible for the proposed CY 2008 ESRD wage index floor of 0.7500, we proposed to also apply the floor to ESRD facilities located in rural Puerto Rico.

For Hinesville, GA (CBSA 25980) which is an urban area without specific hospital wage data, we proposed to continue using the same methodology used to impute a wage index value for that area as we used in CY 2006 and CY 2007. Specifically, we used the average wage index value for all urban areas within the State of Georgia for purposes of calculating the wage index value for Hinesville. Therefore, for CY 2008 we proposed that the wage index value for urban CBSA (25980) Hinesville-Fort Stewart, GA is calculated as the average of the wage index values of all urban areas in Georgia.

We solicited comments on these proposed approaches to calculate the wage index values for areas without hospital wage data for CY 2008 and subsequent years. We indicated 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 of imputing a wage index value for these areas may be feasible. We received one comment on this issue.

Comment: One commenter was supportive of our methodology used in calculating wage index values for areas with no hospital wage data including rural Massachusetts, Puerto Rico, and an urban area in Georgia. However, the commenter requested that we carefully evaluate the extent to which these methodologies would be appropriate in other situations nationwide.

Response: We agree with the commenter. As additional areas are

identified for which hospital wage data does not exist, we will reevaluate the extent to which the methodologies used for Massachusetts, Puerto Rico, and Georgia would be appropriate and consider alternative methodologies on an as needed basis.

We are finalizing the ESRD wage index and associated policies as proposed for CY 2008. In addition, we note that we plan 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).

(iii) Budget Neutrality (BN) Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, requires that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. This means that aggregate payments to ESRD facilities in CY 2007 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. Since we are not proposing any changes to the case-mix measures for CY 2008, the current case-mix budget neutrality will remain in effect for CY 2008. For CY 2008, we again proposed to apply the BN adjustment directly to the ESRD wage index values, as we did in CY 2007. As we 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 based on that proportion (53.711 percent).

To compute the proposed CY 2008 wage index BN adjustment, we used the proposed wage index values, 2006 outpatient claims (paid and processed as of December 31, 2006), and geographic location information for each facility.

Using the treatment counts from the 2006 claims and facility-specific CY 2007 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2007 (the 2nd year of the 4-year transition). The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2008. 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 2008 (the 3rd year of the 4-year transition). The total of these payments became the third year amount of wage-adjusted composite rate expenditures for all ESRD facilities.

After comparing these two dollar amounts (target amount divided by 3rd year new amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2008 ESRD proposed wage index value would result in payments to each facility that remain within the target amount of composite rate expenditures when totaled for all ESRD facilities. The proposed BN adjustment for the CY 2008 wage index was 1.054955.

We also must apply the BN adjustment to the proposed wage index floor of 0.7500 which resulted in a proposed adjusted wage index floor of 0.7912 (0.7500×1.054955) for CY 2008.

Comment: One commenter expressed concern in regard to the calculation of the BN adjustment for the geographic wage index stating that the methodology included in the proposed rule lacked transparency. The commenter urged us to provide the data and methodology used in calculating the BN adjustment.

Response: The commenter did not identify where transparency was lacking or any missing elements that would enable the community to assess the impact of the proposed changes. However, we received a similar request for clarification during last year's rulemaking process and provided an extensive description of the manner in which budget neutrality is applied to the wage index in the CY 2007 PFS final rule with comment period (71 FR 69687 through 69688). While claims data have been updated since publication of that final rule with comment period, the methodology has not changed.

During the CY 2008 PFS proposed rule comment period, we made available an ESRD Composite Rate Payment System File. This file contained select claims level data from the 2006 ESRD facility outpatient claims, updated through December 31, 2006. For more information on this file, see the following page on the CMS Web site at *http://www.cms.hhs.gov/LimitedDataSets/06.asp#TopOfPage.*

After publication of this final rule with comment period, we intend to provide the updated version of the CY 2006 outpatient claims (paid and processed as of June 30, 2007) that were used to compute the BN adjustment.

To compute the final CY 2008 ESRD wage index BN adjustment, we used FY 2004 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital wage data to compute the wage index values, 2006 outpatient claims (paid and processed as of June 30, 2007), and geographic location information for each ESRD facility which may be found through Dialysis Facility Compare. The FY 2004 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 2008 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Dialysis Facility Compare Information can be found on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/.*

Using treatment data from the latest 2006 claims file and facility-specific CY 2007 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2007 (the 2nd year of the 4-year transition). The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2008. Next, we computed the estimated dollar amount that would have been paid to the same ESRD facilities using the ESRD wage index for CY 2008 (the 3rd year of the 4-year transition). The total of these payments became the 3rd year new amount of wage adjusted composite rate expenditures for all ESRD facilities.

After comparing these dollar amounts (target amount divided by 3rd year new amount), we calculated an adjustment factor that when multiplied by the applicable CY 2008 wage index value, will 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 0.7500 is used whenever appropriate.

The final BN adjustment for the CY 2008 wage index is 1.055473.

To ensure budget neutrality, we also must apply the BN adjustment to all index values, including the wage index floor of 0.7500, which results in an adjusted wage index floor of 0.7916 for CY 2008.

(iv) ESRD Wage Index Tables

The final CY 2008 wage index tables applicable to ESRD facilities are located

in Addenda G and H of this final rule with comment period.

I. Independent Diagnostic Testing Facility (IDTF) Issues

In the CY 2008 PFS proposed rule (72 FR 38169 through 38171), we clarified our interpretation of several of the existing performance standards at § 410.33(b), and § 410.33(g), proposed a new IDTF performance standard at § 410.33(g)(15), and a new proposed IDTF provision at § 410.33(i).

We received numerous comments concerning the revisions to existing performance standards and new provisions affecting IDTFs and have revised our proposed changes, where applicable, to reflect the issues brought forth by the commenters. We are adopting the provisions contained in the proposed rule as final with the following changes.

1. Revisions of Existing IDTF Performance Standards

a. § 410.33(g)(6)

In § 410.33(g)(6), we had proposed to revise this existing performance standard to include the requirement that an IDTF must list our designated contractor as a Certificate Holder on the comprehensive liability insurance policy by revising § 410.33(g)(6) to state, ''Has a comprehensive liability insurance policy in the amount of at least $300,000 per location that covers both the supplier's place of business and all customers and employees of the supplier and ensures that this insurance policy must remain in force at all times. The policy must be carried by a nonrelative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, we proposed that the IDTF must: ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; notify the CMS-designated contractor in writing of any policy changes or cancellations; and list the CMS-designated contractor as a Certificate Holder on the policy.''

Comment: One commenter suggested that we amend the § 410.33(g)(6) provision on the comprehensive liability insurance policy to state that IDTFs should have a comprehensive liability insurance policy of at least $100,000 per incident, $300,000 aggregate and that CMS should require the IDTF to list Medicare contractors as certificate holders for notification purposes only.

Response: After receiving numerous comments supporting the proposed figures, we are adopting the proposed figure of $300,000 per incident.

Comment: Several commenters recommended that we revise the proposed performance standard found at § 410.33(g)(6) to remove the requirement that our designated contractor be listed as a Certificate Holder on the liability insurance policy. One commenter supported the proposed changes to the performance standard at § 410.33(g)(6), but expressed concerned about whether underwriters were willing to list the government as a certificate holder on an insurance policy.

Another commenter questioned whether insurance underwriters will be open to the idea of adding the government as a certificate holder on an insurance policy and suggested that CMS survey several insurance carriers which provide this type of coverage to determine if this performance standard is achievable. One commenter stated that the comprehensive liability insurance policy provision (§ 410.33(g)(6)) which requires the IDTF to list the Medicare contractor as the certificate holder on the policy is too burdensome and obtrusive on small business entities. They recommended using a comparable approach to the one required by DMEPOS supplier, and have the IDTF provide a copy of the annual renewal of the insurance coverage for the IDTF to the Medicare contractor (the renewal package would include information on the coverage levels, as well as the premiums paid).

One commenter suggested removing the contractor as the certificate holder for the comprehensive liability insurance policy, but if they are named as a certificate holder for the comprehensive liability insurance policy that it be only for notification purposes.

Response: Given the concerns raised about the increased administrative burden, we agree that our designated contractor should not be included as a Certificate Holder on the IDTF's comprehensive liability insurance policy. We have revised the performance standard found at § 410.33(g)(6) to remove the requirement that our designated contractor be listed as a Certificate Holder on the IDTF's comprehensive liability insurance policy. However, we believe that it is essential that a Medicare fee for service (FFS) contractor be allowed to verify information contained in the comprehensive liability insurance policy. We believe that a Medicare contractor (that is, carrier or Part A/Part B Medicare Administrator Contractor) should be able to verify the issuance of a comprehensive liability insurance policy with an insurance agent or, as necessary, an underwriter. This approach will allow a Medicare FFS contractor to review and verify that a comprehensive liability insurance policy has been issued and is in effect at the time of enrollment and throughout the enrollment period. We have revised § 410.33(g)(6) to read, ''Has a comprehensive liability insurance policy in the amount of at least $300,000 per location that covers both the supplier's place of business and all customers and employees of the IDTF. The policy must be carried by a nonrelative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must—

- Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
- Notify the CMS designated contractor in writing of any policy changes or cancellations.''

b. § 410.33(g)(2)

In § 410.33(g)(2), we proposed to establish a 30-day reporting period for certain reportable events and a 90-day reporting period for all other reportable events.

Comment: One commenter asked that we define the term ''nonrelative owned'' while another commenter asked that we remove this term altogether because we are not precluding self insurance.

Response: While we do not believe that it is necessary to define the term ''nonrelative owned'' in this rulemaking effort, a non-relative owned company applies to insurance policies obtained through a familial relationship, not a related organization or business partner. Therefore, we are not removing this term from the performance standard.

Comment: Several commenters supported our proposal to revise the reporting requirements found in the performance standard found at § 410.33(g)(2). One commenter supported the CMS proposal to revise the reporting requirements found in performance standard at § 410.33(g)(2) to establish separate reporting periods for different reportable events. The proposed changes will provide the information desired by CMS in a timely

manner while minimizing the administrative burdens on both IDTFs and the Medicare contractors caused by the current notification standard.

Response: We appreciate these comments and agree that revising this standard will reduce the administrative burden on both IDTFs and our contractors.

Comment: One commenter recommended that we revise the CMS–855B to list the specific changes that must be reported within 30 calendar days of the change. However, one commenter stated that requiring the reporting of changes depending on the type change in 30 or 90 days puts an unfair burden on IDTFs.

Response: We agree that the CMS–855B should be revised and should list the specific changes that must be reported within 30 calendar days of the change. Currently, IDTFs are required to report all changes in 30 days. Our proposal would limit the number of reportable events that would need to be reported within 30 days of the change. We intend to revise the CMS–855B to clarify which reportable events must be reported within 30 and 90 days. We will use the Paperwork Reduction Act process to seek specific comments in seeking revisions to the CMS–855B.

Comment: One commenter recommended that we allow IDTFs to make changes online.

Response: We are developing the Provider Enrollment, Chain, and Ownership System (PECOS) Web, which will allow all providers and suppliers, including IDTFs, to enroll or report enrollment changes via the Internet. We are hoping to implement PECOS Web in most parts of the country by March 2008.

Comment: One commenter suggested that all changes should be reported to CMS within 90 days or in the alternative. This commenter also recommended that IDTFs report any changes that have occurred in the preceding quarter on a quarterly basis.

Another commenter suggested that we should allow at least 90 days for reporting changes in contact information with the contractor. This commenter also suggested that we further define what the policy and coverage requirements for self insurance and the term ''independent underwriter.''

Response: Section 410.33(g)(2) requires IDTFs to report all changes in 30 days. By adopting our proposal, we limit the number of reportable events that would need to be reported within 30 days of the change. As stated above, we intend to revise the CMS–855B to clarify what items must be reported within 30 and 90 days. Since many IDTFs operate on different schedules, it would not be practical to implement a quarterly reporting requirement.

As a result of the issues raised by the commenters, we are revising § 410.33(g)(2) to read, ''Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare FFS contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.''

c. § 410.33(g)(8)

We received the following comments in response to our proposal at § 410.33(g)(8).

Comment: Several commenters recommended that we consider limiting the types of beneficiary complaints that are subject to the performance standard found in § 410.33(g)(8). Another commenter recommended that the standard found in § 410.33(g)(8) apply only when a beneficiary formalizes their complaint in writing. Other commenters stated that the proposed change in § 410.33(g)(8) is unnecessary, not to mention ambiguous and labor intensive to implement.

One commenter recommended that we model the IDTF documentation requirement after standards established by the Food and Drug Administration. Specifically, this commenter recommends that IDTFs maintain a record for each serious complaint received by the facility for at least 3 years from the date the complaint was received.

Another commenter recommended that we clarify that IDTFs are required to monitor only those beneficiary complaints that relate to the quality of care the patient receives.

One commenter stated that the standard at § 410.33(g)(8) be clarified to eliminate the documentation of routine billing questions so there is no unnecessary burden on small business entities.

One commenter suggested that instead of adopting § 410.33(g)(8) as written for documenting a beneficiary's questions or complaints, IDTFs should be required to develop and adhere to a complaint policy that includes documentation of material medical or billing complaints, and that if CMS adopts the current provision, the word questions should be changed to complaints. The commenter also maintains that IDTFs should be allowed to keep documents that are older than 30 days at a site other than the IDTF's physical location and CMS should clarify how long the IDTFs are required to keep each complaint and whether an IDTF will be required to record the insurance claim number for each complaint.

Other commenters recommended that we clarify § 410.33(g)(8) to specifically state that this standard relates to complaints regarding the provision of service, because as written, it will impose a sweeping new recordkeeping requirement that drastically affects small business entities.

Response: Based upon the comments received, we have revised this provision to clarify and limit the amount of documentation that is necessary when a clinical complaint is received in writing. We also are clarifying and limiting the amount of documentation that is necessary when a clinical complaint is received in writing. We believe that complaints should be readily available for examination and we will establish a time frame for maintaining this documentation. Therefore, we have revised § 410.33(g)(8) accordingly.

Comment: One commenter recommended that we develop a standardized complaint form and an electronic Web-based platform for submitting complaints regarding an IDTF.

Response: We believe that an IDTF can document any formal complaints it receives in the most convenient way possible for that IDTF.

After reviewing public comments regarding our proposed change to § 410.33(g)(8), we are adopting this proposed change with modifications. By revising this language, we believe that we are reducing the paperwork burden on IDTFs to maintain and respond to written clinical complaints, rather than all questions and complaints it receives from beneficiaries. Section 410.33(g)(8) is revised to read, ''Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (for mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

- The name, address, telephone number, and health insurance claim number of the beneficiary.
- The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
- If an investigation was not conducted, the name of the person

making the decision and the reason for the decision.''

By making this change, we believe that we are reducing the paperwork burden on IDTFs by asking them to maintain and respond to written clinical complaints, rather than address all questions and complaints it receives from beneficiaries.

d. § 410.33(b)(1)

We received the following comments in response to our proposal at § 410.33(b)(1).

Comment: Several commenters agreed with our proposal to delete the requirement that the supervising physician is responsible for the overall operation and administration of an IDTF.

Response: We appreciate these comments and are adopting this change in the final regulation.

Comment: One commenter recommended that we delay the implementation of our clarification that a physician providing general supervision can oversee a maximum of three IDTF sites by noting that term, ''sites'' includes fixed, as well as mobile sites.

Response: We believe that a physician providing general supervision can oversee a maximum of three IDTF sites which includes fixed as well as mobile sites.

Comment: One commenter recommended that we clarify that the three site limitation only relates to the provision of general supervision. In addition, one commenter recommended that we clarify that while a physician may only provide general supervision to three IDTF sites, this provision does not apply to the number of interpreting physicians at an IDTF site.

Response: We agree with this comment and will clarify that the supervision limitation only applies to general supervision.

Comment: One commenter stated that our proposal to consider each mobile IDTF unit as one IDTF site was unreasonable.

Response: We disagree and we believe that a physician providing general supervision can oversee a maximum of three IDTF sites. We maintain that fixed and mobile IDTFs essentially are furnishing the same services. We note that the term, ''sites'' includes fixed as well as mobile sites because there are three concurrent locations where testing may occur at a given time.

Comment: One commenter stated individual locations should be counted only if they have separate Medicare PINs.

Response: With Medicare's implementation of the National Provider Identifier (NPI) on or before May 23, 2008, Medicare contractors will no longer issue billing numbers to the public. Providers and suppliers will use their assigned NPI to submit claims to Medicare. As such, organizations may obtain one or many NPIs. Accordingly, we are not able to adopt this suggestion.

Comment: One commenter suggested that it would be inappropriate to require that a mobile IDTF have a different supervising physician for every three office locations that it visits, therefore this provision should apply only to those IDTFs in a fixed location.

Response: We believe that a physician providing general supervision can oversee a maximum of three IDTF sites and note that the term, ''sites'' includes fixed, as well as mobile sites, because there are three concurrent locations where testing may occur at a given time. A mobile IDTF may visit multiple locations and it would still be considered one mobile unit. The number of places a mobile IDTF visits does not change the fact that this is a single unit and up to three fixed base or mobile units may be under the general supervision of one physician.

Comment: One commenter stated that the mobile unit described at § 410.33(b)(1) should be consistent with the language used on the CMS-855B enrollment application.

Response: We will consider revising the CMS-855B to incorporate this recommendation.

Comment: One commenter recommended treating fixed base sites and portable units on a comparable basis in that a supervising physician not be limited to supervising three portable units, but also could supervise three sites from which portable units are dispatched.

Response: A mobile IDTF may visit multiple locations, and it would still be considered one mobile unit. The number of places a mobile IDTF visits does not change the fact that this is a single unit and up to three fixed base or mobile units may be under the general supervision of one physician. Under the commenter's scenario, any number of mobile units could be in use and a physician would not be able to provide general supervision to an infinite number of mobile units.

Comment: One commenter recommended that we revise § 410.33(b) to move to a diagnostic equipment threshold limit instead of an IDTF site limit since, as proposed, the provision allowing fixed based IDTFs to run limitless testing procedures at the IDTF is equated with a mobile unit running one test at a time. Therefore the number of supervising physicians should be determined through testing volume and not location.

Another commenter recommended that a maximum threshold of 15 units per supervising physician would be advisable and that is should be made clear that this section applies to general supervision and not direct or personal supervision.

Response: Due to the varied and ever changing equipment used by IDTFs, it would be impractical to establish such limits.

Comment: One commenter recommended that we conduct additional audits, monitoring, and enforcement actions, where warranted, to address existing compliance problems.

Response: We agree with the commenters that audits, monitoring, and enforcement efforts are effective ways to identify individual compliance issues. We already require that Medicare contractors conduct an onsite visit to verify the performance standards found in this section prior to initial enrollment. We will consider adding and/or redirecting existing resources to ensure that an IDTF remains in compliance with these standards.

Comment: One commenter requested clarification to differentiate between fixed and mobile IDTFs business models and the differences by which IDTFs using these models provide services.

Response: A fixed base IDTF performs all of its diagnostic testing at the practice location found on the Medicare enrollment application (CMS–855), whereas a mobile IDTF travels and performs its diagnostic tests at locations other than a single practice location.

Comment: One commenter requested that we clarify the definition of ''site'' versus ''testing locations'' distinction.

Response: We consider sites and testing locations to be a practice location for both fixed base and mobile IDTFs.

Comment: One commenter suggested that the language at § 410.33(i)(3) is in error and was meant to be a definition, because it explains the first two parts of the effective date provision. The commenter stated that they believe that the date which a signed enrollment application is submitted should be considered the date of filing and that any time lag in contractor decisions should be excluded when determining the date of filing.

Response: We agree with the commenter and are revising § 410.33(b)(1) accordingly.

After reviewing the public comments, we are amending the provision to

remove the following sentence from § 410.33(b)(1), ''The IDTF supervising physician is responsible for the overall operation and administration of the IDTFs, including the employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations''.

We are adopting the provision at § 410.33(b)(1) which clarifies the meaning of what constitutes three IDTF sites to include both fixed sites and mobile units. This includes moving portable diagnostic equipment to another location and used it to provide IDTF services. Accordingly, we believe that a physician providing general supervision as defined in § 410.32(b)(3)(i) can oversee a maximum of three sites (that is, fixed or mobile) where concurrent operations can be performed. In addition, we are clarifying that that this provision applies only to general supervision within an IDTF setting. Section 410.33(b)(1) is revised to read, ''Each supervising physician must be limited to providing general supervision to no more than three IDTF sites. This provision applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.''

2. New IDTF Standards

a. § 410.33(i)

In § 410.33(i), we proposed to establish an initial enrollment date for IDTFs and to limit the retrospective period for which an IDTF can obtain payment for services after enrolling into the Medicare program.

Comment: One commenter recommended that we adopt an accelerated rollout plan of the PECOS Web to facilitate the enrollment process for IDTFs.

Response: We expect to implement PECOS Web in most parts of the country by March 2008.

Comment: One commenter recommended that we ensure that Medicare contractors process enrollment applications in a timely manner so that beneficiaries will have access to quality and convenient healthcare delivery at an IDTF.

Response: We will continue to work with all Medicare contractors to ensure that applications are processed in a timely and accurate manner. With the implementation of PECOS Web, we believe that many of the processing delays that have occurred within the last year will be corrected. Specifically, PECOS Web will facilitate the submission of a complete application and allow applicants to make any necessary changes to their enrollment application in a timely manner.

Comment: Several commenters recommended that we revise our proposals to allow an IDTF to begin billing Medicare for claims with dates of service on or after the day on which the IDTF submits a ''substantially correct'' or ''substantially complete'' enrollment application or the date the IDTF first furnishes services at its location, whichever is later.

Response: We disagree with the recommendation to permit an IDTF to submit claims with dates of service on or after the day which the IDTF submits a ''substantially correct'' enrollment application or the date the IDTF first furnishes services at its location, whichever is later. We believe that it is essential that all providers and suppliers, including IDTFs, submit a complete application at the time of filing or perfect the submission of their enrollment application in response to a contractor's request for information. Accordingly, an applicant who submits a complete application or responds in a timely manner to a request for additional information is not disadvantaged by this proposal. However, it is important to note that if an application is rejected in accordance with the provisions found at § 424.525, the applicant will need to submit a new application to enroll in the Medicare program. In this case, the applicant only will be able to seek payments for those services furnished on or after the date of filing or when the Medicare contractor has approved the second application request.

Comment: One commenter recommended that retroactive billing (once approval has been determined) be allowed back to the time of the initial application (even if the first submission is rejected).

Response: As stated above in this section, we disagree with this recommendation. We believe that an IDTF should be allowed to bill for services furnished on or after the date of filing or the date the practice location became operational. However, we do not believe that it is appropriate to allow an IDTF to bill for services back to the filing date of the initial application if the initial application was rejected due to the nonsubmission of information or denied because the applicant did not meet the program requirements to enroll as an IDTF.

Comment: One commenter recommended that a 60-day period be allowed for retroactive billing before an IDTF is enrolled.

Response: While we believe that an IDTF should be allowed to bill for services furnished on or after the date of filing or the date the practice location became operational, we do not believe that it is appropriate to allow an IDTF to bill for services prior to the filing date associated with when the application was submitted.

Comment: One commenter recommended that Medicare contractors follow a protocol that outlines the items that will require a contractor to reject or deny an enrollment application.

Response: Medicare contractors are bound by applicable enrollment regulations and CMS manual instructions. Specifically, all Medicare contractors are required to follow regulations found at § 424.525 and manual instructions found in publication 100–8, Chapter 10 of the Program Integrity Manual (PIM) when rejecting an enrollment application for insufficient information. In addition, Medicare contractors are required to follow regulations found at § 424.530 and manual instructions found in publication 100–8, Chapter 10 of the PIM when denying an enrollment application.

Comment: One commenter recommended that we not implement our proposal to preclude an IDTF from being allowed to bill Medicare retroactively for services that are rendered prior to the provider being formally approved by the applicable Medicare contractor to participate in the Medicare program.

Response: Since our proposal specifically allows an IDTF to receive reimbursement for services furnished on or after the filing or the date the IDTF opened a new practice location, whichever was later, we believe that we are allowing IDTFs a limited amount for retroactive billing. As stated in the preamble to the proposed rule, the purpose of this rulemaking effort is to establish a date of enrollment for IDTFs where we believe that the enrolling IDTF meets all of the program requirements to participate in the Medicare program.

Comment: One commenter recommended that we clarify that our proposed change in billing be applied only to new or initial enrollment applications and would not affect existing operations when changes or additions are made to an enrollment application, such as the addition of a new physician or piece of equipment.

Response: In general, we agree with this commenter in that the proposed change only will apply to new or initial enrollment applications. Since the provision is designed to limit

retrospective billing prior to enrollment in the Medicare program, we do not believe this change will impact existing IDTFs who are making a change to an existing enrollment record for a fixed or mobile practice location. However, it is important to note that the limitations on retroactive billing will apply to existing IDTFs who are adding a new fixed or mobile practice location to their existing enrollment record. Moreover, a limitation on retroactive billing may apply when there is change of ownership.

Comment: One commenter stated that they had no issues with the effective date of the billing privileges provision. However, this commenter suggested that this provision be tied to a requirement that the CMS designated contractor process the application in a timely fashion.

Response: We are also concerned about delays associated with the enrollment process. However, we recognize that many of the delays are the result of IDTF suppliers not submitting a complete application at the time of filing or failing to submit complete and timely responses to a contractor's request for information.

In addition, we believe that it is appropriate to expect meaningful Medicare contractor processing timeliness standards. As necessary, the agency can update or revise processing standards through the manual instructions and through contracts with Medicare Administrative Contractors. We fully expect that most enrollment applications will be processed in accordance with CMS processing requirements found in Publication 100–8, Chapter 10 of the PIM. The PIM establishes processing standards for initial applications, changes of information, and reassignments that all Medicare contractors must adhere to. Specifically, we currently require Medicare contractors to process 80 percent of initial applications within 60 days, 90 percent of initial applications within 120 days, and 99 percent of initial applications within 180 days. We also require Medicare contractors to process 80 percent of changes of information and reassignments within 45 days, 90 percent of changes of information and reassignments within 60 days, and 99 percent within 90 days.

With the implementation of PECOS Web, an internet version of the Medicare enrollment process, in FY 2008, we expect to establish more stringent contractor processing timeliness standards for applications submitted via PECOS Web.

Comment: One commenter stated that the effective date of the billing privileges provision may economically affect small and medium sized business in that the IDTF must list the credentialed employees on the application itself in order for the application to be processed, and that these businesses cannot use or bill for their services during the time periods that they are not enrolled. Further, the commenter states that it would be impractical to hire these technicians if they cannot use them to perform the tests for the time it takes to get approved.

Response: We disagree with the commenter because all IDTFs should have proper staffing, including credentialed technicians, at the time the IDTF practice location is applying to participate in the Medicare program or when the IDTF is operational.

Comment: One commenter suggested that an IDTF that is enrolled and in good standing in the Medicare program at one location be able to enroll new sites retroactively to the first date of service at the new location.

Response: We disagree with this recommendation because the approval of one practice location does not necessarily mean that a second practice location meets the requirements for approval.

Comment: One commenter recommended that we require that applicants be notified of their enrollment status within 60 days of submitting their applications.

Response: We believe that this comment is outside the scope of this final rule. However, given certain resource limitations, contractors are unable to respond to such status inquiries. With the implementation of PECOS Web, providers and suppliers, except DMEPOS suppliers, will be able to check the status of their applications via the Internet.

After reviewing the public comments we are finalizing the provision at § 410.33(i) to state that we will establish an initial enrollment date for an IDTF that would be the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by Medicare FFS contractor; or (2) the date an IDTF first started furnishing services at its new practice location. We also adopted the ''date of filing'' as the date that the Medicare FFS contractor receives a signed provider enrollment application that the Medicare FFS contractor is able to process for approval. If the Medicare FFS contractor rejects or denies an enrollment application that is not later overturned during the appeals process, the new date of filing would be established when an IDTF submits a new enrollment application that the contractor is able to process to approval.

With the implementation of an Internet enrollment process referred to as the PECOS Web in 2008, the date of filing for applications submitted through PECOS Web will be the date the Medicare 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 contractor processes to approval.

While this change limits the retrospective payments that an IDTF may obtain from the Medicare program, we believe that this approach will ensure that a Medicare contractor is able to verify that an IDTF meets all program requirements at the time of filing, including the performance standards outlined in § 410.33(g) before payment for service occurs.

b. § 410.33(g)(3)

We received the following comments regarding our proposal at § 410.33(g)(3) to expressly preclude hotels and motels from being considered an appropriate site for an IDTF setting.

Comment: One commenter stated that many IDTFs have contracts directly with a hotel or motel where they rent space for studies and that they disagreed with the rules' provision to ban such a situation.

Response: We disagree with this comment because we believe that space located within a hotel or motel can easily be transferred to other uses other than providing sleep studies.

Comment: Several commenters stated that a hotel or motel room is not appropriate places for diagnostic testing to take place.

Response: We agree with these comments and have revised § 410.33(g)(3) accordingly.

Comment: One commenter suggested that the provision at § 410.33(g)(3) be changed to state that the requirements for hand washing and patient privacy only apply to IDTFs that see patients and to clarify that being able to access records electronically fulfills the requirement of storing business and medical records.

Response: We have amended § 410.33(g)(3) to state that the requirements for hand washing and patient privacy only apply to IDTFs that see patients and to clarify that being able to access records electronically fulfills the requirement of storing business and medical records.

We are adopting a revision to § 410.33(g)(3) to expressly preclude hotels and motels from being considered an appropriate site for an IDTF setting.

Based on public comments, we believe that a hotel or motel is not an appropriate place for diagnostic testing to take occur. Accordingly, we have revised § 410.33(g)(3) to read, ''Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mailbox, motel, or hotel are not considered an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.''

Additionally, we have added an exception at § 410.33(g)(3)(ii), where IDTFs that do not see beneficiaries at their locations are exempt from providing hand washing and patient privacy accommodations.

c. § 410.33(g)(15)

At § 410.33(g)(15), we proposed a new performance standard which stated, ''Does not share space, equipment, or staff or sublease its operations to another individual or organization.''

Comment: One commenter stated that they were concerned about the emergence of arrangements in which a physician practice leases a block of time from an imaging provider (such as an IDTF) or agrees to pay the provider a per service fee to use its facility. The group practice then refers its patients to the imaging provider for imaging tests and bills the insurer for the services, usually profiting from the difference between the insurer's payment rates and the fees the practice pays to the imaging provider.

Response: We agree with the commenter and reiterate that our proposals are designed to prohibit such practices.

Comment: Several commenters supported our proposal to prohibit IDTFs from sharing space, equipment, or staff, or subleasing their operations to another individual or organization.

Response: We appreciate these comments and agree that there has been a proliferation of share use agreements between IDTFs and physicians and/or other organizations that have allowed the sharing of space and equipment.

Comment: One commenter stated that they applauded our efforts to address an alarming proliferation of referring physicians entering into ''lease'' or similar purchased test arrangements with imaging centers for the primary purpose of enabling physicians to profit from their own referrals.

Response: We appreciate these comments as our proposals are designed to prohibit such practices.

Comment: Several commenters recommended that CMS not finalize § 410.33(g)(15) because it severely restricts the use of an IDTF's property and places unnecessary limitations on the entity.

Response: We disagree with this comment. With the revisions we are making to § 410.33(g)(15), we believe that an IDTF's property is fully available for use solely by the IDTF. The adopted provision at § 410.33(g)(15) will allow an IDTF to conduct all of its approved diagnostic testing procedures.

Comment: One commenter stated that the proposed rule would prohibit an IDTF from participating in any type of leasing arrangement.

Response: In this final rule with comment period, we are prohibiting the leasing or subleasing of an IDTF practice location, as well as diagnostic equipment that are used in taking the initial diagnostic test. In addition, we are prohibiting leasing and subleasing to a third party.

Comment: One commenter requested that we clarify whether the proposed performance standard found at § 433.10(g)(15) would permit a multi-specialty clinic and an IDTF to be enrolled as a clinic and an IDTF, and for portions of space and staff to be used for both clinic and IDTF activities.

Response: While we understand the commenter's concern, we do not believe that it is appropriate to co-locate a multi-specialty clinic in the same practice location as an IDTF. Specifically, while we are not prohibiting the sharing common of hallways, parking, or common areas, we believe that a multi-specialty clinic cannot occupy or be co-located within the same practice location. For example, a multi-specialty clinic and an IDTF could not enroll or remain enrolled using the same suite number within the same office building.

Comment: Some commenters recommended that we define the term, ''individual or organization'' to exclude hospitals and nonreferring radiologists, because hospitals and nonreferring radiologists are not in a position to self-refer.

Response: We disagree that the terms ''individual and organization'' needs to be defined. For the purposes of this rule, an individual is a person, and an organization is any entity other than an individual.

Comment: One commenter recommended that we permit an adjoining physician practice or a radiology group that is the owner of an IDTF to share space, equipment, and staff.

Response: While we agree that it is common for IDTFs to share common areas (that is, waiting rooms) with the adjoining physician practice or radiology group that is an owner of the IDTF, we do not believe that it is appropriate for IDTFs to share common practice locations or diagnostic testing equipment.

Comment: Several commenters recommended that we not extend the prohibition of sharing space, equipment, and staff to the mobile IDTF setting.

Another commenter recommended that the proposed restriction on sharing space, equipment, and staff should not apply to mobile IDTFs, as this would add both physical and financial burdens that mobile units simply could not meet.

Response: We agree with these commenters that requiring mobile IDTFs to adhere to limitations regarding space, equipment, and staffing may limit beneficiary access to necessary mobile services and increase the costs of providing necessary diagnostic care. Accordingly, we are excluding mobile IDTFs from the provisions found at § 410.33(g)(15).

Comment: One commenter recommended that we revise our proposals to account for certain practical implications concerning the imaging industry, including common and legitimate sharing practices between multiple IDTFs, between IDTFs and hospitals, and between IDTFs and radiologist.

Response: While we agree that it reasonable for IDTFs located within a hospital to share practice locations and diagnostic testing equipment, we continue to have significant concerns regarding the sharing of space by IDTFs in a nonhospital setting.

Comment: One commenter recommended that we revise the performance standard found at § 410.33(g)(15) to state, ''Does not share space, equipment or staff or sublease its operations to another individual, organization, employee or contractor of such organizations, that refers Medicare patients to the IDTF for designated health services.''

Response: We have considered this comment in revising the performance standard at § 410.33(g)(15).

Comment: One commenter believed that the performance standard found in § 410.33(g)(15) applies to hospitals.

Response: Upon review of the comments, we have revised § 410.33(g)(15) to exclude hospitals.

Comment: Several commenters recommended that we clarify that the proposed performance standard found in § 410.33(g)(15) would apply only to newly enrolling IDTFs and not IDTFs already enrolled in the Medicare program. Specifically, these commenters requested that we clarify that this new standard would allow an IDTF to continue to lease personnel and equipment from third parties provided that the IDTF uses the personnel, space, and equipment exclusively throughout the lease term.

Response: We maintain that the provision found in § 410.33(g)(15) applies to both newly enrolling IDTFs, as well as those IDTFs currently enrolled in the Medicare program. This provision does not prohibit an IDTF from leasing space or equipment that is used solely by that IDTF-party, such as a building management company or an equipment manufacturer. This does not preclude an IDTF from leasing any part of its practice location or equipment used in conducting the initial diagnostic procedure to another Medicare-enrolled individual or group to conduct diagnostic testing activities.

Comment: One commenter recommended that we clarify that employees of affiliated employers under the Fair Labor Standards Act are not considered ''shared staff'' under this new standard. In addition, several commenters recommended that the prohibition on sharing ''staff'' be limited to sharing nonphysician personnel.

Response: The new sharing provision has been modified to exclude the prohibition on the sharing of staff.

Comment: One commenter recommended that if we adopt the proposed performance standard found in § 410.33(g)(15) that the implementation date be delayed for at least 12 months to provide IDTFs and physician practices with sufficient time to find new office space, recruit additional staff, notify their patients and generally restructure their existing relationships. Another commenter recommended that we clarify our proposed performance standard found in § 410.33(g)(15).

Response: We agree with commenters and we are adopting a 1-year delay in implementation (effective January 1, 2009) of the space-sharing provision for IDTFs that are currently occupying a practice location with another Medicare-enrolled individual or organization that is found at § 410.33(g)(15)(i).

Comment: One commenter recommended that we clarify whether the proposed prohibition on sharing space, equipment, and staff is intended to apply when the IDTF leases or subleases space from a hospital on a full-time, exclusive basis. Other commenters recommended that we exclude mobile IDTFs from the prohibition to share space because it is impractical in complying with this provision. One commenter stated that the sharing of staff standard is impractical to comply with and should not be extended to mobile IDTFs, because accredited and trained contracted personnel are sometimes necessary to contract with on a temporary basis.

Another commenter suggested that we not apply this provision to mobile IDTFs and instead, permit an IDTF to share space, equipment and staff with an entity that is related to the IDTF, such as through common control or ownership. Also, this commenter recommended that we should clarify in what situation an IDTF could not share staff, such as; supervising physician and nonphysician personnel.

Response: This provision is not intended to restrict an IDTF from entering into a rental agreement for space or equipment, excluding hospitals, as long as that IDTF, or the owner of the IDTF are exclusively using that space or equipment. We are excluding mobile IDTFs from the prohibition on sharing space and staff.

Comment: One commenter stated that the sharing of space provision should not apply to a Medicare-certified IDTF that leases or subleases space and/or qualified technical staff from a hospital on a full time, exclusive basis (they are not ''shared'' with the hospital).

Response: We agree with the comment and the standard has been revised to reflect this concern.

Comment: One commenter wanted clarification on whether we will permit an IDTF to utilize a common area in a building where an IDTF enters into a lease or sublease with a hospital for the full-time, exclusive use of the operation of the IDTF.

Response: We will permit an IDTF to utilize a common area in a building where an IDTF enters into a lease or sublease with a hospital for the full-time exclusive use of the operation of the IDTF. However, the IDTF must have its own practice location that is only used by that IDTF.

Comment: One commenter requested clarification on whether we intend to prohibit only new space, equipment, or staff sharing arrangements from the effective date of the rule or if it will apply to existing arrangements. If it applies to existing arrangements, then the commenter requests that the implementation be delayed by 1 year.

Response: While we intend to prohibit the sharing of space at a practice location from the effective date of the rule for newly-enrolling IDTFs (including those with applications that are still pending as of January 1, 2008), we are adopting a 1-year delay in implementation (effective January 1, 2009) of the space-sharing provision for IDTFs that are currently occupying a practice location with another Medicare-enrolled individual or organization that is found at § 410.33(g)(15)(i).

Comment: One commenter requested clarification as to whether we will permit an IDTF that leases or subleases space and/or staff from a hospital to purchase back-office services from the hospital. (These types of service may include, but are not limited to, transcription, billing, collection, recordkeeping, and computer access services, based upon a flat fee or at cost plus to the hospital).

Response: We will permit an IDTF to lease or sublease space from a hospital and to purchase services from the hospital which may include, but are not limited to, transcription, billing, collection, recordkeeping, and computer access services, based upon a flat fee or at cost plus to the hospital.

Comment: One commenter recommended that there should be an exception made at § 410.33(g)(15) for companies operating both an IDTF and portable x ray supplier, since both are surveyed and subject to multiple standards under the Medicare program.

Response: While we understand this concern, we believe that an IDTF must have a practice location where only one Medicare-enrolled IDTF is furnishing services. If another Medicare-enrolled entity is using the same practice location space as an IDTF, especially for shortened periods of time, our designated contractor is not able to determine which entity is responsible for meeting performance standards at a given time.

Comment: One commenter urged us to address the sharing of space, staff, and equipment provision by specifically excluding radiologists and radiology groups, who are not self-referring, from the sharing arrangements in IDTFs due to the increased costs and possible detriment to the beneficiary (numerous visits to different locations and increased stress) that may occur in this situation.

Response: We believe that the practice location and equipment that an IDTF uses for its initial diagnostic testing cannot be used by another Medicare provider or supplier, and therefore, we

are not excluding radiologists and radiology groups.

Comment: One commenter agreed that it would be inappropriate to commingle the clinical staff listed on the CMS–855 enrollment application during the times that the IDTF is open; however, the commenter maintains that non-clinical space and staff (such as waiting rooms, receptionists, and schedulers) should be shared with other entities.

Response: We agree with this comment and have amended the provision to reflect these concerns.

Comment: One commenter recommends that the sharing of nonclinical space, equipment and personnel be allowed between an IDTF and an adjacent facility, because it does not offer the same potential for abuse as situations where the clinical operations of the IDTF would be commingled.

Response: We have amended the provision found at § 410.33(g)(15) to address these concerns.

Comment: One commenter recommends that the sharing of space between a group or a physician practice and its own IDTF should not be prohibited. Another commenter recommends changing the proposed § 410.33(g)(15) because they believe it would prohibit wholly-owned corporate subsidiaries and affiliated under common control from sharing space, equipment, and staff in a cost efficient manner.

Response: We disagree with this recommendation since it is not feasible to distinguish between two different practices that are co-located at the same practice location. Also, this provision would not prohibit wholly-owned corporate subsidiaries and affiliated entities under common control from sharing equipment, as long as the change in equipment location is timely reported. In addition, the IDTF's practice location must be separately distinguishable and not commingled with another Medicare provider or supplier.

Comment: One commenter recommends changing the proposed § 410.33(g)(15) to read as follows: ''Does not share space, equipment, or staff or sublease it operations to another individual or organization, except for a subsidiary or affiliated IDTF that is wholly owned by, and under the complete control of, the IDTF.''

Response: We understand the commenter's recommendation and we have amended § 410.33(g)(15) to address the commenter's concern.

Comment: One commenter recommends that CMS specifically exempt IDTFs that have common ownership and common control from the definition of ''individual or organization,'' if CMS implements § 410.33(g)(15) as written.

Response: We disagree with the commenter's recommendation. While IDTFs may have common ownership, each practice location is enrolled separately.

Comment: One commenter offered support for our provision to prohibit fixed site IDTFs from sharing space, equipment, and staff or subleasing their operations to another individual or organization.

Response: We appreciate the commenters support on the proposed provisions.

Comment: One commenter suggested excluding radiologist and radiology groups from the definition of individual or organization in the regulatory language at § 410.33(g)(15) so that imaging IDTFs can share space, equipment, and staff with radiologists and radiology groups.

Response: We disagree with this recommendation because IDTFs enroll each practice location separately.

Comment: One commenter suggested that we clarify in the preamble that the prohibition does not preclude affiliated companies (which do not have any referring nonradiologist physicians as owners) that provide services integrally related to the operations of an imaging IDTF (such as interoperable information system, centralized credentialing, staff and billing) from sharing space, equipment and staff.

Response: We modified § 410.33(g)(15) to reflect concerns about the sharing of space and equipment. Since Medicare enrolls each IDTF at a separate location, we believe that it is not necessary to address how affiliated companies interact with an IDTF as long as each IDTF is in compliance with the provisions of this final rule with comment period.

Comment: One commenter suggested that CMS clarify that an ownership or investment interest held by radiologists and radiology groups in an imaging IDTF does not constitute sharing under § 410.33(g)(15).

Response: We agree that an ownership or investment interest held by radiologists and radiology groups in an imaging IDTF does not constitute sharing under § 410.33(g)(15).

Comment: One commenter suggested that we revise this provision to specify that an IDTF cannot share its space, equipment or staff with another individual or organization that has Medicare billing privileges, and that it is okay for another non-Medicare enrolled entity to use the IDTF's space, equipment, and staff.

Response: We agree with the commenter. The IDTF may not share clinical space or the diagnostic equipment involved in the original diagnostic test with a Medicare-enrolled provider or supplier.

Based on public comments, we have removed the sharing of staff aspect of this provision, and we are revising § 410.33(g)(15) to read, ''With the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not—

- Share a practice location with another Medicare-enrolled individual or organization;
- Lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization; or
- Share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.''

We believe that it is inappropriate for a fixed-base (physical site) IDTF to commingle its practice location or the equipment used in conducting the initial diagnostic test with another individual or organization enrolled in the Medicare program. By sharing space and/or equipment, Medicare contractors are not able to determine if an IDTF meets all of enrollment requirements at § 424.500 through § 424.555 or whether each IDTF meets and maintains all performance standards and other requirements under § 410.33 and other applicable requirements.

After examining public comments, we believe that it is appropriate to establish two exceptions to the prohibition associated with sharing space and clinical equipment. These exceptions apply to mobile IDTFs or IDTFs that are co-located within a hospital.

A mobile IDTF, by its very nature, may share space with other Medicare-enrolled entities. As such, we believe that it would be detrimental to the IDTF industry to apply this new performance standard to mobile IDTFs, because this may limit beneficiary access to necessary mobile IDTF services and increase the costs of providing necessary diagnostic care. In addition, we believe that hospital-based IDTFs are inherently located within a larger facility type and based on the need of the hospital, may appropriately share space or clinical equipment to gain operating efficiencies with little additional risk to the Medicare program or its beneficiaries.

Finally, while all IDTF provisions are effective on the implementation date of this final rule with comment period, we believe that additional time may be needed for some IDTFs to change their business model if they are sharing a

practice location with another Medicare-enrolled individual or organization. Accordingly, we are adopting a 1-year transition period for IDTFs that are currently enrolled and are sharing a practice location with another Medicare individual or organization. While this 1-year transition period applies to the provision found at § 410.33(g)(15)(i) related to the sharing of space, it does not apply to the provisions found at § 410.33(g)(15)(ii) or § 410.33(g)(15)(iii). Accordingly, IDTFs are prohibited from maintaining or establishing leasing or subleasing agreements or the sharing of diagnostic testing equipment used in taking the initial diagnostic test, after the effective date of this rule.

3. Additional Comments and Responses

Comment: One commenter recommended that our proposal to prohibit the sharing of space, equipment, and staff be applied consistently in all imaging centers, whether enrolled as an IDTF or as a physician-directed clinic.

Another commenter recommended that any policy initiative intended to eliminate certain suspect leasing or space sharing arrangements should be applied to all imaging providers, not just IDTF providers.

One commenter supported the proposed prohibition on shared equipment but urged us to apply this prohibition to all entities (including physician practices, mobile units, and hospitals) that provide imaging services.

Some commenters believe an exception should be made to include cardiologists that are certified for the interpretation of nuclear cardiology studies in an IDTF as well as allow interpretation of nuclear cardiology studies for an IDTF.

One commenter stated that since self-insurance is permitted, the requirement that the insurance be purchased from a ''non-relative owned company'' should be removed, or replaced with a provision that permits an alternate method of meeting the requirement by maintaining insurance through a relative-owned company that has been approved by a state department of insurance or comparable state agency or that can be validated by a placing broker.

Another commenter recommended that CMS should end payments to independent contractor physicians who are not board-certified in Sleep Disorders Medicine.

One commenter recommended that CMS require interpreting physicians to have board certification in Sleep Medicine in metropolitan areas.

One commenter recommended that we edit the location of service language at § 410.33(e)(2) to redefine the location from which a service is billed.

Another commenter recommended requiring a hospital licensed entity and actual radiology group to be the owners of entities that do not have to register as IDTFs and allow related entities of the hospital and radiology group to also own the imaging center.

Response: We appreciate these comments and we will consider these recommendations in a future rulemaking effort.

J. Expiration of MMA Section 413 Provisions for Physician Scarcity Area (PSA)

Section 413(a) of the MMA added a new section 1833(u) to the Act. That section provided 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. Specifically, section 1833(u) of the Act provided for payment of an additional 5 percent of the payment amount for services furnished by primary care physicians in a primary care scarcity area and by non-primary care physicians in a specialist care scarcity area.

Because the provisions of section 1833(u) of the Act do not apply to services furnished after December 31, 2007, in the CY 2008 PFS proposed rule, we provided notification that these 5 percent incentive payments will no longer be made for services furnished on or after January 1, 2008.

The list of zip codes for both primary care and specialty PSAs can be found on the CMS Web site at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp*.

Comment: We received comments expressing concern over the expiration of this provision. Commenters stated that the expiration of this provision may exacerbate the problems beneficiaries in rural areas experience in accessing medical services.

Response: We acknowledge the commenters' concerns regarding access to care, especially in rural areas. We provided notification of the pending expiration of this provision in the CY 2008 PFS proposed rule. We note that the Congress specifically established the PSA incentive program to apply only to claims for services furnished between January 1, 2005, and January 1, 2008. We do not have authority under the current statute to extend PSA bonus payments beyond this time frame.

K. Comprehensive Outpatient Rehabilitation Facility (CORF) Issues

In the CY 2008 PFS proposed rule (72 FR 38171), we discussed Medicare payment for comprehensive outpatient rehabilitation facility (CORF) services, including nursing services delivered within a CORF, which are defined by HCPCS code (G0128) for such services. We also explained that we use the payment amount established by an existing fee schedule other than the PFS when the PFS does not establish a payment amount for the CORF service. Specifically, we use the existing fee schedules for prosthetic and orthotic devices, DME and supplies, and drugs and biologicals for prosthetics and orthotics devices, durable medical equipment (DME) and supplies, and drugs and biologicals, respectively, provided by CORFs that are considered CORF services. Covered DME, orthotic and prosthetic devices, and supplies provided by a CORF are paid under the DMEPOS fee schedule.

Drugs and biologicals that are not considered to be self-administered are specified as CORF services at section 1861(cc)(1)(F) of the Act. However, as discussed in the proposed rule, we believe that drugs and biologicals provided to CORF patients are not appropriately provided as part of a rehabilitation plan of treatment and, as such, we proposed to remove drugs and biologicals from the scope of CORF services as defined at § 410.100. After reviewing comments, we have decided to retain within the definition of CORF services drugs and biologicals that are not self-administered, as discussed below in section II.K.7. However, as we are not aware of any non-self-administered drugs and biologicals that appropriately may be included as part of a rehabilitation plan of treatment, we intend to closely track the provision of drugs and biologicals in the CORF setting and do not expect CORFs to bill for such drugs and biologicals. In addition, because we believe it is appropriate for pneumococcal, influenza, and hepatitis B vaccines to be administered to CORF patients in the CORF setting, even though such vaccines fall outside the scope of CORF services, we also proposed to revise the conditions of participation at § 485.51(a) to permit CORFs to provide to their patients pneumococcal, influenza, and hepatitis B vaccines in addition to CORF services.

Because the regulations under 42 CFR parts 410 and 413 were never updated to reflect the change in CORF payment methodology from a ''reasonable cost'' basis to 80 percent of the lesser of a

payment amount under an existing fee schedule or the CORF's actual charge, we proposed to add a new subpart M to 42 CFR part 414 to reflect the change in CORF payment methodology.

In addition, we proposed revisions to the definitions of certain CORF services under § 410.100, in order to limit the scope of such services and items to those appropriately provided by qualified CORF personnel and related to the rehabilitation goals of the plan of treatment established under § 410.105(c). Specifically, we proposed to clarify the definition of physician services; respiratory therapy services; psychological and social services; nursing services; drugs and biologicals; supplies, appliances, and equipment; and the home environment evaluation. We also proposed to add clarifying language to § 410.105(b)(3) to make clear that physical therapy, occupational therapy, and speech-language pathology services can be provided offsite in the patient's home. In § 410.105(c), we proposed to clarify that CORF services, that are not skilled rehabilitation services, must directly relate to the physical therapy or other rehabilitation plan of treatment and its associated goals.

1. Requirements for Coverage of CORF Services Plan of Treatment (§ 410.105(c))

In accordance with section 1861(cc)(1) of the Act, requiring that CORF services be furnished ''under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician,'' § 410.105(c) provides that CORF services as defined under § 410.100 are covered only if furnished under a written plan of treatment. Specifically, the plan of treatment must: (1) Be established and signed by a physician prior to the commencement of treatment in the CORF setting; and (2) indicate the diagnosis and anticipated rehabilitation goals, and prescribe the type, amount, frequency, and duration of the services to be furnished. We interpret these provisions as requiring that the services furnished under the rehabilitation plan of treatment must relate directly to the rehabilitation of injured, disabled, or sick patients. Services provided in the CORF setting that do not relate directly to such rehabilitation goals and treatment plan are not covered as CORF services.

Therefore, we proposed to revise § 410.105(c) to clarify our policy that CORF services are covered only if they relate directly to the rehabilitation of injured, disabled, or sick patients. We believe our policy is consistent with the statutory requirements under section 1861(cc) of the Act. Section 1861(cc)(1) of the Act specifies that CORF services must be furnished under a plan of treatment. Section 1861(cc)(1)(H) of the Act further states that ''other items and services'' are considered CORF services only if ''medically necessary for the rehabilitation of the patient.'' We believe the implication of this limitation for ''other items of services'' is that all other CORF services (that is, those listed under sections 1861(cc)(1)(A) through (G) of the Act) also must be necessary for the rehabilitation of the patient. In addition, we noted that section 1861(cc)(2)(A) of the Act specifies that a CORF facility is a facility ''primarily engaged in providing * * * diagnostic, therapeutic, and restorative services to outpatients *for the rehabilitation of injured, disabled, or sick persons*'' (emphasis added). We believe this requirement further signals the Congress's intent that the services provided in a CORF setting be covered as CORF services only if such services relate directly to the rehabilitation of the patient.

Comment: One commenter supported the proposal to clarify that all services provided in a CORF must be directly related to the rehabilitation treatment plan. The commenter noted that this proposal is directly aligned with the goals and purpose of physical therapy.

Response: We appreciate the commenter's support of this clarification. Because the CORF is defined as a facility that is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured, disabled or sick persons, we believe the intent of the statute is that all services rendered in a CORF must relate to the patient's rehabilitation needs which are stated in the patient's plan of treatment established by the physician. Section 1861(cc)(1) of the Act and § 410.100 clarify that physician services, and services of other qualified professionals, can be provided in a CORF; but, a physician must first certify that the patient requires skilled rehabilitation services, including physical therapy, occupational therapy, speech-language pathology, and respiratory therapy, and then establish the CORF patient's rehabilitation plan of treatment.

Therefore, we are finalizing § 410.105(c) as proposed with the exception that we have added language to clarify our policy that the rehabilitation plan of treatment, along with its goals, is specific to the skilled rehabilitation services for physical therapy, occupational therapy, speech-language pathology, or respiratory therapy and that these services are distinct from all other CORF services which, when provided, must directly relate to the goals of the rehabilitation treatment plan.

2. Included Services (§ 410.100)

Section 410.100 establishes the services that are covered under the CORF services benefit, consistent with section 1861(cc)(1) of the Act. Because of the change in payment methodology from that based on cost to payment under the PFS and other existing fee schedules beginning in CY 1999, this section does not reflect our current payment policies. Therefore, we proposed to clarify our payment policy in the introductory paragraph of this section by including a cross reference to proposed § 414.1101, which sets forth the payment methodology for CORF services, including identifying the applicable fee schedule for each CORF service. In addition, we proposed to revise:

- The definition of physician services to reflect the change in payment methodology for CORF services;
- The definitions of physician services, respiratory therapy services, social and psychological services, and nursing services to ensure that these definitions include only those services appropriately provided by qualified nonphysician and physician personnel and related to the rehabilitation plan of treatment established under § 410.105(c); and
- The definition of supplies, equipment, and appliances to conform to the statutory provision at section 1861(cc)(1)(G) of the Act.

We also proposed to remove the provision for drugs and biologicals. Although vaccines are not included in the definition of CORF services at section 1861(cc)(1) and § 410.100, we proposed to make revisions to the CORF conditions of participation at § 485.51 to reflect current coverage and payment policy for vaccines provided in the CORF setting.

3. Physician Services (§ 410.100(a))

Section 410.100(a) defines the physician services included within the scope of CORF services. Specifically, those services of a CORF physician described as administrative in nature are considered CORF services, to the exclusion of diagnostic and therapeutic services, which are physician services under section 1861(q) of the Act and separately billable as physician services under 42 CFR part 414, subpart B. Section 1861(cc)(1) of the Act excludes from the definition of CORF services

any item or service that, if furnished to an inpatient of a hospital, would be excluded under section 1861(b) of the Act. Section 1861(b)(4) of the Act excludes from the definition of ''inpatient hospital services'' the ''medical or surgical services provided by a physician,'' which would include the diagnostic and therapeutic services of a physician. Consequently, diagnostic and therapeutic services provided in the CORF setting by a physician are not considered CORF services. In contrast, because those services of a CORF physician that are of an administrative nature are not ''medical'' services, such services are included in the definition of CORF services.

In accordance with section 1861(cc)(2)(B)(i) of the Act and § 485.70(a)(1), the CORF physician must be either a medical doctor (MD) or a Doctor of Osteopathy (DO). The conditions of participation at § 485.70(a)(2) and (3) further require that the physician have training or experience in the medical management of patients requiring rehabilitation services. The conditions of participation at § 485.58(a)(1)(i) also require the CORF facility physician to provide, in accordance with accepted principles of medical practice, medical direction, medical supervision, medical care services and consultation. In the CY 2008 PFS proposed rule, we proposed to revise § 410.100(a) to clarify that only those physician services required and provided by the CORF facility physician that are administrative in nature are considered CORF services, whereas diagnostic and therapeutic services provided by a physician to CORF patients are considered physician services under section 1861(q) of that Act. Specifically, we proposed to define CORF physician services as those services provided by a CORF facility physician that are administrative in nature, such as consultation with and medical supervision of nonphysician staff, patient case review conferences, utilization review, and the review of the therapy plan of treatment, as appropriate.

Services provided to a CORF patient by the CORF facility physician or other physician that are not administrative in nature but that are diagnostic or therapeutic services are considered physician services under section 1861(q) of the Act. Where these services are covered, they are separately payable to the physician as physician services under the PFS at the nonfacility payment amount.

In addition, § 410.100(a) currently provides that physician services included within the definition of CORF services are reimbursed on a reasonable cost basis under part 413, and that physician services to CORF patients not included within the definition of CORF services but billed as physician services are paid by the carrier on a reasonable charge basis subject to the provisions of subpart E of part 405 of this chapter. This description of the payment methodology for physician services provided in the CORF setting under § 410.100(a) is inconsistent with the payment methodology set forth under section 1834(k)(1) of the Act for CORF services and section 1848 of the Act for physician services, as well as the preamble discussion in the CY 1999 PFS final rule (63 FR 58860). In the CY 1999 PFS final rule, we stated that we would base payment for diagnostic and therapeutic physician services provided to individuals in the CORF setting on the PFS amount for the services. Therefore, we proposed to revise § 410.100(a) to remove the reference to reasonable cost based payments for CORF physician services and the reference to reasonable charge based payments for non CORF physician services. In place of these references, we proposed to revise § 410.100(a) to add a reference to 42 CFR part 414, subpart B, setting forth the payment methodology for non CORF physician services.

Comment: One commenter stated that the nonfacility fee schedule amounts for CORF services fail to fairly compensate the CORF for services provided by a CORF physician that are administrative in nature. The commenter stated that the PFS nonfacility amounts, containing higher PE RVUs (than those for the facility setting) for CORFs, are inappropriately low to cover these costs for the CORF setting. The commenter believes that the required level of physician activity in a CORF is greater than that in a physician office. Since there is no separate facility payment to the CORF, the commenter requests that we develop a new set of codes with associated fees to pay for the required CORF administrative physician services in a manner similar to that we employed to establish G0128 in the CY 1999 PFS final rule to pay for CORF nursing services.

Response: The 1997 BBA required CMS to establish prospectively determined payments for all outpatient physical therapy, occupational therapy and speech-language pathology services regardless of the site-of-service and additionally required that all other CORF services also be based on existing fee schedules. When we implemented these BBA requirements during the CY 1999 rulemaking process, we specifically addressed the issue of a site-of-service differential payment to institutional providers of outpatient therapy services, including CORFs. In the CY 1999 PFS final rule, we reasoned that a site-of-service differential payment to a facility provider would create payment incentives that favor one setting over another. In addition, we believe that the law intended the creation of a ''level playing field'' for these services and that we accomplished this with the selection of the PFS nonfacility rate to pay for all rehabilitation and CORF services. Therefore, we will continue to make payment at the PFS nonfacility rate for CORF services and will not change this policy to allow a separate site-of-service differential payment to the CORF. Accordingly, we are finalizing § 410.100(a) as proposed.

4. Clarifications of CORF Respiratory Therapy Services

Section 1861(cc)(1)(B) of the Act states that CORF services include respiratory therapy services along with physical therapy, occupational therapy, and speech-language pathology services. Because respiratory therapists (RTs) are not recognized as independent practitioners in the Act or regulations, and respiratory therapy services are not specifically identified in a statutory benefit category except as specified in the CORF services benefit at section 1861(cc)(1)(B) of the Act, separate payment, except that made to the CORF provider, is not made for services provided by RTs.

The description of CORF respiratory therapy services currently includes some services that we believe are more appropriately provided by a physician rather than a RT. As discussed above in section II.K.3., diagnostic and other medical services provided in the CORF setting by a physician are not considered CORF services, and therefore may not be included in a respiratory therapy plan of treatment. In addition, the description of respiratory therapy services under § 410.100(e) currently includes services that in accordance with § 410.105(c) must be performed by a physician, and not a RT. For example, only the physician may indicate the clinical diagnosis and rehabilitation goals, and prescribe the type, amount, frequency, and duration of the services to be furnished under the rehabilitation plan of treatment.

Therefore, we proposed to amend § 410.100(e) to revise the definition of respiratory therapy services to include only those services that can be appropriately provided to CORF patients by RTs under a physician-established respiratory therapy plan of

treatment in accordance with current medical and clinical standards and the requirements of § 410.105(c). Specifically, we proposed to remove from the definition of CORF respiratory therapy services at § 410.100(e)(1) the terms ''diagnostic evaluation'', ''management'', and ''assessment'' because these services are performed by the physician to establish the medical and therapy-related diagnosis and the respiratory therapy plan of treatment. These services, referred to in the proposed rule as ''evaluation and management (E/M)'' services, may be provided by either the CORF facility physician, as CORF physician services or as non-CORF physician services, or by the patient's referring physician, as appropriate. We also proposed to remove diagnostic tests and periodic assessment at § 410.100(e)(2)(v) and (vi), respectively, from the description of CORF respiratory therapy services. As discussed above, we believe that under current medical standards, diagnostic tests that are or become necessary for patients receiving rehabilitation services should be provided by physicians. In addition, we believe that under current medical standards, periodic assessment of chronically ill patients in order to determine their need for respiratory services should be within the purview of the physician. We note that these services are covered under the physician services benefit category at section 1861(s)(2)(C) of the Act when provided by the physician to a CORF patient, and therefore, may be separately billable by the physician under the PFS.

In addition to RTs, we noted that the conditions of participation also recognize respiratory therapy technicians as CORF personnel; however, during the CY 1999 PFS rulemaking to recognize the 1997 BBA payment requirements, we did not include services performed by respiratory therapy technicians because we believed that current medical standards for skilled respiratory therapy services provided to patients in the CORF setting required the educational requirements possessed by RTs. This determination to only recognize the services of RTs, and not those provided by respiratory therapy technicians in carrying out the therapy plan of treatment was further supported in the CY 2002 and CY 2003 rulemaking (66 FR 55311 and 67 FR 79999), when we developed and discussed G codes for certain CORF respiratory therapy services and specifically recognized the RT as the appropriate level of personnel to provide these CORF services. The three HCPCS codes G0237, G0238, and G0239 are specific to services provided under the respiratory therapy treatment plan and, as such, are not designated as subject to the therapy caps. Therefore, in the CY 2008 PFS proposed rule, we proposed to revise the description of respiratory therapy services to include only those services that are appropriately provided under a respiratory therapy treatment plan. In so doing, we sought to clarify those services that we believe the physician should provide, such as E/M services, diagnostic tests, and establishing the rehabilitation plan of treatment. In addition, we stated that a condition of coverage for the respiratory therapy service is that it be provided by an individual meeting the educational and training level of the RT, rather than the RT technician. For these reasons, we indicated we would accept comments on the service description at § 410.100(e), and the personnel qualifications at § 485.70(j) and (k) for a respiratory therapist and a respiratory therapy technician, respectively.

Comment: One commenter opposed the proposed revisions to the definition of CORF respiratory therapy services which removes diagnostic E/M services from the list of services at § 410.100(e)(1) and diagnostic tests from § 410.100(e)(2)(v). The commenter suggested that respiratory therapists, by virtue of their training and competency testing, can and do provide such services as part of their scope of work and asks us to add at § 410.100(e)(2) certain tests, specifically ''pulmonary function tests, spirometry and blood gas analyses'', as well as services for ''assessment, evaluation and monitoring of the patient's responses to the respiratory treatment plan.'' The commenter also requested that we reinsert the term ''assessment'' in the definition of respiratory therapy services at § 410.100(e)(1) in order to bring consistency to the definitions of all other CORF therapy services, such as physical therapy, occupational therapy, and speech-language pathology. Lastly, the commenter objected to the CORF requirement that the respiratory therapy treatment plan be entirely established by the physician.

Response: Section 1861(cc)(1) of the Act states that respiratory therapy can be provided in a CORF, by qualified professional personnel, only under a treatment plan established and reviewed by a physician. In order to determine the need for and to construct an appropriate CORF respiratory therapy plan of treatment, a physician provides E/M services and often uses diagnostic tests, such as pulmonary function and spirometry tests, in order to establish the patient's medical and therapy related diagnoses. These findings are then detailed in the patient's rehabilitation treatment plan which, in the CORF, the physician must wholly establish.

The plan of treatment is described at § 410.105(c) and must include services furnished under a written plan of treatment that: (1) Is established and signed by a physician before the treatment is begun; (2) prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals. The respiratory treatment plan must be reviewed at least every 60 days by the physician who must certify that the patient is making reasonable progress in attaining the treatment goals and that the treatment is having no harmful effects. Therefore, we believe that the E/M services and diagnostic services associated with establishing, periodically reviewing, and overseeing the respiratory therapy treatment plan are appropriately furnished by the physician. As discussed above, physician services, including E/M services and diagnostic services performed by the physician, are separate Medicare benefits, defined at sections 1861(q) and 1861(s)(3) of the Act, respectively. These therapeutic and diagnostic services are covered and separately paid to the physician, not the CORF, when they are furnished to a CORF patient in the CORF setting by the physician, as discussed previously in this section at II.K.3.

We agree with the commenter's request to reinsert the word ''assessment'' in the definition of respiratory therapy services at § 410.100(e)(1). Because assessments are conducted as an integral part of any service, we agree that revising the definition more accurately describes the services provided by RTs, as well as other qualified and recognized CORF personnel. As illustrated below, assessments can be made by the RT using the physiologic data gathered from the monitoring services that are inherent to CORF respiratory therapy services.

Also, we would like to clarify the term ''monitoring'' as used in § 410.100(e)(1) specifically as it relates to the provision of CORF respiratory therapy services. As we stated in the CY 2003 PFS final rule with comment period (when we created 3 G-codes—G0237, G0238, and G0239—to better describe CORF respiratory therapy activities), we incorporated the term ''monitoring'' in to each of the 3 G-code descriptors. We further described this ''monitoring'' to include physiologic or

other data about the patient during the period before, during, and after the activities. It can represent, for example, pulse oximetry readings, electrocardiography data, pulmonary testing measurements of strength or endurance performed to assess the status of the patient before, during and after the activities. In order to further illustrate and clarify our intention, we provided an example in which pursed lip breathing, used to create positive pressure in the upper respiratory tract and to improve respiratory muscle action and described as G0237, was identified as an included service in the patient's respiratory therapy treatment plan.

Before providing this service, the RT assesses the patient to determine the appropriateness of providing this pursed lip breathing activity and may check the patient's oxygen saturation level (via pulse oximetry). If appropriate, the RT then provides the initial training and necessary retraining in order to ensure that the patient can accurately perform this activity. After this session, the RT may again check the patient's oxygen saturation level, or perform peak respiratory flow, or other respiratory parameters. These services are considered ''monitoring'' and are bundled into the payment for G0237 (as well as HCPCS codes G0238 and G0239).

Another example of monitoring includes the provision of a 6-minute walk test that is typically conducted before the start of the patient's respiratory therapy activities. When this ''test'' is conducted, the RT uses this information to form an assessment of the patient's condition and uses it to guide and monitor the activities that are furnished as specified in the treatment plan. This assessment, determined by data from monitoring activities is included as part of the activities inherent to G0237. The time spent by the RT, face-to-face and one-on-one, with the patient to conduct these respiratory measures is counted as part of each of the respiratory therapy 15-minute G-codes. When provided as part of a CORF respiratory therapy treatment plan, payment for these monitoring activities is bundled into the payment for other services provided by the RT, including the three respiratory therapy specific G-codes. The bundling of these monitoring activities into each CORF respiratory therapy service is to acknowledge that these activities are inherent to the services we envisioned RTs would provide in the CORF setting. Similarly, assessment, including the use of monitoring data, is included as part of services provided by other rehabilitation therapists. The G-codes were specifically created to better describe the services provided as part of a respiratory therapy plan of care under the CORF benefit.

Comment: One commenter indicated that the personnel qualifications in the regulations for RTs and RT technicians are out of date and that for over a decade the term respiratory therapist has been used to describe both respiratory therapy care professional categories currently defined in the CORF regulations. Rather, the commenter states that the certified respiratory therapist (CRT) and the registered respiratory therapist (RRT) have replaced the older terms, RT techs and RTs, respectively. The commenter explained that the CRT designation is awarded after successfully passing the entry-level examination, while qualifications to sit for the RRT examination include graduation from advanced levels of respiratory therapy educational programs and obtaining the CRT credential. Based on the newer terminology for respiratory therapists, along with information provided regarding the CRT and RRT credentialing processes, the commenter requested that we change the CORF conditions of participation to reflect the newer qualifications. In addition, the commenter requested that we change the coverage provisions to recognize both the CRT and RRT as qualified personnel to provide CORF respiratory therapy services.

Response: Based on the information provided by the commenter, we will work within CMS to develop and update the personnel qualifications for RTs and RT technicians at § 485.70(j) and (k), respectively. This request involves changes to longstanding provisions for CORF personnel qualifications, and we believe that other organizations, individuals, and medical specialties should have the opportunity to comment on such changes. We will propose updated qualifications for the CRT and RRT in future rulemaking to seek and review comments from other interested parties, before finalizing any changes to these personnel qualifications. In that rulemaking, we will revisit the issue of the respiratory therapy professional(s) best qualified to provide services under the CORF respiratory therapy plan of treatment. Until such time, we expect that the RT, and not the RT technician, will provide the services of the respiratory therapy treatment plan as previously discussed in CY 2002 and CY 2003 rulemaking and, again, reinforced in this final rule.

We are finalizing our proposal to revise § 410.100(e)(1), with the exception that we will not remove the term ''assessment'' for the reasons discussed above. We will also adopt the revisions to § 410.100(e)(2), as proposed.

5. Social and Psychological Services

In accordance with section 1861(cc)(1)(D) of the Act, social and psychological services are included within the definition of CORF services under § 410.100(h) and (i), respectively. In addition, § 485.58 specifies that the CORF must provide a coordinated rehabilitation program that includes, at a minimum, social or psychological services, along with physical therapy services and physician services, and that these services must be consistent with the therapy plan of treatment.

As discussed in the CY 2008 PFS proposed rule, the current description of social work services considered CORF services under § 410.100(h) includes: (1) Assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social and emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care. The current description of CORF psychological services under § 410.100(h) includes:

(1) Assessment diagnosis and treatment of an individual's mental and emotional functioning as it relates to the individual's rehabilitation; (2) psychological evaluations of the individual's response to and rate of progression under the treatment plan; and (3) assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment. We believe these current definitions of CORF social and psychological services are too broad. As discussed above in this section, we proposed to revise § 410.105 to clarify our policy that CORF services are covered only if they are provided under the rehabilitation plan of treatment and relate directly to the rehabilitation of the patient. As such, we are concerned that the current descriptions of CORF social and psychological services may be misconstrued to include social and psychological services for the treatment of mental illness, which we believe is outside the scope of coverage for CORF social and psychological services because these services do not relate directly to a rehabilitation plan of

treatment and the associated rehabilitation goals.

In addition, we believe it unnecessary to distinguish between CORF social services and CORF psychological services given their similarities, and therefore, we proposed to merge the two definitions into a single definition of CORF social and psychological services. As noted at section 1861(cc)(2)(B) of the Act, we believe that CORFs are required to provide either social services or psychological services, and not both types of services. We believe that merging the § 410.100(h) and (i) into a single definition of CORF social and psychological services is warranted to clarify the similarities between them.

Therefore, we proposed to clarify the description of social and psychological services at § 410.100(h) to include only those services that address the patient's response and adjustment to the treatment plan; rate of improvement and progress towards the rehabilitation goals, or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment. In addition, we proposed to change the heading at § 410.100(h) from ''social services'' to ''social and psychological services,'' and to eliminate the separate definition for psychological services under § 410.100(i).

Because we proposed to revise the description of social and psychological services in § 410.100(h), we also solicited comments concerning the CORF personnel qualifications in the conditions of participation at § 485.70(g) and (l) for psychologists and social workers, respectively, and comments relating to the appropriate CPT codes to represent these CORF services.

Due to the specificity of the purpose of CORF social and psychological services requiring that these covered services directly relate to the patient's rehabilitation treatment plan, we also invited comments on which CPT codes would be appropriate for CORF social and psychological services. We believe that the procedure codes for health and behavior assessment and treatment, represented by CPT codes 96150 through 96154, specific to the patient's physical health problems, best describe the social and psychological services required in the CORF setting.

Comment: A commenter suggested that the proposed definition of social and psychological services is too restrictive. The commenter recommends including social work, biopsychosocial functioning, and discharge plans in the new proposed definition of social and psychological services.

One commenter is concerned that clarifying that CORFs are not intended to be used to treat mental illness may result in denial of the CORF benefit to persons who need CORF services, but who also suffer from a mental illness (for example, patient with schizophrenia suffers a stroke). A CORF patient's mental illness may need to be accounted for in developing a rehabilitation plan of treatment. The commenter urges us to avoid causing a ''chilling effect'' on those individuals providing social and psychological services in CORFs at the expense of allowing a patient to recover as fully as possible.

A CORF provider cautioned that by not treating social and psychological services as a stand-alone CORF service (like physical therapy or occupational therapy) may have an adverse effect on the patient's ability to make progress toward rehabilitation goals. They also state that social and psychological services may be needed even beyond the conclusion of other CORF services.

Response: We believe that our proposal to combine the descriptions of social services and psychological services into one definition best describes the services that CORFs are required to provide to their patients, as an adjunct to the rehabilitation plan of treatment. A broader definition of these services could be interpreted to include treatment of mental illness which the CORF statute and regulations do not permit, thereby causing Medicare to pay for services that fall outside the clearly defined scope of the CORF benefit.

We proposed to combine the definitions of social services and psychological services to clarify and simplify the associated regulatory provisions. We believe that our proposal does not result in any actual change to either the social or psychological services, or the rehabilitation services, provided to CORF patients that relate directly to their rehabilitation plan of treatment and the associated rehabilitation goals.

Therefore, we will finalize our proposal to combine the descriptions of social services at § 410.100(h) and psychological services at § 410.100(i) into one definition for social and psychological services at new § 410.100(h) to make clear that these CORF services are the same, regardless of whether provided by a qualified social worker or a psychologist.

Comment: One commenter stated that because there are several levels of social work education and licensure for social workers, a recommendation as to the qualifications for CORF social workers depends on whether we change our proposal to include the treatment of mental illness. As proposed, the commenter supports the Bachelor of Social Work (BSW) as the appropriate qualification educational level. However, if the scope of services is expanded to include the treatment of mental illnesses, then the commenter believes that the educational level of the Masters of Social Work (MSW) would be the appropriate qualification.

A CORF provider stated that the personnel qualifications to perform CORF social and psychological services should be either a licensed psychologist at a Masters or PhD level, or a licensed social worker.

A medical society representing psychiatrists suggested we use an existing set of qualifications for CORF psychologists and social workers, such as those established by the Office of Personnel Management.

Response: We believe that the appropriate qualification for individuals providing social and psychological services in the CORF setting is a BSW for social workers and a Masters-level degree for psychologists. In response to the comment, the combination of social and psychological services into one definition was made for clarification and simplification, and does not result in any change to the scope of social and psychological services provided to CORF patients. Therefore, we believe it is appropriate to maintain the existing personnel qualifications for individuals providing these unique services in the CORF setting.

Comment: In terms of what CPT codes might best describe the proposed CORF social and psychological services, one commenter suggested that CPT code 96155 should be added to the suggested list of CPT codes 96150 through 96154 in order to allow CORFs to bill for social and psychological services provided to a patient's family without the patient presence.

Another commenter suggested that limiting the services to those described by CPT codes 96150 through 96154 is potentially too restrictive because it may not describe all of the services provided by CORFs. The commenter believes that this restriction would not permit CORFs to code the social or psychological services provided to the highest specificity, although no specific CPT codes were offered for consideration.

In addition, one commenter believes that using a full range of CPT codes to describe CORF social and psychological services is inappropriate because these codes were not intended to be used for providing non-clinical CORF services. This commenter specifically objects to the use of CPT codes 96150 through

96154 because these services are specifically used by PhD level psychologists to provide clinical services. The commenter notes that other CPT codes are inappropriate to CORF use, including the CPT code range 90801 through 90899 that is used to treat mental illnesses, and the E/M CPT code series (CPT codes 99XXX), because all of these CPT codes represent clinical services. Rather, they believe that the social and psychological services provided in CORFs have ''strong case management and patient assessment components'' as they relate to the rehabilitation treatment plan. Instead of using existing CPT code(s), the commenter suggested we develop HCPCS code(s) specifically for CORF social and psychological services in order to keep case management services clearly distinguished from patient treatment.

Response: In an effort to address the coding issues, at this time we believe that only CPT code 96152, *Health and behavior intervention, each 15 minutes, face to-face; individual,* best describes these unique CORF social and psychological services and should be used to bill for all social and psychological services provided in CORFs.

We are sensitive to the concerns expressed by the commenter that CPT codes 96150 through 96154 do not accurately represent the descriptions of CORF social and psychological services, and that there may be a need to develop a HCPCS code designed specifically for use in the CORF setting. However, in this final rule, we do not believe it is appropriate to create a HCPCS code to reflect the nonclinical nature of the CORF social and psychological services when we did not propose doing so in the proposed rule. However, we will consider the commenter's views in making the determination regarding the necessity to create a new HCPCS code to describe CORF social and psychological services in the future.

6. Nursing Care Services

Because the PFS does not contain a CPT code for nursing services, we established in the CY 1999 PFS final rule a new HCPCS code (G0128) for direct face to face skilled nursing services delivered to a CORF patient by an RN as part of a rehabilitation therapy plan of treatment. In the CORF conditions of participation at § 485.70(b) and (h), qualified personnel for nursing services include an LPN or vocational nurse and an RN, respectively. However, when the HCPCS code G0128 was created for CORF nursing services we determined that a condition for coverage is that the nursing service be provided by an individual meeting the qualifications of an RN, rather than the LPN, for CORF clinical nursing services as they relate, or are part of, the therapy plan of treatment. Because we established coverage for CORF nursing services only when provided by an RN, in the CY 2008 PFS proposed rule, we proposed to revise new § 410.100(i) (that is, the current § 410.100(j) is redesignated as § 410.100(i)) to specifically reflect this coverage decision. We also requested comments on the appropriateness of the personnel qualification standards at § 485.79(b) and (h) for the LPN and for the RN, respectively.

Comment: We received a comment that opposed the proposed revisions that would allow skilled nursing services to be performed only by registered nurses. The commenter suggested that the CORF nursing services provided by either a registered nurse or the licensed practice nurse should be determined by the legal scope of practice as outlined in State law by a State board of nursing.

Response: During the CY 1999 final rule, we defined HCPCS code G0128 as a face-to-face nursing service delivered to a CORF patient that is directly related to a rehabilitation plan of treatment. We believe that the level of skill needed to render clinical nursing services as they relate to, or are supportive of the rehabilitation plan of treatment is more appropriately performed by registered nurses.

Comment: One commenter asked us to provide an example of nursing services that would be appropriately furnished and separately payable as such in a CORF that also meets the criteria of directly relating to the rehabilitation treatment plan. This commenter also requests clarification as to whether an RN can provide services as part of the respiratory therapy treatment plan and if one of the HCPCS G-codes for respiratory therapy services, G0237, G0238, and G0239 can be used to bill for these services.

Response: In the CY 1999 PFS final rule, we established coverage for CORF nursing services only when provided by an RN. HCPCS code G0128 is used to bill for services that are not included in the work or PEs of other therapy or physician services. Because of the advances in medical science since the inception of the CORF benefit in 1982, the need for nursing services necessary to be provided as an adjunct to the rehabilitation treatment plan has decreased significantly. In the CY 1999 PFS final rule, we used the example of a RN who instructs a patient in the proper procedure of ''in and out'' urethral catheterization to illustrate one such nursing service directly related to the rehabilitation treatment plan. At that time, nursing services might have been provided to patients receiving respiratory therapy services relating to tracheostomy tube suctioning. Another nursing service might be related to the cleaning instructions for ileostomy or colostomy bags for a patient receiving physical therapy services where the care is imminent to the start or completion of a therapy session.

Comment: Another commenter noted that CORFs are required to provide the 3 core services, including physician services, physical therapy services, and social or psychological services, and asked that we clarify the amount that these other non-core services—specifically nursing services and respiratory therapy services—can comprise of the total CORF services. The commenter cites examples of CORFs where non-core services comprise the majority of services, sometimes as much as 90 percent or more, including wound care services where RNs are used to provide the majority of these services and other CORFs specializing predominantly in respiratory therapy services. Specifically, the commenter requested that we unambiguously address our intent as it relates to the provision of non-core services.

Response: The CORF statutory provision at section 1861(cc)(2)(B) of the Act and § 485.58 require that the CORF, as a minimum condition of participation, provide three core services— physician services, physical therapy services, and social or psychological services. When a CORF provides only the three required core services, we expect that physical therapy services would comprise a clear majority of the total CORF services, since social and psychological services are provided only as an adjunct to the rehabilitation services and CORF physician services are administrative in nature and not easily identified. However, when a CORF provides physical therapy services and other skilled rehabilitation services, we expect that physical therapy services will be the predominant rehabilitation service provided. The case noted by the commenter where CORFs specialize in providing a preponderance of respiratory therapy services is counter to our expectations.

The example cited by the commenter where the CORF is using RNs to provide wound care services, which together with other non-core services constitute the majority of services provided to a

patient, exemplifies a situation in which the CORF is providing nursing services that are not in support of a rehabilitation plan of treatment. In this situation, the services provided by the RNs do not conform to the requirement that nursing services must directly relate to or further a rehabilitation treatment plan and its goals, and therefore, are noncovered. As we discussed previously in section II.K.6 of this final rule with comment period, we specifically define and require CORF nursing services to relate to the rehabilitation plan of treatment, with such nursing services necessary for the attainment of the rehabilitation goals of the physical therapy, occupational therapy, speech language pathology, or respiratory therapy plan of treatment. We believe only professional therapists/pathologists, such as PTs, OTs, SLPs, and RTs, may appropriately provide these rehabilitation services and that it is inappropriate for an RN to provide these services. Nursing services may not substitute for or supplant the services of these therapists/pathologists, but instead should lend support to or further the services provided by professional therapists/pathologists under the rehabilitation plan of treatment. Therefore, CORF nursing services are covered as CORF services only when provided by a RN and only to the extent that they support or are an adjunct to the rehabilitation services provided by professional therapists/pathologists under the rehabilitation plan of treatment.

In addition to above clarification regarding the coverage and provision of the listed CORF services, we would also like to clarify that CORFs cannot provide services that are not included in the definition of CORF services at § 410.100 (other than vaccines) and that those services included in the definition of CORF services are covered only to the extent that they support or further the rehabilitation plan of treatment. For example, we believe that CORF services do not include the provision of hyperbaric oxygen services, infusion therapy services, or diagnostic sleep studies because they do not meet the definition of CORF services at § 410.100 or they do not relate to the rehabilitation plan of treatment. We believe that these services and other services not specifically listed as CORF services may be covered under other categories of Medicare benefits, such as physician services and diagnostic services.

Comment: One commenter asked us to clarify if a RN could perform respiratory therapy services in a CORF.

Response: As we have discussed, we believe only professional therapists/pathologists, such as PTs, OTs, SLPs, and RTs, may appropriately provide rehabilitation services, such as respiratory therapy services, and that it is inappropriate for an RN to provide these services. Therefore, respiratory therapy services provided by an RN are not considered CORF services under § 410.100. Services performed by an RN may not substitute for or supplant the services of these therapists, but instead are covered as CORF services only to the extent that they support or are an adjunct to the rehabilitation services provided by professional therapists/pathologists under the rehabilitation plan of treatment.

We would like to clarify that any CORF nursing service must be provided by a RN and coded as G0128 indicating that CORF ''nursing services'' were provided. Services provided by an RN may only be billed as CORF nursing services, provided they meet the definition of CORF nursing services at § 410.100(i). We are aware that some CORFs have billed RN services inappropriately as E/M services, such as CPT code 99211. In addition, we believe some physicians have inappropriately billed the services of CORF RNs as incident to physician services. Because CORF services are a distinct benefit category, and because any therapeutic and diagnostic services (as opposed to administrative and supervisory services) furnished by physicians are not CORF services, any service furnished by CORF personnel, including RNs, PTs, OTs, SLPs, and RTs, are not considered to be furnished incident to physicians'' services, and thus cannot be billed as services incident to physician services. Therefore, the CORF nursing services of RNs may only be billed using G0128, provided that such services meet the definition of CORF nursing services at § 410.100(i).

Therefore, we are finalizing § 410.100(i) as proposed.

7. Drugs and Biologicals

Section 410.100(k) currently provides that drugs and biologicals included within the definition of CORF services includes drugs and biologicals that are prescribed by a physician and administered by a physician or a CORF RN and not otherwise excluded from Medicare Part B payment under § 410.29 (relating to self-administered drugs). In addition, in accordance with § 410.105(c), drugs and biologicals administered to a CORF patient will be covered as CORF services only if included as part of the rehabilitation plan of treatment. However, we are unable to identify any physician prescribed drugs or biologicals that are not self administered that would be appropriately provided under a patient's rehabilitation plan of treatment. We also expressed our concerns about the potential for duplicative billing for drugs and biologicals provided in the CORF setting because they could be billed by the CORF or the physician furnishing such drugs and biologicals.

Therefore, we proposed to remove § 410.100(k) and invited comments on this proposed revision, particularly on the appropriateness of including drugs and biologicals under a CORF patient's rehabilitation plan of treatment.

Comment: One commenter objected to the proposed removal of the provision for drugs and biologicals from the CORF benefit and believes there is an inherent risk that neither the CORF nor the physician would be paid for drugs and biologicals provided to CORF patients when they are purchased by the CORF. The commenter explained that, under our proposal, the CORF would no longer be permitted to submit claims for the drugs and biologicals they purchase, and further stated that, under this scenario, the physician also could not be compensated because the drug or biological provided in this manner would not satisfy the CMS incident to rules. The commenter questioned our concerns about the possibility of duplicative billing permitted under the current payment methodologies although they believe that we might be justified in our proposal should we have proof that both the CORF and physician are being paid for the same drug and biological. Until such time, the commenter requested we continue to permit both the CORF and the physician to submit claims for the drugs and biologicals provided to CORF patients.

Another commenter also disagreed with our proposal to remove drugs and biologicals as a CORF service claiming that when the Congress created the CORF benefit, it ''intended to create a new type of facility that could provide all of the services required by a patient in a coordinated fashion.'' They also challenged our authority to remove this provision and believe that duplicative billing possibilities by the CORF and the physician administering the drug or biological is not cause for us to rewrite the statute.

Response: The purpose of our proposal was not intended to deny patients access to or to avoid making payment for medically necessary drugs and biologicals. Because we proposed to make payment directly to physicians for the drugs and biologicals provided in the CORF setting, CORFs opting to continue purchasing these drugs and biologicals would not also be paid.

Nevertheless, we are persuaded by the commenter challenging our legal authority to remove drugs and biologicals from our regulatory definition of CORF services § 410.100 in light of their inclusion in the statutory definition of CORF services under section 1861(cc)(1) of the Act. As explained in the legislative history of the CORF statute, the intent of this benefit was to simplify coordination of, and access to, ''a broad array of rehabilitation services'' (H.R. Rep. No. 96–1167, 96th Cong., 2nd Sess., at 375 (1980). Although as discussed in the proposed rule, we have been unable to identify among currently available drugs or biologicals that are not self-administered any such drugs or biologicals that appropriately may be included in as part of a rehabilitation plan of treatment, we cannot rule out the possibility that others will alert us to such drugs or biologicals or that future non self-administered drugs or biologicals appropriately may be included under a rehabilitation plan of treatment. Therefore, in order to ensure that, should we learn of any non self-administered drugs or biologicals that appropriately may be included in a rehabilitation plan of treatment, we may give effect to Congressional intent that CORFs be able to provide any such drugs or biologicals in coordination with other CORF rehabilitation services, we will not remove the reference to drugs and biologicals from the definition of CORF services under § 410.100 as proposed.

Instead, we will retain the existing definition of CORF-covered drugs and biologicals provided at new § 410.100(j) (that is, the current § 410.100(k) is redesignated as § 410.100(j)) with the exception of adding the word ''by'' to the new § 410.100(j)(1) to clarify our policy that, in accordance with existing professional standards, the administration of the drug can by provided by a RN but not by others under the supervision of an RN. As we are not aware of any non-self-administered drugs and biologicals that appropriately may be included in a rehabilitation plan of treatment, we intend to closely track the provision of drugs in the CORF setting. If in the future we learn that the administration of drugs or biologicals in the CORF setting is an appropriate service to include in the rehabilitation treatment plan, the regulatory framework will allow for coverage of such drugs or biologicals. In the mean time, we do not expect to see CORFs submitting claims for drugs and biologicals for the reasons noted above.

8. Supplies and DME

Payment for supplies and DME as part of CORF services is specified at § 410.100(l) as ''[s]upplies, appliances and equipment'' and includes nonreusable supplies, medical equipment and appliances, and DME as defined in § 410.38 (except for renal dialysis systems). These are CORF covered services when provided for the patient's use outside the CORF whether purchased or rented, and is paid under the DMEPOS fee schedule. We believe that the provision at § 410.100(l) is too broad, out of date, and inconsistent with current terminology used for covered services or items. The CORF provision at section 1861(cc)(1)(G) of the Act applies only to supplies and DME, yet the regulatory provision also encompasses medical equipment and appliances. Because we believe the requirements of § 410.100(l) are inconsistent with those of section 1861(cc)(1)(G) of the Act, we proposed to revise both the title and description at new § 410.100(k) (that is, the current § 410.100(l) is redesignated as § 410.100(k)) by deleting reference to medical equipment and appliances to reflect the CORF statutory provision by including only the items specified under section 1861(cc)(1)(G) of the Act. [**Note:** The preamble discussion incorrectly noted this new section as § 410.100(k) instead of § 410.100(j). Section 410.100(k) is correct in this final rule with comment period.] We also noted that DME, as well as prosthetics, orthotics, and supplies, provided in the CORF setting requires the CORF's participation in the competitive bidding process, where applicable, in accordance with 42 CFR part 414 subpart F. In this final rule with comment period, we have added language at § 414.1105(c)(2) to clarify that payment for DME, prosthetics, orthotics, and supplies determined under the DMEPOS competitive bidding program is a single payment amount, rather than an amount determined under a fee schedule. While a payment amount determined under a competitive bidding program is not generally thought of as a ''fee schedule'' for purposes of section 1834(k)(3) of the Act we believe the term refers to a single payment amount determined through an existing prospective payment system. The Congress amended the Act to replace reasonable cost-based payment for CORF services with prospective payments. Therefore, we believe the reference to ''fee schedule'' at section 1834(k)(3) of the Act is meant to broadly refer to existing prospective payment systems for the CORF-covered services or items, including amounts determined prospectively under a competitive bidding program, and should not be referring only to ''fee schedules'' in the narrow sense. We did not receive comments, in support of or in opposition to, our proposal to specify the new § 410.100(k) to include only supplies and durable medical equipment as specified at section 1861(cc)(G) of the Act in the CORF benefit provision.

Therefore, we are finalizing § 410.100(k) as proposed with the exception that we will add the revision, discussed above, regarding the single payment amount determined under the DMEPOS competitive bidding program.

9. Clarifications and Payment Updates for Other CORF Services

Section 4078 in the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) (OBRA) amended section 1861(cc)(1) of the Act to provide that there is no requirement that any item or service furnished by a CORF in connection with physical therapy, occupational therapy, and speech pathology services under the plan of treatment be furnished at a single fixed location; however, such items and services are covered as CORF services only if payment is not otherwise made under Medicare. In the CY 2008 PFS proposed rule, we noted that such items and services may be covered under the Medicare home health benefit established under sections 1861(g), (m), and (p) of the Act. Accordingly, physical therapy, occupational therapy, and speech-language pathology services provided in the home are not covered as CORF services if such services and related items are covered under the Medicare home health benefit. Because the CORF regulations were not revised to reflect these changes in coverage and payment methodology, we proposed to clarify the regulations at new § 410.100(l) (that is, the current § 410.100(m) which is redesignated as § 410.100(l)) and § 410.105(b)(3) to reflect these requirements.

In § 410.105(b)(3), we proposed to clarify that physical therapy, occupational therapy, and speech-language pathology services can be furnished in the patient's home when payment for these therapy services is not otherwise made under the Medicare home health benefit.

In addition, we proposed to revise § 410.100(l) to clarify that the patient must be present during the home environment evaluation that is performed by the PT, OT or SLP, as appropriate, because we believe that the patient's presence is necessary to fully

evaluate the potential impact of the home situation on the patient's rehabilitation goals.

Comment: Some commenters supported our proposal to clarify the CORF therapy services that can be provided in the home and who can provide these services. One of these commenters expressed concern about the requirement that the patient be present for the home environment evaluation and requested that we further clarify this proposal.

Response: Section 1861(cc)(1)(H) of the Act states that there is no requirement for physical therapy, occupational therapy, or speech-language pathology services to be provided at a fixed location such as at the CORF's physical location. This provision was further clarified in section 4078 of OBRA 1987 to clearly permit that, so long as the physical therapy, occupational therapy, or speech language pathology services are not otherwise covered under the Medicare home health benefit, these therapy services can be provided in the patient's home. Section 410.105(b)(3) also provides that only physical therapy, occupational therapy, or speech-language pathology services can be provided offsite, in the patient's home, and that all other CORF services must be provided in the CORF facility. We also proposed to clarify the provision at the new § 410.100(l) (that is, the current § 410.100(m) is redesignated as § 410.100(l)) regarding the provision of a single home environment evaluation, to include the presence of the patient, which can be performed by a PT, OT, or SLP, as appropriate. [**Note:** The preamble discussion incorrectly noted this new section as § 410.100(l) instead of section § 410.100(k). Section 410.100(l) is correct in this final rule with comment period.]

Therefore, we are finalizing the new § 410.100(l) (that is, the current § 410.100(m) is redesignated as § 410.100(l)), as proposed.

10. Cost Based Payment (§ 413.1)

Section 413.1(a)(2)(iv) currently provides for cost-based payment for CORF services, which reflects the payment methodology provided for under section 1833(a) of the Act, requiring payment on the basis of the lesser of the provider's reasonable costs or customary charges. As discussed above, this payment methodology is inconsistent with section 1834(k) of the Act, requiring that the payment basis for outpatient physical therapy services (including outpatient speech-language pathology services), outpatient occupational therapy services, and all other CORF services provided on or after January 1, 1999 be 80 percent of the lesser of: (1) The actual charge for the services; or (2) the applicable fee schedule amount. Therefore, we proposed to remove § 413.1(a)(2)(iv) to clarify that cost based payment is not applicable to CORF services. We also proposed to remove § 413.1(a)(2)(vi) for OPTs or rehabilitation agencies as referenced at section 1861(p) of the Act, because these providers were also affected by the same payment changes required by the 1997 BBA for physical therapy, occupational therapy, and speech-language pathology services effective for CY 1999.

We did not receive comments to these technical corrections regarding the change in payment methodology for CORFs and OPTs that was effective CY 1999. Therefore, we are finalizing the technical corrections to remove references to cost-based payment for CORFs and OPTs at § 413.1(a)(2)(iv) and (vi).

11. Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) Services

In the CY 2008 PFS proposed rule, we proposed to establish a new regulatory subpart M at 42 CFR part 414 to specify the payment methodology for comprehensive outpatient rehabilitation services covered under Part B of Title XVIII of the Act that are described at section 1861(cc)(1) of the Act. Specifically, this proposed subpart would identify and describe how payment is determined for services included as CORF services under § 410.100.

Proposed § 414.1100 sets forth the basis and scope for payment for CORF services. Proposed § 414.1105 sets forth the payment methodology for CORF services, including identifying the applicable fee schedule for each type of CORF service identified in § 410.100.

Section 1834(k)(1)(B) of the Act provides that the payment basis for CORF services is 80 percent of the lesser of: (1) the actual charge for the services; or (2) the applicable fee schedule amount. The term ''applicable fee schedule amount'' is defined under section 1834(k)(3) of the Act to mean, for services furnished in a year, the payment amount determined under the PFS established under section 1848 of the Act for such services for the year ''or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.'' Accordingly, we proposed at new § 414.1105(a) to base payment for a CORF service on 80 percent of the lesser of the actual charge or the PFS amount for the service when the PFS establishes a payment amount for such service. Payment for CORF services under the PFS is made for physical therapy, occupational therapy, speech-language pathology, and respiratory therapy services, as well as the related nursing and social and psychological services. In the CY 1999 PFS final rule (63 FR 58860), we explained that we interpret section 1834(k)(3) of the Act, defining the term ''applicable fee schedule amount,'' as requiring us to use the payment amount established by an existing fee schedule other than the PFS when the PFS does not establish a payment amount for the CORF service. Therefore, in the CY 2008 PFS proposed rule we proposed at new § 414.1105(c) that payment for covered DME, orthotic and prosthetic devices and supplies provided by a CORF be based on the lesser of 80 percent of actual charges or the payment amount established under the DMEPOS fee schedule under sections 1834 and 1847 of the Act and in 42 CFR part 414, subparts D and F. Finally, we proposed at new § 414.1105(d) that if there is no fee schedule amount established for a CORF service, payment shall be based on the lesser of 80 percent of actual charges or the amount determined under the fee schedule established for a comparable service, as specified by the Secretary.

As discussed in section II.K.3., physician services included within the definition of CORF services under § 410.100(a) are limited to those services of a CORF physician described as administrative in nature, to the exclusion of diagnostic and therapeutic services which are considered separately billable physician services. Medicare generally does not permit providers to separately bill for their administrative costs; rather, such costs typically are subsumed in the payment amounts for covered medical services and items furnished to Medicare beneficiaries. Under the PFS these costs are included in the payment amount as part of the indirect PEs that are reflected in the PE RVUs for each service and also captured as part of the post-visit work RVU component. Similarly, we believe payment to CORFs for the administrative duties of a CORF physician, required as a condition of participation at § 485.58(a), such as participating in patient case review conferences is subsumed within PFS payments to CORFs for physical therapy, occupational therapy, speech-language pathology, and respiratory

therapy services, and the related nursing, and social and psychological services. Generally, administrative costs associated with the provision of such services is incorporated into payment amounts established under the PFS through the PE RVUs representing the resources necessary to perform each service in the physician office or nonfacility setting. Therefore, we believe it unnecessary to separately compensate CORFs for CORF physician services given that such services are administrative in nature, and proposed at § 414.1105(b) not to separately pay CORFs for CORF physician services.

To ensure that CORFs are not paid twice for CORF services, we proposed at new § 414.1105 to base payment for a CORF service on the applicable fee schedule amount only to the extent that payment for such service is not included in the payment amount for other CORF services. Accordingly, under proposed § 414.1105(c) a CORF could not bill separately for supplies included in the PE RVU component of the payment amount established for a service under the PFS. However, we noted that CORFs could bill separately for certain splint and cast supplies for the application of casts and strapping because these supplies have been removed from the payment amounts established under the PFS. We also noted that Medicare makes separate payment for surgical dressings, which are also referenced at section 1861(s)(5) of the Act, only when used by the beneficiary in his or her home. No separate payment is made when these surgical dressings are used in the CORF setting; rather the dressings' costs are bundled into the payment amount established under the PFS for the provided services.

For CORF services based on the payment amount determined under the PFS, we proposed at new § 414.1105(a)(2) to use the PFS amount applicable to services furnished in a nonfacility setting, with no separate payment made for facility costs. We proposed to use the PFS nonfacility amount for CORF services in order to offset any costs of providing such services in the CORF setting. [**Note**: in the proposed rule we incorrectly referenced the codification of the regulation text under proposed subpart M as § 414.1001 or § 414.1101 rather than § 414.1105. However, the proposed regulation text was presented accurately as § 414.1105 in the ''List of Subjects'' under the proposed subpart.]

Other than the objection discussed above in section II.K.7 regarding the proposed removal of the CORF provision for drugs and biologicals, we did not receive other comments about our proposal to create a regulatory provision to specify the payment methodologies for the CORF services identified at section 1861(cc)(1) of the Act. Therefore, we are finalizing our proposal to add a new regulatory provision defining the payment methodologies used to pay for CORF services except that we also include a section for payment of drugs and biologicals included within the definition of CORF services under the new § 410.100(j), as explained in section II.K.7. We will implement this proposal, including the addition of the payment provision for drugs and biologicals included within the definition of CORF services under the new § 410.100(j), and revise, by adding a new subpart M to part 414. The basis and scope for payment for CORF services is set forth at § 414.1100 and § 414.1105 sets forth the payment methodology for CORF services, including identifying the applicable fee schedule for each type of CORF service identified in § 410.100.

12. Vaccines

Section 485.51(a) defines a CORF as a nonresidential facility that ''is established and operated exclusively for the purpose of providing'' rehabilitation services by or under the supervision of a physician. Because vaccines administered in the CORF setting are not rehabilitation services furnished under a plan of treatment relating directly to the rehabilitation of the patient (or, presumably, even medically necessary for the rehabilitation of the patient), in accordance with § 485.51(a), a CORF may not administer vaccines to its patients. However, in the CY 2008 PFS proposed rule we noted that nothing in the Medicare statute would prohibit a CORF from providing pneumococcal, influenza, and hepatitis B vaccines to its patients provided the facility is ''*primarily* engaged in providing * * * diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons'' (section 1861(cc)(2)(A) of the Act). Accordingly, under the statute, such vaccines may be covered separately from the CORF services benefit under section 1861(s)(10) of the Act—defining the term ''medical and other health services'' to include the pneumococcal, influenza, and hepatitis B vaccines—provided the applicable conditions of coverage under § 410.58 and § 410.63 are met. In order to include coverage and payment for these vaccines when provided to CORF patients in the CORF setting, we proposed to amend the CORF conditions of participation at § 485.51 to permit CORFs to provide vaccines to their patients in addition to rehabilitation services. Such vaccines would be covered in the CORF setting provided the conditions of coverage under § 410.58 and § 410.63 are met. In accordance with sections 1833(a)(1) and 1842(o)(1) of the Act, payment for covered pneumococcal, influenza, and hepatitis B vaccines provided in the CORF setting is based on 95 percent of the average wholesale price (AWP).

Comment: We received a few comments strongly supporting the proposal to permit vaccines to be provided in the CORF setting in addition to the CORF services. These commenters also strongly supported our proposal to clarify our policy regarding the administration of vaccines to CORF patients by revising the CORF conditions of participation to permit the provision of vaccines, in addition to CORF services. These commenters believe that increasing the number and types of providers where vaccinations can be furnished will not only help to ensure increased access to these vaccinations but will result in improved health outcomes and lower costs.

Response: We agree with the commenters and will implement our proposal to revise the CORF conditions of participation, accordingly.

L. Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (§ 414.930)

1. Background

a. Statutory Requirements

Section 1861(t)(2)(B)(ii)(I) of the Act lists three drug compendia that may be used in determining the medically-accepted indications of drugs and biologicals used in an anti-cancer chemotherapeutic regimen. The three drug compendia listed are:

- American Hospital Formulary Service-Drug Information (AHFS– DI)
- American Medical Association Drug Evaluations (AMA–DE)
- United States Pharmacopoeia Drug Information (USP–DI)

Section 1861(t)(2) of the Act provides the Secretary the authority to revise the list of compendia for determining medically-accepted indications for drugs. Due to changes in the pharmaceutical reference industry, fewer of the statutorily named compendia are available for our reference. (That is, AMA–DE is no longer in publication; USP–DI has been purchased by Thomson Micromedex and it is our understanding that the

name ''USP–DI'' may not be used after 2007.)

Section 6001(f)(1) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) amends both ''sections 1927(g)(1)(B)(i)(II) and 1861(t)(2)(B)(ii)(I) of the Act by inserting ''(or its successor publications)'' after 'United States Pharmacopeia Drug Information'.'' We interpret this DRA provision as explicitly authorizing the Secretary to continue recognition of the compendium currently known as USP–DI after its name change if the Secretary determines that it is in fact a successor publication rather than a substitute publication.

b. Requests To Amend the Compendia Listings

We received requests from the stakeholder community for recognition of additional compendia under the following authorities:

- Section 1861(t)(2)(B) of the Act which allows the Secretary to identify additional authoritative compendia; and
- Section 1873 of the Act which allows the Secretary to recognize a successor publication if one of the statutorily-named compendia changes its name.

In contrast, others suggested that the Secretary consider elimination of certain listed compendia. However, as we stated in the CY 2008 PFS proposed rule (72 FR 38177), there was no established regulatory process by which we could accept and act definitively on such requests. In addition, we saw the need to increase transparency of decision making criteria.

c. Technology Assessment of Drug Compendia Used To Determine Medically-Accepted Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

We commissioned a technology assessment (TA) from the Agency for Healthcare Research and Quality (AHRQ) on the currently listed compendia (AHFS and USP–DI), as well as other compendia (that is, National Comprehensive Cancer Network (NCCN), ClinPharm, DrugDex, Facts & Comparisons (F&C)) which might provide comparable information. AHRQ contracted the TA to the New England Medical Center (NEMC) and Duke Evidence-based Practice Centers (EPCs) and found little agreement in the evidence cited among drug compendia. In addition, the TA found little agreement between the EPCs' independent identification of evidence on 14 example off-label indications and evidence cited in the drug compendia. The TA can be found at *http://www.cms.hhs.gov/ mcd/viewtechassess.asp?where=index&tid=46.*

d. Medicare Evidence Development and Coverage Advisory Committee (MedCAC)

On March 30, 2006, the MedCAC (formerly the Medicare Coverage Advisory Committee (MCAC)) met in public session to advise CMS on the evidence about the desirable characteristics of compendia to determine medically-accepted indications of drugs and biologicals in anti-cancer therapy and the degree to which the currently listed and other available compendia display those characteristics. All information on this MedCAC meeting can be found on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=33.* The agenda included a presentation of the TA performed for AHRQ by staff of the NEMC and Duke EPCs, scheduled stakeholder presentations, as well as an opportunity to hear testimony from members of the audience. As is customary, the MedCAC panelists elicited additional information from the presenters and discussed the evidence in preparation for a formal vote.

The MedCAC identified the following desirable characteristics:

- Extensive breadth of listings.
- Quick processing from application for inclusion to listing.
- Detailed description of the evidence reviewed for every individual listing.
- Use of pre specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit ''Not recommended'' listing when validated evidence is appropriate.
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies.
- Explicit ''Equivocal'' listing when validated evidence is equivocal.
- Process for public identification and notification of potential conflicts of interest of the compendia's parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

The MedCAC concluded that none of the compendia fully display the desirable characteristics. The voting results can be viewed at the same Web site provided previously for the MedCAC meeting. In addition the MedCAC noted significant variability among the compendia. There was no agreement among the panel members that any particular predetermined number of compendia was desirable.

Participants in the meeting also discussed the clinical usefulness of drug compendia in the treatment of cancer. It was reported that oncologists do not rely on compendia when making treatment decisions, relying instead on published treatment guidelines, clinical trial protocols, or consultation with peers.

Prior to the CY 2008 PFS proposed rule, we received, and reviewed, unsolicited comments from professional societies regarding additions and deletions to the listing of compendia for purposes of section 1861(t) of the Act. We received 46 public comments regarding these provisions on the CY 2008 PFS proposed rule.

2. Process for Determining Changes to the Compendia List

A compendium for the purpose of this section is defined as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment. A compendium: (1) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; (2) is indexed by drug or biological; (3) differs from a disease treatment guideline, which is indexed by disease. We believe that the use of compendia to determine medically-accepted indications of drugs and biologicals in the manner specified in section 1861(t)(2)(B)(ii)(I) of the Act is more efficiently accomplished if the information contained is organized by the drug or biological and if the listings are comprehensive.

We proposed an annual process, incorporating public notice and comment, to receive and make determinations regarding requests for changes to the list of compendia used to determine medically-accepted indications for drugs and biologicals used in anti-cancer treatment as described in section 1861(t)(2)(B)(ii)(I) of the Act. The specific details of the proposed process were outlined in PFS CY 2008 proposed rule (72 FR 38118). We received the following comments on our proposed process.

Comment: Several commenters remarked that we should correlate Part B and Part D compendia for consistency within the Medicare program.

Response: The Social Security Act separately determines the Agency's use

of authoritative compendia for specific programs. The use of any compendium for Part D or for Medicaid is beyond the scope of this regulation.

Comment: Many commenters voiced concerns about the time line proposed by CMS to address requests for changes to the list of compendia.

Response: We are striving to achieve a more expedient and predictable time line that will better serve the needs of those who care for Medicare beneficiaries. We have carefully considered the comments and made the following revisions:

(1) In order to shorten the proposed timeline, CMS will not publish an annual notice for formal requests.

(2) We expect to receive requests annually during a 30-day window starting January 15th.

(3) We expect to post these complete requests received by March 15th for public notice and comment on the CMS Web site.

(4) We will accept public comments for a 30 day period beginning on the day that the request is posted by CMS on the Web site.

Comment: Some commenters suggested alternative review cycles including changing the annual review to: a rolling review process; an every 3-year review process; or an every 5-year review process.

Response: We appreciate the commenters' suggestions regarding alternative review cycles; however, at this time, we believe that an annual review cycle is the best balance of these suggestions to promote a publicly responsive review process. Due to the general stability of the compendium publishing market, an annual review process is sufficient. However, if we determine that the public interest would be served by an immediate compendia review, we reserve the right to internally generate a request at any time.

Comment: Several commenters suggested specific additions to the list of compendia.

Response: The addition or deletion of specific compendia is beyond the scope of this regulation. Formal requests for additions and deletions may be submitted during the annual open request period established in this final rule with comment period.

Comment: The comments received from several associations and manufacturers stated that the language used for the individual desirable characteristics was not clear and that we did not give the appropriate consideration to quality concerns and the potential conflicts of interest.

Response: We appreciate the commenters' concerns and strive to provide clarity on the MedCAC desirable characteristics that we will utilize in the compendia review process. The characteristics presented here represent an evidence-based consensus from the MedCAC panel on the desirability and priority of those characteristics. We recognize that different compendia might attempt to achieve these characteristics in individualized ways. CMS plans to use the desirable characteristics as framework and guidance in the review process. However, we believe that the public interest is best served by CMS attention to the quality and the integrity of each compendium's evidence evaluation process.

Comment: A few commenters made the general suggestion for CMS to prioritize the desirable characteristics identified at the MedCAC meeting, March 2006.

Response: We wish to clarify that the desirable characteristics recommended by the MedCAC will serve as guidance and a framework which will aid in the CMS review process. As stated in the CY 2008 PFS proposed rule, we ''may consider additional reasonable factors in making a determination'' as deemed appropriate. While we have decided not to rank the MedCAC desirable characteristics, we do consider the characteristics referencing transparency and conflict of interest to be of high priority to preserve the integrity and minimize bias during the review process.

Comment: Some commenters stated that a deletion from the list of compendia could cause a beneficiary to lose coverage of an off-label treatment regimen already begun.

Response: We understand the concern expressed by the commenters on a beneficiary's loss of coverage during the continuance of off-label treatment in the absence of compendium support; however local contractors have additional authority to make determinations regarding medically accepted indications. While we require local contractors to use the compendia as a reference in the determination of ''medically-accepted'' off-label treatment regimens, the compendia are not the sole reference for these determinations. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors use ''supportive clinical evidence in peer-reviewed medical literature'' to aid in making determinations of ''medically-accepted'' off-label treatment regimens when appropriate.

Comment: Commenters asked that we recognize compendia indexed by disease.

Response: In order to meet our criteria, a compendium should: (1) Include a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; (2) be indexed by drug or biological; (3) differ from a disease treatment guideline, which is indexed by disease. We believe that the use of compendia to determine medically-accepted indications of drugs and biologicals in the manner specified in section 1861(t)(2)(B)(ii)(I) of the Act is more efficiently accomplished if the information contained is organized by the drug or biological and if the listings are comprehensive.

Comment: Several commenters suggested that we should regulate a time frame for compendia to update their recommendations.

Response: We believe that the public interest is served if compendia generally update their recommendations in a timely manner when new evidence regarding the use of drugs warrants an update. We also believe that this is consistent with spirit of the MedCAC's recommendations. However, medical evidence on a particular use of a specific drug may at times be complex and inconsistent, and thus, merit a prolonged rather than an expedited analysis. We do not believe that we should establish in regulation a specific broad time line requirement at this time. However, we will consider public input regarding a compendium's timely updating of its recommendations as an additional criterion in our compendium review process.

Comment: We received comments suggesting that a compendium's use of grades of evidence may add a confusing factor in determining whether a compendium citation supports a particular drug use. Commenters stated that it is desirable for a compendium to clarify in a summary recommendation whether it regards each drug use as medically-accepted.

Response: We recognize and support the desirability of an explicit summary recommendation for each drug or biological cited in each compendium. This will facilitate the consistent interpretation of off-label recommendations by Medicare contractors.

Comment: One commenter suggested that a recognized compendium should include and identify a well designed clinical trial that is pending FDA approval.

Response: We do not believe that we can specify how a compendium

references materials regarding clinical trials for a drug not yet FDA-approved.

Comment: Two commenters claimed that section 1861(t)(2) of the Act mandates separate processes for adding and removing compendia.

Response: While we appreciate the thoughtful interpretation of the language, we do not agree separate processes are required by the statute.

Comment: One commenter suggested that the identity of the members of the compendium's advisory board and scientific review committee should become public record. The commenter also requested that we to establish a formal process to facilitate stakeholder/compendia communication.

Response: Public identification of members of the compendium's advisory board and the scientific review committees and establishing a formal process for stakeholders/compendia communication is beyond our authority and scope of this regulation.

Based on the public comments received, we have made revisions to the proposed compendia review process. We appreciate the need for a more expedient process to provide a useful compendia list for Medicare providers and have made the necessary changes.

Requests may be submitted in two ways (no duplicates please). Electronic submissions are encouraged to facilitate administrative efficiency. We will identify the electronic address to be used for submissions. Hard copy requests can be sent to the Centers for Medicare & Medicaid Services, Coverage and Analysis Group, Mailstop C1–09–06, 7500 Security Boulevard, Baltimore, MD, 21244. Please allow sufficient time for hard copies to be received prior to the close of the receipt period.

We may consider additional reasonable factors in making a determination. (For example, we may consider factors that are likely to impact the compendium's suitability for this use, such as but not restricted to a change in ownership or affiliation, suspension of publication, the standards applicable to the evidence considered by the compendium, and any relevant conflicts of interest. We may consider that broad accessibility by the general public to the information contained in the compendium may assist beneficiaries, their treating physicians, or both, in choosing among treatment options.)

- We will also consider a compendium's grading of evidence used in making recommendations regarding off-label uses and the process by which the compendium grades the evidence.
- We may, at our discretion, combine and consider multiple requests that refer to the same compendium, even if those requests are for different actions. This facilitates administrative efficiency in our review of requests.
- We will notify the public of additions or deletions to the list of compendia on the CMS Web site.
- In keeping with our desire to shorten the compendia review time line, we will publish our decision no later than 90 days following the close of the public comment period.

M. Physician Self-Referral Issues

1. General

In the CY 2008 PFS proposed rule (72 FR 38122), we proposed several revisions to the physician self-referral regulations. We also solicited comments regarding potential changes to or limitations on the use of the in-office ancillary services exception in § 411.355(b). We received approximately 1100 pieces of timely correspondence in response to these proposals.

We received the following comments regarding finalizing our proposals:

Comment: Many commenters were concerned about the perceived complexity and breadth of the physician self-referral proposals. Several commenters questioned our ability to analyze sufficiently, and give adequate consideration to, the public comments due to the brief time period between issuance of the CY 2008 PFS proposed rule (72 FR 38122) and the statutory deadline for publication of this final rule with comment period. Some commenters suggested that we not finalize any of the proposals at this time. Many of those commenters asserted that we should further contemplate the issues and propose revised regulatory provisions in the CY 2009 PFS proposed rule if we continue to believe that such revisions are necessary.

Response: We are not inclined to follow the commenters' suggestion regarding reproposal of the physician self-referral provisions in the CY 2009 PFS proposed rule. However, given the number of physician self-referral proposals, the significance of the provisions both individually and in concert with each other, and the volume of public comments, we do not believe it is prudent to finalize any of the proposals in this rule (except for the proposal for anti-markup provisions for diagnostic tests, as discussed below in this section). Although we are not finalizing the proposed revisions to the other physician self-referral regulations in this final rule with comment period, we are confident that we have sufficient information, both from the commenters and our independent research, to finalize revisions to the physician self-referral regulations without the need for new proposals and additional public comment. We intend to publish a final rule that addresses the following proposals:

- Burden of proof;
- Obstetrical malpractice insurance subsidies;
- Unit-of-service (per-click) payments in lease arrangements;
- The period of disallowance for noncompliant financial relationships;
- Ownership or investment interests in retirement plans;
- ''Set in advance'' and percentage-based compensation arrangements;
- ''Stand in the shoes'' provisions;
- Alternative criteria for satisfying certain exceptions; and
- Services furnished ''under arrangements.'' Because we did not make a specific proposal regarding the in-office ancillary services exception, but rather merely solicited comments regarding its scope and application, any revisions to the exception in § 411.355(b) will be accomplished through a future notice of proposed rulemaking with provisions for public comment.

A measured, thoughtful approach to the final physician self-referral rules is critical. We believe that the future rulemaking will address the public comments and present a coordinated, comprehensive approach to accomplishing the goals described in the proposed rule, namely, minimizing the threat of program and patient abuse while providing sufficient flexibility to enable those who are parties to financial arrangements to satisfy the requirements of, and remain in compliance with, the physician self-referral law and the exceptions thereto.

2. Changes to Reassignment and Physician Self-Referral Rules Relating to Diagnostic Tests (Anti-Markup Provisions)

Medicare regulations currently prohibit the markup of the technical component (TC) of certain diagnostic tests that are performed by outside suppliers and billed to Medicare by a different individual or entity (§ 414.50). In addition, Medicare program instructions restrict who may bill for the professional component (PC) (the interpretation) of diagnostic tests (Section 30.2.9.1 of the CMS Internet-Only Manual, Publication 100–04, Medicare Claims Processing Manual, Chapter 1, general billing requirements, as amended or replaced from time to time).

In the CY 2007 PFS proposed rule (71 FR 48982), we stated that recent changes to our rules on reassignment concerning the right to receive Medicare payment may have led to some confusion as to whether the anti-markup and purchased interpretation requirements apply in certain situations where a reassignment has occurred pursuant to a contractual arrangement. In addition, we expressed concern about the existence of certain arrangements that we believe are not within the intended purpose of the physician self-referral exception for in-office ancillary services, which permits physician group practices to bill for certain services referred by group physicians and furnished by a contractor physician in a ''centralized building.'' We also expressed concern that allowing physician group practices or other suppliers to purchase or otherwise contract for the provision of diagnostic testing services and to then realize a profit when billing Medicare may: (1) Lead to program and patient abuse in the form of overutilization of services; and (2) result in higher costs to the Medicare program (71 FR 49054). In the CY 2007 PFS proposed rule, we proposed to amend § 424.80 to provide that, if the TC of a diagnostic test (other than a clinical diagnostic laboratory test paid under section 1833(a)(2)(D) of the Act, which is subject to the special rules set forth in section 1833(h)(5)(A) of the Act) is billed by a physician or medical group (the ''billing entity'') under a reassignment involving a contractual arrangement with a physician or other supplier who performs the service, the amount billed to Medicare by the billing entity would be limited. We also proposed that, to bill for the TC, the billing entity would be required to perform the interpretation. In addition, we considered imposing certain conditions on when a physician or medical group can bill for the reassigned PC of a diagnostic test. For our physician self-referral rules, we proposed to modify the definition of ''centralized building'' at § 411.351. Finally, we solicited comments on the specific application of our proposals. (See the CY 2007 and CY 2008 PFS proposed rules for more information on these proposals (71 FR 49054 through 49057 and 72 FR 38179 through 38180, respectively).)

We received numerous comments on the proposals in the CY 2007 PFS proposed rule. Because we decided to study the issues further, we did not finalize our proposals in the CY 2007 PFS final rule with comment period. Rather, based on the comments received and other information that we considered, in the CY 2008 PFS proposed rule, we proposed to impose an anti-markup limitation on the TC and PC of diagnostic tests. We stated that we would apply the anti-markup provision irrespective of whether: (1) The billing entity outright purchases the TC or the PC; or (2) the physician or other supplier performing the TC or PC reassigns his or her right to bill the Medicare program to the billing entity (unless the performing supplier is a full-time employee of the billing entity). That is, we proposed to limit the payment to the billing entity to the lowest of: (1) The performing physician's or other supplier's net charge to the billing entity; (2) the billing entity's actual charge; or (3) the fee schedule amount for the service that would be allowed if the physician or other supplier performing the service billed directly. To prevent gaming, whereby the performing physician's or other supplier's net charge to the billing entity is inflated to cover the cost of equipment or space that is leased by the billing entity to the performing physician or other supplier, we stated that we would define ''net charge'' as exclusive of any amount that takes into consideration such charges.

We also stated that we were concerned that overutilization of diagnostic tests could continue despite our proposal to apply an anti-markup provision to TCs that are reassigned to, or outright purchased by, group practices. That is, we intended to address the situation in which the TC is performed by a part-time or leased employee of the group practice in a ''centralized building,'' and the group neither receives a reassignment from the employee technician (if the technician is not able to bill for the TC in his or her own right), nor purchases the TC outright from the technician. Therefore, we proposed to apply an anti-markup provision to TCs that are performed in a centralized building, and sought comments on whether we should have such a provision and, if so, how we should effect such a provision (for example, by amending the definition of ''centralized building'' or through some other means). We stated that we would except from the anti-markup provision PCs performed by a physician pursuant to an arrangement with an independent laboratory as we do not believe that such PCs ordered by an independent laboratory pose a significant risk of program abuse because the independent laboratory does not order the diagnostic test. We proposed revisions to § 424.80 (reassignments) and § 414.50 (purchased diagnostic tests). (We did not propose regulatory text revisions for our proposals to apply an anti-markup provision to TCs that are performed in a centralized building, and not apply the anti-markup provision to PCs billed by independent laboratories whose personnel do not order the diagnostic test.)

Many commenters supported our proposals to prohibit the markup of the TC and PC of diagnostic tests in order to prevent physicians, physician group practices, and medical groups from profiting through the ordering of such tests. Commenters that supported our proposals often cited a concern about overutilization. Many commenters were opposed to our proposals. These commenters stated that the Medicare program and its beneficiaries are better served by physicians who refer tests to specialists (such as pathologists who contract directly with group practices), instead of physicians who use large reference laboratories. These commenters asserted that, because physicians develop a working relationship with particular pathologists, and because the pathologists ''specialize'' in a particular type of biopsy (for example, prostate biopsies), results are obtained more quickly and quality is enhanced. Finally, most commenters who responded to our proposal to apply an anti-markup to reassignments from part-time employees, irrespective of whether they were in support generally of our proposals, opposed this specific proposal.

After careful consideration of all of the comments, we are adopting our proposals, with modification. We are imposing an anti-markup provision on TCs 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 billing supplier), if the TC is outright purchased or if the TC is performed at a site other than the office of the billing physician or other supplier.[1] (For purposes of the anti-markup provisions, the ''office of the billing physician or other supplier'' has its common meaning. The term is defined at revised § 414.50(a)(2)(iii) as space where the physician or other supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician

[1] We note that, in our proposals, we used the term ''billing entity'' to refer to a billing physician or medical group. In this final rule with comment period, the anti-markup provisions potentially apply to TCs and PCs billed by *any supplier; therefore, we use the terms ''billing physician or other supplier'' and ''billing supplier.'' These terms are used interchangeably.*

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.) We are also imposing an anti-markup provision on PCs 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 billing supplier), if the PC is outright purchased or if the PC is not performed in the office of the billing physician or other supplier. Also, part-time employees are treated no differently than full-time employees or contractors who reassign benefits.

We are primarily revising § 414.50, although we have also revised § 424.80 by adding (d)(3) to alert the reader that, in the case of the reassignment of the TC or PC of a diagnostic test, the reader should consult § 414.50 to investigate whether the anti-markup provisions apply to the TC or PC. We are also revising our definition of ''entity'' at § 411.351, which is relevant to our rules on physician self-referral. Currently, the definition of ''entity'' provides an exception for a physician's practice when it bills Medicare for a diagnostic test in accordance with § 414.50. We are revising the definition of ''entity'' at § 411.351 to exclude a physician's practice when it bills Medicare for the TC or PC of a diagnostic test in accordance with § 414.50.

Examples of the application of the final provisions to particular facts appear immediately below, followed by a discussion of the specific comments we received on our proposals. We note that the following examples are intended only to illustrate the application of the anti-markup provisions of this final rule with comment period; they are not intended to address whether the physician self-referral rules would prohibit payment due to financial relationships that may exist between the billing supplier and any physician ordering a test or performing the TC or PC of a test.

Example 1. A urology group practice contracts with a leasing company that supplies a technician and a pathologist to perform testing on prostate samples. The technician performs the tissue sampling and the pathologist reads the slides. All work is done outside of the office of the billing group practice, and instead is performed in space that is rented exclusively ''24/7'' by the group practice (thus meeting the definition of a ''centralized building'' at § 411.351) for the sole purpose of providing pathology services for the group's patients. Because the centralized building does not qualify as ''the office of the billing physician or other supplier,'' the anti-markup provisions apply to both the TC and the PC, and the group may bill Medicare the lowest of the following: (1) The leasing company's net charge to the group; (2) the group's actual charge; or (3) the fee schedule amounts for the TC and interpretation that would be allowed if the leasing company were enrolled in and billed Medicare directly.

Example 2. Same as Example 1, except that the TC and PC are performed by the group practice's employee technician and a pathologist who is an independent contractor of the group practice, respectively. Here, the anti-markup provisions again apply to both the TC and the PC because the work was not done in the ''office of the billing physician or other supplier'' (that is, the office of the group practice). It does not matter that the technician is an employee and the pathologist is an independent contractor because the work was not performed in the office of the billing group practice.

Example 3. A physician in a group practice orders a diagnostic test and a technician who is a part-time employee of the group performs the test in the group's office. A physician who is an independent contractor of the group performs the PC in the group's office and reassigns his or her right to payment to the group. The anti-markup provisions do not apply to the group's billing of the TC or the PC.

Example 4. Same as Example 3, except that the independent contractor physician performs the PC in his or her home and reassigns his or her right to payment to the group. The group's billing of the TC is not subject to the anti-markup provision, but the group's billing of the PC is subject to the anti-markup provision because the work was not performed in the office of the billing supplier.

Example 5. A group practice purchases both a diagnostic test and its interpretation from a laboratory and bills the TC and PC to Medicare. The anti-markup provisions apply to both the TC and the PC. Because the TC and the PC were purchased, the location(s) at which the TC and the PC were performed does not matter.

Example 6. A group practice orders a diagnostic test from an independent laboratory. The laboratory performs the test and contracts with a physician to perform the PC. The laboratory bills Medicare for both the TC and the PC. The laboratory is not subject to the anti-markup provision for the PC, because the laboratory did not order the test.

Example 7. Same as Example 6, except that a physician orders a diagnostic test from an independent diagnostic testing facility (IDTF). The IDTF bills Medicare for both the TC and the PC of the test. The anti-markup provisions do not apply because the IDTF did not order the test.

a. Authority

Comment: Several commenters questioned whether we have the authority pursuant to section 1842(n) of the Act to impose an anti-markup provision as described in the CY 2008 PFS proposed rule. The commenters specifically noted that, in section 1842(n) of the Act, the Congress directed the Secretary to impose an anti-markup on the TC of diagnostic tests, yet our proposal applied to the TC and the PC of diagnostic tests. Commenters stated that the interpretation of a diagnostic test is a physician service, and that section 1848 of the Act mandates that physician services be paid the lesser of the billing physician's actual charge or the fee schedule amount, and therefore, we have no authority to extend the anti-markup rule to physician services.

Response: We believe that several provisions of the Medicare statute provide us with the requisite authority to impose anti-markup provisions on the TC and PC of certain diagnostic tests. Section 1842(n)(1)(A) of the Act, which was enacted as part of the Omnibus Budget Reconciliation Act of 1987, provides that, if the diagnostic test was not performed or supervised by the billing physician and also was not performed or supervised by a physician with whom the billing physician shares a practice, the Medicare payment is the lower of the costs (net of any discount) charged by the performing supplier to the billing physician, or the performing supplier's reasonable charge (or other applicable limit). This is commonly known as the anti-markup provision. Although, to date, this statutory provision has been implemented through the regulation in § 414.50 that imposes an anti-markup provision on the TC only of a diagnostic test, nothing in this section limits our authority to apply this section to the PC of a diagnostic test.

Moreover, we believe that we can interpret the language ''shares a practice'' as giving us the authority to impose an anti-markup provision on the TC of tests that are outright purchased by a billing physician or group, as well as on the TC of tests for which payment is reassigned to the billing physician or group. Although we previously implemented this statutory provision through regulation in § 414.50 by enacting an anti-markup provision on the TC of ''purchased'' diagnostic tests from an outside supplier, the statutory provision does not speak in terms of ''purchased'' tests. In the intervening time since CMS promulgated the regulation in § 414.50, other changes to the Medicare program, in particular, the changes made by section 952 of the MMA to the reassignment exceptions authority, have created incentives for conduct that we believe increases the risk of overutilization and abuse of the Medicare program. We believe that the language ''shares a practice'' in section 1842(n)(1) of the Act can cover not just

tests that are outright purchased, but also tests for which payment is reassigned to the billing supplier. We are amending § 414.50 in this final rule to provide that TCs and PCs that are not performed in the office of the billing physician or other supplier are subject to the anti-markup provision. We believe that, if the TC or PC is not purchased and is performed in the office of the billing supplier by an employee (whether full-time or part-time) or an independent contractor who reassigns benefits, a sufficient nexus with the practice of the billing supplier (that is, the billing physician or group) is established such that the employee or independent contractor may be viewed as ''sharing a practice'' with the billing supplier for purposes of section 1842(n)(1) of the Act. In addition, we believe that we have authority under sections 1102(a) and 1871(a) of the Act (our general rulemaking authority) to impose anti-markup provisions on the TC and PC of diagnostic tests in order to fully effectuate the Congress' intent in enacting section 1842(n)(1) of the Act.

We find additional authority in section 1842(b)(6) of the Act. This section generally prohibits Medicare payment to anyone other than the Medicare beneficiary or the physician or other person who furnished the item or service to the beneficiary. We allow a physician or other supplier to bill for tests and test interpretations that are purchased from an outside supplier because we have deemed the test or interpretation to be performed by the billing supplier; however, we are not *required* to deem the test or interpretation as having been performed by the billing supplier, nor are we required to do so without placing limits on the amount the purchasing supplier may bill. Likewise, whereas section 1842(b)(6) of the Act also provides exceptions (known as the reassignment exceptions) to the general rule that payment may be made only to the beneficiary or the physician or other person who furnished the item or service, such exceptions allow us (''payment may be made''), but do not require us, to make payment to an individual or an entity other than the beneficiary or the physician or other person who furnished the item or service to the beneficiary. (We note that the Congress specifically provided for CMS to implement safeguards in the context of reassignments pursuant to a contractual arrangement. Section 952 of the MMA permitted Medicare to pay a physician or entity billing for an item or service as a result of a reassignment created pursuant to a contractual arrangement, regardless of the site of service. However, in section 952 of the MMA, the Congress specifically authorized the Secretary to subject such arrangements to ''such program integrity and other safeguards as the Secretary may determine to be appropriate.'') Therefore, we believe that we have ample authority under section 1842(b)(6) of the Act to place restrictions on the billing of tests and interpretations when the tests or interpretations were performed by someone other than the billing supplier, particularly with respect to situations in which there is the potential for overutilization.

We do not view the application of the anti-markup provision to the PC of diagnostic tests as representing a conflict with section 1848 of the Act as stated by the commenters. Although section 1848 of the Act does outline how physician services will be paid in the typical situation, section 1848 of the Act does not preclude us from setting conditions on physician payment or from deviating from the payment methodology outlined in section 1848 of the Act where a physician or other supplier is seeking to take advantage of a special situation made available to physicians or other suppliers by CMS. Payment pursuant to the terms of section 1848 of the Act is available for all the diagnostic tests in question. Physicians and other suppliers are free not to take advantage of the purchased test option or the reassignment option, and bill and receive payment only for tests they have personally performed. Where physicians and other suppliers choose to take advantage of these options, for purposes of convenience or for other reasons, we have the authority under our general rulemaking authority in sections 1102(a) and 1871(a) of the Act, as well as under our authority to set conditions for the payment of purchased and reassigned tests in section 1842(b)(6) of the Act, to promulgate rules to ensure that these options do not increase the likelihood of Medicare program abuse.

b. Scope of Application of the Anti-Markup Provisions

Comment: One commenter offered alternatives to our proposals. The commenter stated that, at least initially, the anti-markup provisions should apply exclusively to gastroenterology, dermatology, and urology physician group practices because those specialties order a significant number of pathology tests. The commenter suggested that we could subsequently broaden application of the anti-markup provisions to the extent that ''new abusive'' arrangements develop. Alternatively, according to the commenter, CMS could define the specialties to which the anti-markup provisions would apply on the basis of objective criteria. For example, the anti-markup provisions could apply to group practices billing for pathology services where at least 75 percent of the members are from a single nonpathology specialty and where at least 75 percent of the pathology services billed by the group practice were ordered by members of the group. The commenter asserted that such a definition should cover most of the abusive arrangements that have developed in recent years. The commenter urged us to impose a broad prohibition on profiting from pathology tests, which would apply without regard to whether the histotechnologists are full-time employees or independent contractors of the group practice. According to the commenter, a prohibition on profiting could be accomplished by prohibiting any markup over the direct costs incurred by the group practice in providing such services, and direct costs should be limited to the compensation paid to the persons providing the services and the cost of the equipment and supplies utilized in performing the services. Finally, the commenter suggested the alternative of amending the requirements for ''group practices'' in § 411.352 to prohibit gastroenterology, dermatology and urology group practices from profiting from Medicare payments for pathology services performed within the group practice.

Response: We decline to adopt any of the approaches suggested by the commenter. The anti-markup provisions in this final rule with comment period apply to group practices (as well as all other suppliers) regardless of specialty. We believe that making the rule applicable to all suppliers ensures fair and equitable treatment among types of suppliers and also ensures that the potential for overutilization is addressed regardless of the particular type of supplier involved. As we discuss in greater detail below, we agree with the commenter that it should not matter whether the person performing the TC is a full-time employee, part-time employee or independent contractor. If the TC (or PC) is purchased, or if it is performed in a place other than the office of the billing supplier, the anti-markup provision will apply, irrespective of the employment status of the person performing the TC (or PC). We are not revising the requirements for ''group practices'' at § 411.352 at this time. We did not propose to amend

these provisions and believe that such a change would be outside the scope of the proposed rulemaking.

Comment: A commenter suggested that we consider an anti-markup provision that would apply to any group practice where at least 90 percent of the practice is comprised of a single specialty other than pathology that orders the pathology tests billed by the group. The anti-markup rule should prohibit the markup of the direct costs incurred by the group (such as compensation paid to the histotechnologists and pathologists, and equipment and supplies utilized).

Response: We believe that the commenter's suggestion would be cumbersome and difficult to administer, and therefore, we are not persuaded to adopt it. We believe that the anti-markup rules that we have finalized are much more practical and will be an effective deterrent to the ordering of medically unnecessary tests.

Comment: One commenter stated that the anti-markup provisions should apply equally to all physicians, including pathologists. The commenter noted that, in some cases, a pathologist performing the PC purchases the TC from a hospital or another pathology laboratory and bills globally. In addition, the commenter asserted that it is a myth to say that pathologists do not order tests and, therefore, should be exempt from the proposed anti-markup provision applicable to the PC of a diagnostic test. Another commenter stated that there is no more likelihood of abuse in specialty physician-owned pathology laboratories than with pathology groups ordering expensive and unneeded special tests and stains on specimens that they then interpret in the pathology group-owned histology laboratory.

Response: The revisions to § 414.50 and § 424.80 concerning the anti-markup requirements apply equally to all physicians, including pathologists. We recognize that, in some situations, a pathologist may order additional tests to be performed by an outside pathologist. Where a pathologist orders and bills for a test that he or she did not personally perform, the anti-markup provisions may apply to the TC or PC, or both (depending on whether the TC or PC was purchased or, if not, whether the TC or PC was performed in the pathologist's office). If the pathologist did not order the test, the anti-markup rules do not apply.

Comment: One commenter requested clarification that § 414.50 applies only to physicians and medical groups, and not to suppliers, such as medical foundations, that, under State laws governing the corporate practice of medicine, are required to enroll in Part B as a clinic or group practice. The commenter asserted that, in States prohibiting the corporate practice of medicine, many suppliers enrolled as a clinic or group practice are unable to directly employ the radiologist or other physician who performs a test interpretation.

Response: In this final rule with comment period, we are revising § 414.50 to apply to all suppliers. However, the anti-markup provisions do not apply to TCs and PCs that are not purchased and that are performed in the office of the billing physician or other supplier. Therefore, in the commenter's example, if clinic personnel order, for example, the TC and PC, and the TC and PC are performed in the clinic's office, neither the TC nor the PC will be subject to the anti-markup provisions.

Comment: Two commenters asserted that IDTFs operate similarly to independent laboratories in that the tests are ordered by a financially independent physician. The commenters also said that the physician performing the interpretation sees the patient. Therefore, the commenters recommended that we provide an exception to the proposed anti-markup rules for purchased interpretations for imaging suppliers, such as IDTFs, if the current purchased interpretation rules are met.

Response: We are not persuaded to provide an exception to the final anti-markup provisions for purchased interpretations for imaging suppliers if the current purchased interpretation rules are met. We note that, if the interpreting physician sees the patient, the purchased interpretation rules are not fully met. Therefore, the imaging supplier is not satisfying all of the purchased interpretation rules, and the imaging supplier should only bill for the TC portion of the test.

Comment: One commenter requested clarification that the anti-markup proposals do not apply to radiologists who have contractual arrangements with IDTFs. The commenter asserted that radiologists and IDTFs are not in a position to refer to each other or to themselves because both are dependent upon referrals from other physicians in the community. Another commenter asked us to clarify that the anti-markup for the PC will not apply to an IDTF that purchases the PC from the interpreting physician, particularly in States in which the corporate practice of medicine doctrine applies. Another commenter stated that the anti-markup provision for the PC should not be applied to physicians or group practices that bill for the professional services performed by an independent contractor or part-time employee if those services were performed pursuant to the order of another practitioner who is independent of the group, and thus would not profit from his or her referral.

Response: As finalized, the anti-markup provisions are applicable to all types of suppliers. However, in the situation in which an IDTF, radiology practice, or other supplier does not order the diagnostic test, the anti markup provisions do not apply.

Comment: A few commenters questioned whether the proposed anti-markup provision, for the PC of diagnostic tests, would apply to IDTFs that purchase the PC from an interpreting physician, particularly in States where the corporate practice of medicine prohibits an IDTF from hiring the physician as an employee.

Response: The anti-markup rules will not apply to entities that are enrolled as an IDTF where the IDTF does not order the test. If the IDTF orders the test, the anti markup provisions will apply to the same extent that they apply to other suppliers.

Comment: A few commenters urged us to clarify in § 424.80 that the anti-markup provisions apply to reassignments under both the contractual arrangement exception as well as the employee reassignment exception. The commenters also suggested that § 424.80 and § 414.50 should state that the anti-markup provisions are limited to claims submitted by physicians and medical groups and do not apply to claims submitted by independent laboratories. The commenters were concerned that the preamble language on the applicability of the anti-markup provisions to independent laboratories was not carried over and included in the regulatory text in § 424.80 and § 414.50.

Response: We have determined to revise § 414.50, with a cross reference in new § 424.80(d)(3). As finalized, the anti-markup provisions apply to reassignments under both the employee exception and the contractual arrangements exception, to the extent that the services for which payment is reassigned are not performed in the office of the billing physician or other supplier. The anti-markup provisions apply to a billing supplier only if the billing supplier orders the TC. Therefore, if an independent laboratory does not order the TC, the anti-markup provisions will not apply to the laboratory billing of the TC or the PC.

Comment: Two commenters urged us to create an exception for entities that are located off-campus from a hospital

which are jointly owned by radiologists and the hospital and which have an exclusive contract for the provision of professional interpretations to the hospital. According to the commenters, it is important to allow such joint ventures to exist, because the profits generated by the ventures give financial stability to community hospitals that otherwise would be financially impaired as outpatient imaging continues to migrate away from the hospital. In States in which the corporate practice of medicine doctrine exists, the joint ventures do not directly employ the physicians, but rather typically contract with the professional radiology practice to provide the PC. The commenter stated that the radiologists providing the professional reads are neither full-time employees nor exclusively employed by the joint venture imaging center to which they reassign their right to Medicare payment.

Response: We do not believe that it is necessary to create such an exception. The comment is unclear as to which entity, the joint venture imaging center or the hospital, is billing for the service; however, if the imaging center is billing for the PC, the anti-markup provision will not apply if the physician performs the PC in the imaging center's office. If the imaging center, or an entity related to it by common ownership or control, orders the TC, and the physician does not perform the PC in the imaging center's office, the anti-markup provision will apply.

Comment: Some commenters believed that the anti markup provisions should not apply to imaging suppliers that meet the purchased test rules in CMS manuals.

Response: In the CY 2007 PFS proposed rule, we stated that we were considering placing restrictions on the ordering of PCs that would be similar to the purchased interpretation rules in our manuals. After giving the matter considerable thought, we believe that an anti-markup billing provision is necessary to guard against potential overutilization and that it would not be sufficient simply to require that billing entities meet the purchased interpretation rules in our manuals.

Comment: In the proposed rule, we proposed to add new § 424.80(d)(3) to require that, in order to bill for the TC, the billing entity must directly perform the PC of the service. Two commenters asked that we clarify what we meant by ''directly perform.'' Other commenters recommended that we clarify in § 424.80 the requirement to bill for the TC of a diagnostic test, and clarify in § 414.50 the requirement that a billing entity must directly perform the PC of the service.

Response: We are not finalizing the proposed change to § 424.80(d)(3). We note that the requirement continues to appear in our manuals at CMS Internet-Only Manual, Pub. 100–04, Chapter 1, section 30.2.9. Currently, we are considering whether to retain this requirement in the manuals or to withdraw it.

Comment: One commenter supported generally the establishment of an anti-markup provision on purchased interpretations, but voiced concerns that our proposal to incorporate the billing rules for purchased diagnostic testing services to all reassigned services (unless performed by a full-time employee of the group) could adversely affect the billing practices of pathologists and pathology groups who often depend upon the reassignment rules to bill for services performed by independent contractor and part-time pathologists. Therefore, the commenter requested an exception from our proposed rules for independent laboratories and single-specialty pathology physician groups.

The commenter also asserted that reassignment arrangements between pathology groups do not raise the same threat of abuse because the vast majority of pathology services are initiated by a request for a consultation from a referring physician of another specialty, and the pathologist is not in a position to influence the referrals from ordering physicians. The commenter further stated that a broader exception for single-specialty pathology physician groups and independent laboratories that covers both the TC and PC of a pathology service is supported by the existing physician self-referral law and regulations. The commenter stated that, the ''Congress recognized that certain physicians, specifically pathologists, diagnostic radiologists and radiation oncologists, who order certain services pursuant to a consultation with another physician do not have the same risk of abuse and, consequently, will not be treated as having made a restricted referral to an entity with which they have a financial interest.'' The commenter urged us, for this same policy reason, to recognize an exception for single-specialty pathology physician groups and independent laboratories that bill for pathology services performed or supervised by another pathologist, whether an independent contractor or full-time or part-time employee.

Response: In order to be fair and to avoid the appearance of giving preferential treatment to one physician specialty group over another, the anti-markup provisions on the TC and PC of diagnostic tests are potentially applicable to all physician specialty groups that order tests and wish to bill for the TC or PC, or both, performed by another person or group and billed as a purchased test or billed through a reassignment. (Whether the anti-markup provision for the TC or the anti-markup provision for the PC will, in fact, apply depends on whether the TC or the PC was purchased, or, if not purchased, whether the TC or the PC was performed in the office of the billing physician or other supplier.) Therefore, we are not recognizing an exception for single-specialty pathology physician groups that bill for pathology services performed or supervised by another pathologist, unless the single-specialty pathology physician group does not order the test. If a pathologist in the single-specialty pathology physician group orders and bills for the test performed by another supplier, the anti-markup rules apply. If the pathologist does not order the test and wishes to bill for the test, which is performed by another supplier, the anti-markup rules will not apply. Finally, we note that clinical diagnostic laboratory tests performed by independent laboratories and paid under section 1833(a)(2)(D) of the Act are not subject to the anti-markup provisions pertaining to diagnostic tests.

c. Overutilization

Comment: Many commenters in favor of the proposed rulemaking cited overutilization as a concern in the existing billing and payment environment. Commenters opposed to our proposals denied that contractual arrangements for pathology services lead to overutilization.

In support of their contention that current arrangements facilitate overutilization, some commenters cited various studies for the proposition that physician self-referral leads to increased utilization. For example, one commenter cited 1989 studies from the OIG and GAO that found that physicians who had an ownership or investment interest in a laboratory ordered more tests than those physicians who did not have such an interest. This commenter also noted that an analysis by the Florida Cost Containment Board in 1998 found that physician-owned clinical laboratories, diagnostic imaging centers, physical therapy centers, and rehabilitation centers performed more procedures on a per-patient basis than those facilities that were not physician-owned. The commenter also cited the 2007 study by

the McKinsey Global Institute that found that the United States spends more of its wealth on health care than any other developed country, and that one reason for the difference in spending is due to profit incentives in physician ownership of medical facilities. Other commenters mentioned the 2007 OIG studies of three urology practices, which the commenters described as finding that all three practices substantially increased the number of biopsies ordered per patient after entering into an arrangement for contracted pathology services, and that, after entering into such an arrangement, all three practices billed significantly more biopsies than what their respective carriers paid on average to other suppliers. One commenter cited a study by the Center for Health Policy Studies that examined the effects of State ''direct billing'' laws. Under such laws, the pathologist or entity performing the ordered pathology services is required to bill for the services. This study found that laboratory charges per enrollee under private health insurance programs were 41 percent higher in non-direct billing States than in direct billing States. Another commenter stated that a study in the American Journal of Roentgenology in 2002 confirmed that physician self-referral may be contributing to the uncontrolled growth in imaging services. According to the commenter, that study reported that, when a managed care organization prohibited certain non-radiologist specialties from billing for imaging services, total billings for imaging declined 20 to 25 percent from the amount of billings that were expected based on the previous trend in imaging growth.

One commenter stated that it is unaware of any evidence of overutilization by gastroenterologists who have entered into contractual arrangements for pathology services. Another commenter stated that its managed ''pod labs'' are vital to the accurate detection and treatment of prostate cancer and do not expose Medicare to an undue risk of program abuse. The commenter asserted that no data supports the accusation that its managed laboratories facilitate the generation of medically unnecessary biopsies, and in any event, clinical indications for prostate biopsy are not subject to manipulation.

Another commenter stated that urological pathology volume is based upon objectively demonstrated medical necessity, and is not affected by profit margin or who is billing for services. This commenter suggested that specific requirements could be placed on contractual arrangements to address overutilization concerns, while preserving the benefits of these types of arrangements. The commenter stated that the best way to ensure that contractual arrangements are maximizing their potential for improving care and outcomes, while discouraging overutilization, is to prohibit arrangements that are merely passive investments of the treating physicians. The commenter asserted that physicians who own off-site pathology laboratories should be actively involved in their direction and supervision, and responsible for the services provided by the laboratory. The commenter offered several specific recommendations, including: (1) If a group practice intends to bill for the TC, it must also perform the PC; (2) consistent with CLIA regulations, a pathologist may not be the medical director of more than five laboratories; and (3) refined credentialing criteria for pathologists. In its comments to the CY 2008 PFS proposed rule, MedPAC stated that it agrees that allowing physicians to purchase or contract for the provision of diagnostic tests and to realize a profit when billing Medicare could lead to overuse of services and higher program costs.

One commenter discussed available types of diagnostic tests for prostate cancer and stated that there does not appear to be any added benefit to the patient from receiving a 12-part biopsy series instead of a smaller number. According to the commenter, this method of biopsy results only in increased diagnosis of minimal prostate disease or atypical small acinar proliferations, which leads only to further biopsies and increased medical costs. The commenter stated that the argument of urologists, that 12 biopsies is the standard of care, is shown to be fallacious by the fact that, when members of a particular urology group perform prostate biopsies in local hospitals, they are doing only two-part biopsies. However, another commenter stated that he knows of more than one urologist who routinely submitted two core biopsies for review, but after employing a pathologist, switched to 12 core biopsies. Another commenter stated that patient care improves with contractual arrangements because the test results are timelier and are of higher quality. Faster results, together with the opportunity to collaborate with pathologists, permit urologists to better manage their patients' care. According to the commenter, the number of cores taken for each prostate biopsy is a direct result of the evolving understanding of the nature of prostate cancer, rather than, as some state, the formation of urology specialty laboratory arrangements between urologists and pathologists. One commenter stated that, whereas it understood our concern of overutilization, the current malpractice system creates far more incentive to perform unnecessary tests.

Two commenters stated that the incessant complaints of profits being made at the expense of the Medicare program do not serve any purpose. The commenters claimed that, unless a profit can be achieved, no one will perform services needed by Medicare or any other program. The commenters suggested that, regardless of who collects the fees for pathology and laboratory services and makes a profit, whether an individual pathologist, a commercial laboratory, or a physician specialty practice, this should not be a focus of CMS. Rather, CMS should review the standards of care and hold suppliers to those standards. The commenters pointed out that the National Comprehensive Cancer Network developed standards for a patient with early prostate cancer. At first, the standard was only two cores. In the mid 1990s, the standard was increased to six cores, then, with additional research, the standard was increased to ten cores, and, recently, the recommendation was further increased to 12 cores. The research has shown a dramatic increase in prostate cancer detection with increased core sampling. The commenters stated that it is hypocritical that pathologists are claiming overutilization of services by physician specialty groups, when these same pathologists accepted 12 core biopsies without a whisper of discontent. These commenters asserted that overutilization would cease to be an issue if CMS actively pursued those practitioners, including pathologists, who do not follow the accepted and published standards of care.

Response: It is difficult to determine whether and the extent to which overutilization is due to, or facilitated by, arrangements that allow the referring physician or group practice to bill for the TC and the PC of diagnostic tests. Our proposals were not predicated upon a belief that there was a correlation between the size of the group practice and the volume of diagnostic tests and the risk of program abuse. We appreciate that, for a particular practice specialty, an increase in biopsies ordered may be due to a change in business arrangements that produces profits for the referring physician or group practice, or it may be due to a change in the standard protocols (or in

the referring physician's or group's perception of the appropriate standard of care). Nevertheless, studies have shown that, in the aggregate, utilization of diagnostic tests increases in the case of physician self-referral. We believe it is appropriate to guard against the potential for overutilization through an anti-markup provision on the TC and PC of diagnostic tests. We decline to use a specific number of prostate biopsies as a trigger point for application of the anti-markup provisions, as we believe the appropriate number of biopsies is largely patient-specific.

Comment: Several commenters stated that contractual arrangements for anatomic pathology testing pose no risk of overutilization because Medicare patients would not be subjected to unnecessary testing due to the invasive nature of test procedures such as colon or prostate biopsies.

Response: We are skeptical that the risk of overutilization for biopsies is appreciably less than that of other types of diagnostic tests. In any event, in enacting the anti-markup provision in section 1842(n)(1) of the Act, the Congress made no exception for biopsies or other minimally invasive tests, and in order to effectuate Congressional intent we are not providing for such an exception.

d. Quality and Patient Access

Comment: Many commenters, both in favor of and against the proposed rulemaking, focused on the issue of the quality of the diagnostic testing, particularly pathology services.

Two commenters stated that the financial incentive inherent in some arrangements can result in physicians selecting laboratories not on the basis of quality but on the potential for profit from these arrangements. One commenter believes that ''by reducing pathologists to the status of indentured servants of clinicians who 'own' the patients and their biopsies, the autonomy and quality of the pathology services provided is fatally eroded.'' According to one commenter, aspects of pathology practice, such as the adequacy of the biopsy, the sampling procedure, the need for deeper or additional sections, the severity of a process, the adequacy of margins, the need for re-excision, the appropriateness of special studies, and the need for outside expert consultation despite increased expense, ultimately are decided based on what provides the maximum economic benefit to the ordering and billing physician. The other commenter stated that a gastroenterology group practice that had been sending its pathology work to his pathology practice ended the relationship because it entered into an arrangement with another pathology group under which the gastroenterology group practice could bill for the TC. The commenter stated that the gastroenterology group said that there was no dissatisfaction with quality or the service of the commenter's work, but rather it was purely a business decision that enabled the gastroenterology group practice to capture additional revenue in an environment of shrinking reimbursement. Another commenter stated that he received a biopsy for review that was performed on a urologist who routinely sent his (the urologist's) patients' biopsies to his (the urologist's) employed pathologist. The commenter stated that what was good enough for the urologist's patients was not good enough for the urologist.

One commenter stated that captive pathology arrangements are detrimental to patient care. The commenter stated that a local gastroenterology group was able to locate a pathologist who was desperate for work and who reads the biopsies only once a week. The commenter called the turn-around time of once per week ''atrocious.'' The commenter claimed that pathologists who are not willing to work for less than fair market value are being put out of work by physicians who are ignorant of the value of quality pathology services and who hire anyone willing to read slides for any price under any condition. Another commenter asserted that, although gastroenterologists claim they get better service from pathologists who allow the gastroenterologists to bill for the pathology services, the ''better service'' is, in reality, more money for the gastroenterologists.

One commenter stated that surgeons and surgical pathologists need to work in close contact with each other, and that the pathologist in a ''pod lab'' has little or no interaction with surgeons and other clinicians. Hospital-based pathologists meet on a regular basis with surgeons and other clinicians to share insights and perspectives on cases, sometimes with immeasurable patient benefit. The ''pod lab'' arrangement impacts negatively upon the ''pod'' pathologist's professional growth. Another commenter suggested that we should be aware that the ''current campaign'' against so-called ''pod labs'' is led by a few self-interested private pathologists, some in leadership positions in their national organizations, who wish to monopolize the outpatient biopsy market. The commenter stated that these pathologists are using scare tactics to paint with the same brush any nontraditional pathology arrangement, without regard to any real demonstration of quality problems. The commenter suggested that, instead of focusing on the ''straw man'' of ''pod labs,'' we should require all suppliers of pathology services to demonstrate quality of service and appropriateness of utilization in order to end the ongoing abusive pathology practices that are occurring in traditional pathology groups, independent laboratories and academic medical centers.

One commenter asserted that the use of contractual arrangements allows specialization by pathologists that otherwise would be seen only in the largest medical centers or reference laboratories. Moreover, the commenter stated that pathologists who work together in contractual arrangements with various groups have the unique opportunity to consult with each other on a regular basis. An entity that manages ''pod labs'' stated that internal data generated by group practices that refer to their own managed laboratories show a higher positive incidence of prostate cancer now than before they contracted with the commenter. One commenter contended that most gastroenterologists who enter into contractual arrangements with pathology laboratories do so in order to achieve a higher quality of patient care through timely diagnoses and the use of pathology personnel who are experts in gastrointestinal and liver pathology. The commenter expressed certainty that our proposal would have an adverse effect on practice efficiency and the quality of patient care.

A commenter stated that large corporate laboratories do not always provide the highest level of care available. According to the commenter, large laboratories have an incentive to hire the cheapest physician labor in order to ''churn out'' a high volume of services. The commenter argued that the interaction between the urologists in a group practice and a dedicated pathologist in that practice will lead to better outcomes. Another commenter stated that some gastrointestinal group practices have opened their own pathology laboratories because they believed that the pathology reports they received from general laboratory companies were in some ways lacking. A commenter echoed that sentiment, and added that the fact that the pathologist was practicing in its office meant that the group can easily discuss the pathologist's findings with him and even review slides together.

One commenter contended that, based on her experience gained from working for large, national laboratories, sections are poorly processed there and, often,

much of the tissue is lost. According to the commenter, extra ribbons are not collected at these laboratories and immunostains often do not contain the area suspicious for carcinoma. There is no communication with the physician's office and usually no clinical information is exchanged. She further asserted that group practices that send tissue samples to large laboratories run the risk that an inexperienced pathologist could be performing the work. The commenter related a personal experience in which biopsies were read at a large national laboratory as showing HGPIN, a precursor to adenocarcinoma. The commenter stated that the slides she reviewed on re-biopsy showed no HGPIN, and, not only was the patient made to worry unnecessarily, but the mistaken biopsy review led to the expense of a re-biopsy and another reading. Another commenter stated that its clients say that it provides better quality services and in a timelier manner than do the national commercial laboratories. According to the commenter, this is because physician practices that send anatomic pathology specimens to large commercial laboratories do not choose the pathologists who interpret the slides and thus do not know the qualifications of the pathologist.

Response: We believe that, everything else being equal, there can be some advantages to a physician or group practice referring to the same pathologist, if the referring physician or group practice chooses the pathologist on the basis of his or her qualifications and experience, and the service that he or she provides. However, we also believe that, where there is a financial reward for choosing a pathologist or other diagnostic specialist based on financial self-interest, there is the potential to disregard, or at least subordinate, quality considerations. This final rule with comment period eliminates the profit incentive in choosing a pathologist or other specialist while preserving the referring physician or group practice's right to continue to use the pathologist or other specialist of its choosing. That is, if a billing group practice currently has a contractual arrangement with a particular histotechnologist and particular pathologist because it believes that the histotechnologist and the pathologist provide superior quality and service, it may continue to refer to them; it only will be prevented from marking up the TC and PC (unless the TC and PC are not purchased and are provided in the office of the group practice).

Comment: Many commenters asserted that there would be no adverse effect on patient access if the proposal was adopted. Other commenters stated that patient care would be significantly disrupted if the proposal was adopted. Specifically, commenters stated that the proposed changes would limit access to multiple urologic services in a local area, namely, radiation therapy, lithotripsy, and many in-office procedures such as thermal ablative procedures for prostate obstruction. These commenters contended that many in-office procedures are never performed in hospitals, and that, if the proposed changes to the reassignment and purchased diagnostic test rules become effective, it would be difficult, if not impossible, to provide these services to Medicare beneficiaries.

Response: We are skeptical that our proposal would cause any patient access problem. There appear to be adequate choices throughout the country for physicians and group practices to obtain timely access to diagnostic testing. No evidence was brought to our attention that a patient access problem previously existed and was somehow alleviated when physicians and group practices began entering into contractual arrangements for the provision of pathology and other diagnostic services. In any event, as noted above, our proposal as finalized does not prohibit physicians and group practices from continuing to use the same diagnostic services that they have been using to date.

e. Purchased Tests as They Relate to Reassigned Tests

Comment: We received comments stating that physician contractual arrangements with pathologists constitute an attempt to evade the restrictions of the physician self-referral law. Several commenters stated that there is no practical distinction between a purchased service and a reassigned service. One commenter stated that the proposal effectively eliminates the reassignment rules. The commenter argued that, although CMS states that, under section 952 of the Act, it is required to recognize contractual reassignments only to the extent they meet program integrity and other standards determined by the Secretary, the commenter asserts that the Congress surely did not mean that this statutory provision could be administratively repealed by merging it into the already existing purchased diagnostic test rules. Another commenter stated that our proposal appears to be mixing the purchased diagnostic test policies with contractual reassignments, which could result in confusion for the imaging industry.

Response: We are concerned that some current arrangements are not in accord with the spirit or the letter of the anti-markup provision in section 1842(n)(1) of the Act. Section 1842(n)(1)(A) of the Act, which was enacted as part of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203), provides that, if a diagnostic test described in section 1861(s)(3) of the Act (other than a clinical diagnostic laboratory test) was not performed or supervised by the billing physician and also was not performed or supervised by a physician with whom the billing physician ''shares a practice,'' Medicare payment is the lower of the costs (net of any discount) charged by the performing supplier to the billing physician, or the performing supplier's reasonable charge (or other applicable limit). We implemented the anti-markup provision of section 1842(n)(1) of the Act by promulgating current § 414.50, ''Physician billing for purchased diagnostic tests.'' The current version of § 414.50 applies to TCs performed by an ''outside supplier,'' but that term is undefined. We acknowledge that some have understood § 414.50 as applying only to TCs that are outright purchased, instead of reassigned, but as we indicated in the CY 2007 PFS proposed rule (71 FR 49056), and as some commenters have noted, reassigned tests are functionally the equivalent of purchased tests. When section 1842(n)(1) of the Act was enacted, there was perhaps more of a difference between purchased tests and reassigned tests, but subsequent events have blurred the distinction between tests that are outright purchased and tests for which payment is reassigned.

At the time section 1842(n)(1) of the Act was enacted, reassignments under the contractual arrangement reassignment exception in section 1842(b)(6)(A)(ii) of the Act were permitted only to the extent the work was performed on the premises of the billing supplier. Therefore, at that time, a physician reassigning benefits to another physician was either an employee of the billing supplier or a contractor who was furnishing the services on the premises of the billing supplier. However, in our January 4, 2001 (Phase I) final rule with comment period, we provided that, for purposes of our rules on physician self-referral, an independent contractor physician is a ''physician in the group practice,'' as defined at § 411.351, during the time the physician is providing care to the group practice's patients ''in the group practice's facilities'' (66 FR 885 through

886, 955). Further, in that same rulemaking, we provided that a group practice's facilities (again, for purposes of our rules on physician self-referral) can include a ''centralized building'' (66 FR 888 through 889). As defined at § 411.351, space qualifies as a group practice's ''centralized building'' if it is leased ''24/7'' by the group practice, irrespective of the amount of square footage of the space and irrespective of the proximity (or lack thereof) to the group's facilities. Following that rulemaking, a group practice could, in compliance with our rules on physician self-referral, refer patients for designated health services (DHS) (such as diagnostic testing) to an independent contractor physician, and such physician could perform or supervise the performance of diagnostic tests in a centralized building, provided that all requirements of an exception were satisfied. Further, the independent contractor physician arguably satisfied the ''on the premises'' requirement of section 1842(b)(6)(A)(ii) of the Act and, thus, was permitted to reassign benefits to the group practice for the work performed in the centralized building, because we considered a centralized building to be the group practice's facilities. In any event, in section 952 of the MMA of 2003, the Congress amended section 1842(b)(6)(A)(ii) of the Act to remove the requirement that the services must be performed on the premises of the billing supplier in order to utilize the contractual arrangement exception. Therefore, following the MMA amendment, it is clear that independent contractor physicians who perform or supervise the performance of diagnostic tests in a centralized building may reassign payment for such tests to the group practice that owns or leases the centralized building.

Being mindful of the Congress' intent to impose an anti-markup on the TC of diagnostic tests that are not performed or supervised by a physician who ''shares a practice'' with the billing physician, we are amending § 414.50 in this final rule with comment period to provide that TCs that are not performed in the office of the billing physician or other supplier are subject to the anti-markup provision. With respect to a physician organization (such as a group practice), we consider the ''office of the billing physician or other supplier'' to be medical office space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally. Therefore, with respect to group practices, we do not consider space to be the ''office of the physician or other supplier'' if that space does not meet the requirement regarding patient care services in revised § 414.50(a)(2)(iii) (for example, space that is utilized as a ''centralized building'' for purposes of the exceptions for physician services and in-office ancillary services in § 411.355(a) and (b), respectively, but in which the group practice provides diagnostic testing services only).

We believe that, if the TC is performed by an employee (full-time or part-time), or by an independent contractor who reassigns benefits, in the office of the billing physician or other supplier, a sufficient nexus with the practice of the billing supplier is established. (In this regard, we note that, if the TC is performed by someone other than an employee or a contractor who reassigns benefits, that is, someone who sells the test to the billing physician or other supplier, the anti-markup provision will apply regardless of where the service is performed.) Further, we see no reason to distinguish between the TC and the PC of diagnostic tests for purposes of the anti-markup provisions. Although the Congress did not establish an anti-markup provision in section 1842(n)(1) of the Act or elsewhere for the PC of diagnostic tests, the omission may have been inadvertent. That is, it is not immediately clear why the Congress, if it wished to prevent overutilization of diagnostic testing, would not have desired an anti-markup on the PC, because without such a provision, the incentive to order unnecessary tests (and profit on the PC) remains. We believe that, in order to fully effectuate the Congress' intent to prevent or limit the ordering of unnecessary diagnostic tests, it is necessary to impose an anti-markup provision on the PC of diagnostic tests. Accordingly, our revisions to § 414.50 apply to PCs to the same extent as they apply to TCs.

We see no reason to distinguish between physicians and physician group practices on the one hand, and other types of suppliers on the other hand, that bill for diagnostic tests. In the proposed rule, we used the terminology ''physician or medical group,'' which we borrowed from the existing manual provisions on purchased tests and purchased test interpretations. However, the term ''medical group'' is not defined and is not commonly used elsewhere. We are amending § 414.50 so that it applies to a billing ''physician or other supplier.'' Any enrolled supplier that bills for a diagnostic test or its interpretation is potentially subject to the anti-markup provisions in § 414.50.

f. Definition of ''Entity''

Comment: One commenter stated that, although we proposed to expand the purchased diagnostic test rule in § 414.50 to apply also to the purchased PC of a diagnostic test, it was not entirely clear whether we proposed to expand the scope of the exception in the definition of ''entity'' at § 411.351 for purposes of our rules on physician self-referral. The commenter noted that the definition of ''entity'' at § 411.351 provides that a physician's practice is not acting as an ''entity'' when it bills Medicare for ''a diagnostic test in accordance with § 414.50.'' The commenter contended that the phrase ''diagnostic test'' is currently interpreted to mean only the TC, in part because § 414.50 currently applies only to the TC. The commenter also stated that if the scope of § 414.50 is expanded to cover both the TC and the PC, one could interpret the phrase in § 411.351, ''diagnostic test in accordance with § 414.50,'' to mean that a physician practice is not an entity when it bills Medicare for either the TC or the PC in accordance with § 414.50. The commenter suggested that, if we finalize our proposal to apply an anti-markup provision to purchased TCs and PCs, we should revise the definition of ''entity'' at § 411.351 to clarify that the exception for purchased diagnostic tests applies to both the TC and the PC. Another commenter also supported changing the definition of ''entity'' at § 411.351 to except from that definition a supplier that is billing for the PC in accordance with the anti-markup provisions of § 414.50.

Response: Under our physician self-referral rules in part 411, subpart J of this chapter, a physician may not refer a patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member) has a financial relationship, and the entity may not bill Medicare for such DHS, unless an exception applies. The definition of ''entity'' at § 411.351 ''does not include a physician's practice when it bills Medicare for a diagnostic test in accordance with § 414.50.'' The rationale for excluding from the definition of ''entity,'' and hence from the application of our physician self-referral rules, a physician practice that is billing for a TC that is subject to the anti-markup provision, is that there is no risk of overutilization arising from a financial relationship between the referring physician and the physician's practice billing for the service. We believe the same rationale should apply to PCs made subject to an anti-markup provision under this final rule with

comment period. We are amending slightly the definition of ''entity'' at § 411.351 to make clear that the exclusion applies to both TCs and PCs. As amended, the pertinent language reads ''does not include a physician's practice when it bills Medicare for the TC or the PC of a diagnostic test for which the anti-markup provision is applicable in accordance with § 414.50.''

We note that, under our physician self-referral rules, an independent contractor physician is a ''physician in the group'' for purposes of the physician services exception in § 411.355(a) and the in-office ancillary services exception in § 411.355(b), only with respect to services performed on the group's premises (including a ''centralized building'' as defined at § 411.351). Therefore, one practical effect of the change in the definition of ''entity'' is that a group practice that currently may not bill for a PC performed by an independent contractor physician, because the independent contractor physician is not performing the PC on the group's premises, will be able to do so without running afoul of the physician self-referral rules if the PC is billed in accordance with the anti-markup provisions of this final rule with comment period.

g. Employment Status

Comment: A commenter that supported our proposed changes to the reassignment rules pertaining to diagnostic tests stated that it was appropriate for CMS to focus on the billing of diagnostic tests performed by someone other than a full-time employee. The vast majority of commenters that addressed the employment status issue, however, opposed applying the anti-markup provisions to part-time employees and independent contractors based simply on their employment status. Three commenters asserted that the proposed changes are unnecessary and would negatively impact the way physicians provide care to patients, possibly resulting in the termination of part-time physicians or a prohibition on part-time physicians furnishing diagnostic tests. Many commenters claimed that, if the proposed changes to the purchased diagnostic test rules are implemented, physicians and group practices would not be able to provide certain routine medical procedures if limited to using full-time employees. One commenter requested that we exempt part-time employees and independent contractors from the anti-markup rules provided that the billing supplier satisfies a physician self-referral exception and the services are furnished in the billing supplier's office. A few commenters proposed that CMS not apply the anti-markup requirements to technicians who work on-site at the medical group and who work at least half-time for that specific group.

One commenter stated that limiting reimbursement for the PC of diagnostic tests performed by outside suppliers would create an incentive to hire full-time staff and then overutilize pathology services in an attempt to recoup the costs of such personnel. The commenter urged us not to penalize physician groups by having the anti-markup rules apply when using part-time employees or independent contractors who furnish services on less than a full-time basis. Two commenters considered our proposal to be premised on the unsupported belief that group practices that perform a lower volume of diagnostic tests and, therefore, need only employ pathologists on a part-time basis, present more risk of program abuse. Another commenter stated that forcing suppliers and their staff into full-time relationships will impose needless costs and will require forgoing efficiencies that are available through more flexible supplier-staff relationships. Several commenters believed that applying an anti-markup provision based upon the employment status of the technician or physician would unfairly disadvantage individuals who want to work only part-time (for example, mothers of young children). One of these commenters stated that we essentially placed a hurdle in front of group practices that wish to accommodate the professional and personal needs of its employees, and that, given the shortage of qualified health professionals in many areas, we should be making it easier, and not more difficult, for professionals to provide care.

Response: We agree that it is not necessary or advisable to premise the application of the anti-markup provisions on the employment status of the person performing the TC or PC. We are revising the language in § 414.50 to clarify that an outside supplier is 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 supplier under a reassignment that meets the requirements of § 424.80. Therefore, diagnostic testing services furnished by part-time employees and independent contractors in the office of the billing supplier will not be subject to the anti-markup rules, unless the services of the independent contractor are billed as a purchased diagnostic test.

Comment: One commenter stated that the anti-markup provisions should apply only when the diagnostic service is provided in a centralized building outside of the physician's primary office site where he or she provides his or her professional services, and should not apply based on the employment status of the individual performing the TC.

Response: We agree generally and have revised § 414.50 and § 424.80 to specify that the anti-markup rules apply to purchased tests and interpretations (regardless of site of service) and to TCs and PCs performed at a site other than the office of the billing supplier. With respect to physician group practices, the group's ''office'' is the medical office space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally. The group's office does not include space utilized by the group as a ''centralized building'' (or other space) where only (or primarily) diagnostic testing is performed by radiologists or pathologists.

Comment: One commenter found the proposed definition of an outside supplier as someone other than a full-time employee of the billing physician or medical group to be confusing and inconsistent with the definitions at § 411.351. Thus, the commenter recommended replacing the term ''full-time employee of the billing physician or medical group'' with the defined term ''member of the group or member of a group practice.''

Response: In the CY 2007 PFS proposed rule (71 FR 49054), we proposed that TCs and PCs that are reassigned under the contractual arrangements exception in section 1842(b)(6)(A)(ii) of the Act would be subject to an anti-markup provision. We received comments expressing concern that our proposals would be ineffective to the extent that contractors who performed TCs and PCs for multiple group practices would now become part-time employees of the same group practices. In response, in the CY 2008 PFS proposed rule, we proposed that the anti-markup provisions would apply to reassigned TCs and PCs that are not performed by full-time employees. However, we believe we can guard adequately against potential overutilization by imposing an anti-markup provision on purchased PCs and TCs, and, with respect to non-purchased TCs and PCs, imposing an anti-markup provision on the TCs and PCs that are performed outside of the office of the billing physician or other supplier, without regard to the employment status of the person

performing the TC or PC, thus leaving intact the part-time employment arrangements that have traditionally existed. Therefore, we believe it is unnecessary and inadvisable to adopt the commenter's suggestion.

Comment: Several commenters requested that we clarify what is meant by a ''full-time employee.'' They urged us to use the Department of Labor's Bureau of Labor Statistics standard, which is 35 hours per week.

Response: For the reasons stated above, we do not believe it is necessary to define ''full-time employee.''

Comment: Several commenters suggested that we exempt TCs and PCs furnished by part-time employees of the billing supplier from the anti-markup provisions, provided that the employees are working exclusively for one billing supplier, such as a single health care organization. Other commenters suggested that, instead of providing that the anti-markup provisions would apply to the TCs and PCs performed by part-time employees, we apply an anti-markup provision to work performed by employees who work for more than a certain number of physician practices.

Response: We considered creating an exception from the anti-markup provisions for services provided by part-time employees who work exclusively for one billing supplier. We also considered restricting the application of the anti-markup provision to work performed by employees who work for more than a certain number of physicians' practices. We rejected both approaches as unnecessary given our decision to base the application of the anti-markup primarily on the site of service, as well as because we believe that each approach would add undue complexity to the rule and would be difficult for both billing suppliers and for us to administer. We will monitor the effectiveness of our site-of-service approach in addressing our concerns regarding potential overutilization. If arrangements that currently are taking place at a site other than the office of the billing physician or other supplier simply migrate to the ''office of the billing physician or other supplier'' in order to escape the application of the anti-markup provisions, we may revisit the idea of imposing an anti-markup provision for services performed by a technician or physician who works for more than a certain number of physician practices.

h. Deductibles and Coinsurance

Comment: Several commenters observed that there appeared to be a drafting error regarding the application of deductibles and coinsurance to the anti-markup limits in proposed § 414.50 and § 424.80. In both sections, the maximum payment is set as an amount that is net of deductibles and coinsurance, that is, ''less the applicable deductibles and coinsurance.'' The commenters noted that the price limitation should represent the Medicare allowable amount, which should include any coinsurance or deductibles to be paid by the Medicare beneficiary. One of the commenters stated that the current language could be interpreted such that the combined Medicare and beneficiary payment to the physician could exceed the amount that a physician paid an outside supplier of a TC or PC by 20 percent, the applicable coinsurance for PFS services. The commenter recommended that the language be revised to read ''the payment to the billing physician or medical group, *including applicable deductibles and coinsurance,* may not exceed the lowest of the following amounts.''

Response: Proposed § 414.50 and proposed § 424.80 stated that, payment to the billing supplier, ''less the applicable deductibles and coinsurance'' may not exceed the lowest of the following amounts: (1) The supplier's net charge to the physician; (2) the physician's actual charge; or (3) the fee schedule amount for the test that would be allowed if the supplier billed directly. The quoted language referenced above is identical to that in current § 414.50 and is virtually identical to that in section 1842(n)(1) of the Act. We read the statute and regulations as saying that the contractor's payment to the billing supplier, in the situation in which the anti-markup provision applies, is the lowest of the performing supplier's net charge, or the billing supplier's actual charge, or the applicable fee schedule amount, *less* any applicable deductible and coinsurance amounts.

We agree with the commenters that the *total* payment (that is, by the contractor and the beneficiary or third party payor on behalf of the beneficiary) is limited to the lowest of the three amounts specified above. This interpretation represents historical Medicare policy, and we believe that this policy has been implemented correctly by the carriers. However, we are refining the language of the regulation as suggested by the commenter for greater clarity. We do not consider this a substantive change. We are revising § 414.50 to read ''the payment to the billing physician or other supplier (*including applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary*) for the technical or professional component of the test may not exceed the lowest of the following amounts * * *''

i. Net Charge

Comment: Several commenters addressed the question of how to determine the net charge for purposes of applying the anti-markup provisions. Commenters asserted that most physicians are paid an aggregate monthly or annual amount for their services and therefore there is no ''charge'' to report on a claim. One commenter stated that independent contractors are frequently paid based on time spent furnishing the services, as opposed to a per-interpretation price. Alternatively, payment may be made at a fixed rate per month or year. Yet another model is a per-service price reflecting a blended rate of different payor pricing, not just the Medicare allowable amount. Employees, including part-time employees, are often salaried. Consequently, according to the commenter, there is no cost or charge per professional interpretation, and it would be impossible for a group practice to determine the unit price for purposes of the anti-markup provision. The commenter contended that all of the various types of employment relationships would have to be restructured, at great cost and administrative burden, to practices.

One commenter stated that it would not be administratively feasible to determine the net charge per test in order to apply the anti-markup provisions to part-time employees or independent contractors who are paid on an hourly basis or a per-diem rate. Other commenters complained that the proposed rules do not address how the billing entity is supposed to determine the net charge per service on the claim. According to these commenters, it causes confusion as well as the risk of false claims liability to require physician practices to include a charge for all diagnostic test services. Another commenter pointed to what it saw as difficulties in allocating charges between the TC and the PC when a billing supplier purchases both the TC and the PC.

A few commenters urged us to provide guidance on how to determine the ''net charge'' for a service. One commenter requested that we clearly state that the billing entity must calculate its net unit price, which may reflect payments divided by the number of slides referred; for example, if the billing entity pays a supplier a set amount per month or per year to prepare and read all the slides that were

referred. One commenter stated that it agreed with the proposed approach of not allowing the net charge to reflect the cost incurred by the performing supplier of leasing equipment or space from the billing supplier. The commenter expressed concern, however, that participants in some joint venture laboratories may inappropriately attempt to inflate the acquisition cost of the service, and suggested that we not permit other related costs, such as separately purchased or leased equipment, supplies, insurance, etc., to be included when determining the amount charged by the person performing the TC or PC. If these costs were included, it would have the effect of raising the net charge, and permit the billing suppliers to charge Medicare a higher price.

Response: We are leaving the responsibility for determining the net charge for a test with the billing supplier. The anti-markup provision imposed on the PC through this final rule with comment period is similar to the longstanding provision for prohibiting a markup on the TC. Thus, we do not believe most suppliers will 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. Suppliers that incur difficulty in calculating the net charge may structure arrangements so that the anti-markup provisions do not apply (for example, by ensuring that tests and interpretations are not purchased and are performed in the office of the billing physician or other supplier), may allow the performing supplier to bill for the TC or PC, or may use a payment method (such as per-procedure) that yields an easily ascertainable net charge. Suppliers must calculate the net charge in a reasonable manner. This final rule with comment period does not prevent suppliers from using any particular method that yields an accurate net charge. For example, in some situations, it may be appropriate to divide a technician's weekly compensation by the number of procedures performed to arrive at the net charge for each procedure performed during that week. Because suppliers would have the burden of establishing that the charge billed was the net charge, suppliers should retain contemporaneous documentation of the methodology and information used to calculate the net charge.

We are not adopting at this time the commenter's suggestion that, to guard against parties artificially inflating the cost of the TC or PC, we specifically prohibit the performing supplier to take into account, when calculating its net charge, the costs of equipment or services (such as insurance), obtained from the billing supplier. However, we note that, to the extent that a billing supplier would sell goods or services at an inflated price so as to game the application of the anti-markup provisions, such excess compensation may constitute a violation of our rules on physician self-referral and may also be a violation of the anti-kickback statute (section 1128B(b) of the Act). We will monitor financial relationships between billing and performing suppliers and, if it appears that parties are attempting to evade application of the anti-markup provisions through the sale of goods and services, we may modify the provisions.

Comment: One commenter expressed concern about expanding the anti-markup provision to cover the PC, noting that, because a per-interpretation price is not the most efficient method of compensation for purchased PCs, practices would likely develop a system of compensation that would pay the reading physician differently depending on the patient's payor. For example, practices might pay the reading physician on a salary basis for reads for patients of private and non-Medicare payors and on a per-read basis for Medicare patients. According to the commenter, this could result in lower costs associated with non-Medicare patients than with Medicare patients, depending on the way in which the physician and the practice negotiate payment for the different groups of patients. The commenter questioned whether it is appropriate to charge Medicare more on a per-procedure basis than other payors.

Response: Nothing in this final rule with comment period requires practices to pay for professional services for Medicare patients on a per-procedure basis or using any particular payment method. What is important is that the practice calculates an accurate net charge for purposes of these regulations. In reviewing the accuracy of the net charges of a practice that pays differently for professional services based on the payor status of the patients, we would look to see whether the use of different payment structures results in inappropriate shifting of costs to Medicare (that is, by paying physicians more for Medicare reads than non-Medicare reads, the practice is able to collect more reimbursement under the anti-markup provisions). Moreover, we note that section 1128(b)(6)(A) of the Act provides for the permissive exclusion of providers or suppliers that submit bills or requests for payment based on charges or costs to Medicare that are substantially in excess of the party's usual charges or costs, absent a finding of good cause for the differential. Responsibility for that statute is delegated to the OIG.

Comment: One commenter questioned whether the anti-markup provisions would apply to diagnostic tests performed through block lease arrangements. This commenter (and another commenter) also stated that it would be difficult to calculate the per-test charge on tests performed in block lease arrangements.

Response: The anti-markup rules do apply to diagnostic tests performed through block lease arrangements, and the burden is on the billing entity to determine how to calculate its net charge per test.

Comment: Several commenters urged us to ensure that the calculation of the payment level under the anti-markup rules will not impose new administrative burdens on the billing supplier. A few commenters stated that the billing supplier should be able to mark up the PC between 7 and 10 percent to cover the costs of billing. A few commenters asserted that the proposed anti-markup provisions will adversely affect group practices that wish to bill globally for interpretations performed by teleradiologists located outside of the billing group practice's office. The commenters were concerned that billing physicians or other suppliers would not be able to include administrative expenses in the price paid for the interpretation. One commenter stated that, by limiting reimbursement to a practice's actual acquisition cost, we are ignoring the role of the RBRVS system to appropriately establish a proper payment amount for services.

Response: Where the anti-markup provisions are applicable, the billing supplier will be responsible for calculating the net charge. Suppliers that do not wish to contend with calculating the net charge will have to structure arrangements so that the anti-markup provisions do not apply (for example, by requiring the suppliers performing the TC and PC to bill for them, or by ensuring that the TC and PC are performed in the office of the billing physician or other supplier), or utilize a per-procedure method of payment or other method that yields an easily ascertainable net charge. Similarly, suppliers that do not wish to incur the cost of billing without being able to mark up the TC or PC, should structure arrangements so that the anti-markup provisions do not apply.

Comment: One commenter contended that, in a medical foundation context, there is no way to determine the net charge to the foundation for the services of the interpreting physician. The commenter stated that the anti-markup proposal would result in the need to generate artificial invoices, greatly complicating and needlessly burdening medical foundations.

Response: A medical foundation, or any other medical group practice, billing for the TC or PC of a diagnostic test that it did not perform will need to calculate its own net charge per test. We perceive no need to generate artificial invoices. The purpose of this requirement is to address potential program abuse where physicians and other suppliers order tests and bill for tests that they did not perform at a markup from the price paid for the test.

Comment: Several commenters inquired how we would be able to verify the true cost of purchasing a TC or PC of a diagnostic test. The commenters questioned our rationale for this proposal and asserted that the proposal would be detrimental because it would have the effect of precluding suppliers from recouping overhead costs. The commenters voiced concerns that we are trying to eliminate purchased diagnostic tests entirely.

Response: We can verify the true cost of a purchased TC or PC by requesting supporting documentation from the provider or supplier. The burden of proof in substantiating the validity of a claim rests with the billing provider or supplier. The anti-markup provisions finalized in this rule are not designed to prevent the billing supplier from recovering overhead expenses or to eliminate purchased diagnostic tests entirely, but rather to minimize program and patient abuse. Where the TC or PC is performed in the office of the billing physician or other supplier, the billing supplier will be able to recoup some or all of the overhead it incurs in the performance of the TC or PC by billing at the fee schedule amount (or at the Medicare limiting charge amount). If, however, the billing supplier has incurred overhead expenses for a TC or PC that was performed at a site other than the office of the billing supplier (such as in space leased by a billing group practice and utilized by the group practice as a ''centralized building'' that does not meet the definition of ''office of the billing physician or other supplier'' at § 414.50(a)(2)(iii)), the billing supplier will not be able to recoup the overhead, but rather will be limited to the lowest of the performing supplier's net charge, the billing supplier's actual charge, or the applicable fee schedule amount. (In the unlikely event that the lowest of the three amounts is either the billing supplier's actual charge or the applicable fee schedule amount, the billing supplier may be able to recoup its overhead but nevertheless would be receiving less payment than the performing supplier's net charge.) We believe that this result is appropriate. If billing suppliers were able to recoup overhead incurred for TCs and PCs that are performed at sites other than their offices, the effectiveness of the anti-markup provisions would be undermined, because there would be an incentive to overutilize to recover the overhead incurred for purchasing or leasing space.

Comment: One commenter recommended that we require, as a condition for reassignment of a purchased interpretation, that the parties to the arrangement calculate a net charge for the service. The commenter stated that, if this condition applied, per-diem or other time-based arrangements, which are more susceptible to markups, would not be permitted.

Response: We realize that, in most circumstances, a group practice would not want to pay an independent contractor more for a service than the payment it receives from an insurer for furnishing the service. However, we are under the impression that some physician group practices that have exclusive contracts with hospitals under which the group practice furnishes all PCs of inpatient and outpatient radiology services often hire independent contractors to provide PCs that are needed at night or on weekends. We have been informed that, in some of these cases, the group practice willingly pays its independent contractors more for their services than the group practice receives in reimbursement so that the group practice physicians do not have to provide services late at night. There may also be other reasons (for example, as an improper inducement for referrals) why parties could agree to an amount that does not accurately reflect the true net charge.

As explained above, we believe that a group practice may pay an independent contractor on a per-diem or hourly basis, and also arrive at an appropriate amount to bill Medicare for each service based on the number and differing work intensities of the services provided.

Comment: One commenter recommended that we prohibit any mark-up over the direct costs incurred by the group practice in providing diagnostic testing services. Direct costs would be defined as limited to the compensation paid to the persons providing the services and the cost of equipment and supplies utilized in performing the services. One commenter asserted that the proposed restrictions would not allow a billing practice to be paid for its legitimate overhead costs. Two commenters requested that we permit employers to include in the calculation of a supplier's net charge the lower of the following: (1) A reasonable practice expense (PE) derived from its own relative value cost; or (2) the actual overhead costs attributable to the supplier. The commenters suggested that this would permit a group to utilize part-time diagnostic physicians without financially penalizing the employer, and at the same time safeguard against artificially inflated overhead costs.

Response: In effect, the commenters requested that we adopt a ''net charge plus'' approach. In order for the anti-markup provisions to have real effect, it is necessary that payment by Medicare be limited to the lowest of: (1) The physician's or other supplier's net charge to the billing supplier; (2) the billing supplier's actual charge; or (3) the fee schedule amount for the service that would be allowed if the physician or other supplier billed directly. If we were to allow billing suppliers to include costs in addition to the performing supplier's net charge, we would defeat the purpose of the anti-markup provisions.

Comment: A few commenters requested that we ensure consistency in the language in § 414.50 and § 424.80. For example, proposed § 414.50(a)(3)(i) states that net charge does not include ''any charge that is intended to reflect the cost of equipment or space leased to the outside supplier,'' whereas § 424.80 states that it does not include ''any charge that is intended to cover or address the cost of this equipment.''

Response: As noted above, we have effectuated the anti-markup provisions by revising § 414.50, and by placing a cross reference to that section in new § 424.80(d)(3). The language of proposed § 414.50(a)(3)(i), ''reflect the cost of equipment or space leased'' survives.

Comment: One commenter recommended that we include in the net charge the costs incurred by the purchasing supplier to facilitate test interpretations, specifically, the cost of teleradiography to transmit images to the interpreting physician and the cost of producing a written report of the interpretation.

Response: To the extent that costs such as those noted by the commenter are incurred by the billing supplier, as opposed to the performing supplier, we are not persuaded to permit the inflation

of the net charge to include such costs. As discussed above with respect to the recoupment of overhead costs, we believe that allowing billing suppliers to recoup the costs suggested by the commenter would defeat the purpose of the anti-markup provisions.

i. Miscellaneous

Comment: One commenter suggested that, as an alternative to an anti-markup provision, we prescribe a fixed dollar amount (for example, based on a percentage of what Medicare would pay for the PC if billed directly), as a ceiling for Medicare payment. The ceiling would be adjusted for certain PEs such as *bona fide* collection costs and bad debt.

Response: We believe that setting a fixed dollar amount for diagnostic tests and interpretations performed under particular circumstances is problematic. There would be difficulties in determining what the fixed dollar amount should be, and what, if any, PEs should be taken into consideration to augment the fixed dollar amount. In addition, we did not propose such an approach, and believe it may be outside the logical outgrowth test for issuing final rules to adopt the commenter's approach in this final rule with comment period. Moreover, even if we were able to adopt such an approach without first specifically proposing one, it would take us considerable time to study the feasibility of prescribing a payment ceiling for TCs and PCs under particular circumstances, and we believe that it is important to issue a final rulemaking on this subject without further delay in order to address our current concerns with potential overutilization.

Comment: Two commenters stated that, in addition to restrictions contained in the proposed rule, we should also require that: (1) A pathologist not be allowed to work for more than one physician group practice; (2) a pathologist not be allowed to work for, or have any arrangement with, independent reference laboratories; and (3) medical liability insurance for the pathologist should be paid by the physician group practice billing for the pathologist's services. (The commenters explained that the purpose of the second proposed requirement is to eliminate the possibility that a reference laboratory could provide a pathologist to a physician group practice in return for receiving the right to bill for the TC.) One of the commenters was also concerned that, if a single pathologist is performing work for the billing physician practice, appropriate or optimal quality assurance will not take place. The commenter stated that, in her pathology group practice, all malignancies are reviewed by at least two pathologists.

Response: With respect to the commenters'' first suggested requirement, we proposed that an anti-markup provision would apply to PCs that are reassigned by someone who is not a full-time employee of the supplier billing for the PC, because we were concerned with the potential for overutilization where a single physician performs interpretations for more than one group practice in contiguous centralized buildings (such as in ''pod'' or ''condo'' laboratories). Specifically, we were concerned that a physician who formerly reassigned benefits under the contractual arrangements reassignment exception could simply be made a part-time employee of a number of group practices. As noted above, in response to public comments, we are not imposing an anti-markup on the PC of a diagnostic test simply because the PC was performed by someone other than a full-time employee of the billing supplier. Rather, we are addressing our concerns regarding potential overutilization by imposing an anti-markup on the PC of a diagnostic test if it is purchased or if it is not performed in the office of the billing physician or other supplier. We believe our decision to impose an anti-markup provision on PCs that are ordered by the billing supplier and performed at a site other than the office of the billing supplier (for example, in space that the billing supplier utilizes as a ''centralized building'' but that does not meet the definition of ''office of the billing physician or other supplier'' in revised § 414.50(a)(2)(iii)), regardless of the employment status of the physician, will adequately address our concerns with overutilization. As for the other two proposed requirements and the second commenter's implied proposed requirement, we do not believe it is within the scope of this rule to attempt to restrict a pathologist from working for more than one supplier, or to require a group practice to pay for a pathologist's malpractice premiums, or to impose quality standards for pathologist performed PCs.

Comment: A commenter recommended that we revise the definition of ''centralized building'' at § 411.351 to include the following language: ''In the case of a space used for the performance of the [TC] of a diagnostic test, which is billed by a group practice, such space can qualify as a centralized building only if the group complies with the requirements of § 414.50 or § 424.80(d)(3) when billing for the [TC].'' The commenter also suggested that, by changing the definition of ''centralized building,'' a physician or medical group would be prohibited from marking up what it paid for the TC of a test that was performed in a centralized building, unless it was performed by a full-time employee.

Response: We are not revising the definition of ''centralized building'' in this rule. Because the anti-markup provisions will apply to all TCs and PCs that are both: (1) Ordered by a group practice (or an entity related to the group practice by common ownership or control; *see* § 413.17 regarding ''common ownership or control''); and (2) performed at a site other than the office of the physician or other supplier, it is not necessary at this time to narrow the definition of a ''centralized building'' in order to guard against potential overutilization.

Comment: One commenter expressed concern regarding physicians who have invested heavily in in-office equipment and have followed CMS guidelines established for the in-office ancillary services exception in § 411.355(b) for purposes of the physician self-referral rules. The commenter recommended that we regulate the usage of ancillary services through medical necessity guidelines and by requiring that the services be provided at fair market value, rather than by the proposed changes to the reassignment and purchased test rules.

Response: As finalized, the anti-markup provisions do not apply to non-purchased TCs and PCs performed in the office of the billing physician or other supplier. We note that in the CY 2008 PFS proposed rule, we sought comments as to whether we should narrow the in-office ancillary services exception, including whether we should exclude certain types of services from the protection of the exception. We received many comments on this issue, and if we are inclined to make any changes to the in-office ancillary services exception we will first propose such changes in a notice of proposed rulemaking.

Comment: One commenter urged us to require that imaging technology be provided only by physicians trained in modality-specific interpretation of imaging procedures who follow the guidelines of specialty organizations such as the American College of Cardiology and the American Society of Echocardiography. In addition, the commenter supported the accreditation of facilities that provide such imaging services, provided that we allow adequate time for practices to become accredited by relevant organizations that

are dedicated to improving the quality of imaging services.

Response: The comment is outside the scope of the proposed rule. Moreover, currently we do not have the statutory authority to restrict payment for these procedures to physicians who possess the training and accreditation recommended by the commenter.

Comment: One commenter urged us to enforce the anti-markup requirements on purchased diagnostic tests by auditing pathology practices and laboratories. The commenter contended that there is widespread ordering of unnecessary tests by pathologists with no regulatory oversight by CMS. The commenter suggested that effective enforcement and application of current anti-markup rules to the pathology community would obviate the need to add new regulations that would limit physician practices from providing quality pathology services to their Medicare patients. The commenter also suggested that we adopt reasonable protocols and standards for the review of Pap smears, among other tests, which, according to the commenter, would significantly reduce unnecessary testing by pathologists and result in tremendous cost savings to the Medicare program.

Response: Our contractors perform pre-pay and post-pay reviews of services, including reviews to determine if the services were reasonable and necessary. However, the extremely large number of claims that contractors must handle each year, as well as the difficulty in sometimes knowing whether services were reasonable and necessary, underscores the need to adopt rules to address the potential for overutilization in other ways, rather than relying solely on reviews for medical necessity. The proposed anti-markup provisions would apply equally to all physicians, including pathologists. However, section 1842(n)(1) of the Act does not authorize the anti-markup on diagnostic tests to apply to clinical laboratory tests, and we did not propose to extend the anti-markup provisions to such tests. We are concerned with preventing the billing supplier from ordering unnecessary tests for profit. Laboratories typically do not order tests, and therefore, there has not been a concern about abuse by laboratories in purchasing diagnostic tests. The comment that we should adopt protocols or standards for the review of Pap smears and other tests is outside the scope of the proposed rule.

Comment: One commenter urged us to prohibit any markup of the TC of surgical pathology specimens and let each physician decide where the TC is performed in addition to where the PC is performed.

Response: Section 414.50 and section 30.2.9 of Pub. 100–04, Chapter 1, CMS Internet-Only Manual, currently prohibit markups of the TC of a diagnostic test if the TC is performed by an outside supplier. As finalized, our revisions to § 414.50 will prohibit the markup of a TC if the TC is ordered by the billing supplier and is either purchased or performed somewhere other than the office of the billing supplier. Physicians are permitted to determine where the TC and PC are performed, provided that the arrangement is in compliance with the purchased test rules and physician self-referral rules.

Comment: One commenter stated that the proposed anti-markup provisions are unfair and would interfere with existing business relationships. The commenter asserted that medical practices should have the freedom to hire in-house professionals or contract with other practices to perform services without fear of financial penalty.

Response: We are not persuaded that our anti-markup proposals, as finalized in this final rule with comment, are unfair. The proposals as finalized are designed to reduce overutilization of diagnostic tests, so that tests are ordered because they are medically necessary and are not ordered because a profit can be made on each test. Practices can maintain relationships with other professionals on a part-time or contractual basis. If the services are furnished in the office of the billing supplier, the anti-markup rules will not apply, unless the services of an independent contractor are billed as a purchased test.

N. Beneficiary Signature for Ambulance Transport Services

Section 424.36 requires that a beneficiary's signature must appear on all claims submitted for Medicare services, unless the beneficiary has died, or another exception applies. However, ambulance suppliers and providers have stated that, in emergency situations, it is often impossible or impractical for ambulance providers or suppliers to obtain a beneficiary's or other authorized person's signature on a claim to properly bill Medicare for ambulance transport services because: (1) Many beneficiaries are incapable of signing claims due to their medical condition at the time of transport; (2) another person authorized to sign the claim under § 424.36(b) is not available, or is unwilling to sign the claim at the time of transport; and (3) if an individual listed in § 424.36(b) is not available or is unwilling to sign a claim on behalf of the beneficiary at the time of transport, it is impractical later to locate the beneficiary (or the beneficiary's authorized representative) to obtain a signature on the claim form before submitting it to Medicare for payment.

As stated in the CY 2008 PFS proposed rule (72 FR 38187), we are sympathetic to the concerns of ambulance providers and suppliers insofar as emergency transport services are involved. Therefore, we proposed to revise § 424.36 to provide that, for emergency ambulance transport services, where the ambulance provider or supplier documents that the beneficiary was physically or mentally incapable of signing a claim form at the time the service was provided and that none of the individuals listed in § 424.36(b)(1) through (b)(5) [2] was available or willing to sign a claim on behalf of the beneficiary, the ambulance provider or supplier could submit the claim without a beneficiary signature. Under our proposal, such claim submission would be permitted only if: (1) The beneficiary was physically or mentally incapable of signing the claim form at the time the service was provided; (2) none of the individuals listed in § 424.36(b)(1) through (b)(4) was available or willing to sign the claim form on behalf of the beneficiary at the time the service was provided; and (3) the ambulance provider or supplier maintains in its files for a period of at least 4 years from the date of service certain documentation. Required documentation would include: (1) A signed contemporaneous statement, made by an ambulance employee present during the trip to the receiving facility, that the beneficiary was physically or mentally incapable of signing a claim form and that none of the individuals listed in § 424.36(b)(1) through (b)(4) was available or willing to sign the claim form on behalf of the beneficiary at the time the service was provided; (2) the date and time the beneficiary was transported, and the name and location of the facility where the beneficiary was received; and (3) a signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the time and date that the beneficiary was received by that facility.

For non-emergency ambulance transport services, the ambulance

[2] We are making a technical change in the final rule. The references in the proposed rule to § 424.36(b)(5) were in error, as individuals are specified only in § 424.36(b)(1) through (b)(4).

provider or supplier would continue to be required to obtain a beneficiary's signature on a claim form (or the signature of someone who is authorized to sign on behalf of the beneficiary under § 424.36(b)(1) through (b)(4)) prior to submitting claims to Medicare.

We received comments from two national associations that represent providers and suppliers of ambulance services and hospitals. The remainder of the comments came from ambulance owners and employees. The commenters generally agreed that we should eliminate the beneficiary signature requirement entirely when a beneficiary is mentally or physically incapable of signing a claim and no other person authorized to sign a claim on behalf of the beneficiary is available or willing to sign at the time of transport. In addition, the commenters argued that the proposed documentation requirements would be costly and burdensome to ambulance providers and suppliers.

We are adopting our proposal, with modification. Specifically, we are allowing a secondary form of verification to be used in lieu of the proposed signed contemporaneous statement from a representative of the facility that received the beneficiary (which remains an alternative). We are also amending § 424.32(a) to clarify that the beneficiary signature requirement is satisfied if one of the exceptions in § 424.36 is satisfied. Finally, we are making a technical change to our proposal. In the proposed rule, we stated that ambulance providers and suppliers could utilize proposed § 424.36(b)(6) if none of the individuals listed in § 424.36(b)(1) through (b)(5) were available or willing to sign the claim on behalf of the beneficiary at the time the service was provided. The references to § 424.36(b)(5) were in error, as individuals are specified only in § 424.36(b)(1) through (b)(4).

Comment: The majority of the commenters opposed our proposed changes to the beneficiary signature requirements in § 424.36. The commenters stated that the proposed changes would have the unintended effect of increasing the administrative and compliance burden on providers and suppliers of ambulance services and on the hospitals.

Response: The proposal would not have imposed any additional burdens on providers and suppliers of ambulance services. Rather, the proposal, which we are adopting with some modification, set forth an alternate method of satisfying the beneficiary signature requirement for claims submitted for emergency ambulance services. Those ambulance providers and suppliers that believe that it is burdensome to comply with new § 424.36(b)(6), may avail themselves of the other means specified in § 424.36 for satisfying the beneficiary signature requirement.

Comment: Commenters asserted that when a beneficiary is physically or mentally incapable of signing a claim, the ambulance industry has already been signing claims on behalf of such beneficiaries in accordance with the requirements listed in the CMS Internet-Only Manual (IOM), Pub. 100–02, Medicare Benefit Policy Manual, Chapter 10, Section 20.1.2 and IOM, Pub. 100–04, Medicare Claims Processing Manual, Chapter 1, Section 50.1.6(A)(3)(c), without any objections from CMS contractors. The commenters stated that the ambulance industry has also been relying on § 424.36(b)(5) as further authority to sign claims on behalf of beneficiaries when beneficiaries are incapable of signing and the requirements of § 424.36(b)(1) through (b)(4) have not been met.

Response: Section 424.36(b)(5) applies only if the beneficiary is physically or mentally incapable of signing the claim and none of the persons listed in § 424.36(b)(1) through (b)(4) is available to sign the claim. Note that we interpret § 424.36(b), including § 424.36(b)(5), as meaning that neither the beneficiary nor any of the persons listed in § 424.36(b)(1) through (b)(4) is available at all, not just that none of them is available at the time the service is performed. Thus, even assuming that § 424.36(b)(5) applies to ambulance providers (and we believe that this subparagraph was intended to apply only to institutional providers such as a hospital), an ambulance provider would not be allowed to rely on § 424.36(b)(5) to sign a claim for ambulance services simply because the beneficiary was incapable of signing the claim at the time of delivery to the hospital or ESRD facility and none of the persons listed in § 424.36(b)(1) through (b)(4) was available and willing to sign the claim for ambulance services at the time of delivery. Instead, the provider would be required, in advance of submitting the claim, to make reasonable efforts to locate and obtain a signature from the beneficiary or, if the beneficiary is not capable of signing, one of the alternative individuals specified in § 424.36(b)(1) through (b)(4). It would make little sense to specify different categories of individuals in § 424.36(b)(1) through (b)(4) who could sign a claim on behalf of a beneficiary who is unable to sign, if a provider was allowed to file a claim without making an effort to obtain a signature from one of the other authorized individuals. To the extent that ambulance *suppliers* have been relying on § 424.36(b)(5) under any circumstances, such suppliers have been failing to follow the regulations, as this subparagraph does not pertain to suppliers. We are clarifying § 424.36(b)(5) to provide that, before a provider may avail itself of the exception in § 424.36(b)(5), it must make reasonable efforts (including over a reasonable period of time) to have either the beneficiary or one of the individuals specified in § 424.36(b)(1) through (b)(4) to sign the claim. Similarly, the sections of the CMS IOM cited by the commenters, Pub. 100–02, Chapter 10, section 20.1.2 and Pub. 100–04, Chapter 1, section 50.1.6(A)(3)(c) imply that reasonable efforts must be made to locate other individuals prior to submitting the claim. We plan to issue clarifying instructions in the near future, to ensure that our regulations and manual instructions on the beneficiary signature requirement are fully consistent with each other.

In contrast, the proposal, as adopted with modification, allows ambulance providers and suppliers, in the case of emergency transport, to sign the claim, if certain documentation requirements are met, where the beneficiary is not capable of signing the claim *at the time of transport*.

Comment: Most of the commenters agreed that some of our proposed documentation requirements are already being followed by ambulance providers and suppliers. However, they strongly objected to proposed § 424.36(b)(6)(ii)(C), which would have required a signed contemporaneous statement from a representative of the facility that received the beneficiary, documenting the name of the beneficiary, and the date and time the beneficiary was received by that facility. The commenters asserted that it is not practical or feasible to obtain a signed contemporaneous statement from a representative of the receiving facility documenting the name of the beneficiary and the date and time the beneficiary was received by that facility. The commenters stated that hospital personnel in emergency departments often are either too busy or refuse to sign any forms when receiving a patient. In addition, the commenters contended that attempting to obtain a signature from a representative of the hospital would decrease the amount of time available for ambulances to serve their respective communities. Therefore, the commenters recommended that CMS modify the proposed beneficiary

signature requirements for ambulance services in § 424.36(b)(6) to include only proposed subsection § 424.36(b)(6)(i). One commenter stated that a signature from hospital staff does not add any more credibility to the ambulance provider or supplier's claim that the patient was unable to sign the claim than what is already present from the EMT's attestation that the patient was unable to sign.

Response: We are not persuaded to modify the proposed alternative to the beneficiary signature requirement in § 424.36(b)(6) to include only § 424.36(b)(6)(i). The purpose of the proposed requirement to secure a signed contemporaneous statement from a representative of the facility that received the beneficiary, as a means of satisfying the alternative, was to ensure that someone other than an ambulance employee verifies the transport and receipt of the beneficiary; the purpose was not to obtain verification that the beneficiary was unable to sign the claim. We continue to believe that in many, if not most, cases the ambulance transport personnel will have no difficulty in securing a signature from personnel at the hospital or other facility that acknowledges receipt of the patient. Indeed, it is our understanding that, as protection from liability or for other purposes, some ambulance providers and suppliers routinely secure a signature from the receiving facility in order to document that the patient was transported. We note that our proposal would not have required the hospital or other receiving facility to do anything more than acknowledge receipt through a signature. That is, the ambulance provider or supplier could add a signature block and an attestation clause, acknowledging receipt, to its trip ticket or other form that would already contain the necessary patient information (that is, the beneficiary's name and the date and time of delivery). However, after further consideration, we are revising § 424.36(b)(6)(ii)(C) to provide an alternative to the requirement under § 424.36(b)(6) that ambulance providers or suppliers must obtain a signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility. The final rule allows the ambulance provider or supplier to meet the condition specified in § 424.36(b)(6) by obtaining a secondary form of verification, prior to submitting the claim for payment. Secondary methods of verification may include the patient care or trip report, the patient medical record, the hospital registration/admissions sheet, the hospital log, or other internal hospital or facility records. Regardless of its specific form, the documentation must be from the receiving facility must indicate that the beneficiary in question was transported to the facility by the ambulance provider or supplier that is submitting the claim, and must be signed by a representative of the facility.

Comment: One commenter stated that the proposal was fair and correct, would not create a heavy burden on the service provider and can be accomplished in a timely manner. A signed contemporaneous statement used on a limited basis and tightly controlled so that it will not become a routine event should help compliance in this area. A clear and standardized format for the contemporaneous statement should be issued to allow for proper compliance with the new rule.

Response: We understand the commenter as supporting our proposal and as saying that ambulance providers and suppliers should not be entitled to routinely rely on proposed § 424.36(b)(6), but rather should be able to rely on this exception only when the beneficiary is, in fact, unable to sign the claim, and only when the proposed documentation requirements have been satisfied. We agree that in most cases an ambulance provider or supplier should not have difficulty in obtaining a signature from the hospital or other facility that acknowledges receipt of the beneficiary; however, we are modifying the proposal to provide for an alternate method of documenting that the beneficiary was transported to the facility. We do not believe that it is necessary to prescribe a specific form for ambulance providers and suppliers to use as a contemporaneous statement to document the transport of the beneficiary, but instead are allowing ambulance providers and suppliers to use existing forms of their own, or, where necessary, to modify their forms to comply with the requirements of the new § 424.36(b)(6)(ii). We again emphasize that ambulance providers and suppliers that do not wish to take advantage of the new exception in § 424.36(b)(6) to the beneficiary signature requirement, may instead obtain the beneficiary's signature prior to submitting the claim, satisfy one of the exceptions in § 424.36(b)(1) through (b)(5), or, where appropriate, bill the beneficiary.

Comment: Several commenters recommended that we eliminate the beneficiary signature requirement entirely. They believe that the requirement is not necessary because, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report that described the condition of the beneficiary, treatment, origin/destination, etc. Also, the origin and destination facilities complete their own records, which document that the beneficiary was sent or received. Commenters stated that if it becomes necessary to audit claims, CMS can obtain information from the transporting and receiving facilities in order to establish that the beneficiary was, in fact, transported as claimed by the ambulance provider or supplier.

Response: We proposed an alternative, optional method of fulfilling the beneficiary signature requirement for claims for emergency transport services. We did not propose to eliminate the signature requirement and are not prepared to do so at this time. The beneficiary signature requirements help ensure that services were in fact rendered and were rendered as billed. Although we agree that documentation obtained from the transporting and (particularly) from the receiving facility may help to alleviate any concern whether services were furnished or were furnished as claimed, we do not believe that it is our responsibility to attempt to locate such documentation should claims be called into question (and it is also uncertain whether we would have the right to compel the transporting or receiving facility to provide us with such documentation). Therefore, to the extent that an ambulance provider or supplier wishes to use third-party documentation to demonstrate that a beneficiary was transported as claimed, instead of having the beneficiary sign the claim or meeting one of the exceptions in § 424.36(b)(1) through (b)(4), it must follow the procedures in new § 424.36(b)(6).

Comment: Most of the commenters questioned the need for the beneficiary signature, because they asserted that the beneficiary signature is no longer necessary given that it is not required for the assignment of benefits or the authorization of records release to CMS or its contractors. In addition, the commenters stated that almost every covered ambulance transport is to or from a facility (that is, a hospital or skilled nursing facility) where a valid signature is already on file. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services, or any related services. The commenters believe that ambulance transport to a facility, for purposes of receiving treatment at that facility, constitutes a

''related service,'' because the ambulance transports the patient to or from that facility for treatment or admission. Commenters also noted that, with respect to beneficiaries who are eligible both for Medicare and Medicaid, a signature is already on file with the State Medicaid office. Therefore, they argued that duplicating the requirement for a signature is costly and burdensome on ambulance service providers.

Response: The purpose of the assignment of benefits signature is different than the purpose of the beneficiary signature to file a claim. As stated above, the purpose of the beneficiary signature to file a claim is to ensure that services were furnished and were furnished as billed. Although the assignment of benefits signature is not required for services billed on mandatory assignment, the beneficiary signature is still required for submitting a claim to Medicare.

A beneficiary's signature on file at a hospital or a skilled nursing facility does not indicate that an ambulance provider or supplier was authorized to submit a claim for transport services on behalf of the beneficiary or that transport services in fact were furnished. Rather, the signature on file at a facility is used for claims filed by that facility for treatment the facility furnished to the beneficiary. Similarly, the fact that a beneficiary's signature may be on file with a State Medicaid office (or elsewhere) does not in any way speak to the issue of whether the ambulance provider or supplier was authorized to submit a claim for transport services on behalf of the beneficiary or that transport services in fact were furnished.

Comment: A commenter stated that when submitting claims electronically, a provider or supplier must answer ''Y'' or ''N'' for the question of whether the provider or supplier has obtained a beneficiary signature. The commenter suggested that we should add language to the regulations to indicate that the beneficiary signature requirement will be met if one of the exceptions to the requirement is met.

Response: We agree that it is proper and accurate to answer ''Y'' (for yes) to the question in the case where the beneficiary has not signed the claim but one of the alternatives in § 424.36(b) through § 424.36(e) has been satisfied. We are clarifying § 424.32(a)(3) (basic requirements of all claims) accordingly.

Comment: Many commenters stated that the proposal would encourage ambulance providers and suppliers to seek signatures from patients who are in need of medical care and under mental duress. They stated that beneficiaries under duress should not be required to sign anything.

Response: We agree that beneficiaries under duress should not be required to sign claims; in fact, we consider a beneficiary signature obtained under duress to be invalid. We do not agree, however, that our proposal encouraged ambulance providers and suppliers to obtain beneficiary signatures under duress. As stated above, the proposal was intended to provide ambulance providers and suppliers with another alternative to obtaining the beneficiary's signature. It was not, and the final rule is not, a narrowing of the available alternatives to ambulance providers and suppliers. Moreover, the commenters appear to assume that if ambulance providers and suppliers are to obtain a beneficiary's signature, they must do so at the time of transport. However, ambulance providers and suppliers have always been able to obtain the beneficiary's signature (or the signature of one of the persons specified in § 424.36(b)(1) through (b)(4)) at any time prior to submitting the claim. In fact, as noted above, before providers may avail themselves of the exception in § 424.36(b)(5), they are required to make reasonable efforts to have the beneficiary or one of the persons specified in § 424.36(b)(1) through (b)(4) sign the claim. With this final rule, ambulance providers and suppliers, in the case of emergency transport services, may submit the claim without making such reasonable efforts if they satisfy the documentation requirements of new § 424.36(b)(6).

O. Update to Fee Schedules for Class III Durable Medical Equipment (DME) for CYs 2007 and 2008

1. Background

a. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Classifications

Under § 414.210, for Medicare payment purposes, fee schedules are determined for the following classes of equipment and devices:

- Inexpensive or routinely purchased items as specified in § 414.220.
- Items requiring frequent and substantial servicing, as specified in § 414.222.
- Certain customized items, as specified in § 414.224.
- Oxygen and oxygen equipment, as specified in § 414.226.
- Prosthetic and orthotic devices, as specified in § 414.228.
- Other DME (capped rental items), as specified in § 414.229.
- Transcutaneous electric nerve stimulators (TENS), as specified in § 414.232.

We designate the items in each class of equipment or device through our program instructions.

Under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c), the Food and Drug Administration (FDA) must classify devices into one of three regulatory classes: Class I, class II, or class III. FDA classification of a device is determined by the amount of regulation necessary to provide a reasonable assurance of safety and effectiveness; class III devices typically posing the greatest risk. See the CY 2008 PFS proposed rule (72 FR 38188) for a specific explanation of the three regulatory classifications of devices.

b. DMEPOS Payment

Section 302(b)(1) of the MMA amended section 1847 of the Act to require the Secretary to establish and implement competitive acquisition programs for the furnishing under Medicare Part B of certain types of DMEPOS. Section 1847(a)(2)(A) of the Act provides that devices determined by the FDA to be class III devices under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) cannot be included in the competitive acquisition programs. As part of the transition to competitive acquisition, the Congress mandated in sections 1834(a)(14)(G) through (I) of the Act that the fee schedule amounts for DME, other than class III devices, be frozen at 2003 levels through 2008.

For class III devices, section 1834(a)(14)(G)(i) of the Act mandates that an annual update factor based on the percentage change in the consumer price index for urban customers (CPI–U) be applied to the fee schedule amounts for CYs 2004 through 2006. Section 1834(a)(14)(H)(i) of the Act, as added by section 302 of the MMA, gives the Secretary discretion in determining the appropriate fee schedule update percentage for CY 2007 for DME which are class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c(a)(1)(C)).[3] Specifically, for 2007, the 2006 fee schedule amounts for class III devices are to be updated by the percentage change determined to be appropriate by the Secretary, taking into account recommendations contained in

[3] Section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act has been codified as 21 U.S.C. 360c(a)(1)(C). Accordingly, we believe that the references to 21 U.S.C. 360(c)(1)(C) in sections 1834(a)(14)(G)(i), (H)(i), and (I)(i) of the Act are scrivener's errors.

a report of the Comptroller General of the United States under section 302(c)(1)(B) of the MMA. Also mandated by section 1834(a)(14)(I)(i) of the Act, for 2008, the 2007 fee schedule amounts for class III devices are to be increased by an annual factor based on the percentage change in the CPI–U, as applied to the 2007 payment amount determined after application of the percentage change under section 1834(a)(14)(H)(i) of the Act.

As stated above in this section of this final rule with comment period, section 1834(a)(14)(H)(i) of the Act mandated that the Secretary take into account recommendations by the Comptroller General of the United States, who is the head of the Government Accountability Office (GAO), when determining the appropriate update percentage for class III devices for 2007. On March 1, 2006, the GAO published a report, ''Class III Devices do not Warrant a Distinct Annual Payment Update'' (GAO–06–62). The GAO concluded in that report, ''because the initial payment rates for all classes of devices on the Medicare DME fee schedule are based on retail prices or an equivalent measure, they account for the costs of class III and similar class II devices in a consistent manner. Distinct updates for two different classes of devices are unwarranted.'' The GAO recommended that the Secretary establish a uniform payment update to the DME fee schedule for 2007 for class II and class III devices.

In the May 1, 2006 **Federal Register**, we published the Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues proposed rule (71 FR 25660). We solicited comments on how to determine the appropriate fee schedule percentage change for class III devices for 2007 and 2008. We stated that we would consider the comments received in conjunction with the recommendations in the GAO report in determining the appropriate update percentage for these devices for 2007 and 2008.

A majority of the submitted public comments indicated that the GAO report was flawed since it did not recommend a specific update factor or take into account changes over time in the costs of producing, supplying and servicing class III devices. Several commenters recommended that we continue to use the CPI–U to adjust fee schedule amounts for class III devices, but offered no substantive information that would otherwise support a distinct update factor for class III devices. Another commenter recommended that the class III proposal be included in a separate rulemaking procedure because it is not related to competitive acquisition.

2. Update to Fee Schedule

We believe that the GAO has done a thorough job in reviewing Medicare payment rules and methods and issues associated with the costs of furnishing class III devices. Accordingly, we agree with the finding in the report that the costs of furnishing class II and class III DME devices have been factored into the fee schedule amounts calculated for these devices. We also agree with the GAO recommendation that a uniform payment update be established to the DME fee schedule for 2007 for class II and class III devices. For class II devices, the MMA provided for a zero percent payment update from 2004 through 2008. Accordingly, for 2007, in the CY 2008 PFS proposed rule we proposed a zero percent update for class III devices (72 FR 38188 through 38189). Also, in accordance with the MMA, we proposed to use the percent change in the CPI–U to update the class III device 2007 fee schedule amounts for 2008.

Comment: One commenter supported an update based on the CPI–U but did not provide any additional information. A second commenter indicated that class III devices are innovative, beneficial, cost-effective devices and supported a reasonable payment update but did not recommend a specific update and also did not provide any information explaining why class III devices should receive a different update for 2007 than other DME.

Response: We do not believe that the information submitted by the commenters provides any information that would indicate that class III devices warrant a different update than other DME. Accordingly, for 2007, we are adopting the proposed update methodology of applying a zero percent update for class III devices. Also, in accordance with the MMA, we are adopting the proposed methodology of applying the percent change in the CPI–U to update the class III device 2007 fee schedule amounts for 2008. The change in the CPI–U for the 12-month period ending with June 2007 was 2.7 percent. Therefore, a 2.7 percent increase will be applied to the 2007 fee schedule amounts for class III DME to determine the 2008 fee schedule amounts for these items.

P. Discussion of Chiropractic Services Demonstration

In the CY 2006 PFS final rule with comment period (70 FR 70266) and the CY 2007 PFS final rule with comment period (71 FR 69707), we included a discussion of the 2-year chiropractic services demonstration that ended on March 31, 2007. This demonstration was authorized 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 will include the detailed analysis of budget neutrality and the proposed

offset during the CY 2009 PFS rulemaking process.

Comment: We received a number of comments on the methodology for determining budget neutrality. One commenter indicated that it continues to oppose our methodology for assuring budget neutrality under the demonstration. Instead of the application of an adjustment to the national chiropractor fee schedule, the commenter recommends that CMS make an adjustment to the totality of services payable under the Part B Trust Fund. This would be consistent with the requirements in section 651(f)(1)(A) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Another commenter stated that CMS should apply budget neutrality only to the chiropractic codes used in the demonstration project. Because the demonstration did not require a physician referral, physicians should not be penalized for any utilization of chiropractic services. The commenter further noted that if budget neutrality is not limited to the chiropractic codes, CMS should incorporate estimates of the impact on other services into its SGR ''law and regulation'' factor estimates.

Response: Section 651(f)(1)(B) of the MMA requires that ''* * * the Secretary shall ensure that the aggregate payment made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.'' The statute does not specify a specific methodology for ensuring budget neutrality. Our methodology meets the statutory requirement for budget neutrality and appropriately impacts the chiropractic profession that is directly affected by the demonstration. The budget neutrality adjustment under the PFS will be limited to adjusting chiropractor fee schedule codes (comprised of the 3 currently covered CPT codes 98940, 98941, and 98942). No other codes would be affected.

Comment: One commenter noted that there are numerous dimensions to the analysis of effectiveness of treatment. By restricting our analysis only to Medicare expenditure, CMS would miss the important dimension of the effect of care on the beneficiary. Combining claims data with a measurement of functional status would permit a more useful examination of the impact of expanding chiropractor services. The commenter recommends that if CMS undertakes any further examination of the effectiveness of any intervention for neuromuscular conditions, functional status be considered.

Response: The budget neutrality analysis is only one part of a broader evaluation of the chiropractic services demonstration. A survey was conducted of beneficiaries who received chiropractic services under the demonstration to determine the benefits of treatment and satisfaction with the chiropractic care provided under the demonstration. These results will be included in a Report to Congress on the demonstration.

Q. Technical Corrections

1. Particular Services Excluded From Coverage (§ 411.15)

Sections 612 and 613 of the MMA added coverage under Part B for cardiovascular disease screening tests and diabetes screening tests, effective for services furnished on or after January 1, 2005, subject to certain eligibility and other limitations. These provisions were implemented in the CY 2005 PFS final rule with comment period (69 FR 66236) and were codified in § 410.17 and § 410.18, respectively. However, at the time we neglected to make additional conforming changes to § 411.15, which discusses particular services excluded from coverage, to reflect this expansion in coverage.

To conform the regulations to the MMA provisions, we proposed a technical correction to the provisions in § 411.15 by specifying additional exceptions to provide payment for cardiovascular disease screening tests and diabetes screening tests that meet the eligibility limitation and the conditions for coverage that we specified under § 410.17, Cardiovascular Disease Screening Tests, and § 410.18, Diabetes Screening Tests.

Comment: One commenter suggested that the psychiatric screening examination should be included in the list of preventive health screenings and examinations exceptions from services that are excluded from Medicare coverage under proposed § 411.15. The commenter suggested the advantage for having Medicare cover psychiatric screening examination is that better patient outcomes and decreased use of services often occur as a result of early identification of psychiatric disorders.

Response: The purpose of the proposed technical correction in § 411.15 was to conform that provision to the cardiovascular disease screening test and the diabetes screening test benefits that were established in § 410.17 and § 410.18, respectively. These two part B screening benefits were specifically authorized by sections 612 and 613 of the MMA. The proposed rule did not address the possibility of coverage of a psychiatric screening examination under Medicare Part B. There is no statutory provision that authorizes a benefit for psychiatric screening. Therefore, the commenter's suggestion in this regard falls outside the scope of this final rule.

2. Medical Nutrition Therapy (§ 410.132(a))

In the CY 2006 PFS final rule with comment period (70 FR 70160), we added individual medical nutrition therapy, as represented by HCPCS/CPT codes G0270, G0271, 97802, 97803, and 97804 to the list of telehealth services. In the CY 2008 PFS proposed rule, we proposed a technical correction to § 410.132(a) to conform the regulations to include an exception for services provided at § 410.78. This revised paragraph reads as follows: ''(a) *Conditions for coverage of MNT services.* Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the treating physician. Except as provided at § 410.78, services covered consist of face to face nutritional assessments and interventions in accordance with nationally accepted dietary or nutritional protocols.''

Comment: We received one comment concurring with the proposed technical correction.

Response: We are finalizing the technical correction to § 410.132(a) as proposed.

3. Payment Exception: Pediatric Patient Mix (§ 413.184)

In the CY 2006 PFS final rule with comment period (70 FR 70214), we revised § 413.180 through § 413.192 regarding criteria and the application procedures for requesting an exception to the ESRD composite rate payment. As part of the revisions we intended to amend the section heading of § 413.184 to reflect that, as specified in the statute, this exception only pertains to a pediatric ESRD facility. However, this change was not made. Therefore, we proposed to revise the section heading of § 413.184 to read as follows: ''Payment exception: Pediatric patient mix.''

We did not receive any comments regarding this proposal. Therefore, we are finalizing this provision as proposed.

4. Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§ 410.32(a)(1))

Section 1861(r)(5) of the Act was amended by section 4513(a) of the BBA to allow Medicare payment for a chiropractor's manual manipulation of the spine to correct subluxation, without requiring the subluxation to be demonstrated by an x-ray. The BBA provision was effective for services furnished on or after January 1, 2000. Prior to this statutory change, the subluxation was required to be demonstrated by an x-ray. Because chiropractors are limited by statute in the services they can provide under Medicare, it was necessary to create an exception to the requirement that diagnostic services (including x-rays) must be ordered by the treating physician as provided in § 410.32(a). This exception, which permits a physician who is not a treating physician to order and receive payment for an x-ray that is used by a chiropractor, is specified in § 410.32(a)(1).

Because of the BBA change, which removed the requirement that subluxation must be demonstrated by an x-ray, the so-called ''chiropractic exception'' at § 410.32(a)(1) is no longer warranted. We do not believe it is necessary or appropriate to continue to permit payment for an x-ray ordered by a nontreating physician when a chiropractor, not the ordering physician, will use that x-ray. Therefore, we proposed to revise § 410.32 by removing paragraph (a)(1) and redesignating paragraphs (a)(2) and (a)(3) as (a)(1) and (a)(2), respectively.

Comment: We received several comments on this proposal. Some commenters noted that x-rays are not necessary to identify spinal subluxations, but stated that the ability to obtain an x-ray for Medicare beneficiaries is critical to providing responsible, safe, and medically prudent care. They stated that without this ability they fear beneficiaries and the chiropractic profession as a whole will be at a higher risk for receiving and providing the wrong type of care. The majority of commenters expressed concern that without the chiropractic exception at § 410.32(a)(1), the beneficiary may incur greater out of pocket expenses to obtain a noncovered x-ray when needed by the chiropractor. Other commenters believed that the overall costs for medical services may increase because a beneficiary wanting to seek chiropractic care directly may elect to first seek care for their condition from a medical doctor (MD) or doctor of osteopathy (DO) to obtain an order for a covered chiropractic x-ray, resulting in added costs for physician E/M services. Finally, many chiropractors commented that they are qualified to provide x-rays and other services that Medicare does not cover when furnished by a chiropractor and they believe that x-rays can be essential to rule out ''red flags'' and contraindications that may indicate the need for further diagnostic imaging or a referral to another health care professional.

Response: We believe that retaining the chiropractic exception would be inconsistent with the statutory provision at section 1861(r)(5) of the Act which defines a chiropractor as a physician only for the purposes of sections 1861(s)(1) and 1861(s)(2)(A) of the Act and only with respect to treatment by means of manual manipulation of the spine (that is, to correct a subluxation). This statutory provision does not include diagnostic services at section 1861(s)(3) of the Act, which is the benefit category under which x-rays are covered under Medicare. In addition, commenters noted that x-rays are not required to identify subluxations; rather, commenters stated that they use the x-rays to rule out other conditions where manual manipulation of the spine would be contraindicated or for which further imaging studies are indicated. While the use of x-rays for this purpose is outside the scope of covered chiropractic services, it is also not addressed by the chiropractic exception at § 410.32(a)(1). The chiropractic exception only permits a non treating physician to order an x-ray to identify a subluxation. Therefore, we are finalizing our proposal to revise § 410.32 by removing paragraph (a)(1) and redesignating paragraphs (a)(2) and (a)(3) as (a)(1) and (a)(2), respectively, so that it is consistent and conforms to the statutory revisions mandated by the BBA.

R. Other Issues

1. Recalls and Replacement Devices

In the CY 2008 PFS proposed rule (72 FR 38191), we included a discussion about recent recalls of implantable cardioverter-defibrillator (ICDs) and cardiac resynchronization therapy defibrillators (CRT–Ds). These recalls, as well as previous recalls of ICDs and pacemakers in CY 2004 and CY 2005, raise issues both with regard to the additional costs of replacement devices and with regard to the additional physicians' services and diagnostic tests that beneficiaries who have these devices often need.

The impact of the costs of replacement devices for Medicare payment of inpatient and outpatient hospital services is addressed in separate rulemaking for the respective inpatient and outpatient hospital payment systems. However, in the CY 2008 PFS proposed rule, we also acknowledged there are costs associated with physician monitoring of patients treated with recalled devices. This could involve extra visits to physicians' offices or hospital outpatient departments, as well as additional diagnostic tests which might be needed to care for the beneficiaries who have the recalled devices. Based on our concern of the potential costs to both Medicare and the beneficiary for these unforeseen extra services, we solicited comments on how to identify and address additional health care costs and Medicare expenditures associated with device recall actions.

Comment: We received several comments acknowledging the potential for additional costs that may result from recalled devices, particularly in light of the increases in technology. Commenters stated that such costs should be the responsibility of device manufacturers and not the Medicare program, private payers, or the general public. Some commenters expressed concern that we would impose a financial penalty on physicians who deal with the consequences of product recalls. Several of the commenters suggested alternatives that could be used to address this issue, such as development of a modifier or a specific ''recall code'' that could be used to track the additional time and work associated with these recalls, and urged us to ensure that these additional costs are accounted for in the SGR target. Commenters also stressed that any proposal should be ''vetted'' through the appropriate stakeholders.

Response: We appreciate the suggestions that the commenters provided. It is not our intention to ''penalize'' physicians who care for patients affected by implantable device recalls. Rather, it is our intention to ensure that costs of the additional physicians' services and diagnostic tests associated with recalled devices are recognized and appropriately addressed. We will consider the concerns and suggestions provided by the commenters as we develop a plan to address this issue.

2. Therapy Standards and Requirements

a. Revisions to Personnel Qualification Standards for Therapy Services

In the CY 2005 PFS final rule with comment period (69 FR 66354), we amended § 410.59, § 410.60, and § 410.62 to refer to the qualifications for physical therapists (PTs), occupational therapists (OTs) and speech-language pathologists (SLPs) at § 484.4, which sets the personnel qualifications required under the HHA Conditions of Participation.

Section 484.4 contains requirements for persons furnishing services in HHAs that include physical therapists (PTs), physical therapist assistants (PTAs), occupational therapists (OTs), occupational therapy assistants (OTAs) and SLPs. The CY 2005 PFS final rule with comment period clarified that the personnel qualifications in § 484.4 are applicable to all outpatient PT, OT, and SLP services ''in order to create consistent requirements for therapists and therapy assistants'' (69 FR 66345).

In the CY 2008 PFS proposed rule (72 FR 38191), we proposed to update the personnel qualifications in § 484.4 for PTs, PTAs, OTs, and OTAs. We also proposed to revise the qualifications for SLPs to remove a reference to audiologists in the definition for speech-language pathologists because a speech-language pathologist would not have a Certificate of Clinical Competence in audiology, as implied by the regulation, unless that person was dually qualified as an audiologist.

We proposed these changes for the following reasons.

- The current regulations at § 484.4 contain outdated terminology relating to several of the relevant professional organizations.
- The standards that now exist in the fields of physical therapy and occupational therapy have changed since a substantial portion of these qualification requirements were developed.
- Some of the current qualification requirements do not address individuals who have been trained outside of the United States, or refer to outdated requirements.
- These revisions would have the benefit of establishing consistent standards across provider/supplier lines.

Although all States license PTs, some States have no licensing provisions for PTAs, OTs, OTAs, and SLPs. We proposed to revise our requirements to recognize as qualified PTs, OTs, PTAs, or OTAs who meet their respective State qualifications (or have received State recognition as PTs, OTs, PTAs or OTAs) before January 1, 2008.

We did not propose to allow those who, before January 1, 2008, meet only the State qualifications to practice physical therapy, and not the education requirements, to provide services under the Home Health PPS or the Hospice PPS. As we indicated in the CY 2008 PFS proposed rule, we did not expect that there are therapists furnishing services in a HHA or hospice that do not meet either the current or proposed revised qualifications.

Grandfathering Provision for Home Health

Comment: Commenters were concerned about the inconsistency in standards between settings, stating that there is no justification for the absence of a grandfathering provision for therapists and assistants practicing in Home Health settings. Many also indicated a concern that currently licensed or regulated professionals would not be allowed to continue to practice in a HHA or hospice, and recommended that sufficient time be allowed before implementation of the new standards for new professionals to meet their training.

Response: The commenters make a compelling case for the grandfathering provisions to be applied uniformly across payment systems. We agree that it is important to apply consistent standards and we will apply the grandfathering provision in all settings as specified in part 484 of our regulations. Since all of part 484 describes personnel qualifications, we refer to part 484 in this rule rather than specifically to § 484.4. The cross-reference has also been changed in the regulation text from § 484.4 to part 484 in all applicable sections. Although we proposed that these grandfathering provisions would be included in revisions to § 409.17, § 409.23, § 410.43, § 410.59, § 410.60, § 482.56, § 485.70, § 485.705, § 491.9, the application of the grandfathering provisions to home health in part 484 makes some sections of proposed regulation text unnecessary and necessitates changes in the language of others. The changes proposed to sections § 485.705 and § 491.9 have been omitted, as they are no longer necessary.

Delay in Implementation of New Personnel Qualifications

Comment: Some commenters requested that we delay implementation of consistent therapy standards and qualifications until we can apply them consistently to SNF services, and provide education to providers and suppliers.

Response: We believe a 2-year delay in implementation of personnel qualifications will provide sufficient time for new personnel to come into compliance with the new standards. Therapists and assistants who met the qualifications of their State's practice act (in other words, who are licensed, certified or otherwise regulated by the State as a practitioner in the particular discipline) prior to December 31, 2009, will not be required to upgrade their qualifications. However, in States that have no regulations for practitioners in a particular discipline and for services furnished incident to the services of physicians where licensure does not apply, therapists and assistants must be qualified by education and examination as described in this final rule with comment period. Those who currently qualify to provide services without licensure by meeting the Medicare education or examination standards in effect at the time of the CY 2008 proposed rule will continue to qualify under those policies. On January 1, 2010, any individual who has not met the earlier requirements must meet the new requirements.

Consistent Policy Standards

Comment: Many commenters indicated we have not provided a justification for applying the personnel and policy standards that we have articulated for Part B services consistently to Part A services. Most of these comments came from commenters who also support the right of States to create Medicare standards, who represent interest groups other than Medicare beneficiary/therapy users, and who believe we favor professional organizations in setting policies.

Response: Under both Medicare Part A and B, we must ensure that all services are described within a statutory benefit category. In order to do so, we frequently establish qualifications for health care professionals who furnish, or are involved in furnishing, Medicare services. In many Part A settings, we have historically relied on Medicare contractors to review facility records, State laws and local policies to determine that services have been furnished by qualified therapists. As a result of information provided by new contractors, which has been confirmed by numerous comments to the proposed rule, we have concluded that therapy is not always being furnished by individuals trained as therapists—even in some Part A settings. Therefore, we believe it is critical that we establish in regulations consistent standards for

qualified therapists in the Medicare program.

Comment: Some commenters objected to the use of the terms therapy and rehabilitation to mean physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. The commenters recommended allowing any State licensed or authorized health professional to provide rehabilitation services if the provider's medical staff and State law would permit them to do so. The commenters recommended convening a work group to discuss the creation of rational personnel qualifications and scope of services.

Response: The terms ''therapy'' and ''rehabilitation'', as used in this section of this final rule with comment period, apply only to the Medicare benefit for PT, OT, and SLP services and to the qualified professionals who provide them. The qualifications have been established to assure that all of the personnel who provide these services are suitably trained in the discipline they practice. We see no reason to believe the skills and training required to furnish therapy and rehabilitation in Part A settings are less than those required in Part B settings, and therefore, qualifications for personnel in the inpatient setting should not be less stringent than in the outpatient setting. Therefore, we will adopt the proposed qualifications (with minor modifications), and these qualifications will be made applicable in Part A and Part B settings.

Grandfathering Provision

Comment: Many commenters believe that a grandfathering provision is not necessary for physical therapists and speech-language pathologists since the changes to their qualifications are not substantial.

Response: We agree and have removed reference to physical therapists and speech-language pathologists from the relevant grandfather clauses in the final rule with comment period.

Comment: Several commenters believe that our proposal to require those who were grandfathered to continue to practice at least part time without an interruption of more than 2 years is not necessary, and that the language is confusing.

Response: We agree and have removed the requirement for continued practice from this final rule with comment period.

Comment: We received many comments concerning application of a requirement for State licensure, registration, certification or other regulation to physical therapist assistants. The commenters indicate large numbers of PTAs in California and other States are licensed but do not meet the proposed education and examination requirements. The commenters report implementation of the proposed qualifications would cause severe access problems for beneficiaries and operational disruption for facilities. All commenters supported the adoption of a grandfather clause to allow currently practicing PTAs to continue furnishing services to Medicare patients, and many requested the grandfathering be implemented when the rule is finalized in November, rather than January 1, 2008.

Response: We will recognize as qualified to provide Medicare services those therapists and assistants who are licensed or otherwise regulated by their States before December 31, 2009. Individuals who are not licensed or otherwise regulated as PTs, OTs, PTAs, and OTAs in their States may furnish services incident to a physician's service if they meet the education and examination requirements in this final rule with comment period. These changes will be effective on the date this final rule with comment period is effective.

Personnel Qualifications—General

For therapists and assistants trained outside the United States or trained by the United States military, we proposed standards we considered comparable to those applied to therapists and assistants trained in the United States. However, we noted we would not recognize as qualified therapists or therapy assistants individuals trained in other disciplines for purposes of furnishing PT, OT, or SLP services to Medicare beneficiaries.

Comment: APTA recommends the use of the term ''substantially equivalent'' to replace ''comparable'' to avoid confusion in the language concerning those trained outside the United States.

Response: We have modified the language to substitute in regulations the term ''substantially equivalent'' for ''comparable''.

Comment: Several commenters believe that the qualifications for military trained OTs/OTAs (when applicable) and PTs/PTAs should be the same as for all OTs/OTAs and PTs/PTAs.

Response: We agree that separate qualifications for U.S. military-trained therapy personnel are not necessary for PTs, OTs, and OTAs, since the training programs available in the military already meet the same standards as other U.S.-trained OTs and PTs and OTAs. For PTAs who may, in the future, be trained in the military, we will apply the standard of substantial equivalency consistent with those trained outside the United States, or the same standards as other United States trained PTAs, as appropriate.

Comment: Some commenters recommended that licensure be the only qualification for PTs and OTs. The commenters recommended we defer to individual States or to the medical staff of a hospital to determine the qualifications for physical therapists and occupational therapists.

Commenters agreed generally that we should rely on State licensure in those States where it exists and for those settings where licensure is applicable. The commenters note that there have been attempts to deregulate health professions in the name of regulatory reform and they recommend inclusion (for OT) and continuation (for PT) of education and exam requirements to assure there will be standards in place when licensure does not apply.

Response: We believe it is appropriate, as we proposed, to require qualifications related to education and examination to address those situations where licensure does not apply. We added language in regulations to indicate that when licensure or other regulation is not applicable for therapists and assistants, the education and examination requirements apply.

Comment: Several commenters support applying the proposed qualifications and therapy standards for staff providing services incident to the services of physicians. Some continue to object to the implementation of section 1862(a)(20) of the Act.

Response: Section 1862(a)(20) of the Act excludes from payment under Medicare Parts A and B any expenses for outpatient PT or OT services furnished incident to the services of a physician that do not meet the standards and conditions that apply to therapists, except ''any licensing requirement specified by the Secretary.'' Therefore, as we described in the proposed rule, we will not apply the requirement that therapists and assistants be licensed or otherwise regulated by a State in the case of services furnished incident to the services of physicians. We will apply education and examination requirements.

In the proposed rule, we explained that when we referred to persons who are licensed, certified, and otherwise regulated by a State, we interpreted ''otherwise regulated'' to mean that, while a State may not regulate a profession by granting a license or certifying educational or training

credentials, it may nevertheless regulate the practice of a profession by application of certain other requirements.

We received no comments on the use of this term, and therefore, we intend to use it as proposed. Because we believe the term ''certification'' is redundant to ''otherwise regulated'', that term has been omitted.

Occupational Therapy

We proposed to require that OTs beginning their practice after January 1, 2010, must be licensed, certified, registered or otherwise regulated as an OT, and have graduated from an occupational therapist curriculum accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association (AOTA), and also have successfully completed the certification examination developed and administered by the National Board for Certification in Occupational Therapy (NBCOT). We established that ''successfully completed'' means the individual must perform sufficiently well on the exam to receive (or be eligible to receive) certification. For services incident to a physician's or nonphysician practitioner's service where the licensure requirement does not apply, we proposed the education and examination requirements continue to apply.

OT Comments

Comment: AOTA recommended qualifications based on licensure or education and examination.

Response: We require qualifications based both on licensure and on education and examination so that there are appropriate qualifications that apply where licensure is not applicable, for example, to therapy services furnished incident to the physician's service.

Comment: The NBCOT recommended that qualified OTs be credentialed by their examination and be members in good standing of their organization. The AOTA recommended that AOTA approve any new credentialing body that might develop in the future.

Response: We recognize that currently the ACOTE or the World Federation of Occupational Therapists (WFOT) credential education programs for OTs and/or OTAs and the NBCOT determines eligibility and furnishes examinations. We have modified the policy to approve those organizations and added ''or successor organizations'' to allow for changes in the ACOTE title. We do not agree membership in NBCOT should be a requirement. Since NBCOT is already approved by The American National Standards Institute (ANSI), the National Commission for Certifying Agencies and the National Organization for Competency Assurance, CMS does not believe it is necessary to grant AOTA's request to permit it to approve any future credentialing body.

International OT/OTA

We also proposed that OTs who are educated outside the United States: (1) Be graduates of an occupational therapy curriculum accredited by the WFOT; (2) have successfully completed the NBCOT International Occupational Therapy Eligibility Determination (IOTED) review; and (3) have successfully completed the certification examination for Registered Occupational Therapist. We proposed to adopt similar standards for OTAs (but with an OTA curriculum) and requested comments on qualifications for internationally educated occupational therapy assistants.

Comment: The AOTA and NBCOT support the proposal that the internationally educated OT standards should be comparable to United States trained OTs and that the NBCOT conduct the credentialing process for these OTs. The AOTA requests that there be a way to allow a professionally recognized credentialing body other than NBCOT to develop or administer the examination.

NBCOT reports there are no internationally trained OTAs and recommends qualifications for such OTAs be stricken from the rules.

Response: This final rule with comment period recognizes the ACOTE, NBCOT or WFOT to contribute to credentialing internationally trained OTs and OTAs. Although NBCOT may not now recognize internationally trained OTAs, such OTAs do exist. In addition, we are adopting regulations in anticipation of any international programs that meet the qualifications in the future.

Comment: AOTA commented that the proposals for those who began practice between December 31, 1977, and January 1, 2008, are archaic and cannot be directly applied to many professionals qualified by their States.

Response: We agree that the current language is not applicable and we have updated this language for the new qualifications in this final rule with comment period, adding current credentialing bodies for United States trained and internationally trained OTs. To assure that no one covered under the existing qualifications is inadvertently disqualified, the prior language continues to apply for those who are not licensed but were qualified under the previous policy.

Comment: Commenters note that many States allow graduate OTs and OTAs to furnish services under a temporary license or permit while eligible for examination. The commenters expressed concern that the qualifications in the proposed rule would limit new graduates from entering the workforce.

Response: We agree that it is not necessary to change the current requirement of eligibility for the examination for United States trained OTs and OTAs when they are licensed or otherwise regulated by their States. However, we will require foreign trained OTs and OTAs (when applicable) to have passed the examination, and not merely be eligible for it. We believe this requirement is appropriate in the case of foreign trained individuals in order to ensure that they have acquired sufficient knowledge through their education program to pass the examination and, thus, are adequately prepared to begin furnishing services to Medicare beneficiaries.

Physical Therapy

For PTs, we proposed the therapist must be licensed as a physical therapist by the State in which practicing and accredited by the CAPTE based on APTA guidelines. When the licensure requirement is not applicable (that is, for services furnished incident to the services of physicians and NPPs), we proposed to require that PTs must be accredited by the CAPTE. We requested comments on qualifications for PTs which include satisfactory completion of a curriculum and a national examination each approved by the APTA.

Comment: APTA recommended that we remove the requirement that a PT pass a National Examination approved by the APTA. Since all States require a national licensing exam, APTA does not believe it is necessary for APTA to approve the exam. State Boards supported State licensing requirements, which include examination.

Response: In cases where the licensing standards do not apply (for therapy services incident to a physician's service or in the event a State deregulates PT practice), we believe it is important to have standards in place to ensure that an individual is qualified to furnish physical therapy services. We will not finalize the requirement for APTA to approve the licensing exam. Instead, we will accept a national licensing exam used by State boards to qualify personnel who have

been trained in a physical therapy curriculum.

We proposed that licensure or certification, or other regulation by the State in which services are furnished would be required for PTAs under our regulations. We also proposed that PTAs be accredited by the CAPTE. We requested comments on appropriate qualifications for PTAs.

Comment: APTA believes it is critical that we require approval by APTA for foreign trained PTAs. The Commission on Accreditation of Physical Therapist Education (CAPTE) of the APTA has been nationally recognized since 1977 as the only organization that approves PT and PTA education programs; it has no financial interest in the credentialing bodies for PTs or PTAs.

Some commenters disagreed with our proposal to allow the APTA to approve the credentialing body that establishes qualifications for foreign trained PTs and/or PTAs. They suggest that the U.S. Citizenship and Immigration Services and the Department of Homeland Security approve credentialing bodies that set standards and credential individuals and the States decide whether to license that individual. The commenters note there are currently no approved foreign PTA programs.

Response: While commenters tell us there are no foreign PTA programs that meet their credentialing standards, there may be PTA programs in foreign countries that meet the standards in the future. Therefore, this final rule with comment period addresses this future need. The CAPTE of the APTA is approved by the U.S. Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA). We find no reason to doubt that CAPTE/APTA will make fair determinations on the appropriateness of educational programs in the United States or credentials evaluation organizations for foreign trained PTs and PTAs. However, in response to comments, we have recognized both CAPTE and a credentials evaluation organization identified in 8 CFR 212.15(e) (the Homeland Security Act) as it relates to physical therapists and assistants to determine an education program to be substantially equivalent to PT and PTA entry level education in the United States. We believe the additional requirement for passing a national examination will mitigate any variations in credentialing.

Comment: Several commenters stated that adoption of the proposed qualifications for PTs would usurp the rights of State governments in licensing and determining the scope of practice for healthcare professionals, creating ''a monopoly for curriculum approval''.

Response: As we indicated in the proposed rule, we believe it is important to establish consistent and meaningful standards and conditions for the provision of Medicare covered services. Professional standards change periodically and these are often eventually adopted by State licensing boards, each of which has different language in its statutes. We believe the standards we proposed would not usurp or interfere with the adoption of standards by States. Rather, in most cases the standards incorporate the State standards. However, we believe it is necessary for CMS to address circumstances where State licensing or other regulation are not applicable. We are not creating a monopoly for curriculum approval by recognizing CAPTE. While it is the only existing credentialing body used by the States in their licensing process, we assess other credentialing qualifications if they are developed. Therefore, we are finalizing standards that include State standards (licensing or other regulation), as well as education and examination. We will assess other credentialing qualifications if they are developed.

b. Application of Consistent Therapy Standards

(1) Personnel Qualifications

We believe therapy services should be provided according to the same standards and policies in all settings, to the extent possible and consistent with statute. Therefore, we proposed to revise our regulations to cross-reference the personnel qualifications for therapists in § 484.4 to the personnel requirements for PTs, OTs, PTAs, OTAs, and SLPs in the following sections:

- § 409.10 and § 409.16 (Inpatient hospital services and inpatient critical access hospital services).
- § 409.23 (Posthospital SNF care).
- § 410.43 (Partial hospitalization services).
- § 410.59 (Outpatient occupational therapy services).
- § 410.60 (Outpatient physical therapy services).
- § 410.62 (Outpatient SLP services).
- § 418.92 (Hospice).
- § 482.56 (Optional hospital services, Rehabilitation services).
- § 485.70 (Specialized providers).
- § 485.705 (Clinics, Rehabilitation agencies, Public health agencies).
- § 491.9 (Rural health clinics and Federally qualified health centers (FQHCs)).

We also solicited comments on whether the personnel qualifications at § 484.4 should be made applicable in other settings.

Consistent Personnel Qualification Standards

Comment: Many commenters supported consistent personnel qualifications. Commenters indicated beneficiaries deserve to be treated by qualified professionals in both inpatient and outpatient settings.

We also heard from commenters who oppose the application of consistent qualifications for therapists in Part A settings. The commenters stated that if only qualified physical therapists provide physical therapy services in Part A settings, it will prevent hospitals from continuing to employ athletic trainers to provide physical medicine and rehabilitation services. The commenters suggest the medical staff should decide the qualifications for therapists at a hospital.

Response: The policies outlined in the proposed rule apply only to therapy services. The State Operations Manual Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 1, 05–21–04) § 482.56 Condition of Participation: Rehabilitation Services indicates that therapy services, if provided, must be in accordance with acceptable standards of practice which include compliance with any applicable Federal or State laws, regulations or guidelines, as well as standards and recommendations promoted by APTA, ASHA, and AOTA. In States where there are no personnel qualifications for therapists or assistants, hospitals should currently be following the personnel qualification standards set by those professional organizations. Most States and all of the professional organizations require graduation from approved education programs and a passing grade on a national examination. Therefore, we do not anticipate that adherence to the personnel qualifications in this final rule will cause any changes in hospital personnel.

At the same time, we recognize that there may be athletic trainers (AT), lymphedema specialists, low vision specialists, nurses, physicians, and other staff employed in hospital settings who furnish other services for which they are qualified, and for which payment is included in the payment to the facility. Those services should be appropriately documented as, for example, athletic training or lymphedema services. Where the services of health care professionals who are not PTs, OTs, PTAs, OTAs, or SLPs are now being appropriately furnished, documented and reimbursed,

we anticipate the application of consistent personnel qualifications relating to PT, OT and SLP services will have no effect on the appropriate provision of these other services. In settings where therapy services are separately billable, there will only be an impact on current practice if services that are being documented as PT, OT, or SLP services are being furnished by personnel who do not meet the requirements to be considered qualified therapists. Personnel who do not meet the applicable professional standards to be considered qualified therapists cannot furnish or be paid for PT, OT, and SLP services.

Comment: Several commenters indicated that therapy services are not covered in rural health clinics.

Response: Rural Health Clinics (RHCs) provide a core set of primary health care services as defined in statute. RHC services include the services that would commonly be furnished in a physician's office, (such as PT, OT, and SLP services), but only when directly provided by a Medicare approved RHC provider, such as a physician, nurse practitioner, or physician assistant. A certified nurse midwife, clinical psychologist, and or clinical social worker may provide RHC services, but not PT, OT, or SLP services, because PT, OT, and SLP services are not in their scope of practice. A face-to-face encounter with any other practitioner including, for example, a PT, OT, or SLP, athletic trainer, kinesiologist, or registered nurse is not covered as an RHC encounter, even if the service may be medically necessary, because these are not Medicare approved RHC providers (as defined in statute). Since therapists are not approved RHC providers, we will remove the reference in § 491.9 to personnel qualifications for therapists.

Consistent Policies

(2) Application of Consistent Therapy Standards

In tandem with cross-referencing Part A and Part B therapy personnel requirements in the regulations, we proposed to clarify our policies to improve consistency in the standards and conditions for Part A and Part B therapy services. Many, but not all, of the policies described for therapy services in Part B settings are also appropriate to Part A settings.

Specifically, in § 409.17, we proposed to clarify that hospital services include physical therapy, occupational therapy, and SLP. We also proposed to add regulations for inpatient hospital services to include a plan for therapy services consistent with the plan required for outpatient therapy services. We invited comment on PT, OT, and SLP plan of treatment policies that are appropriately applied to all therapy services, whether provided under Medicare Part A or B.

While the concept of consistent policies was strongly supported, many commenters were concerned about the application of specific Part B policies to Part A settings.

Comment: Several commenters indicated concern that application of the Part B policies, especially plan and documentation polices, to the inpatient hospital setting would impact treatment and increase the paperwork burden to staff.

Response: We are aware that inpatient stays are short. If clinically appropriate documentation is now provided, the new policies are unlikely to increase the burden. We have not delineated which of the Part B policies would apply in Part A specifically to allow some flexibility in the application of the general treatment guidelines as appropriate to the setting. We anticipate addressing these issues in manual instructions.

We note that we continue to believe the general concept that therapy services should be provided in a similar manner by qualified personnel in all settings is an appropriate one.

Comment: The AOTA requests that any change to the therapy plan of care be incorporated ''as soon as possible'' rather than ''immediately.''

Response: We recognize that the term ''immediately'' could be relative. Therefore, we have substituted ''as soon as possible'' to refer to changes in the plan in § 424.24 and § 482.56.

Comment: Commenters indicated concern that the outpatient plan of care certification requirement would be transferred to inpatient policy and that an ordered service that is being provided under the care of a hospital physician would also require certification for every change in the provision of treatment.

Response: The policy at § 409.17 and § 482.56 is compatible with the concept of the therapy plan as part of the overall plan in a facility. Also, we defer to hospital policies and procedures for changes to the plan. Guidance will be provided in manuals concerning modifications in the provision of care that do not constitute changes to the plan. Requirements concerning orders for establishment of a therapy plan (development and implementation) in the hospital are not changed by this final rule with comment period. We anticipate clarifying further in manual instructions documentation requirements that are consistent with the care of inpatients and will take into account comments received. We believe that, in general, good practice would call for documentation of significant changes to the patient's response to treatment in all settings, even if the Medicare program does not specifically require it.

Comment: AOTA asserts that in the inpatient setting, goal setting and treatment planning may not fit the mold of what is typically required by CMS in outpatient settings, that is, functional restoration. They indicate concern that therapy will not be provided consistent with their professional guidelines or scope of practice.

Response: We recognize that some of the services furnished by therapists in the acute inpatient hospital setting may not achieve functional changes expected in other settings. We have noted in § 482.56 that the provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice. Although documentation is not relevant to billing in this setting, it is still critical that the services furnished be accurately documented. We anticipate issuing further guidance regarding documentation for therapy services in hospital settings in Medicare manuals.

Comment: AOTA requests removal of the reference to review of the plan prior to certification in § 409.17(e). APTA agrees that the review language is unnecessary.

Response: We agree that it is unnecessary in the regulation to remind physicians or nonphysician practitioners to read the plan before they certify it and we have removed the paragraph from § 410.61(e) and § 409.17(e), and § 482.56(e).

Comment: Several commenters agree with the proposal that in the hospital setting the physician's review and approval of a therapy plan should be implied in the physician's review and approval of a facility plan that includes therapy services. The commenters believe the same rationale applies to services furnished in skilled nursing facilities and urge CMS to state that, in the SNF Part A setting, review of the therapy plan is implied by the physician's review of the facility plan.

Response: We agree with the commenters regarding the implied physician review and approval of the therapy plan in the Part A SNF setting. We have recognized this issue previously in the preamble to the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Update Notice (69 FR 45780),

where we stated that '' * * *. It is not necessary for a SNF to obtain a separate physician signature on the therapy treatment plan itself prior to billing Part A for therapy services * * *.''

Delay in Implementing Policies

Comment: Many commenters requested delays in the implementation of the policies for Part A therapy services, indicating they want time to have input into the manual guidelines and may need time to learn new procedures.

Response: We will delay the implementation of the policies pending the issuance of manual guidance which we anticipate that we will develop in mid 2008.

Students

Comment: Many commenters believe that it is imperative that we not inadvertently develop a policy that prevents students from receiving clinical training. APTA suggests we consider conforming the policies for students to the SNF policy for services provided by aides and students. The SNF policy allows services by aides and students in the ''line of sight'' of the therapist to count toward minutes accrued on the Minimum Data Set.

Response: We will consider conforming all policies for student supervision to the SNF policy for line of sight supervision, and will address this issue in manual guidance.

c. Outpatient Therapy Certification Requirements

In 1988, in an attempt to control the expanding utilization of therapy services, we added a 30-day recertification requirement for outpatient therapy services to our regulation at § 424.24. This requires that a physician certifies a plan of care for 30 days, regardless of the appropriate length of treatment. To continue treatment past 30 days, the physician is required to recertify the plan. As explained in the CY 2008 PFS proposed rule, after many years of experience with the current recertification requirements, we now believe that requiring recertification at 30-day intervals may not always provide sufficient flexibility to the physician to order the appropriate amount of therapy for the patient's needs. Therefore, we proposed to change the plan recertification schedule in § 424.24 to an episode length based on the patient's needs, not to exceed 90 days.

Comment: We received strong support for changing the recertification schedule to a date determined by the physician (not to exceed 90 days) from the therapy associations, medical societies, facilities, and individuals. They emphasized that physician approval of a clinically appropriate length of treatment at the initial certification will improve the patients' access to treatment, reduce administrative burden to physicians, therapists and office staff and reduce unnecessary visits for patients. Several indicated that a limit is not necessary since the physician should determine the episode length. MedPAC indicated a concern about reducing the number of physician reviews of the services in the context of the increasing utilization of therapy services

Response: We agree that a physician is qualified to certify the appropriate length of care in the initial certification; and that recertification should be required as often as the individual's condition requires. However, we believe a 90-day limit is a reasonable modification of the policy at this time. We will continue to review the utilization of therapy services to assess any changes in the relative utilization patterns for beneficiaries or providers/suppliers that may suggest changes in practice related to this policy. As we proposed, after 2 years, if we determine that there are changes in relative utilization patterns that suggest inappropriate utilization of therapy services based on the certification timing, we will reconsider this policy.

Comment: One commenter stated that a physician generally does not have statistical data from which to make a decision regarding the appropriateness of initiation or continuation of therapy, and, therefore, recertification of therapy by physicians seems meaningless. The commenter urges the use of risk-adjusted data based on gains in functional status relative to number of visits to inform physician decision making for appropriate utilization.

Response: We agree that collection of data related to the patient's functional condition and relative utilization of services may be useful in our ongoing development of recommendations for alternatives to therapy caps. On September 6, 2007, we released a Request for Task Order Proposals to the pool of contractors under the CMS MRAD (Master Research And Development) contract vehicle. The goal of this request for proposals is to develop recommendations for alternatives to therapy caps for CMS covered Outpatient Therapy services.

Comment: There was very strong support for extension of the 90 day recertification policy to CORF settings, consistent with the proposed policy for all other settings. There were no comments opposed to consistent recertification policy in the CORF.

Response: We will apply this policy consistently across settings, including the CORF reference in § 410.105(c)(ii)(2) and 424.27(b).

Review of Plan

We proposed that review of the plan as required in § 424.24 would continue to be required at certification and recertification. Since the plan may be established by a nurse practitioner, a clinical nurse specialist, or a physician assistant (nonphysician practitioners), as well as a physician, we proposed to modify the language in § 410.61 to include those professionals among those who may review the plan. Since the certification and recertification of the plan for Part B services requires a signature, we proposed to remove the current redundant requirement at § 410.61(e) to date and sign a review at the same time the plan is certified. In addition, we proposed to revise § 424.24 to remove reference to a certification ''statement.''

Comment: We received one comment supporting the changes to the review language and no dissenting comments.

Response: We are finalizing the proposed changes to the review of plan language in this final rule with comment period.

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

a. 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–PD) are required to establish electronic prescription drug programs to provide for electronic transmittal of certain information to the prescribing provider and dispensing pharmacy and pharmacist. This would include 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. The MMA 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 beneficiaries, directly or through an intermediary, would be required to comply with any applicable final standards that are in effect.

b. 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 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; 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, on June 23, 2006 (71 FR 36020), HHS published an interim final rule 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. As use of either of these two named versions of the NCPDP SCRIPT standard is permitted, for ease of reference, we will simply refer to ''NCPDP SCRIPT'' in this rule.

The November 7, 2005 final rule also established an exemption to the requirement to utilize NCPDP SCRIPT for entities that transmit prescriptions or prescription-related information 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 a image of the prescription or prescription-related information). Providers and dispensers who use this technology are not compliant with NCPDP SCRIPT. 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.

c. Elimination 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 listed at § 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.

In our November 7, 2005 final rule discussion of computer-generated faxing, we distinguished between cases where the prescriber's or dispenser's software has the ability to generate transactions utilizing the NCPDP SCRIPT, but the prescriber has not activated the feature on their software, and other cases where software (such as a word processing program) is used to create a document that can be sent as a fax that results in print out or displays a image of a prescription or response at the receiving end, but does not have true e-prescribing (electronic data interchange using NCPDP SCRIPT) capabilities.

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 capabilities.

It might also 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.

Because the elimination of the computer-generated facsimile exception 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, on 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 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.

Comment: Several commenters concurred with our proposal to eliminate the exemption for computer-generated faxes. These 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) and that once the benefits of true e-prescribing are realized by a core group of prescribers and dispensers, word of mouth would help foster more extensive adoption.

Less than half of all 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 possess the ability to generate NCPDP SCRIPT compliant transactions using their software or can comply by obtaining a version upgrade under their maintenance agreements. Some commenters also questioned whether lifting the exemption would move the industry forward toward, or raise barriers to, greater use of true e-prescribing. We also received comments from some individuals who erroneously thought that we had proposed the elimination of all faxes, including paper-to-paper faxes.

Response: For new e-prescribers, the cost of implementing a product that can generate an NCPDP SCRIPT-compliant transaction would not differ from a

product that could not, and we expect that, over time, the market will move toward the exclusive use of NCPDP SCRIPT-compliant transactions. Moreover, the adoption of the PQRI structural measure discussed section II.S.1. of this final rule with comment period will provide an incentive to providers to implement e-prescribing. We recognize that pharmacies that are not now conducting transactions that utilize NCPDP SCRIPT will incur costs to implement this capability, and that pharmacies will likely experience an increase in e-prescribing transaction volumes and costs. However, those costs would be balanced by administrative savings. We refer to the November 7, 2005 final rule (70 FR 67568) for a further discussion of potential costs associated with e-prescribing.

As more prescribers and dispensers embrace interoperable health information technology in general, and the use of e-prescribing standards in particular, they will see real value and realize costs savings. Dispenser data entry time and transcription errors due to data re-entry or illegible paper prescriptions will be reduced. Prescribers and dispensers will spend less time on the phone requesting and responding to refill requests. Improved workflow will free up staff time for patient counseling and other services. Patient safety will improve as providers are linked with medication history, allergy information and/or drug contraindications that will result in a reduction of adverse drug events.

Comment: Many commenters agreed that the proposed compliance date of January 1, 2009 was a reasonable timeframe for those who needed to comply. Others urged us to extend the compliance date to April 1, 2009, to coincide with the projected effective date of the next set of e-prescribing standards, or to January 1, 2010, to give prospective e-prescribers more time to identify compliant products. Some commenters recommended that the requirement to use the adopted e-prescribing standards should only apply to those prescribers/dispensers who have software or applications that have the ability to generate transactions utilizing NCPDP SCRIPT. Others suggested that the use of computer-generated faxes continue to be permitted for those prescribers and dispensers who already have the functionality to engage in transactions utilizing NCPDP SCRIPT, and allow those who adopt software that generates transactions utilizing NCPDP SCRIPT after the compliance date of January 1, 2009, an additional 1 year to comply with the NCPDP SCRIPT requirement.

Response: The 2006 CMS e-prescribing pilot noted that the majority of e-prescribing software currently being used by prescribers is already able to transmit information using NCPDP SCRIPT. Moreover, commenters agreed that most current e-prescribers could become compliant by installing an NCPDP SCRIPT-enabled version upgrade. Therefore, we believe that the January 1, 2009 compliance date provides adequate time for current e-prescribers in the industry to comply with the NCPDP SCRIPT e-prescribing standard provisions while encouraging other prescribers and dispensers to move closer toward true e-prescribing. We do not see a purpose in affording new e-prescribers an additional year to comply, since it should not take more time to implement an NCPDP SCRIPT-compliant product than a noncompliant product.

Comment: Many commenters suggested that we continue to allow for the use of computer-generated faxes in the case of transmission failure and network outages.

Response: Computer-generated faxes may be needed for prescriptions which fail in electronic data interchange (EDI) transmission. Allowing computer-generated faxes as a fall back measure would allow the prescription to be expedited to the pharmacy, ensuring timely dispensing of the medication, thus enhancing patient safety. We agree that there should be a viable contingency plan in the event that an EDI-transmitted prescription fails due to network transmission failures or similar, temporary communication problems that are episodic and non-repetitive in nature. We find the use of computer-generated faxes, but only in instances of the aforementioned transmission failures or similar communication problems of a temporary/transient nature, to be an acceptable and viable solution. We do not, however, consider it to be a permanent substitute for ongoing EDI transmission problems. As we will continue to allow computer-generated faxes as a fallback in cases of temporary/transient transmission failures and communications problems, we will not totally eliminate but instead amend the exemption for computer-generated facsimile transmission from the NCPDP SCRIPT Standard to account for this contingency.

Comment: Approximately one-fourth of commenters from all sectors of the health care industry called for the delay of the elimination of the exemption for computer-generated faxes until such time as the Drug Enforcement Agency (DEA) changes its rules to allow the e-prescribing of controlled substances. Commenters believe that the current DEA position on disallowing e-prescribing of controlled substances creates a barrier to adoption, and the proposed CMS compliance date of January 2009 will only exacerbate the issue.

Response: As we have no indication as to when the Drug Enforcement Agency will make a determination on the e-prescribing of controlled substances, it would be difficult for us to predicate eliminating the exemption for computer-generated faxes based upon such an unknown timetable. However, we concur with commenters who stated that the inability to prescribe these controlled substances electronically hampers e-prescribing adoption by providers. We continue to work with the DEA to help facilitate a solution that addresses both the enforcement requirements of the DEA with respect to prescribing of controlled substances, and the needs of the healthcare community for a solution that is scalable and commercially viable.

Comment: One commenter suggested that we exempt controlled substances from this requirement.

Response: The November 7, 2005 E-prescribing final rule (70 FR 67568) recognizes the DEA's role in the enforcement of the prescribing of controlled substances. As controlled substances cannot be legally e-prescribed, an exemption from the NCPDP SCRIPT standard for the e-prescribing of controlled substances would have no effect.

Comment: Some commenters were confused as to whether the computer generated fax exemption would affect the exemption in the long term care setting, and requested that we clarify that prescribers and dispensers in the long term care setting were exempt from the requirement to use NCPDP SCRIPT despite the amendment of the exemption of the computer generated faxes.

Response: Our amendment of the exemption for computer generated faxes does not apply at this time to the long term care industry as defined under Medicare Part D. At the time the CY 2008 PFS proposed rule (72 FR 38194) was published in the **Federal Register**, the long term care industry exemption for using adopted standards in e-prescribing (as contained in the November 7, 2005 final rule (70 FR 67568)) was, and remains, in place. Based on the comments we received, we are finalizing an amendment of the exemption for computer-generated faxes.

S. 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)

In addition to the provisions of the MIEA–TRHCA discussed in sections II.B. (GPCIs) and II.F. (CAP), additional provisions of the MIEA–TRHCA are discussed in this section of the final rule with comment period.

1. Section 101(b)—Physician Quality Reporting Initiative (PQRI)

a. Background

(i) Program Background and Statutory Basis

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 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 authorizes ''Transitional Bonus Incentive Payments for Quality Reporting'' in 2007, specifically 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.

For 2007, section 1848(k)(2)(A)(i) of the Act, as added by the MIEA–TRHCA, provides that the quality measures for the PQRI shall be the 66 physician quality measures published as 2007 Physician Voluntary Reporting Program (PVRP) quality measures on the CMS web site as of the date of enactment of this subsection, except for any changes based on the results of a consensus-based process in January 2007. Based on actions approved at the AQA Alliance (formerly the Ambulatory Care Quality Alliance) meeting on January 22, 2007, 8 measures were added to the 66 measures from the PVRP. Thus, the final ''2007 PQRI Quality Measures'' comprise 74 measures, which are applicable to specific combinations of patient conditions and Medicare Physician Fee Schedule (PFS) covered professional services. The measure titles, descriptions, and specifications are available for download from the PQRI Measures/Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

Section 1848(k)(2)(A)(ii) of the Act does not allow for any further additions to or deletions from the 2007 PQRI Quality Measures after January 2007, and does not allow modifications or refinements (such as code additions, corrections, or revisions) to the detailed specifications for the 2007 PQRI quality measures after the July 1, 2007, beginning date of the reporting period. The final 2007 specifications for the 2007 PQRI quality measures are available as a download from the Measures/Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri*. Additional information on the 2007 PQRI is also available from this section of the CMS Web site, including, but not limited to:

- Tools to help professionals select measures;
- Tools to help professionals capture data on 2007 PQRI quality measures;
- Explanations of the calculation of eligibility for and amount of bonus payment for satisfactory reporting; and
- A description of the methodology that we will use to validate whether professionals have satisfactorily reported the MIEA–TRHCA required minimum number of applicable measures.

Section 1848(k)(2)(B) of the Act further requires that the Secretary publish in the **Federal Register** not later than August 15, 2007, proposed quality measures that would be appropriate for eligible professionals to use to submit data to the Secretary in 2008. The final 2008 PQRI quality measures must be determined and published by November 15, 2007, as specified in section 1848(k)(2)(B) of the Act as amended by the MIEA–TRHCA.

(ii) Overview of the PQRI Section in the Final Rule With Comment Period

In the CY 2008 PFS proposed rule (72 FR 38196 through 38199), we provided a slightly longer summary of the MIEA–TRHCA requirements and the PQRI program than is provided immediately above in this section, and explained our interpretation of applicable statutory and government-wide policies relevant to defining a consensus organization and consensus-based measure development process, and our policy for determining which measures meet requirements for inclusion in PQRI. In satisfaction of the MIEA–TRHCA requirement to publish proposed 2008 PQRI measures by August 15th, 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 implications of including or not including any specific measure(s), and on our plans to explore mechanisms for submission of electronic clinical performance measurement information and/or summary measure results information extracted from electronic health records (EHRs) and/or clinical data registries.

In this PQRI section of the final rule with comment period, we first address the general or overview public comments.

(iii) General/Program Comments and Responses

Comment: We received a number of comments commending CMS and the PQRI program for being responsive to stakeholder concerns, focusing on health care quality and performance improvement, and consistently using accurate and inclusive terminology (for example, where appropriate, ''eligible professionals'' rather than ''physicians'') while implementing on an aggressive timeline a functional program with an extensive and well-received education and outreach component. A number of commenters also expressed a desire to continue to work with us in a spirit of partnership to advance and improve the program and its utility to beneficiaries, professionals, and the industry at large.

Response: We appreciate the constructive input of the wide variety of stakeholders who have provided insights, information, and partnered with us to disseminate informational materials about PQRI to the eligible professionals in the health care community. We plan to continue dialogue with stakeholder organizations and will consider their and PQRI participants' input (including questions and comments submitted via informal, as well as formal, channels of inquiry) as we continue working to provide 2007 PQRI participants with reporting rate and clinical performance results feedback reports and (for those participants achieving satisfactory reporting per MIEA–TRHCA requirements) PQRI incentive payments in mid-2008, and as we develop and implement strategies for individual-clinician-level and related quality reporting and improvement initiatives for 2008 and beyond.

Comment: We received numerous comments identifying specific ways in which commenters recommended we enhance the PQRI in the future. One theme was that, although defined per MIEA–TRHCA as professionals eligible to participate in PQRI, some clinicians may be unable to participate due to lack of PQRI measures applicable to their practices. A closely related concern was that some clinicians with otherwise applicable PQRI measures may be

unable to participate due to data submission relying on the Part B PFS Fee-For-Service claims mechanism. These limitations include that some PQRI-eligible professionals (such as physical and occupational therapists) who cannot currently participate in PQRI because reimbursement for the MPFS covered professional services they furnish is claimed in a format (X12 837–I electronic transaction or the UB04 form) that does not allow for attribution of each service to the individual professional who furnished it.

Several commenters suggested that submission of electronic clinical information (ECI) from registries and/or electronic health records (EHRs) may potentially address the limitations of claims-based quality measures data submission. Other commenters simply urged us to find a mechanism, potentially a claims-based mechanism, to afford all eligible professionals the opportunity to participate prior to proceeding with PQRI subsequent to 2007.

Response: We agree with the goal of offering the opportunity to participate in PQRI to as many eligible professionals as feasible and practical, consistent with the MIEA–TRHCA statutory requirements. In support of this goal, especially where there are gaps in available consensus measures for specific practitioners, we have worked to encourage and contract for the development of quality measures and to fund consensus projects. For 2008, we have supported via contract with Quality Insights of Pennsylvania (QIP) the development of structural measures and measures applicable to a broad cross-section of PQRI eligible professionals, including some nonphysician practitioners (NPPs) who had few or no measures available in 2007. We prioritized development of these measures based on the existing gaps in measures available or otherwise in development and on a need to address as broad a cross section of eligible professions or specialties as possible within the limited volume of measures for which we could support development in time for inclusion in the 2008 PQRI.

We plan to continue working to fill gaps in available consensus-endorsed or -adopted measures consistent with available time and resources. However, we largely depend on and encourage the development of measures by professional organizations and other measure developers. We note that MIEA–TRHCA includes a provision that requires the Secretary to include measures developed by specialty societies. Ideally, in the future CMS would not need to be closely involved in the development of clinician-level quality measures, but would select from measures that meet the MIEA–TRHCA requirements.

In regard to the potential use of nonclaims mechanisms for submission of electronic clinical information, we agree with this goal; however it is not feasible to implement for 2008. In regard to claims-based alternatives to enable participation by professionals for whose covered professional services payment is made under or based on the MPFS but claimed via institutional formats (X12 837–I electronic transaction or UB04 form), we have analyzed the possibilities and determined that the MIEA–TRHCA requirement that satisfactory reporting and amount of any incentive payment be determined at the individual-professional level cannot be satisfied without extensive modifications to the claims processing systems of CMS and providers, which would represent a material administrative burden to us and providers, and/or modifications to the industry standard claims formats, which would require substantial time to effect via established processes and structures that we do not maintain or control.

Comment: Although most commenters acknowledged that we proposed and will finalize 2008 measures in response to MIEA–TRHCA statutory mandate, numerous commenters expressed concerns that we are proceeding with design and implementation of PQRI 2008 before we have been able to evaluate the 2007 PQRI. One such commenter specifically declined to comment on the 2007 PQRI in advance of public availability of 2007 PQRI evaluation information and requested that we solicit comments on the 2007 PQRI, and the 2007 PQRI evaluation information, in the CY 2009 PFS proposed rule. Specific examples of evaluation information that commenters requested CMS consider and publish include:

- Rates of participation by eligible professionals;
- Cost or administrative burden of the PQRI from the perspective of participating professionals and the Medicare program;
- The apparent impact of PQRI on professionals' clinical performance; and
- The impact on beneficiaries.

Some of these commenters, and several other commenters who did not specifically raise concerns about program-level evaluation, requested that we consider delaying the start of the 2008 reporting period until mid-2008 to give 2007 participants a chance to assess their 2008 results to identify process changes to improve their 2008 reporting rate and clinical performance results.

Response: We are in the process of operationalizing, in a phased manner appropriate to data availability and analytic infrastructure implementation, a comprehensive ongoing program monitoring strategy that will provide interim indications, at the program level, of some of the same aspects of the program we will ultimately examine in our evaluation(s) of the impact of the 2007 program after the conclusion of the 2007 reporting period. To the extent feasible within the limits of available resources including, but not limited to, funding and sufficiently complete data, we anticipate conducting an evaluation of the 2007 PQRI. The aspects of PQRI impact we would expect to assess include participation rates by specialty/profession, associated trends in clinical performance and beneficiary outcomes, and other observable impacts on participants, the Medicare program, and beneficiaries. Although we have not yet finalized the operational details of our evaluation strategy, we do anticipate making the results of the evaluation, at the national level, available to the public. We may also make publicly available the results of such analyses aggregated at other meaningful levels (for example, State, specialty, or profession). We 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.

This section of the final rule with comment period is specific to the establishment of measures appropriate for use by professionals to submit quality-of-care data in 2008, as we are directed to do by section 101(b) of the MIEA–TRHCA. The incentive bonus requirements and reporting period for PQRI in 2008 are addressed in section 101(d) of the MIEA–TRHCA, Physician Assistance and Quality Improvement (PAQI), section (II.S.5.) of this final rule with comment period. Such details of the 2008 bonus-incentive program are beyond the scope of this MIEA–TRHCA Section 101(b), PQRI section of this final rule with comment period.

Comment: A number of comments requested or recommended that we make readily available on an ongoing basis more detailed information on the measure development process and measures in development. Numerous commenters also requested final

measure specifications be published as far in advance of the beginning of the reporting period as possible, and that more detailed information about measures proposed or finalized for use in PQRI be published in, at the same time as, or in advance of future rulemaking.

Response: We agree that it could be useful to our stakeholder partners in health care quality measurement and improvement, including but not limited to potential measure developers, to make available in a prominent place (such as the CMS PQRI Web site) additional information on measure development in context of PQRI, potentially including guidance to other publicly available sources of general information on health care quality measurement and development of specific metrics. We will consider our options to accomplish this in a practical and sustainable way and use various appropriate communications channels to notify stakeholder organizations and the community at large of our strategy once we have developed it.

We agree with the commenters that it is desirable to provide final measure specifications sufficiently in advance of the reporting period to allow reasonable time for professionals to analyze new or revised measures and implement any needed changes in their office workflows to accurately capture and successfully submit data on a selection of measures applicable to their practice on which they can act to improve the quality of the services they furnish. We are aware that such ''lead time'' should also help the eligible professionals' specialty or professional societies be better prepared to support the professionals' selection of relevant, actionable measures. Having detailed information on measures available in advance of the reporting period also enhances the ability of vendors (such as practice-management software, billing services, and electronic health records vendors) to support professionals' successful implementation of revised data-capture processes for the measures.

The MIEA–TRHCA requires that we publish the final list of 2008 PQRI measures no later than November 15, 2007. We would expect to publish detailed specifications shortly after that date. Detailed measure specifications for measures new or revised for 2008 PQRI will be published on the Measures/Codes page of the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri.* These detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable. The detailed technical specifications for measures in the final listing for the 2008 PQRI remain potentially subject to corrections until the start of the 2008 reporting period, as we stated in the proposed rule.

Comment: Many commenters expressed concerns that recent legal rulings raise concerns about whether the individual participating professionals' reporting and clinical performance results may constitute administrative data potentially subject to disclosure requirements of the Freedom of Information Act (FOIA). Commenters urged that any clinician performance program or system should remain voluntary and its results confidential.

Response: Commenting on or otherwise addressing the legal standing of PQRI participants' reporting and performance results in context of FOIA, other applicable statutes, or case law is outside the scope of this rule. At this time, we have no plans to publish without participants' voluntary consent either 2007 or 2008 PQRI participants' reporting or performance results in a way that would be specifically identified or readily identifiable at the individual-professional, group practice-site, or billing unit (Taxpayer Identification Number) levels. As mentioned in response to comments urging us to share information resulting from its 2007 PQRI program-evaluation analyses, we do plan to make available information at various meaningful levels of aggregation other than the individual professional, practice, or billing unit.

Comment: Several commenters recommended specific enhancements to PQRI participant feedback reporting including displays of additional analyses (beyond the measure calculation as specified) for specific measure(s) and/or provision of interim reporting and performance results during the 2008 reporting period. Some commenters recommended we conduct additional analyses of measure data but did not specifically tie that recommendation to the participant feedback report content.

Response: Detailed design of the participant feedback reports and specific analyses of PQRI data for purposes other than calculating bonus payment eligibility or amount (for example, for future measure development or refinement) are outside the scope of this section of this final rule with comment period. However, we will consider these recommendations as part of the ongoing dialogue with the stakeholder and participant community in order to collaboratively identify ways to enhance the measures' and/or program's value to its participants and the Medicare program. We are currently assessing the feasible options and timeframe within which we may be able to provide meaningful interim feedback reports to 2008 PQRI participants. As a matter of practical, operational reality, it is highly probable that we will not be able to make any 2008 interim feedback reports available until after we make available the 2007 final feedback reports. The 2007 PQRI was unable to offer during the reporting period any interim feedback reports of participants' reporting and performance rates to date because the aggressive statutory timeframe for implementing the program did not allow for the necessary data infrastructure (including analytic programming and report access mechanisms) to be implemented in time to provide accurate, meaningful results feedback for 2007 in an appropriately secure/confidential report access environment prior to mid 2008.

Comment: Some commenters requested specific or general clarifications or additional guidance on the PQRI program, and how to code its measures, in the implementation support tools (for example, a handbook, or worksheets) provided on the CMS PQRI Web site.

Response: Although not directly applicable to the proposed rule content on which we sought comment, these comments are appreciated and will be taken into consideration along with other input that these materials' users have provided via less formal avenues of communication.

Comment: Many commenters expressed concern that the burden of data collection and submission may be an obstacle to program participation for some practices. Some commenters further noted that the claims-based submission process may be particularly burdensome for those practices that are simultaneously implementing electronic health records or whose PQRI-eligible members already participate in a medical data registry.

Response: To implement a data submission mechanism that was technically feasible for CMS and providers, and that is broadly available to and already used by the vast majority of PQRI-eligible professionals, we determined that claims-based data submission is the only possible mechanism for 2007 and the only viable mechanism for full operationalization in 2008. Thus, measures appropriate for use by professionals to submit quality-of-care data to CMS in 2008 must be specified for claims-based submission and analysis. We are, however, committed to exploring and supporting practical, effective mechanisms for quality-of-care data submission that

promote efficiency by streamlining participants' and our data collection and handling. As discussed below in this section, in the registry- and EHR-based submission topics of this section of this final rule with comment period, we plan to test in 2008 registry- and EHR-based mechanisms for data submission, in order to develop the potential ability to fully implement such mechanisms in the future. Those professionals whose practices that have implemented the referenced HIT will have available EHR and e-prescribing structural measures for reporting in 2008, which would, if reported, count toward professionals' eligibility for the incentive payment discussed below in section II.S.5. of this final rule with comment period.

Comment: Several comments recommended or urged us to consider using the group practice as the unit of analysis, and to consider developing and implementing sampling methodologies at the group level as a means of reducing reporting burden in the future.

Response: The 2007 unit of analysis is established at the individual-professional level by MIEA–TRHCA, and we have not proposed to change that for 2008. As the 2007 PQRI evaluation results become available and further legislative action provides additional guidance, such alternatives may indeed prove important to explore or develop.

b. MIEA–TRHCA Requirements for Measures Included in the 2008 PQRI

(i) MIEA–TRHCA Requirements for 2008 Quality Measures

(A) Overview and Summary

As noted in the CY 2008 PFS proposed rule (72 FR 38196 through 38197), section 1848(k)(2)(B)(i) of the Act requires, ''for purposes of reporting data on quality measures for covered professional services furnished during 2008, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or 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. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.''

Section 1848(k)(2)(B)(ii) of the Act requires that ''[n]ot later than August 15, 2007, the Secretary shall publish in the **Federal Register** a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008. The Secretary shall provide for a period of public comment on such set of measures.''

In the CY 2008 PFS proposed rule (72 FR 38197), we explained our interpretation of these statutory requirements and the policies used in selecting measures to propose as appropriate for professionals to use to submit data on the quality of covered professional services furnished to Medicare beneficiaries in 2008.

In examining the statutory requirements of section 1848(k)(2)(B)(i) of the Act, 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 measures set for submitting quality data on covered professional services furnished during 2008. Likewise, the requirement for measures to have been developed using a consensus based process 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 a physician or an organization representing a particular specialty. Similarly, we interpret the requirement that 2008 measures include structural measures, such as the use of EHRs and electronic prescribing technology, to mean that the 2008 measure set must include at least 2 structural measures.

In examining sections 1848(k)(2)(B) of the Act, we believe that 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 2008. We do not interpret 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 2008 set of quality measures. We next discuss 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 2008 in the context of other applicable Federal law and policy.

The MIEA–TRHCA requires that measures used for 2008 be identified by the Secretary as having been endorsed or adopted by a consensus organization and have been developed through the use of a consensus-based process. As stated in the proposed rule (72 FR 38197 through 38199), we believe that these requirements should be interpreted in the context of the National Institute of Standards and Technology Act (NISTA) (15 U.S.C. 271 et seq.) as amended by the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113) (NTTAA) and implemented by Revised OMB Circular No. A–119 (OMB A–119) dated February 10, 1998.

Per the NTTAA, except when it is inconsistent with applicable law or otherwise impractical, all Federal agencies and departments shall use standards that are developed or approved by voluntary consensus standards bodies. OMB A–119 provides specific policy guidance to agencies on the appropriate interpretation of agency responsibilities under the NTTAA. As we discussed in the proposed rule (72 FR 38197 through 38199), OMB A–119 establishes as government-wide policy that agencies ''must use voluntary consensus standards, both domestic and international, in its regulatory and procurement activities in lieu of government unique standards, unless use of such standards would be inconsistent with applicable law or otherwise impractical.'' OMB A–119 further explains that in determining whether use of existing voluntary consensus standards in its regulatory and procurement activities is otherwise impractical, '' 'Impractical' includes circumstances in which such use would fail to serve the agency's program needs; would be infeasible; would be inadequate, ineffectual, inefficient, or inconsistent with agency mission; or would impose more burdens, or be less useful, than the use of another standard.'' OMB A–119 also provides that ''voluntary consensus standards'' are standards developed or adopted by voluntary consensus standards bodies, and defines ''voluntary consensus standards body'' as an organization maintaining the following attributes: (1) Openness; (2) Balance of interest; (3) Due process; (4) An appeals process; (5) Consensus; which is defined as general agreement, but not necessarily unanimity, and also includes a process for attempting to resolve objections by interested parties. The process requires that, as long as all comments have been fairly considered, each objector is advised of the disposition of his or her objection(s) and the reasons for the disposition, and the consensus body members are given an opportunity to change their votes after reviewing the comments. Voluntary consensus

standards must include provisions requiring that owners of relevant intellectual property have agreed to make that intellectual property available to all interested parties on a nondiscriminatory, royalty-free, or reasonable royalty basis.

Other types of standards that are distinct from voluntary consensus standards but that may be used by federal agencies when voluntary consensus standards are not available and practical to address the government's programmatic needs, include government-unique standards, industry standards, company standards, nonconsensus standards, or de facto standards which are developed in the private sector but not in the full consensus process of a voluntary consensus standards body. For further discussion of the NTTAA, OMB A–119, and their relevance to quality measures for use of professionals to submit quality-of-care data to the Secretary, please review the 2008 MPFS Proposed Rule PQRI section at 72 FR 38197–38199.

Two consensus organizations are referenced in section 1848(k)(2)(B): the National Quality Forum (NQF) and the AQA Alliance. The NQF has a formal organizational structure and established processes that are intentionally designed to comply with the NTTAA and OMB A–119. Membership is open and includes a broad cross-section of stakeholder perspectives. In determining whether or not to endorse a standard, the NQF uses a formal process that consists of five principal steps that follow a project's conceptualization, prioritization, and planning. The steps are: (1) Consensus Standard Development; (2) Widespread Review; (3) Member Voting and Member Council Approval; (4) Board of Directors Action; and (5) Evaluation that includes an appeals process. The NQF meets the NTTAA requirements for a voluntary consensus standards body within the meaning of the NTTAA and its endorsed healthcare quality measures constitute voluntary consensus standards within the meaning of NTTAA.

The AQA is also referenced in section 1848(k)(2)(B) of the Act as a consensus organization for the purpose of identifying measures that have successfully completed review by a consensus organization, though it does not feature all of the structural characteristics or processes of a voluntary consensus standards body per NTTAA and the OMB A–119. By citing AQA as an example of an acceptable consensus organization, section 1848(k)(2)(B) of the Act establishes that AQA adoption satisfies the requirement of section 1848(k)(2)(B) of the Act that PQRI quality measures be adopted or endorsed by a consensus organization. We believe it follows that the Congress did not intend to require all 2008 quality measures under section 1848(k)(2)(B) of the Act to meet the requirements to be considered voluntary consensus standards under the NTTAA. However, by giving NQF and AQA as examples of consensus organizations, we believe the Congress intended that consensus organizations should, in the context of section 1848(k)(2)(B) of the Act, have a breadth of stakeholder involvement and voting participation substantially comparable to that of the NQF or AQA.

Given the potential for apparent overlap of NQF and AQA as consensus organizations under the MIEA–TRHCA, it is important to distinguish their roles. As currently established, the principal purpose of AQA for physician quality measures is to select among NQF endorsed measures for coordinated implementation. However, during a time of rapid physician quality measures development and implementation, it is impractical to delay implementation of physician quality measures until the formal processes of NQF are completed. Therefore, AQA has been able to enable CMS to incorporate new measures into the quality reporting system by providing consensus review acceptable under MIEA–TRHCA for implementation of a measure prior to actual NQF endorsement. In the event of a determination by NQF to decline endorsement of a particular measure after it had been adopted by AQA, we anticipate that AQA would withdraw its adoption of such a measure.

Turning to the requirement of a consensus-based process for developing quality measures, we interpret this requirement in light of the NTTAA and the importance of broad consensus for health care quality measures used for regulatory purposes. In this context we have outlined in the proposed rule, and rather than cite the proposed rule, we will for readers' convenience reiterate below the process of health care quality measurement development and distinguish basic development steps from the completion of a consensus-based development process as required under MIEA–TRHCA.

Many organizations are involved in the development of health care quality measures. These organizations include physician organizations, health care providers, Federal agencies, accreditation organizations, disease-focused not-for-profit organizations, research organizations, and health plans. The basic development processes of leading health care quality measure developers generally use standardized methods that include identification of a quality goal or gap, literature and evidence review, expert and technical evaluation, specification development, testing, organizational review, and that may include public comment.

In the framework of the NTTAA, upon completion of the basic development work, healthcare quality measures do not constitute voluntary consensus standards, even though they may have utilized consensus as a mechanism of achieving agreement among the developer's participants or within the developer's organizational structure. Rather, to achieve the status as a voluntary consensus standard under NTTAA, the measure must go through the additional development that occurs through the broader consensus process of consensus endorsement. During this process, based on the need to achieve agreement, quality measures are often modified in order to achieve the necessary broad consensus.

Consistent with this concept, we interpret ''consensus-based process for developing measures'' as used in MIEA–TRHCA 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 based on at least a level of openness, balance of interest, and consensus reflected in the structures and processes of the NQF or the AQA as of the date of enactment of MIEA–TRHCA.

Based on the considerations previously discussed, we apply the following policies in identifying measures that meet the MIEA–TRHCA 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 2008 measures:

(1) We 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) of this section, 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 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, and the provisions of 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, as of the earlier of November 15, 2007, or the date of publication of this final rule, a measure has been specifically considered by NQF for possible endorsement but NQF has declined to endorse it, we proposed not to include it in the final set of 2008 PQRI Quality Measures, even if previously adopted by AQA.

(5) Although the AQA 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, and the measure has not been specifically declined for endorsement by NQF, a quality measure that has been adopted by the AQA (or another consensus organization with comparable consensus-organization characteristics), will meet the requirements of MIEA–TRHCA if we determine that it is appropriate for eligible professionals to use to submit data.

(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 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 MIEA–TRHCA. However, the MIEA–TRHCA does not limit consensus organizations to the NQF or the AQA, nor restrict the field of potential consensus organizations. The MIEA–TRHCA, 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 the physician level measures may be carried out by a variety of different organizations. We do not interpret the MIEA–TRHCA 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 physician quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

(8) The policies we proposed were based on the preference as articulated in NTTAA and OMB A–119 for ''voluntary consensus standards'' to government-unique standards. However, the MIEA–TRHCA does not require that quality measures meet the NTTAA or OMB A–119 definition of ''voluntary consensus standards'' in order to be used for PQRI. Thus, though we prefer to use quality measures meeting the NTTAA and OMB A–119 criteria for voluntary consensus standards, neither this CMS preference nor the NTTA or OMB A–119 preclude CMS from exercising our discretion under the MIEA–TRHCA to select measures for PQRI meeting the less stringent consensus requirements of the MIEA–TRHCA, when necessary to meet our program needs as determined by the Secretary.

(B) Summary of Comments and CMS's Responses

Comment: Many commenters thanked us for clarifying the requirements for consensus-based development, consensus endorsement or adoption, and the basic, high level structure of the measure-development process. As discussed above in context of the PQRI program/overview content and comments topic, multiple commenters requested additional and more detailed information about measure development and related processes and organizations. In context of the consensus requirements, several commenters requested further explanation of the detailed definition or distinction between the stages of measure development.

Response: We are pleased that many commenters that found our description of the measurement development processes useful and were supportive of our interpretation of the statutory requirements for consensus endorsement and adoption and consensus-based development process. In terms of providing additional clarification, the status for PQRI implementation of measures that have been approved by AQA but declined for endorsement by NQF is clarified in the final language. Measures approved by AQA are sufficient for inclusion in 2008 PQRI in terms of the statutory requirements for consensus-organization adoption or endorsement and consensus-based development requirements of MIEA–TRHCA. Measures, however, that have been specifically declined for endorsement by NQF, are not selected for use in 2008 PQRI, based on our preference for Voluntary Consensus Standards (72 FR 38198).

Comment: Many commenters requested or recommended that measure development processes employ robust mechanisms for incorporation of broadly inclusive consensus and/or public comment during the initial, as well as final phase of development. However, some commenters expressed the counterbalancing concern that we should more specifically clarify that appropriate quality measures for PQRI should in fact be based on evidence interpreted in processes which include consensus methods and organizations, as opposed to measures that are based primarily on stakeholder consensus about measure need and design without a firm foundation in scientifically sound clinical evidence.

Response: As described in the proposed rule (72 FR 38197 through 38198) the basic (initial) development processes of measure developers typically include various standardized processes that include both an evaluation of the evidence base for a measure and a public comment opportunity. We do not believe that we should delineate these processes via rulemaking, nor require a particular evidence base for a measure. Rather, the adequacy of measures from these and many other standpoints is subject to evaluation during the consensus process.

Comment: Several commenters suggested we consider establishing as policy that quality measures to be used by, and analyzed at the level of, individual PQRI-eligible professionals, must be developed by clinician-controlled organizations to assure relevance and promote uptake by the eligible professional community. Multiple commenters suggested explicit preference be given for measures developed or endorsed by physician

specialty societies, in context of consensus-organization review and CMS measure selection processes. Some commenters stated that the AMA–PCPI should be the sole source for physician-level measures. One commenter specifically presented an interpretation of the MIEA–TRHCA requirement for the 2008 PQRI measures to include measures submitted by a physician specialty as meaning that the 2008 PQRI should include only measures developed by physician organizations, to assure physician control of available measures applicable to assessing the clinical performance of individual physicians. Other commenters expressed differing viewpoints, commenting on the importance of an open process for initial measure development, and noting that no single organization stands ready to lead in the quality arena. Multiple commenters pointed to concerns about existing measure development and consensus organizations particularly in terms of structure and transparency, opposing any single organization controlling measurement development, opposing requiring PQRI measurement development to come solely from physician controlled organizations, and supporting alternatives to existing organizations.

Response: Physician involvement and leadership is standard in the work of both measure developers and consensus organizations. As a result, physicians are actively involved at all levels of measurement development and consensus adoption and endorsement. We are in agreement that physician expertise is an important ingredient in measurement development and in the consensus process. We further recognize the leadership of physician organizations, as is reflected in the large number of physician quality measures included in PQRI which were developed by the AMA–PCPI and its participating specialty societies.

However, we do not agree that physicians should be in complete control of the process of measure development, as would be the case if measures were required to be developed solely by physician-controlled organizations. Any such restriction would unduly limit the basic development of physician quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. Rather, as we described in the proposed rule, the basic steps for developing the physician level measures are appropriately carried out by a variety of different organizations. We do not interpret the MIEA–TRHCA to place special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Similarly, we do not interpret MIEA–TRHCA to require that each measure included in the 2008 PQRI have been developed by a physician specialty.

Finally, we do not interpret MIEA–TRHCA to limit the field of potential consensus organizations to those it named as examples of acceptable organizations, so long as the requirements for broad consensus we articulated as required under MIEA–TRHCA is achieved. The MIEA–TRHCA, thereby, maintains flexibility in potential sources of measure consensus review, which is, like having multiple sources of measure development, key to maintaining a robust marketplace for development and review of quality measures.

Comment: Many commenters suggested we establish a centralized process or structure to prioritize measure development in specific ways. Some commenters recommended priority be given to meaningful, actionable gaps in care or specific high-impact disease conditions. Others recommended that the first priority be assuring measure availability for all PQRI-eligible professions and specialties. Commenters recommended a centralized establishment of national priorities for measure development and suggested that such prioritization would help to align clinician-focused quality measures with measures used in other governmental and private-sector initiatives focused on other provider types, and advance measurement and close gaps in care for high-prevalence and/or high-cost conditions.

Response: Health care quality measures are currently developed by a variety of organizations and used by a variety of governmental, nongovernmental, and public-private partnership initiatives which have various and at times differing programmatic needs for quality measures. Although a cooperative and voluntarily coordinated approach to agreeing upon quality goals which would guide development and selection of measures may be of value, the Secretary retains the authority to select from available measures meeting applicable statutory requirements those most appropriate for use in this program.

Comment: Many commenters illustrated, directly or indirectly, that the proposed rule language (72 FR 38198 through 38199) reads to a material proportion of reviewers as meaning or implying that a measure must be both adopted by the AQA ''and'' endorsed by the NQF to be included in the PQRI for 2008. Several of these comments also specifically requested clarification of the status of measures that will, as of the date CMS finalizes the list of 2008 PQRI quality measures, be AQA-adopted but not yet reviewed by NQF.

Response: In general, the consensus requirement under the MIEA-TRHCA is met if a measure is either NQF-endorsed or AQA-adopted. However, where an AQA-adopted measure has been specifically considered by NQF but declined for endorsement, we have not selected such measures for 2008. This derives from our stated preference for standards of a voluntary consensus standards organization (such as NQF) over an organization which does not (such as AQA). Also, as stated in the proposed rule (72 FR 38198), in the event of a determination by NQF to decline endorsement of a particular measure after it had been adopted by AQA, we anticipate that AQA would withdraw its adoption of that measure. Thus, a measure that has been AQA adopted and then reviewed by NQF with a decision to decline endorsement we would expect would, soon after the NQF decision, be *neither* NQF-endorsed *nor* AQA-adopted and therefore it would be undesirable to include a measure imminently destined to not retain approval of either consensus organization simply because we may have been identifying final 2008 measures during the brief period of lag between the NQF's decision to decline endorsement and the AQA's opportunity to reconsider its adoption of the measure.

To further clarify this point, of the measures proposed for 2008 (72 FR 38199 through 38202), the only ones that might be removed as a result of having been AQA adopted but then subsequently declined NQF endorsement are certain measures that were included in the 2007 PQRI on the basis of AQA adoption and that have since been declined for endorsement by NQF after specifically being considered.

For newly-proposed measures (those not part of the 2007 PQRI set), either NQF or AQA consensus endorsement or adoption is sufficient for PQRI. Most of these measures will have been adopted by the AQA but not yet reviewed by NQF. Others may have been endorsed by the NQF, but not yet adopted by the AQA.

Comment: One commenter suggested that the entirety of the PQRI section of the proposed rule could potentially be

construed to imply that there may be, based on which specific entities develop or own a measure, different levels of consensus-standard status required for measures to qualify for our consideration for inclusion in PQRI.

Response: The measure developer was listed for identification purposes only. This was necessary for measures that when proposed were still under development. The remaining measures that had achieved consensus endorsement or adoption were sufficiently identified by consensus organization, without listing the developer. The statutory requirements for consensus-organization adoption or endorsement, consensus-based development and statutory and policy preferences for measures that have achieved the status of voluntary consensus standards apply equally to all potential PQRI quality measures regardless of the organization type or specific identity of any given measure's developer or owner.

Comment: We received a large number of comments on the interpretation of the requirement of per Section 1848(k)(2)(B)(i) of the Act, that 2008 PQRI measures ''shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA)''. These comments reflected a diversity of opinion amongst various stakeholders on key conceptual points related to the balance between rigor and flexibility in measure review and approval, as well as on the suitability of specific organizations for their roles as we define them in the PFS rule.

Many commenters encouraged us to rely solely on highly structured, scientifically rigorous processes for measure approval to promote stability in measures over time. Many other comments advised against requiring a degree of formality or scientific rigor in the review process that would unduly slow the availability and implementation of new quality measures to fill current gaps in professionals or clinical foci for which applicable measures exist.

Several commenters closely related to the recommendation of reliance on more rigorous review processes further suggested we identify a single voluntary consensus standards body to be considered qualified to establish measures as PQRI measures. The rationales provided for this suggestion include enhanced probability of a cohesive or coordinated universe of endorsed measures and prevention of endorsement of duplicate or near duplicate (''competing'' or ''conflicting'') measures.

The value of having multiple consensus organizations available to approve measures was noted by many comments that were closely related to, or that were elaborating upon, maintaining flexibility and adaptability of the universe of available measures. These commenters included observations that setting requirements that limit the total available capacity for measure review will slow the development not only of specific additional quality measures but likely also innovative advancement in the science of health care quality measurement. Some of these commenters urged us to remain alert for the development of additional organizations into potential consensus organizations on par with the NQF or with the AQA as of the date MIEA–TRHCA was signed into law, and two commenters named two specific potential candidates that might choose to develop to that degree in the near future.

Response: We believe the existence of multiple consensus organizations promotes availability of a broad array of measures from which we can select those most appropriate for use in PQRI based on program policy goals. The availability of the AQA as a consensus organization meeting the requirements of MIEA–TRHCA, though it does not meet the full NTTAA and OMB A–119 criteria for a voluntary consensus standards body (VCSB), has proven important to the consensus development of the 2008 PQRI measures. Specifically, the AQA's more flexible and expeditious processes have made measures available on a shorter timeline than would be possible within the more rigorous processes of a VCSB. At present, we are able to identify only the NQF and the AQA as satisfying the consensus organization requirements of MIEA–TRHCA. Should additional organizations develop to feature consensus characteristics at least comparable to the level of openness, balance of interest, and broadly representative voting membership demonstrated by the AQA as of the date MIEA–TRHCA became law, we would consider measures endorsed by those organizations eligible for consideration for inclusion in PQRI.

We concur with the commenters identifying the desirability of alignment or harmony of quality measures across settings to more effectively promote overall CMS quality goals. We strive to achieve synergy between measures used in various settings and quality related initiatives to the extent practical.

Comment: Many commenters concurred with our interpretation that NQF is a VCSB per NTTAA and OMB A–119. Several commenters also commended NQF for the scientific rigor of its structure and review processes. Some commenters in favor of establishing a single consensus organization entity whose approval would qualify a measure for PQRI inclusion went on to name NQF as the leading or only named candidate for such an organization. Simultaneously, multiple concerns were raised about the uneven (project-driven) NQF funding stream and its resultant potentially long or uncertain review timeframes, and the potential for this to impede measure development. Several comments also raised concern that the NQF's processes for review of physician-applicable measures are not yet as developed and predictable as those measures applicable to other types of providers. A few commenters noted that the NQF determinations on physician-applicable measures apparently vary unpredictably between workgroups and that the appeals process is not clearly identifiable.

Some comments recommended that CMS or another agency should provide steady core funding to the NQF on an ongoing basis.

Response: The NQF is currently the only organization we identified that reviews health care quality measures while simultaneously meeting the NTTAA and OMB A–119 definition of a VCSB. NQF processes for review and endorsement of physician-applicable measures are expected to develop and stabilize as it gains more experience with such measures. We will continue to monitor the NQF and its processes and work with NQF and its members to promote the prompt achievement of that growth.

The funding stream of the NQF is outside the scope of this rulemaking. The concerns raised over the current NQF funding mechanism and internal operational structures does, however, highlight the desirability of having an alternative source or multiple alternative sources of consensus-organization review of quality measures to assure that the measure has been vetted in a process that offers at least a reasonable degree of openness, balance of interests, and broad voting participation.

Comment: Multiple comments expressed concerns about the AQA's structure and original intended purpose not being ideally suited to its current role in PQRI, and its role in the measure endorsement process being confusing or its role not clearly adding value to the process. Multiple other comments commended the AQA as currently

structured, including its responsiveness, openness, breadth of participation, and utility as a forum for building consensus among stakeholders in quality measurement. Several comments also noted that the AQA is currently re-evaluating its structure, and recommended either that the AQA be required to restructure itself to meet the NTTAA and OMB A–119 criteria for a VCSB or that we reassess the AQA after any restructure to assure that it retains at least the comparable level of consensus-organization characteristics that it featured at the time MIEA–TRHCA became law.

Response: As noted above in this section, we interpret that the AQA currently meets the MIEA–TRHCA intended definition of a consensus organization for purposes of measure approval, as its mention in MIEA–TRHCA as an example of a consensus organization confirms it did at the time the statute was enacted. Further, we have expressed what we understand its value to be for the purpose of making quality measures available for consideration for inclusion in the PQRI. We do not have direct control over the AQA; requiring the AQA to take any specific action or restructure in any specific way would be outside the scope of CMS authority. However, we are observing the AQA's re-evaluation of its structure and will consider altering its role in relation to approval of future PQRI measures based on its resultant structure.

Comment: Several commenters requested we specifically define the minimum criteria to be a non-VCSB consensus organization meeting the requirements of MIEA–TRHCA.

Response: We have defined the requirement as being that an organization must possess a level of consensus-organization characteristics at least comparable to those of the AQA as of the date MIEA–TRHCA became law. To attempt to quantify or score an organization's level of consensus characteristics would be difficult to do in a way that was not misleading or arbitrary. The key features, as stated in the proposed rule (at 72 FR 38198), include openness, balance of interest, and consensus based on voting participation.

c. The Final 2008 PQRI Quality Measures

In the proposed rule (72 FR 38199), we solicited comments on the implications of including or excluding 148 specific quality measures in 7 broad categories. We received numerous comments both general and measure-specific, which are summarized and addressed as follows.

Comment: Many comments on measure inclusion were general or conceptual and, in fact, mirrored comments on prioritization of measure development or endorsement.

Specific to measure selection, some commenters supported our including or excluding measures based on a targeted focus on specific gaps in care, while other commenters supported maximum inclusivity of conditions, services, and professionals. Some of the comments specific to measure selection stated two main perspectives: (1) We should set the priorities and/or prioritization process in collaboration with a maximally inclusive and representative cohort of stakeholders (to specifically include pharmaceutical, device, and information technology manufacturers and trade associations, as well as clinicians and consumers); and (2) the prioritization or selection of quality measures should be accomplished by a VCSB in a formal consensus process.

Response: In selecting measures, we have sought to achieve a broad opportunity for eligible professionals to participate, and to promote the quality goals forming the basis for the measures themselves. The general quality goal underlying the measures as developed is a performance gap relating to important processes or outcomes of care. While we agree that prioritized themes for quality improvement can be useful in certain contexts, for PQRI the scope of practice of the various eligible professionals varies significantly. Therefore, it would be difficult to limit measures selected to a few specific prioritized quality goals without also limiting the opportunity to participate. With respect to the role of a VCSB under MIEA–TRHCA, it is to achieve consensus endorsement of particular measures, rather than to prioritize measures for PQRI. The responsibility for selection of measures for PQRI is directed to the Secretary, based on proposing measures, soliciting public comment, and then finalizing the measures. Public comment could include the views of a VCSB as to which measures are most appropriate for PQRI based on quality goals or other considerations. These could then be considered, in conjunction with the other public comments and the program needs as determined by the Secretary, in finalizing the measures.

Comment: Several comments in context of measure selection urged us to select or prioritize for PQRI inclusion measures aligned or harmonized with those used in other governmental initiatives that focus other provider types in addition to or instead of individual PQRI-eligible professionals.

Response: We concur with comments identifying the desirability of alignment or harmony of quality measures across settings to more effectively promote overall CMS quality goals. We strive to achieve such synergy among settings and initiatives to the extent practical.

Comment: We received several comments specifically commending or recommending inclusion of specific quality measures, including, but not limited to: Specific eyecare measures; vaccination and preventive services measures; diabetic foot and ankle measures; and perioperative care measures including venous thromboembolism(VTE) prophylaxis.

Response: All of the proposed measures strongly supported by multiple comments are included in the final 2008 measures listed below in this section.

Comment: We received many comments expressing concern that the following 2007 PQRI measure that has achieved NQF endorsement was not included in measures proposed for 2008: ''Age Related Macular Degeneration: Dilated Macular Examination''.

Response: As noted in the proposed rule's correction notice (72 FR 43581), the omission of this measure was a technical/editorial error that was corrected via that notice. The measure titled ''Age Related Macular Degeneration: Dilated Macular Examination'' is included in the final list in Table 7.

Comment: Several commenters recommended changes to specific quality measures' titles, definitions, and detailed specifications or coding. Many of these recommendations were based on alternative interpretations of clinical evidence or concerns about the utility of the measures. Some requests were specifically concerned that measures be expanded or constrained to include or exclude specific professionals from those to whom the measure may be applicable.

Response: Quality measures that have completed the consensus processes of NQF or AQA have a designated party (generally the developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer or maintainer to make any changes to the basic elements of a measure. Examples of such basic elements would be the particular process of care covered by the measure, professional services to which the measure applies, or the diagnosis (or diagnoses) defining the denominator

population. A request to modify any basic elements of a measure should be addressed to the measure's maintainer. In addition, NQF has for its endorsed measures an established maintenance process which may be accessed. Measure maintenance and modification activities are conducted by the developers/owners and/or maintainers of measures outside the CMS rule-making process. In implementing the measures for PQRI, CMS may, when necessary, make certain technical modifications to assure that reporting and performance rates can be calculated. These technical modifications do not modify the basic elements of the measure and are carried out in collaboration with the measure developer/owner or maintainer.

Comment: Many commenters requested the inclusion for 2008 of additional measures not proposed as PQRI measures in the proposed rule. Measures requested included additional structural measures, additional measures of medication use appropriateness and compliance, measures applicable to additional clinical topics, and the measures identified in the proposed rule as mandatory for erythropoietin stimulating agent reimbursement in 2008.

Response: The MIEA–TRHCA requires that measures proposed for use in the 2008 PQRI be published in the **Federal Register** prior to August 15, 2007. We are also 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 the proposed rule for inclusion in the 2008 PQRI that were recommended to CMS via comments on the proposed rule have not been placed before the public with opportunity for the public to comment on them within the rulemaking process. 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 the proposed rule cannot be included in the 2008 measures MIEA–TRHCA requires be finalized via publication in the **Federal Register** by November 15, 2007. However, we have captured these recommendations and will have them available for consideration in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent.

The measures we identify for 2008 in this final rule with comment period will be final as of the effective date of this final rule, and no changes (no additions or deletions of measures) will be made after that date. However, as was done for 2007, we may make modifications or refinements, such as code additions, corrections, or revisions, to the detailed specifications for the 2008 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 2008 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, but in no event later than December 31, 2007. No further changes to the specifications will be made after the start of the 2008 reporting period. The measures' detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable.

The final 2008 PQRI Quality Measures are listed in Tables 7 through 13, and fall into 7 broad categories. The final measures for 2008 were selected based upon the following:

- The achievement of NQF endorsement or AQA adoption by the earlier of November 15, 2007, or the date of publication of this final rule with comment period;
- Identification in the proposed rule for use in 2008 with opportunity for public comment via the rulemaking process;
- Development completion in a sufficiently timely manner that implementation for 2008 would be practical;
- Their importance in relation to quality goals;
- Their meaningfulness as measures of quality;
- Their utility in the PQRI program such as through augmenting the scope of services provided by eligible professionals to which PQRI measures apply;
- The degree to which they meet the needs of the Medicare program and their functionality in terms of ability to be collected and calculated in the PQRI program;
- Statutory requirement for inclusion in quality measures for 2008.

(i) Measures Selected From the 2007 PQRI Quality Measures

We include in the final 2008 PQRI measures the following 2007 PQRI measures in Table 7, proposed as 2008 PQRI measures (72 FR 38199 through 38200). The measures in Table 7 include measures submitted by specialties, in compliance with section 1848(k)(2)(B) of the Act.

TABLE 7.—2007 PQRI MEASURES

Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus.
Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus.
High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus.
Screening for Future Fall Risk.
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).
Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease.
Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI).
Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction.
Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression.
Medication Reconciliation.
Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.
Characterization of Urinary Incontinence in Women Aged 65 Years and Older.
Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation.
Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy.
Asthma: Pharmacologic Therapy.
Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.
Stroke and Stroke Rehabilitation: Carotid Imaging Reports.
Primary Open Angle Glaucoma: Optic Nerve Evaluation.

TABLE 7.—2007 PQRI MEASURES—Continued

Age-Related Macular Degeneration: Dilated Macular Examination.
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.
Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.
Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.
Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (when indicated in All patients).
Osteoporosis: Management Following Fracture.
Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture.
Aspirin at Arrival for Acute Myocardial Infarction (AMI).
Electrocardiogram Performed for Non-Traumatic Chest Pain.
Electrocardiogram Performed for Syncope.
Vital Signs for Community-Acquired Bacterial Pneumonia.
Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia.
Assessment of Mental Status for Community-Acquired Bacterial Pneumonia.
Empiric Antibiotic for Community-Acquired Bacterial Pneumonia.
Asthma Assessment.
Perioperative Care: Timing of Prophylactic Antibiotics—Administering Physician.
Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage.
Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy.
Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.
Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered.
Stroke and Stroke Rehabilitation: Screening for Dysphagia.
Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services.
Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.
Osteoporosis: Pharmacologic Therapy.
Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery.
Preoperative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery.
Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures).
Appropriate Treatment for Children with Upper Respiratory Infection (URI).
Appropriate Testing for Children with Pharyngitis.
Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.
Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy.
Multiple Myeloma: Treatment with Bisphosphonates.
Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry.
Hormonal Therapy for Stage IC–III ER/PR Positive Breast Cancer.
Chemotherapy for Stage III Colon Cancer Patients.
Plan for Chemotherapy Documented Before Chemotherapy Administered.
Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery.
Advance Care Plan.

Please note that detailed specifications for some 2007 PQRI measures may have been updated or modified during the NQF endorsement process during 2007. The detailed 2008 PQRI measure specifications for any given measure may, therefore, be different from detailed specifications for the same measure used for 2007. All specifications for 2008 measures must be obtained from the specifications document for 2008 measures, which will be available on the CMS PQRI Web site on or before December 31, 2007.

The following measures proposed for 2008 (72 FR 38200) are not included in the final 2008 PQRI measures listed in Table 7 because they have been considered by NQF and did not achieve endorsement:

- Dialysis Dose in End Stage Renal Disease (ESRD) Patients.
- Hematocrit Level in ESRD Patients.

Comment: We did not receive any comments specifically suggesting that any of the 2007 PQRI measures proposed for 2008 be removed from the 2008 PQRI measures. Some commenters suggested alternative measures apparently in addition to the measures we had proposed.

Response: We have not included in final 2008 PQRI measures any measures that were not identified in the proposed rule as proposed 2008 measures for the reporting system as required by Section 1848(k)(1) and 1848(k)(2)(B) of the Act. As discussed above in this rule, we were obligated by MIEA–TRHCA and other applicable statutes to publish and provide opportunity for public comment on proposed PQRI quality measures. Measures recommended via comments on the proposed rule that were not included in the proposed rule have not been placed before the public with opportunity for the public to comment on their potential use in PQRI. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2008 measures MIEA–TRHCA requires be finalized via publication in the **Federal Register** by November 15, 2007. However, we have captured these recommendations and will have them available for consideration in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent.

(ii) AMA—PCPI Measures

The measures listed in Table 8, which were developed via the American Medical Association (AMA) Physicians Consortium for Performance Improvement (PCPI), are finalized as 2008 PQRI measures as of the date of publication of this final rule with comment period. All of these measures were proposed as 2008 PQRI measures (72 FR 38200 through 38201). The measures listed in Table 8 achieved AQA adoption or NQF endorsement on or before October 31, 2007.

We will publish the detailed specifications for all final PQRI measures on the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri* on or before December 31, 2007.

TABLE 8.—AMA/PCPI MEASURES FINALIZED FOR 2008 WITH CONSENSUS-ORGANIZATION APPROVAL BY 10/31/2007

Prevention of Ventilator-Associated Pneumonia—Head elevation.
Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter Insertion Protocol.
ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in patients with CKD.
Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).
Influenza Vaccination in patients with End Stage Renal Disease (ESRD).
Vascular Access for patients undergoing Hemodialysis.
Plan of Care for ESRD patients with Anemia.
Plan of Care for Inadequate Hemodialysis in ESRD patients.
Plan of Care for Inadequate Peritoneal Dialysis.
Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD.
Testing of patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia.
Initial Hepatitis C RNA Testing.
HCV Genotype Testing Prior to Therapy.
Consideration for Antiviral Therapy in HCV Patients.
HCV RNA Testing at Week 12 of Therapy.
Hepatitis A and B Vaccination in patients with HCV.
Counseling patients with HCV Regarding Use of Alcohol.
Counseling of patients Regarding Use of Contraception Prior to Starting Antiviral Therapy.
Patients who have Major Depression Disorder who meet DSM IV Criteria.
Patients who have Major Depression Disorder who are assessed for suicide risks.
Patients with Osteoarthritis who have an assessment of their pain and function.
Acute Otitis Externa (AOE): Topical Therapy.
Acute Otitis Externa (AOE): Pain Assessment.
Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.
Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility.
Otitis Media with Effusion (OME): Hearing Testing.
Otitis Media with Effusion (OME): Antihistamines or Decongestants—Avoidance of Inappropriate Use.
Otitis Media with Effusion (OME): Systemic Antimicrobials—Avoidance of Inappropriate Use.
Otitis Media with Effusion (OME): Systemic Corticosteroids—Avoidance of Inappropriate Use.
Breast cancer patients who have a pT and pN category and histologic grade for their cancer.
Colorectal cancer patients who have a pT and pN category and histologic grade for their cancer.
Appropriate initial evaluation of patients with Prostate Cancer.
Inappropriate use of Bone Scan for staging Low-Risk Prostate Cancer patients.
Review of treatment options in patients with clinically localized Prostate Cancer.
Adjuvant Hormonal therapy for High-risk Prostate Cancer patients.
Three-dimensional radiotherapy for patients with Prostate Cancer.
Chronic Kidney Disease (CKD): Blood Pressure Management.
Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis—Stimulating Agents (ESA).

The AMA PCPI measures that were proposed in Table 17 of the proposed rule (72 FR 38200 through 38201) were under development at the time the proposed rule was published. Several of these measures did not complete development or did not complete development in a sufficiently timely manner to permit implementation in the 2008 PQRI program. We have not included in the final PQRI measures listed in Table 8 the following proposed 2008 measures (from Table 17 of the proposed rule, 72 FR 38200 through 38201) for which development was not completed or not completed in sufficient time for implementation for 2008:

- Stress Ulcer Disease (SUD) Prophylaxis in Ventilated Patients
- Perioperative Temperature Management for Surgical Procedures Under General Anesthesia
- Assessment of Thromboembolic Risk Factors in patients with Atrial Fibrillation
- Chronic Anticoagulation in patients with Atrial Fibrillation
- Monthly INR Measurements in patients with Atrial Fibrillation
- GFR Calculation in patients with Chronic Kidney Disease (CKD)
- Permanent Catheter Vascular Access for patients Receiving Hemodialysis
- Patients with Osteoarthritis who receive Anti inflammatory or Analgesia Medication
- Documentation of hydration status in Pediatric Patients with Acute Gastroenteritis (PAG)
- Weight measurement in patients with PAG
- Recommendation of appropriate oral rehydration solution in PAG patients
- Education parents of PAG patients
- Perioperative Cardiac risk assessment (history)
- Perioperative Cardiac risk assessment (current symptoms)
- Perioperative Cardiac risk assessment (physical examination)
- Perioperative Cardiac risk assessment (electrocardiogram)
- Perioperative Cardiac risk assessment (continuation of Beta Blockers).

During completion of the measure development process, the measure developer eliminated the restriction to ventilated patients of the proposed (72 FR 38201) measure titled, ''Prevention of Catheter-Related Bloodstream Infections in Ventilated Patients—Catheter Insertion Protocol''. This measure is, therefore, listed in the Final 2008 PQRI measures in Table 8 as ''Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter Insertion Protocol''.

During completion of the measure development process, several of the measures proposed for 2008 in Table 17 of the proposed rule (72 FR 38200 through 38201) were combined into one measure by the measure developer. The final, combined measures contain the substantive components of each of the measures. The following is reflected in the Final 2008 PQRI Measures listed in Table 8:

- Proposed measures (72 FR 38201) titled ''Blood Pressure Measurement in patients with CKD'' and ''Plan of Care for patients with CKD and Elevated Blood Pressure'' were combined into the measure entitled ''Chronic Kidney Disease (CKD): Blood Pressure Management.''
- Proposed measures (72 FR 38201) ''Calcium, Phosphorus and Intact

Parathyroid Hormone Measurement in patients with CKD'' and ''Lipid Profile in patients with CKD'' were combined into the measure in Table 8 entitled ''Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).''

• Proposed measures (72 FR 38201) ''Hemoglobin Monitoring in patients with CKD'' and ''Erythropoietin Overuse in patients with CKD and normal Hemoglobin'' were combined into the measure in Table 8 entitled ''Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).''

During the measure development process, several measures listed in the proposed rule (72 FR 38201) as pertaining to the medical conditions Acute Otitis Externa (AOE) and Otitis Media with Effusion (OME) were narrowed to apply to only one or the other. The measure developer made these refinements as a result of more in-depth consideration of the evidence for the clinical relevance of each specific measure to each or either condition. Modifications to the measures' titles reflect these decisions. Otitis Media with Effusion (OME) was eliminated from the proposed 2008 measures below. The revised measure titles are listed in Table 8 for each proposed 2008 measures:

• Measure proposed (72 FR 38201) as ''Patients with Acute Otitis Externa (AOE) or Otitis Media with Effusion (OME) who receive Topical Therapy'' is now entitled ''Acute Otitis Externa (AOE): Topical Therapy.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who have a pain assessment'' is now entitled ''Acute Otitis Externa (AOE): Pain Assessment.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who are inappropriately prescribed antimicrobials'' is now entitled ''Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use''. Acute Otitis Externa (AOE) was eliminated from the proposed (72 FR 38201) measures below. The revised measure titles are listed in Table J2 for each proposed 2008 measures.

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who have an assessment of tympanic membrane mobility'' is now entitled ''Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who undergo hearing testing'' is now entitled ''Otitis Media with Effusion (OME): Hearing Testing.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who inappropriately receive antihistamines/decongestants'' is now entitled ''Otitis Media with Effusion (OME): Antihistamines or Decongestants—Avoidance of Inappropriate Use.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who inappropriately receive systemic antimicrobials'' is now entitled ''Otitis Media with Effusion (OME): Systemic Antimicrobials—Avoidance of Inappropriate Use.''

• Measure proposed (72 FR 38201) as ''Patients with AOE/OME who inappropriately receive systemic steroids'' is now entitled ''Otitis Media with Effusion (OME): Systemic Corticosteroids—Avoidance of Inappropriate Use.''

Comment: We received several comments from organizations involved in the measure development process noting that the measure titles as proposed in Table 17 of the proposed rule (72 FR 38200 through 38201) were incorrect or obsolete based on progress in measure development between the time the proposed rule went on display (July 2, 2007) and the date the commenters submitted their comment letters (various specific dates at the end of August, 2007).

Response: As stated above, the measure titles in Table 8 reflect the correct titles as of the conclusion of the development process preparing these measures for consensus-organization review in the late summer and early fall of 2007.

Comment: We received comments in support of certain measures listed in Table 8, such as the Chronic Kidney Disease measures. Other commenters suggested including additional measures not proposed as 2008 PQRI measures. No commenters opposed inclusion of any of the measures listed on Table 8.

Response: The measures from Table 16 of the proposed rule (72 FR 38200 through 38201) that were sufficiently completed in time for use in the 2008 PQRI are included in Table 8. As discussed above, several of the CKD measures proposed in Table 16 of the proposed rule (72 FR 38201) have been combined into with one another as listed in Table 8.

As iterated above in response to comments on measures in Table 7, we cannot include in the 2008 PQRI measures that were not published as proposed 2008 PQRI measures in the **Federal Register** by August 15, 2007. We have, however, made note of the measures suggested and may consider them for inclusion in future quality-reporting initiatives to which they may be relevant.

(iii) Nonphysician Measures

We include measures in the final 2008 PQRI quality measures listed in Table 9 developed by Quality Insights of Pennsylvania (under the Medicare Quality Improvement Organization (QIO) contract for the State of Pennsylvania) that were proposed as 2008 PQRI measures in Table 18 of the proposed rule (72 FR 38201 through 38202). These measures were developed primarily to afford expanded reporting opportunities for NPPs who had few or no measures available in 2007. Some may also be applicable to physicians. The clinicians who could report each measure are identified in the measure's detailed specifications, which will be available on the Measures/Codes page of the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri* as far in advance of the 2008 reporting period as practical. We have not included in the final PQRI measures listed in Table 9 the following measures proposed in Table 18 of the proposed rule (72 FR 38201 through 38202) whose development was not completed in a sufficiently timely manner for implementation in the 2008 PQRI program:

• Universal Hypertension Screening.

• Universal Hypertension Screening Follow-up.

During completion of the measure development process, several of the measures proposed for 2008 in Table 18 of the proposed rule (72 FR 38201 through 38202) were combined into one measure by the measure developer. The final, combined measures contain the substantive components of each of the measures. The following is reflected in the Final 2008 PQRI Measures listed in Table 8:

• Proposed (72 FR 38201) measures titled ''Universal Weight Screening (BMI)'' and ''Universal Weight Screening Follow-up (BMI)'' were combined into the measure entitled ''Universal Weight Screening and Follow-up.''

• Proposed (72 FR 38201) measures ''Patient Co-development of Treatment Plan'' and ''Patient Co-development of Plan of Care'' were combined into the measure in Table 8 entitled ''Patient Co-development of Treatment Plan/Plan of Care.''

Comment: We received numerous comments pertaining to the measures proposed in Table 18 of the proposed rule (72 FR 38201 through 38202), now listed in Table 9 of this final rule with

comment period. Most of these comments addressed the scope of applicability of these measures to particular non-physician specialties, such as speech language pathologists (SLPs) and occupational therapists.

Response: The applicability of the final 2008 PQRI measures is dependent on whether the given practitioner can bill for the services identified by the procedures or services represented by the Current Procedural Terminology (CPT) Category I codes in the measure's denominator per its detailed specifications. The inclusion of specific procedures or services in a measure's denominator is determined during the measure development and consensus process, based on the clinical relevance of the measure to particular services/procedures. The determination of services/procedures to which a specific measure is relevant and therefore applicable is not subject to change via the rulemaking process. The measures in Table 9 achieved AQA consensus adoption on or before October 19, 2007. These measures have not yet been reviewed by the NQF.

We will publish the detailed specifications for all final PQRI measures, including these QIP nonphysician measures, on the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri* on or before December 31, 2007.

TABLE 9.—QUALITY INSIGHTS OF PENNSYLVANIA NONPHYSICIAN MEASURES

Universal Weight Screening (BMI) and Follow-up.
Universal Influenza Vaccine Screening and Counseling.
Universal Documentation and Verification of Current Medications in the Medical Record.
Screening for Clinical Depression.
Screening for Cognitive Impairment.
Patient Co-development of Treatment Plan/Plan of Care.
Pain Assessment Prior to Initiation of Patient Treatment.

(iv) Structural Measures Currently Under Development

We include structural measures in the final 2008 PQRI measures listed in Table 10 developed by Quality Insights of Pennsylvania (under the Medicare Quality Improvement Organization (QIO) contract for the State of Pennsylvania), that were proposed as 2008 measures in Table 19 of the proposed rule (72 FR 38202). These measures meet the requirement of section 1848(k)(2)(B)(i) of the Act.

Comment: Numerous comments expressed support of the measures listed in Table 10. Other commenters stated a belief that there is a lack of scientific evidence to support the benefits of e-prescribing.

Response: As required by MIEA-TRHCA, the final 2008 PQRI measures shall include structural measures such as the use of EHRs and electronic prescribing technology. The determination of the sufficiency of the scientific basis for quality measures is part of the review and evaluation during the measure development and consensus processes. The measures are included in Table 10. These measures were adopted by the AQA on or before October 31, 2007.

TABLE 10.—QUALITY INSIGHTS OF PENNSYLVANIA STRUCTURAL MEASURES

HIT—Adoption/Use of E-Prescribing.
HIT—Adoption/Use of Health Information Technology (Electronic Health Records).

(v) Additional AQA Starter-Set Measures

We include measures in the final 2008 PQRI measures from the AQA starter set that were not included in the 2007 PQRI quality measures but that are relevant to Medicare beneficiaries and which we proposed as 2008 measures in Table 20 of the proposed rule (72 FR 38202). We have not included in the final 2008 measures listed in Table 11 the following measure that was listed in Table 20 of the proposed rule (72 FR 38202), because its adaptation to the claims-based provider-self-reported format was not found to be feasible:

- Beta Blocker Therapy (persistent for 6 months or more) Post MI.

We received several comments in support of the measures listed in Table 20 of the proposed rule (72 FR 38202) and now listed in Table 11, as preventive care measures and measures related to smoking cessation.

TABLE 11.—ADDITIONAL AQA STARTER-SET MEASURES

Dilated eye exam in diabetic patient.
Screening Mammography.
Colorectal Cancer Screening.
Inquiry regarding Tobacco Use.
Advising Smokers to Quit.

(vi) Other NQF-Endorsed Measures

We include in the final 2008 PQRI measures other measures endorsed by the NQF that were not included in the 2007 PQRI quality measures but that were proposed as 2008 measures (72 FR 38202) and that are relevant to Medicare beneficiaries, address overuse/misuse of pharmacologic therapy, and/or that expand the specialty applicability and patient population. We have not included in the final PQRI measures listed in Table 12 the following proposed measure (72 FR 38202), because its adaptation to the PQRI format was subsequently not found to be feasible:

- Annual Therapeutic monitoring for patients on the following persistent medications: Angiotensin Converting Enzyme Inhibitor (ACE)/Angiotensin Receptor Blocker (ARB), Digoxin, Diuretics, Anticonvulsants; and Statins.

We received several comments in support of including the measures listed in Table 12. We did not receive any comments opposing the inclusion of any of the measures listed in Table 12.

TABLE 12.—OTHER NQF-ENDORSED MEASURES

Inappropriate antibiotic treatment for adults with acute bronchitis.
Disease Modifying Anti-rheumatic Drug Therapy in Rheumatoid Arthritis.
Angiotensin Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy for patients with coronary artery disease and diabetes and/or left ventricular systolic dysfunction (LVSD).
Urine screening for microalbumin or medical attention for nephropathy in diabetic patients.
Influenza vaccination for patients ≥ 50 years old.
Pneumonia vaccination for patients 65 years and older.

(vii) Podiatric Measures

We include measures in the final 2008 PQRI quality measures listed in Table 13 developed by the American Podiatric Medical Association (APMA). These two measures are finalized as 2008 PQRI measures as of the date of publication of this final rule with comment period. These measures were proposed as 2008 PQRI measures in Table 21 of the proposed rule (72 FR 38202), and were

adopted by the AQA on or before October 31, 2007.

A third proposed measure (72 FR 38202), titled ''Diabetic Foot and Ankle Care, Peripheral Arterial Disease: Ankle Brachial Index (ABI) Measurement'' has not achieved AQA adoption or NQF endorsement in time to be included in this final rule with comment period, and is therefore not included in the final 2008 PQRI quality measures.

Comment: A number of comments expressed support of these measures. We received comments requesting correction of the title of this topic and the substantive title/heading for the table from ''Podiatric Measures'' to ''Diabetic Foot and Ankle Measures'' to reflect the potential applicability of these measures beyond podiatrist. At the same time, we received comments that these measures are not applicable to orthopedic surgeons.

Response: We have retained the original measure-category title to reflect the developer, and thus the origin of the measures, rather than the scope of applicability. This identification of nomenclature is aligned with the nomenclature used for other categories of measures, such as those in Table 11, which are identified as originating in the AQA Starter Set rather than by the type of services to which they pertain. MIEA–TRHCA makes no presumption as to applicability based solely on measure title or specifications, let alone the categorization that may be applied to various groups of measures for identification and ease of reference. Rather, measures are presumed applicable to a practitioner based on the scope and pattern of practice of the physician reporting the measure in combination with its specifications.

TABLE 13.—PODIATRIC MEASURES

Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation.
Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear.

d. Addressing a Mechanism for Submission of Data on Quality Measures via a Medical Registry or Electronic Health Record

(i) Addressing a Mechanism for Submission of Data on Quality Measures via a Medical Registry—Background and Summary of Proposed Rule

As explained in the proposed rule (72 FR 38202), section 1848(k)(4) of the Act, as amended by the MIEA–TRHCA, requires that ''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 proposed rule, we discussed what constitutes a medical registry and the general desirability of registries serving as an alternative to claims based reporting. We proposed to address reporting from medical registries by testing one or more of five mechanisms for such reporting during 2008, and requested comment on five options for data submission by registries. These options vary as to whether individual beneficiary-level data is submitted by the registry, as well as the number and type of data elements needed from the registry. The five options were described in detail in the proposed rule (72 FR 38203 through 38204).

The 2008 registry reporting is only a test of the feasibility and accuracy for the two selected submission options (identified as Options 2 and 3 in the proposed rule (72 FR 38203 through 38204)) and described again, in summary, below in response to comments. In order to qualify for the incentive bonus for PQRI data submission, practitioners will need to continue their quality data codes through the claims process.

(ii) Addressing a Mechanism for Submission of Data on Quality Measures via a Medical Registry—Summary of Comments and CMS's Responses

Comment: The majority of the comments advocated the use of option 2, 3, or 5. There was not significant support for option 1 or option 4; instead the preponderance of comments on options 1 and 4 were in opposition to their implementation.

Response: We have decided to test options 2 and 3 in 2008.

We agree that option 1 should not be tested. Under this option only the quality data codes for selected PQRI measures would be reported by the registry without submission of associated diagnosis or service rendered. Under this option, the denominator information would have to be obtained from the claims and linked to the quality data codes submitted via the registry. This option would create an added administrative burden for the CMS systems that would need to link data from the two sources at the beneficiary or episode/encounter/procedure level.

We also agree that option 4 should not be tested. Option 4 would place significant burden upon practitioners, by requiring practitioners not only to submit claims to Medicare for the services provided, but also enter data obtained from the explanation of benefits into the registry.

Option 5, which calls for a ''data dump'' was supported by some commenters as this option would potentially provide the most complete and robust set of data for purposes of clinical improvement. It could also be beneficial in evaluating a physician's practice, particularly since it would not necessarily need to be limited to Medicare Part B beneficiaries or soley PQRI measures. Thus, while we agree that data submission via registry-based mechanisms in models such as Option 5 has significant potential over time because of the comprehensiveness of the data, we do not believe that this option is currently practical for implementation even on a test basis. We intend to continue to explore ways to enhance our ability to capture registry data so that it may be suitable for future use.

Under Option 2, the registry would provide the quality data codes and diagnosis codes and beneficiary identification (HIC) numbers or other limited beneficiary information for identification. Using the beneficiary information to match registry information to a submitted claim for a particular service, CMS would have the data needed to calculate a practitioner's reporting and performance rates.

Under Option 3 the registry will calculate and submit reporting and performance rates for various measures to CMS, rather than have CMS calculate the rates. While this is compatible with the role of a registry in providing feedback to the physician, for future PQRI implementation, a validation process for the registry calculations would need to be in place and provided to CMS.

Comment: Many commenters requested that registry-based mechanisms for 2008 be made a fully operational alternative through which participants could achieve satisfactory reporting and quality for a 2008 PQRI incentive payment. Several commenters suggested we find a way to let participants in testing activities ''get credit'' toward PQRI reporting for their participation in the test.

Response: We proposed a test of registry submission (72 FR 38203 through 38204). It is not feasible or practical to implement registry submission without such testing. Any registries and any of their subscribers participating in any testing activities in 2008 will be participating in this data-submission testing on a strictly voluntary basis. Any registry seeking to participate in the testing should notify their subscribers to continue submitting

quality data codes on their Part B professional services claims in order to pursue PQRI bonus payments.

Comment: We received several comments requesting that a specific organization's registry be deemed or ''certified'' to satisfy PQRI reporting. Additionally, it was suggested that we implement a mechanism to make those professionals submitting data to the registry potentially able to qualify for a 2008 PQRI bonus payment on the basis of participating in the registry. We received several related comments suggesting we consider deeming specialty boards' maintenance of certification (MOC) programs so that successful participation in a deemed MOC would qualify a professional for a 2008 PQRI bonus payment.

Response: We believe that, in the long run, registries having such deemed status may be a very suitable and desirable way for quality data submission and measures calculation to be conducted for physicians and other practitioners. However, at the present time we do not find it feasible or practical to implement such a suggestion.

Comment: Several commenters encouraged us to maintain for the foreseeable future multiple options for PQRI participants to submit data, including claims based, as well as registry or EHR-based submission mechanisms. Some of these comments noted that the state of the art for medical registries is embryonic to nascent. Commenters also noted that the percentage of eligible professionals who use EHRs capable of successful data extraction and transmission to a CMS data warehouse is relatively low. Related comments recommended we develop a long term strategy that will be sufficiently flexible to allow for innovative developments in the registry field as it begins to grow in sophistication and market penetration.

Response: For 2008, claims-based submission will remain the only mechanism of PQRI quality measure data submission. We hope in future years to make alternative ECI-based submission mechanisms available. However, we recognize that for the near future, claims-based submission is likely to be the only mechanism that will provide an avenue for virtually all eligible practitioners to participate within PQRI. As a result, we would anticipate that claims based submission would be maintained.

Comment: Several commenters expressed concern that many registries are proprietary and charge a fee for using the registry. Commenters expressed concern about using proprietary registries, specifically that such use raises potential antitrust (barrier to competition) issues, as well as barriers to participation by professionals who would have to subscribe to a proprietary registry. Several commenters urged that any CMS registry-based mechanism be in the public domain and supported by a public domain registry available to individual professionals.

Response: In the proposed rule, we discussed registry-based reporting as an alternative, not a requirement. We agree that physicians should not be required to use any particular proprietary service. Rather, the purpose in addressing registries is to allow physicians who find it desirable to submit data to registries to be able to avoid duplicate data submission to CMS through the claims process.

Comment: A few commenters expressed concern that creating new registries or altering existing interfaces would be burdensome and costly.

Response: We are not recommending developing new registries and any decision to do so should be made independently of PQRI. Nevertheless, there are currently various registries in existence which may, ultimately, be capable of interfacing with the CMS data warehouse. As has been previously discussed, for 2008, we will only be testing registry-based data submission. As envisioned for the future, registry-based submission of quality-measures data would be an alternative, not a requirement.

Comment: Some comments expressed concerns about transmitting patient data through registries or EHRs in context of applicable statutes, regulations, and policies protecting patient privacy.

Response: Preserving the confidentiality of patients' individually identifiable and protected health information is a high priority at CMS. Generally, personally identifiable data on individuals and/or their health are protected by the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA). HIPAA establishes protections specific to certain individually identifiable health information, and the Privacy Act establishes the protections specific to certain information that the government maintains which is individually identifiable. HIPAA and its extensive implementing regulations have established privacy and security standards for health care plans, health care clearinghouses, and providers that conduct electronic transactions covered by HIPAA. These entities are termed ''covered entities''. All patient registries, EHRs, data transmission, and data storage done by or on behalf of a covered entity must be HIPAA compliant. The claims-based method of reporting currently uses patient identifiers for submission of quality data along with data required to process the provider's claim for payment. The use of registries or EHRs would require, for purposes of validation, the same information as currently used by the claims-based method of submitting quality-measures data.

(iii) Addressing a Mechanism for Submission of Data on Quality Measures Via a Medical Registry—Final Plan

For 2008, we will test Options 2 and 3 on a voluntary basis, based on self-nomination by the registries. Each registry participating in the testing of each option must maintain compliance with all applicable statutory and regulatory requirements and any contractual obligations to the professionals/providers for processing, storing, and transmitting the data required by the option.

Functionally, the registry would act as a data submission vendor for the eligible professional. A ''data submission vendor'' is defined for purposes of this rule as an entity that has permission from the eligible professional to provide medical registry data to the Quality Reporting System developed per the MIEA–TRHCA. This definition parallels the definition of ''data submission vendor'' as used in other programs, such as the Hospital Compare data-submission process, where examples of such vendors include Joint Commission Oryx vendors.

In the testing process, again in parallel to similar mechanisms already implemented for other provider types by CMS, we anticipate the registry, acting as a data submission vendor, will submit data to the CMS clinical data warehouse, using a CMS-specified record layout based on the quality measures' specifications as published by CMS. For purposes of this rule, the term ''CMS clinical data warehouse'' is defined as a clinical data warehouse designated by CMS for use in this testing. The exact warehouse infrastructure may vary between the testing activity in 2008 and any full implementation of registry-based data submission that may in the future follow from that testing.

Options 1 and 4 as described in the proposed rule will not be tested in 2008, and we do not envision any future consideration. Thus, they are not described in this rule. Option 5, while of potential interest for future consideration, is also not described

below. As options 2 and 3 will be tested in 2008, they are described below.

Option 2: Registries provide the quality codes and diagnosis codes. In testing this option, we will use claims data extracted from the National Claims History to capture the payment information at the NPI/Tax ID level. All PQRI reporting and performance calculations will be performed using registry data. The registries will, therefore, be required to include specific data elements in their databases in order to include the codes needed to calculate performance measures and to match registry data to claims data. Although not identified in the proposed rule, we have upon further technical analysis concluded that along with data elements previously identified, patient identifiers will also be needed from the registry under this option. Patient identifier data are needed specifically in order to allow matching of registry data with Medicare claims. It is our understanding that for many, if not all, registries, inclusion of at least the patient identifier data elements will represent an addition to their databases.

While developing and through the implementation of the testing phase we may discover additional data elements are needed to support reliably valid analyses. The following is a list of examples of the minimum data elements we believe will be needed from a registry under Option 2:

- Beneficiary/procedure-level data (ICD 9 and CPT codes)
- HCPCS quality-data codes (G codes and CPT category II codes and modifiers)
- NPI and Tax ID
- Date of service
- Beneficiary Date of Birth
- HIC number

Option 3: Registries calculate the reporting and performance rates for Medicare beneficiaries only, and submit these rates to CMS (that is, aggregate information by NPI within a Tax ID). We assume no beneficiary level information will be shared. Registries will be required to include data elements in their databases to capture either quality-data codes or the clinical data needed to compute the quality-data codes. Registries will be required to perform the necessary calculations to be able to submit completed numerator/denominators for both reporting and performance rates. Additionally, the registries must have a validation strategy in place.

For any option, the registry must maintain compliance with all applicable statutory or regulatory requirements and any contractual obligations to the providers for processing, storing, and transmitting the data required by the option. To be considered an appropriate registry from which we can accept and process data for the purposes of calculating PQRI measures, a registry must also comply with the interoperability standards recognized by the Secretary, and therefore, applicable to HHS initiatives. Examples of standards recognized by the Secretary include Consolidated Health Informatics Initiative (CHI) standards and standards subsequently recognized by the Secretary under Executive Order 13410 in place of CHI standards. A description of the specific health informatics standards adopted by the Federal government, as well as the specific interoperability standards recognized by the Secretary, is available on the HHS Office of the National Coordinator for Health Information Technology (ONC) Web site at *http://www.hhs.gov/healthit/chiinitiative.html.*

We will request that registries interested in participating in the testing of the registry based quality data submission project self nominate. A letter stating the registries interest should be received by CMS by 6 PM, Eastern time, on January 4, 2008. Self-nomination letters should be sent to: ''PQRI IT Testing Nomination'', Centers for Medicare and Medicaid Services Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3–02–01, Baltimore, MD 21244–8532.

We plan to select for testing, from the self nominees, a group of registries that comply with all applicable statutory and/or regulatory requirements, and any contractual obligations to the professionals/providers for processing, storing, and transmitting the data required by the option(s) tested. Registries selected must also comply with applicable system interoperability standards recognized by the Secretary and be technically capable of interfacing with the CMS clinical warehouse electronic data exchange interface. The number of registries selected for testing may be limited to those that are technically capable or those that already contain key minimum data elements for testing purposes. Additionally, the actual level of complexity and effort required for testing from the CMS data infrastructure may also limit registry participation in the testing phase. (Experience with other initiatives has suggested that some data submission vendors and their software are more easily interfaced and tested with the CMS data warehouse electronic data exchange interface than others.)

In addition to the requirements listed above in this section, any registry that self-nominates for 2008 testing must, at a minimum, have the following characteristics:

(1) Be able to separate and report information for Medicare beneficiaries only.

(2) Use at least 1 PQRI measure that is selected for 2008 inclusion. We will consider other measures recommended by specialty registries for possible future use in quality reporting and performance.

(3) Provide the data as outlined in the rule for the particular available option under which they are submitting data (that is, being able to report using option 2 and/or option 3).

(4) Have a validation process for their data.

(5) Have or have applied for a QualityNet Exchange account.

We expect that information on the results of the testing in 2008 will be posted on the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri.*

(iv) Electronic Health Records (EHRs)

The proposed rule noted (72 FR 38204) that we would explore the operational feasibility of accepting clinical quality data for a limited number of PQRI measures from EHRs, and solicited comments on this concept. The summaries of, and our responses to, the numerous comments we received on this topic are presented at the end of this PQRI-specific section.

Having conducted further technical analyses and reviewed public comments received on the proposed rule, we have determined that we will, in 2008, partner with several self nominated EHR vendors/groups that we select to develop and test EHR clinical quality data submission. Since mechanisms for submission of electronic clinical data extracted from an EHR will only be for testing purposes in 2008, vendors should notify their clients that the practitioners will need to submit their quality data codes through the claims process to be eligible for a 2008 bonus payment.

EHR vendors/groups who wish to participate in the development and testing process may self-nominate by sending a letter to CMS expressing their interest. Self-nomination letters should be sent to: ''PQRI IT Testing Nomination'', Centers for Medicare and Medicaid Services Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3–02–01, Baltimore, MD 21244–8532.

The letter must be received by CMS by 6 p.m., e.s.t., on January 4, 2008. Vendors who are selected for this process must:

(1) Be able to submit data according to the HL7 technical specifications for submission of data to the Outpatient Clinical Warehouse, as defined for the Doctor's Office Quality—Information Technology (DOQ–IT) Project; and

(2) Have or have applied for a QualityNet Exchange account.

As with registry-based mechanisms, vendors and their customers (eligible professionals) who choose to participate in the testing in 2008 will be doing so on a strictly voluntary basis. We will continue to express this, and will urge EHR vendors to explain this to their customers when seeking volunteers to participate in the testing with them.

For more information on required capability (1), above, please see the QualityNet Exchange User's Guide, and the DOQ–IT measures' technical specifications (as implemented in the DOQ–IT project), both available for download free of charge from *http://qualitynet.org.* Additionally, 5 overlapping DOQ–IT and PQRI quality measures have been updated for potential use in the 2008 testing. The updated detailed technical specifications for these five DOQ–IT/PQRI overlapping measures are available for download from the 2008 PQRI Information page of the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri.*

Comment: Numerous comments were received regarding accepting clinical quality data from EHRs for use in PQRI. While some commenters opposed the idea of using EHR-derived data in PQRI, the majority of responses were in favor of accepting clinical quality data from an EHR.

Response: Although we will be unable to offer EHR-based data submission mechanism on other than a test basis, we are encouraged by the generally positive response to the pursuit of this option due to its substantial potential to enhance data quality and reduce data collection burden on providers.

Comment: Numerous comments expressed concerns about data security, especially as it pertains to patient privacy, and patient privacy as it relates to CMS use of the quality data, in the context of EHR-based data submission mechanisms.

Response: Preservation of patient confidentiality is imperative. It is the inescapable responsibility of every party that collects, stores, handles, or uses patients' personally identifiable health information for any purpose. In order to participate in the 2008 testing, all participating parties must be able to ensure that uses and disclosures of protected health information EHRs, data transmission mechanisms, and data receipt and storage systems will be in compliance with all applicable statutes and regulations and any contractual obligations to the professionals/providers for processing, storing, and transmitting the data required by each option tested. Moreover, although EHR submission may involve identifiable personal health information, that information is limited to what is minimally necessary to be able to audit the data accuracy and completeness in addition to the particular clinical information (lab values, vital sign values, documentation of a procedure or test ordered or performed) necessary to calculate the performance measure. It does not involve submitting the entire patient medical record, and it is possible that the information as transmitted can have the patient's actual identifying information (for example, name, and HIC number) ''masked'' by using a practice-internal chart ID # or other method that still allows for accurate audit.

Comment: Multiple comments urged us to develop and implement EHR-based data submission mechanisms in a way that minimizes the burden such submission might impose.

Response: We agree that data submission burden is an important factor to consider in PQRI data submission.

Comment: We received several comments expressing concern over professionals losing ''control'' of patient records as a result of EHR-based PQRI quality data submission. The comments appeared to assume that our plan was *either* to import and maintain within our data warehouse entire patient medical records *or* to implement an interface that would allow our warehouse to access and mine the data from patients' medical records.

Response: The patient's health record is populated and maintained in a practitioner's office, regardless of whether its content is stored on paper or electronic format or media. Nothing in this rule affects the rights of patients or practitioners with respect to the information contained in a patient's health record.

We plan to accept clinical data that is extracted from medical records and then submitted to us by a professional (or a data-submission vendor acting on a professional's behalf).

We would not attempt to upload entire medical records into the data warehouse, only the data elements minimally necessary to accomplish the purposes of PQRI. We do not plan to enable our system to directly mine data from the practice's medical records database; that will need to be accomplished by the professional or a data vendor acting on the professional's behalf. The data submission requires an affirmative action on the part of the professional to submit the data or to instruct his or her data submission vendor to submit the data to our warehouse.

2. Section 110—Reporting of Hemoglobin or Hematocrit for Part B Cancer Anti-Anemia Drugs (§ 414.707(b))

Medicare Part B provides payment for certain drugs used to treat anemia. Anemia is common in cancer patients and may be caused by either the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation therapy, and surgical therapy. Anemia occurs when the number of red blood cells is reduced by an anti-cancer treatment. This happens due to the effect of chemotherapy or radiation therapy on the bone marrow, wherein red blood cells are produced by dividing precursor cells. This chemotherapy effect is commonly referred to as ''bone marrow suppression.'' Anemia may also result from blood loss in association with surgical therapy for the cancer.

Anemia adversely impacts the quality of life for beneficiaries being treated for cancer. Fatigue and reduced performance capacity are the side effects of anemia that cancer patients report as the most disabling and contributing to poor quality of life. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically erythropoiesis stimulating agents (ESAs) such as recombinant erythropoietin and darbepoietin. Although other pharmacologic interventions are available, ESAs are the most commonly used drugs to treat anemia in this setting. Notably, recent research has prompted a Black Boxed warnings in the labels for ESAs, noting significant adverse effects including a higher risk of mortality and tumor progression in some populations.

In 2006, we implemented a revised ESA claims monitoring policy based on the last hemoglobin or hematocrit value from the preceding month on Medicare claims for payment of ESAs administered to beneficiaries with anemia due to end-stage renal disease (ESRD) receiving dialysis treatments in facilities. For many years prior, we have required the reporting of these red blood cell indicators on the Medicare claims by ESRD facilities to ensure that the beneficiaries' anemia was addressed.

Section 110 of the MIEA-TRHCA amends section 1842 of the Act by adding a new subsection (u) that reads as follows: ''Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.'' Section 110 of the MIEA-TRHCA requires such reporting for drugs furnished on or after January 1, 2008. In addition, subsection (b) directs the Secretary to use the rulemaking process under section 1848 of the Act to address the implementation of this requirement.

By requiring the reporting of anemia quality indicators for Medicare Part B anti-anemia drugs that are used in the context of cancer treatment, we will facilitate assessment of the quality of care for this condition. We will use the information reported to help determine the prevalence and severity of anemia associated with cancer therapy, the clinical and hematologic responses to the institution of anti-anemia therapy, and the outcomes associated with various doses of anti-anemia therapy.

While not specifically addressing other indications, the recent research on the adverse effects of ESAs in patients with cancer does raise concerns as to whether patients receiving ESAs for other conditions, such as in the treatment of HIV-AIDS and for some surgical patients, are also at higher risk. We solicited public comment on the potential of expanding this regulation to include all uses of ESAs.

Comments and Responses

In general, commenters responded favorably to requiring the reporting of the most recent hemoglobin or hematocrit level on claims seeking payment for the administration of ESAs for all uses. One commenter supported broadening the requirement for reporting hemoglobin and hematocrit levels for all ESA claims and stated that such requirements would provide valuable data concerning reasonable care. The commenter stated that any new information on the use of ESAs for other, non-cancer diseases gained by the data collection would be helpful in understanding the effects of ESA use in different diseases. Another commenter supported the broad goal of gathering the information to improve the quality of care. Thus, in light of the potential adverse events from ESA use and in accordance with our reading of Congressional intent, we believe it is appropriate to require reporting of the hemoglobin or hematocrit with respect to all ESA claims, and therefore, we have revised the regulations text to reflect this policy in this final rule with comment period.

Most commenters' concerns were limited to the implementation of the requirement and possible subsequent undue administrative burden placed on providers. A few commenters addressed a recently published National Coverage Determination on the use of ESAs for certain patients and others included comments related to our ESAs claims monitoring policy (EMP). We are not addressing those comments in this final rule with comment period as the issues are outside the scope of this regulation.

Comment: A commenter recommended that we exercise caution in implementing the anemia quality indicator secondary to a recent Food and Drug Association (FDA) Black Boxed Warning (BBW) on the use of ESAs. The commenter noted that anemia measures were removed from the Physician Consortium for Performance and Improvement ESRD measurement set pending further clarification by either the FDA or the National Kidney Foundation.

Response: This final rule with comment period does not establish new or additional standards related to anemia or the administration of ESAs. It simply mandates the reporting of the most recent hemoglobin or hematocrit level on claims for payment of the administration of ESAs to treat anemia. Similar to claims for ESAs administered in renal dialysis facilities, the requirement to report a recent hemoglobin or hematocrit on claims for the administration of ESAs for any use is not a development of a clinical standard. Thus, we believe that collecting this information will not impact nor be impacted by any consensus standard organizations' development of practice standards, quality measures or new scientific evidence.

Comment: A commenter asked that we clarify if the reporting requirement applies to all anemia treatment, which includes, but is not limited to, the use of ESAs.

Response: The statutory requirement does not limit the scope to ESAs. We recognize that other drugs and vitamin and mineral supplements such as Vitamin B12, folic acid, and iron may also be used in the treatment of anemia. ESAs are only FDA approved for the treatment of anemia while the other agents are commonly used to treat a variety of conditions other than anemia. Vitamin and mineral supplements are commonly self administered and we expect that most uses of these agents would not result in claims for Medicare payment in the context of the treatment of anemia related to anti cancer therapy. However, if payment is requested for these anti-anemia drugs furnished to an individual for the treatment of anemia in connection with the treatment of cancer, we believe that they are within the scope of the statute.

We believe that the reporting of hemoglobin or hematocrit levels on claims for ESAs is consistent with Congressional intent that quality indicator data be submitted for patients receiving anti-anemia drugs and to ensure that anemia is addressed.

Comment: Several commenters recommended that we provide clear instruction on the scope and reporting of the hemoglobin or hematocrit levels.

Response: We will use the change request process to issue implementing instructions to Medicare contractors. Instructions to Medicare contractors include requirements for provider education.

Comment: Several commenters expressed concern that the requirement will be burdensome for providers. One commenter asked that we delay the implementation of this requirement until the administrative burden to practitioners is understood.

Response: We do not have the authority to delay the effective date of the statutory requirement. In addition, we believe that reporting the most recent hemoglobin or hematocrit level on a claim for ESA will not result in undue administrative burdens on providers. Many local Medicare contractors already require such reporting for claims submitting within their jurisdictions. ESRD providers have been reporting hemoglobin or hematocrit levels on claims for ESAs for several years.

Comment: A commenter recommended that should we broaden the reporting requirement to all ESA use and that we should assess minimal data sets for understanding how beneficiaries with various underlying conditions respond to a particular course of anemia management.

Response: We appreciate the recommendation and shall review available data sets when assessing responses to anemia management.

Comment: A commenter recommended that we include anemia quality indicators in the Physician Quality Reporting Initiative (PQRI) data reporting.

Response: This comment is addressed above in the section of this final rule specific to 2008 PQRI measures. The identification or establishment of PQRI

measures is not within the scope of this section of this final rule with comment period.

Comment: A commenter asked that retail pharmacies be exempt from this requirement.

Response: The MIEA TRHCA does not provide for any exemption for retail pharmacies.

Comment: One commenter asked that we clarify whether a provider may report a hematocrit or hemoglobin level.

Response: A provider seeking payment for ESAs may report the patient's most recent hematocrit or hemoglobin level on the claim.

Comment: Several commenters asked that we clarify the requirement to report ''the most recent'' hemoglobin or hematocrit level. They expressed concern that we may require a patient to have a hemoglobin or hematocrit level drawn each time an ESA is administered.

Response: We are not determining in this regulation when a hematocrit or hemoglobin level should be drawn to inform a provider's decision to administer ESA therapy. The requirement is that ''the most recent'' hemoglobin or hematocrit level be reported on the claim. Thus, the provider should report the most recent level preceding the ESA administration. We recognize that in some instances the same hemoglobin or hematocrit value might be reported on more than one claim.

Comment: Several commenters stated that we should permit providers to report hematocrit or hemoglobin levels in either box 19 or 24A of the CMS 1500 form. The CMS 1500 form was recently modified to allow reporting in box 24A; however, many providers utilize billing vendors that provide software and are unable to modify their product in time for the January 1, 2008 implementation.

Response: We will consider this information when developing claims processing systems instructions.

Comment: One commenter suggested that we employ Q codes for reporting the most recent hemoglobin or hematocrit levels. The commenter stated that permitting a provider to report the level in box 19 would not allow an automated extraction of the data element (the hemoglobin or hematocrit level) for data analysis.

Response: We are working with claims processing systems to ensure appropriate retrieval of data sets.

3. Section 104—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 this service is furnished by the hospital pathologist for a hospital patient, it is separately billable. If the independent laboratory's pathologist furnishes the PC service, it is usually billed with the TC service as a combined service.)

In the CY 2000 PFS final rule with comment period (64 FR 59408 through 59409), we stated that we would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Before that provision, any independent laboratory could bill the carrier under the PFS for the TC of physician pathology services for hospital patients. As stated in the CY 2000 PFS final rule with comment period (64 FR 59408 through 59409), this policy has contributed to the Medicare program paying twice for the TC service, first through the inpatient prospective payment rate to the hospital where the patient is an inpatient and again to the independent laboratory that bills the carrier, instead of the hospital, for the TC service.

Therefore, in the CY 2000 PFS final rule with comment period (64 FR 59408 through 59409), in § 415.130, we specified that for services furnished on or after January 1, 2001, the carriers would no longer pay claims to the independent laboratory under the PFS for the TC of physician pathology services for hospital patients.

Ordinarily, the provisions in the PFS final rule with comment period are implemented in the following year. However, in this case, the change to § 415.130 was delayed 1 year (until January 1, 2001), at the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements. Moreover, our full implementation of § 415.130 was further delayed by section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA) and section 732 of the MMA, which directed us to continue payment to independent laboratories for the TC of physician pathology services for hospital patients through CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69700), we announced that beginning January 1, 2007, we would no longer allow the carriers to pay the independent laboratory for the TC of physician pathology services to hospital patients. In effect, we would be: (1) Implementing the provisions of the CY 2000 PFS final rule with comment period whose implementation had been delayed by section 542 of the BIPA and section 732 of the MMA; and (2) ensuring that the Medicare program does not make duplicate payments for the same service.

Subsequent to publication of the CY 2007 PFS final rule with comment period, the MIEA–TRHCA was enacted. Section 104 of the MIEA–TRHCA provided for an additional 1 year extension to allow carriers to continue to pay independent laboratories under the PFS for the TC portion of physician pathology services furnished to patients of a covered hospital.

Consistent with this legislative change, we are amending § 415.130(d) to specify that for services furnished after December 31, 2007, an independent laboratory may not bill the carrier for the TC of physician pathology services furnished to a hospital inpatient or outpatient.

Comment: Many commenters asked us to implement the grandfather provision on a permanent basis, and if this cannot be accomplished administratively, the commenter requested that we implement this provision no earlier than July 1, 2008. The commenter indicated that this delay would allow the grandfathered independent laboratories the opportunity to implement new billing requirements and inform customers of this change.

Response: We will delay implementation of this provision only if legislation is enacted requiring a further delay. Otherwise, we will, as explained in the CY 2008 PFS proposed rule, implement this provision effective for TC services furnished on or after January 1, 2008.

Comment: A commenter indicated a potential problem in the preamble language of the CY 2008 PFS proposed rule that explains the implementation of the TC physician pathology provision effective January 1, 2008. In the CY 2008 PFS proposed rule, the preamble reads, ''Consistent with this legislative change, we are amending § 415.130(d) to reflect that for services furnished after December 31, 2007, an independent laboratory may not bill the carrier for physician pathology services furnished to a hospital inpatient or outpatient'' (72 FR 38205). As currently written, this language would mean that the independent laboratory cannot bill the carrier for the PC of physician pathology services for hospital patients, an unintended result.

Response: The preamble inadvertently omitted the term ''technical component'' and should read, ''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.'' We proposed this language in the regulations text of the proposed rule and are finalizing this language in this final rule with comment period.

4. Section 201—Extension of Therapy Cap Exception 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 services furnished as outpatient hospital services. Section 1833(g)(2) of the Act provides that, for CY 1999 through CY 2001, the caps were $1500, and for the calendar years after 2001, the caps are equal to the preceding year's cap increased by the percentage increase in the Medicare Economic Index (MEI) (except that if an increase for a year is not a multiple of $10, it is rounded to the nearest multiple of $10).

The cap for CY 2008 will be $1810 per beneficiary for PT and SLP services combined, and $1810 for OT services. Therapy caps apply to expenses incurred for therapy services in all outpatient settings except the outpatient hospital department. As explained below in this section, the statute requires that we implement the therapy caps without providing for an exceptions process beginning on January 1, 2008.

Section 5107(a) of the DRA required the Secretary to develop an exceptions process for the therapy caps effective for expenses incurred during CY 2006. Details of the CY 2006 exceptions process were published in a manual change on February 13, 2006 (CR4364, which consists of Transmittal 855, Transmittal 47, and Transmittal 140). Section 201 of the MIEA–TRHCA extended the exceptions process to apply for expenses incurred through December 31, 2007. Therapy cap exception policies for 2007 were specified in Change Request 5478 which consists of three transmittals with current numbers of—

- Transmittal 1145CP, Pub. 100–04;
- Transmittal 63BP, Pub. 100–02; and
- Transmittal 181PI, Pub. 100–08.

The transmittals are incorporated into the Internet Only Manuals available at *http://www.cms.hhs.gov/Manuals* and are also available on our Web site at *http://www.cms.hhs.gov/Transmittals/*.

In accordance with the statute as amended by the MIEA–TRHCA, we will continue to implement therapy caps, but the exceptions process will no longer be applicable for expenses incurred for services furnished beginning on January 1, 2008. As noted previously in this section, under current law, therapy caps will continue to apply to expenses incurred for therapy services after December 31, 2007, with one exception. That is, in accordance with section 1833(g) of the Act, the therapy caps will remain inapplicable to expenses incurred for therapy services furnished in the outpatient hospital setting.

We received several comments on this proposal.

Comment: Most commenters understood that we have no authority to change therapy caps, but still commented in favor of repealing them. Some commenters supported the continuation of the exceptions process as a well-conceived method of eliminating unnecessary treatment. Some commenters objected to the inapplicability of the caps for therapy expenses incurred in the outpatient hospital setting. One commenter supported the repeal of therapy caps and stated it is not an effective cost control when a steady source of replacement patients is available.

Another commenter opposed the policy underlying the statutory provision to apply a financial cap on therapy services. The commenter cited other means of ensuring appropriate utilization of therapy services including CCI edits, edits required by the Deficit Reduction Act, local coverage determination policies, and Transmittal 63, which required greater documentation. The commenter indicated that we are effectively achieving the objective to assure appropriate utilization of therapy services without the financial caps.

Response: We do not have the authority to repeal therapy caps, to change the exception to applicability of the caps for services provided in the outpatient hospital setting, or to extend the therapy cap exceptions process beyond the period for which was made applicable by statute (CYs 2006 and 2007).

Comment: Several commenters urged CMS to implement the recommendations contained in the Computer Science Corporation (CSC) Outpatient Therapy Service Pilot Report of 2006 to collect patient-specific data using available measurement tools. Although they acknowledged that we may have concerns about the use of proprietary tools, the commenter urged the use of therapy-specific tools already on the market that were recommended by both CSC and MedPAC, including the National Outcomes Measurement System.

Response: In evaluating alternative payment systems, we will consider all methods of obtaining the required patient-related information including reports of past and future contract deliverables.

Comment: Many commenters are deeply concerned about the negative impact the caps would have, in the absence of the exceptions process, on an estimated 14.5 percent of the physical therapy (PT) users who would exceed the cap. The commenters commended CMS for progress made toward alternatives to the financial caps in recent years and urged a high priority in resources and funding to continuing research to identify alternatives that would also ensure access to medically necessary therapy services. The commenters support the collection of patient outcome data with patient assessment tools and use of risk adjustment to account for individual differences. They support the ongoing study for which CMS recently issued a Request for Task Order (RTOP–CMS–07–033) and look forward to participating in the study.

Many commenters reported that they will be collecting and reporting outcome data before January 1, 2008. They urged CMS to use clinical outcome data to determine the amount of care needed by individuals and offered assistance in data collection.

Response: We recently issued a request for proposals (RTOP–CMS–07–033) to continue our study of therapy services. The study will: (1) Identify, collect and use therapy-related information that is tied to beneficiary needs and treatment effectiveness; and (2) develop payment method alternatives to the current cap on outpatient therapy services.

We welcome any information concerning clinical outcome data studies from providers or suppliers. If the information is applicable to our deliberations on payment alternatives, we will consider it along with the results of past and future contract deliverables.

Comment: One commenter recommended that we continue to collect outpatient therapy utilization information for 2006 and 2007.

Response: We contracted with the CSC (HHSM–500–2007–00322G) to extract 2006 therapy utilization data and provide a high level analysis. To the extent possible, we intend to further

study the impact of therapy caps including the 2006 exceptions process.

5. Section 101(d)—Physician Assistance and Quality Initiative (PAQI) Fund

Section 1848(l) of the Act, as added by section 101(d) of the MIEA–TRHCA requires the Secretary to establish a Physician Assistance and Quality Initiative (PAQI) Fund (the Fund) which shall be available for physician payment and quality improvement initiatives, and which may include application of an adjustment to the update of the PFS conversion factor (CF). The provision makes available $1.35 billion to the Fund for services furnished during CY 2008. Specifically, the provision directs the Secretary to provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire $1.35 billion for payment for physicians' services furnished during CY 2008. The provision also requires that if expenditures from the Fund are applied to, or otherwise affect, a CF for a year, the CF for a subsequent year shall be computed as if the adjustment to the CF had never occurred. We note that the Transitional Medical Assistance, Abstinence Education, and Qualifying Individual Programs Extension Act of 2007 (Pub. L. 110–90) recently was signed into law and it provides an additional $325 million to be used as a part of the PAQI Fund for payment with regard to services furnished in 2009 and $60 million for payment for physicians' services furnished on or after January 1, 2013. The legislation does not make any other changes to the program, and therefore, remains as discussed in the proposed rule.

As the MIEA–TRHCA legislation indicates, this Fund can be used for physician payment and quality improvement, including application of an adjustment to the update of the conversion factor. In the CY 2007 PFS proposed rule, we proposed to use the $1.35 billion to fund bonus payments to be made during CY 2009 for physician reporting of measures during CY 2008. Specifically, we proposed that the physician quality initiative for CY 2008 be structured and implemented in the same manner as the 2007 PQRI with regard to the professionals eligible to participate in the program, reporting quality measures via claims submission, and the standards for satisfactory reporting.

The differences between CY 2007 and CY 2008 that we currently anticipate are noted below in this section. As we monitor the implementation of the 2007 PQRI and possibly make refinements to the 2007 program, we anticipate that such refinements would also apply under the 2008 program. Such refinements, should they be needed, will be noted with guidance linked from the CMS quality reporting Web site at *http://www.cms.hhs.gov/PQRI*.

As with the 2007 PQRI, we proposed that eligible professionals who successfully report a designated set of quality measures in 2008 may earn a bonus payment of a percentage of total allowed charges for covered Medicare services, subject to a cap based on the volume of quality reporting. In contrast to 2007, we proposed that eligible professionals could report applicable measures for services furnished from January 1, 2008 through December 31, 2008, and allowed charges during such period would be the basis for calculating the bonus payments. We proposed that the CY 2008 measures that we finalize in this final rule with comment period would apply for CY 2008. We also proposed to estimate all of the bonus payments that would be payable to physicians using the same method as the one used for reporting during 2007 and to calculate the amount of the bonus payment, after the close of CY 2008 reporting period. Given that we proposed to use the PAQI Fund for the 2008 PQRI program, we also proposed that the bonus payments to individual physicians be subject to an aggregate cap of $1.35 billion. Because we proposed to scale aggregate payments to physicians in a manner such that Medicare would pay $1.35 billion during CY 2009 for measures reported for services furnished during CY 2008, we were unable to provide an exact percentage for the bonus payment. However, we anticipated that the bonus payments would be approximately 1.5 percent of allowed charges for participating professionals (and we did not expect that the ultimate percentage amount would exceed 2 percent).

Comment: Comments received on the proposed rule were generally opposed to using the PAQI Fund for CY 2008 PQRI bonus payments. Almost all comments on this issue requested that we use the entire $1.35 billion to help offset the estimated negative 9.9 percent physician update for CY 2008.

Response: In the CY 2007 PFS proposed rule, we acknowledged this alternative approach of using the $1.35 billion in some manner to reduce the update to the PFS of negative 9.9 percent that is projected for CY 2008. However, we noted that there are fundamental operational problems with this approach that make it not feasible. The $1.35 billion is a fixed dollar amount. Once the amount is reached, there is no authority to pay any more than that amount. Medicare is an entitlement program that covers medically necessary services for eligible beneficiaries, but such coverage is not limited to a fixed dollar amount for a year. While we estimate that the $1.35 billion would reduce the negative update by approximately 2 percentage points, actual spending could be above or below the estimate. To insure that we do not exceed the Fund amount, we would have to estimate an amount to reduce the update by that is low enough to ensure the $1.35 billion funding cap is not exceeded. While this approach might reduce the CY 2008 negative update, it could still leave money in the Fund. We are concerned that there may be potential oversight or other legal consequences in the event that we significantly exceed the Fund or do not apply the entire Fund. Therefore, we believe the best use of the Fund is to apply it to extend PQRI into CY 2008.

Comment: Commenters asserted that use of the PAQI Fund for anything other than the physician update was inconsistent with Congressional intent. Commenters cited TRHCA language that the Fund ''may include application of an adjustment to the update of the conversion factor.'' Commenters further noted that this use must have been Congressional intent, since the legislation includes explicit language of how to deal with the update in subsequent years when the Fund is used towards the update: ''[I]n the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor * * * the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.''

Many commenters cited the Congressional Budget Office's cost estimate for the TRHCA legislation, which anticipated CMS developing a plan to use approximately 90 percent of the Fund in CY 2008 and the remaining funds in CY 2009. These comments cited section 101(d) of the MIEA–TRHCA, where the Congress stated that the Fund should be used ''to the maximum extent feasible'' for physicians' services during CY 2008, interpreting Congressional intent to be that CMS do its best to distribute most of the money in CY 2008, and any remaining monies in CY 2009.

Commenters rejected the rationale that there were serious legal and operational barriers to applying the PAQI Fund to the physician update; they expressed confidence that we could find some way to use the Fund to offset the reduction.

Further, commenters noted that it was within our discretion to apply the PAQI Fund to the physician update, and they were highly critical of our unwillingness to take administrative steps to mitigate the negative 9.9 percent physician update.

Response: Section 101(d) of the MIEA–TRHCA directs the Secretary to establish a PAQI Fund to be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the CF under that subsection. The legislation clearly indicates that the Secretary has the discretion to use the Fund for physician payment and quality improvement initiatives, including application of an adjustment to the update of the conversion factor. However, we are not required to use the funds for the update.

As noted above, there are fundamental operational problems with applying the PAQI Fund to the conversion factor update. We are concerned that there may be potential oversight or other legal consequences in the event the Agency significantly exceeds the Fund or does not apply the entire Fund. For the reasons previously discussed, we believe it is in the best interests of the program to apply this Fund to the extension of PQRI.

Comment: Commenters rejected the notion that use of the $1.35 billion to fund the CY 2008 PQRI is the best way to insure physicians get the greatest benefit from the PAQI Fund's resources. Commenters stated that the PQRI does not provide all physicians with an opportunity to participate and that many specialties treat patients with conditions for which PQRI measures do not apply. In contrast, using the Fund to offset the negative update for CY 2008 would benefit all physicians.

Response: Medicare payment systems need to encourage reliable, high quality and efficient care, rather than making payment simply based on the quantity of services provided and resources consumed. Applying the $1.35 billion to PQRI bonuses allows CMS to further the goal of improving quality and efficiency by utilizing the infrastructure that both physicians and Medicare have invested in for the CY 2007 PQRI. We believe implementing this Fund through an extension of the PQRI program is the best way to ensure that the Fund is being used to increase quality and efficiency of care for Medicare beneficiaries.

Comment: Commenters rejected the notion that using the PAQI Fund for bonuses would improve quality. For most physicians, the proposed estimated 1.5 percent bonus payment is insufficient to cover the costs to institute such quality reporting measures. Commenters noted that if CMS truly wished to encourage more providers to participate in the PQRI, ''new money'' must be found to fund the initiative. Commenters suggested bonuses between 5 and 10 percent of allowed charges would more reasonably cover the costs of improving their infrastructure to appropriately report quality measures.

Response: Funding the PQRI is consistent with the goal of improving quality and efficiency in Medicare. Eligible professional can participate in the PQRI by reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. We provide educational resources on the PQRI Web site that allow eligible professionals to integrate PQRI reporting into their care delivery process without significant changes in their infrastructures.

We appreciate the desire of eligible professionals to improve their infrastructure to better track quality of care. For many eligible professionals, such infrastructure is already in place for PQRI and will not require additional investment. However, we note that PQRI bonuses are financial incentives to participate in a voluntary quality reporting program and were not intended to cover the costs of significantly improving the infrastructure of eligible professionals.

Comment: Many commenters noted that the PQRI has not been proven to have any positive effect on patient care or health outcomes. Rather than utilizing the $1.35 billion to support an unproven program, it would be better to directly improve physician reimbursement and better cover the costs of the necessary care they are currently providing to beneficiaries.

Response: The PAQI Fund was made available to the Secretary for physician payment and quality improvement initiatives. We are actively engaged with the physician community in identifying ways to align Medicare's physician payment system with the goals of health professionals for high-quality care. Using the PAQI Fund to pay for the PQRI aligns reimbursement with quality and efficiency. We have worked collaboratively with the physician community to develop measures that capture the quality of care being provided to our Medicare beneficiaries. The PQRI encourages physicians to provide the type of care that is best suited for our beneficiaries: Care focused on prevention and treating complications; and care focused on the most effective, proven treatments available.

We acknowledge the relative newness of the PQRI. To that end, we are committed to continue working with the physician community in an open and transparent way to insure that the PQRI supports the best approaches to provide high quality health care services.

Comment: Commenters noted that Congressional intent was to provide some relief and stability to the physician payment system during CY 2008. However, under the terms of the proposed rule, CMS cannot let physicians know the amount of the reporting bonus until well after the close of the CY 2008 reporting period, and physicians would not receive bonuses until some time in CY 2009.

Response: Section 101(d) of the MIEA–TRHCA charges the Secretary with a timely obligation of all available funds for services furnished during CY 2008, directing the Secretary to provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire $1.35 billion for physicians' services furnished during CY 2008. Although the legislation is clear that payment of the Fund is based on services furnished during CY 2008, the legislation does not limit the Secretary to paying from the PAQI Fund during CY 2008.

Comment: One commenter stated that quality payments should not be geographically adjusted. The commenter suggested that PQRI payments should be based on RVUs, not allowed charges.

Response: Section 101(c) of MIEA–TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who choose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5 percent of their allowed charges during that period, subject to a cap. In the CY 2008 PFS proposed rule (72 FR 38206), we proposed that the physician quality initiative for CY 2008 be structured and implemented in the same manner as the 2007 PQRI, as described above. This includes calculating the amounts of the 2008 bonus payments based upon a percentage of allowed charges, as was statutorily required for 2007 bonus payments. By definition, allowed charges include the geographical adjustments in payments, as determined by the geographic practice cost indices (GPCIs), which

reflect the variation in practice costs from area to area.

III. Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; Ambulatory Inflation Factor Update for CY 2007

As discussed in the CY 2008 PFS proposed rule (72 FR 38207), under the ambulance fee schedule, the Medicare program pays for transportation services for Medicare beneficiaries when other means of transportation are contraindicated. Ambulance services are classified into different levels of ground (including water) and air ambulance services based on the medically necessary treatment provided during transport. These services include the following levels of service:

For Ground—

- Basic Life Support (BLS).
- Advanced Life Support, Level 1 (ALS1).
- Advanced Life Support, Level 2 (ALS2).
- Specialty Care Transport (SCT).
- Paramedic ALS Intercept (PI).

For Air—

- Fixed Wing Air Ambulance (FW).
- Rotary Wing Air Ambulance (RW).

A. History of Medicare Ambulance Services

1. Statutory Coverage of Ambulance Services

Under sections 1834(l) and 1861(s)(7) of the Act, Medicare Part B covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated by the beneficiary's medical condition. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 Social Security Amendments suggest that the Congress intended that—

- The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and
- Only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and Rep. No. 404, 89th Cong., 1st Sess. Pt 1, 43 (1965)).

The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

2. Medicare Regulations for Ambulance Services

Our regulations relating to ambulance services are set forth at 42 CFR part 410, subpart B and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Therefore, ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations as specified in § 410.40. Part 414, subpart H, describes how payment is made for ambulance services covered by Medicare.

3. Transition to National Fee Schedule

The national fee schedule for ambulance services was phased in over a 5-year transitional period beginning April 1, 2002, as specified in § 414.615. As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national ambulance fee schedule. In accordance with section 414 of the MMA, we added § 414.617 which specifies that for ambulance services furnished during the period July 1, 2004, through December 31, 2009, the ground ambulance base rate is subject to a floor amount, which is determined by establishing nine fee schedules based on each of the nine census divisions, and using the same methodology as was used to establish the national fee schedule. If the regional fee schedule methodology for a given census division results in an amount that is lower than or equal to the national ground base rate, then it is not used, and the national fee schedule amount applies for all providers and suppliers in the census division. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the fee schedule portion of the base rate for that census division is equal to a blend of the national rate and the regional rate through CY 2009. Thus, as of January 1, 2007, the total payment amount for ground ambulance providers and suppliers is based on either 100 percent of the national ambulance fee schedule amount, or a combination of 80 percent of the national ambulance fee schedule and 20 percent of the regional ambulance fee schedule.

B. Ambulance Inflation Factor (AIF) During the Transition Period

As we noted in the previous section, the national fee schedule for ambulance services was phased in over a 5 year transition period beginning April 1, 2002, as specified in § 414.615. During the transition period, the ambulance inflation factor (AIF) was applied separately to both the fee schedule portion of the blended payment amount (regardless of whether a national or regional fee schedule applied) and to the supplier's reasonable charge or provider's reasonable cost portion of the blended payment amount, respectively, for each ambulance provider or supplier. Then, the two amounts were added together to determine the total payment amount for each provider or supplier.

C. Ambulance Inflation Factor (AIF) for CY 2008

Section 1834(l)(3)(B) of the Act provides the basis for updating payment amounts for ambulance services. Section 414.610(f) specifies that certain components of the ambulance fee schedule are updated by the AIF annually, based on the consumer price index for all urban consumers (CPI–U) (U.S. city average) for the 12-month period ending with June of the previous year. In the CY 2008 PFS proposed rule, we stated the AIF for CY 2008 would be announced as part of this final rule with comment period. For CY 2008, the percentage is 2.7 percent. In addition, as set forth in Section III.D., we also proposed to announce the AIF for CY 2009 and subsequent years via CMS instruction and on the CMS Web site.

D. Revisions to the Publication of the Ambulance Fee Schedule (§ 414.620)

Currently, § 414.620 specifies that changes in payment rates resulting from incorporation of the AIF will be announced by notice in the **Federal Register** without opportunity for prior comment. As explained in the CY 2008 PFS proposed rule, we believe it is unnecessary to undertake notice and comment rulemaking to update the AIF because the statute and regulations specify the methods of computation of annual inflation updates, and we have no discretion in that matter. Thus, the annual AIF notice does not change or establish policy, but merely applies the update methods specified in the statute and regulations.

As discussed in the proposed rule, by mid-July of each year, we have the CPI–U for the 12-month period ending with June of such year. Therefore, we know what the AIF for the upcoming calendar year will be by mid-July of each year. However, § 414.620 currently states that the AIF will be announced in the **Federal Register**. Each document published in the **Federal Register** requires scheduling and a thorough review by CMS, HHS, and OMB prior to publication. Therefore, even though we

know the AIF by mid-July of each year, the final rule announcing the AIF is not published until November. This publication timeframe does not allow Medicare contractors the optimal amount of time to update their systems to implement the proper payment for Medicare ambulance claims by January 1 of the coming year. In addition, it does not provide an optimal amount of time for either the Medicare contractors or the ambulance industry to take advantage of testing systems to make sure that the update is working properly as implemented. We believe that announcing the AIF via CMS instructions and on the CMS Web site would enable the AIF to be released earlier in the calendar year, allowing the Medicare contractors to test their data systems, and to timely effectuate and provide accurate payments on Medicare ambulance claims.

Therefore, we proposed to revise § 414.620 to state that we will announce the AIF via CMS instruction and on the CMS Web site and to remove the language that states that we will announce the AIF by notice in the **Federal Register**.

Comment: Comments received regarding the issue of announcing the AIF via CMS instruction and on the CMS Web site were very supportive of this proposal.

Response: As we proposed, we are revising § 414.620 to state that CMS will announce the AIF via CMS instruction and on the CMS Web site, and to remove the language that states that we will announce the AIF by notice in the **Federal Register**.

IV. Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

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

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section IV.B. and IV.C. of this final rule with comment describes the methodology used to review the comments received on the RVUs for physician work, including the additional codes from the 5-Year Review of work RVUs, and the process used to establish RVUs for new and revised CPT codes. Changes to the RVUs and billing status codes reflected in Addendum B are effective for services furnished beginning January 1, 2008.

B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule

The CY 2007 PFS final rule with comment period (71 FR 69624) contained the work RVUs for Medicare payment for existing procedure codes under the PFS and interim RVUs for new and revised codes beginning January 1, 2007. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In the CY 2008 PFS proposed rule we also proposed work RVUs for additional codes from the 5-Year Review of work RVUs. In this section, we address comments and summarize the refinements to the additional codes from the 5-Year Review of work RVUs, the interim work RVUs published in the CY 2007 PFS final rule with comment period, and our establishment of the work RVUs for new and revised codes for the CY 2008 PFS.

C. 5-Year Review of Work RVUS

1. Additional Codes From the 5-Year Review of Work RVUs

The CY 2008 PFS proposed rule (72 FR 38146) discussed the RUC recommendations on work RVUs for a number of codes from the 5-Year Review that were deferred from the CY 2007 PFS rulemaking and listed the specific codes in Table 10. We proposed to accept all of the RUC recommendations, with the exception of CPT code 93325, *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography),* which we proposed to bundle. We also noted that CPT codes 92557, 92567, 92568, 92569, 92579, 92601, 92602, 92603 and 92604 previously had no work RVUs assigned to them.

Many commenters expressed support for our proposed valuations of many of the services. However, other commenters expressed specific concern or disagreement with the proposed valuation of approximately 17 codes.

To evaluate these comments, we used a process similar to the process used since 1997. (See the CY 1998 PFS final rule published in the October 31, 1997 **Federal Register** (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multi specialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel, which are contained in Table 14: Work RVU Revisions for Additional 5-Year Review Codes. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- Clinicians representing the commenting specialty(ies), based on our determination of those specialties which are most identified with the services in question. Although commenting specialties were welcomed to observe the entire refinement process, they were only involved in the discussion of those services for which they were invited to participate.
- Primary care clinicians nominated by the AAFP and the American College of Physicians.
- Carrier Medical Directors.
- Clinicians who practice in related specialties and have knowledge of the services under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the PFS. We assembled a set of reference services and asked the panel members to compare the clinical aspects of the work for the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the reference set, we attempted to include: (1) Services that are commonly furnished for which work RVUs are not controversial; (2) services that span the entire spectrum of work intensity from the easiest to the most difficult; and (3) at least three services furnished by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion for each service, each participant rated the work for that procedure. Ratings were individual and confidential; there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome that presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In general terms, we used statistical tests to determine whether there was enough agreement among the groups on the panel and, if so, whether the agreed-upon work RVUs were significantly different from the proposed work RVUs

in the CY 2008 PFS proposed rule to demonstrate that the proposed work RVUs should be modified. We did not modify the work RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new work RVUs should be, we eliminated the outlier group, and looked for agreement among the remaining groups as to the basis for new work RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the CY 1993 PFS final rule published in the November 25, 1992 **Federal Register** which described the statistical tests in detail (57 FR 55938). Our decision to convene a multi-specialty panel of physicians and to apply the statistical tests described above in this section was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

Table 14 lists the additional codes for the 5-Year Review on which we received comments. This table includes the following information:

- *CPT/HCPCS Code.* This is the CPT or alphanumeric HCPCS code for a service.
- *Modifier.* A modifier 26 is shown if the work RVUs represent the professional component (PC) of the service.
- *Description.* This is an abbreviated version of the narrative description of the code.
- *Proposed Work RVUs.* This column includes the work RVUs proposed in the CY 2008 PFS proposed rule for each reviewed code.
- *Requested Work RVUs.* This column identifies the work RVUs requested by the commenters. If the commenters requested different RVUs, the table lists the highest requested RVUs.
- *RUC Recommendation.* This column identifies the work RVUs recommended by the RUC that appeared in the CY 2008 PFS proposed rule.
- *2008 Work RVUs.* This column contains the work RVUs for the CY 2008 PFS.
- *Basis for Decision.* This column indicates whether the CY 2008 work RVUs resulted from comments received or the refinement panel process.

TABLE 14.—WORK RVU REVISIONS FOR ADDITIONAL 5-YEAR REVIEW CODES

CPT/HCPCS code [1]	Mod	Descriptor	Proposed work RVU	Work RVUs requested by commenters	RUC rec	2008 work RVU	Basis for decision
92557		Comprehensive hearing test	0.60	1.40	0.60	0.60	Refinement.
92579		Visual audiometry (vra)	0.70	1.70	0.70	0.70	Refinement.
99326		Domicil/r-home visit new pat	2.27	2.85	2.27	2.63	Refinement.
99327		Domicil/r-home visit new pat	3.03	3.75	3.03	3.46	Refinement.
99328		Domicil/r-home visit new pat	3.78	4.26	3.78	4.09	Refinement.
99334		Domicil/r-home visit est pat	0.76	1.25	0.76	1.07	Refinement.
99335		Domicil/r-home visit est pat	1.26	2.00	1.26	1.72	Refinement.
99336		Domicil/r-home visit est pat	2.02	2.75	2.02	2.46	Refinement.
99337		Domicil/r-home visit est pat	3.03	4.05	3.03	3.58	Refinement.
99343		Home visit, new patient	2.27	2.65	2.27	2.53	Refinement.
99344		Home visit, new patient	3.03	3.60	3.03	3.38	Refinement.
99345		Home visit, new patient	3.78	4.26	3.78	4.09	Refinement.
99347		Home visit, est patient	0.76	1.10	0.76	1.00	Refinement.
99348		Home visit, est patient	1.26	1.70	1.26	1.56	Refinement.
99349		Home visit, est patient	2.02	2.50	2.02	2.33	Refinement.
99350		Home visit, est patient	3.03	3.45	3.03	3.28	Refinement.
93325		Doppler color flow add-on	0.07	0.30	CPT	0.07	Comments.

[1] All CPT codes and descriptors copyright 2007 American Medical Association.

Discussion of Comments by Clinical Area

For CPT code 92557, *Comprehensive audiometry threshold evaluation and speech recognition*, and CPT code 92579, *Visual reinforcement audiometry (VRA)*, the RUC recommended 0.60 work RVUs for CPT 92557 and 0.70 work RVUs for CPT code 92579, which we accepted.

Comment: Commenters disagreed with the RUC-recommended work values for these services, which we had accepted. The commenters believed that the recommended values were not appropriate considering the time and intensity involved in performing these services. Based on these comments, we referred these codes to the multi-specialty validation panel for review.

Response: As a result of the statistical analysis of the 2007 multi-specialty validation panel ratings, we have assigned 0.60 work RVUs to CPT code 92557 and 0.70 work RVUs to CPT code 92579.

For CPT code 99326, *Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; a detailed examination; and medical decision making of moderate complexity;* CPT code 99327, *Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; a comprehensive examination; and medical decision making of moderate complexity;* CPT code 99328, *Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; a comprehensive examination; and medical decision making of high complexity;* CPT code 99334, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused interval history; a problem focused examination; straightforward medical decision making;* CPT code 99335, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity;* CPT code 99336, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:*

A detailed interval history; a detailed examination; medical decision making of moderate complexity; CPT code 99337, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity;* CPT code 99343, *Home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; a detailed examination; and medical decision making of moderate complexity;* CPT code 99344, *Home visit for the evaluation and management of a new patient, which requires these three components: A comprehensive history; a comprehensive examination; and a medical decision making of moderate complexity;* CPT code 99345, *Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; a comprehensive examination; and medical decision making of high complexity;* CPT code 99347, *Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused interval history; a problem focused examination; straightforward medical decision making;* CPT code 99348, *Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused interval history; a problem focused examination; straightforward medical decision making;* CPT code 99349, *Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed interval history; a detailed examination; medical decision making of moderate complexity;* and CPT code 99350, *Home visit for the evaluation and management of an established patient, which requires at least tow of these three key components: A comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity,* the RUC recommended that the work RVUs for these codes be maintained at their current values: 2.27 work RVUs for CPT code 99326; 3.03 work RVUs for CPT code 99327; 3.78 work RVUs for CPT code 99328; 0.76 work RVUs for CPT code 99334; 1.26 work RVUs for CPT code 99335; 2.02 work RVUs for CPT code 99336; 3.03 work RVUs for CPT code 99337; 2.27 work RVUs for CPT code 99343; 3.03 for CPT code 99344; 3.78 work RVUs for CPT code 99345; 0.76 work RVUs for CPT code 99347; 1.26 work RVUs for CPT code 99348; 2.02 work RVUs for CPT code 99349; and 3.03 work RVUs for CPT code 99350, which we accepted.

Comment: Commenters disagreed with the RUC-recommended work values for these services, which we had accepted. The commenters disagreed with the RUC-recommended work RVUs and believed the services were undervalued. The commenters also believed that the home visit work RVUs should remain ''relatively'' the same with respect to office visit codes as they did prior to the five-year review and requested that CMS reject the RUC recommended work RVUs and follow their survey values. Based on these comments, we referred these codes to the multi-specialty validation panel for review.

Response: As a result of the statistical analysis of the 2007 multi-specialty validation panel ratings, we have assigned 2.63 work RVUs to CPT code 99326; 3.46 work RVUs to CPT code 99327; 4.09 work RVUs to CPT code 99328; 1.07 work RVUs to CPT code 99334; 1.72 work RVUs to CPT code 99335; 2.46 work RVUs to CPT code 99336; 3.58 work RVUs to CPT code 99337; 2.53 work RVUs to CPT code 99343; 3.38 work RVUs to CPT code 99344; 4.09 work RVUs to CPT code 99345; 1.00 work RVUs to CPT code 99347; 1.56 work RVUs to CPT code 99348; 2.33 work RVUs to CPT code 99349; and 3.28 work RVUs to CPT code 99350.

For CPT code 93325, *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)*, the RUC 5-Year Review workgroup recommended sending the code to the CPT Editorial Panel so that it could bundle CPT code 93325 into doppler echo code 93307. However, we believe that the technology of doppler imaging has evolved over the past 2 decades to enable color flow velocity and spectral analysis, both important components of doppler imaging, to be furnished concurrently or in concert to obtain more accurate interpretation and documentation of the anatomy and physiologic function of the structure(s) and organ being evaluated. Since the services described in 93325 have become intrinsic to the performance of other echocardiography services, we proposed to bundle 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350 and assign CPT code 93325 a status indicator of ''B'' (Bundled).

Comment: Commenters uniformly opposed this proposal. They did not support the bundling of CPT codes 93325 into all of the codes we proposed. The commenters would prefer for CMS to adopt the new CPT code and not bundle CPT code 93325 with any other codes with CPT code 93325. The commenters believed we are circumventing the existing process to address bundling of these services and we should follow that process. Alternatively, the commenters believed that if we must bundle the codes, then we should increase the RVUs for the codes in which CPT code 93325 is being bundled to recognize the work, PE, and malpractice components that are unique to CPT code 93325.

Response: Based on comments received, we have decided to accept the RUC recommendation and allow the RUC to value the new CPT code for CY 2009 for bundling CPT code 93325 with CPT codes 93320 and 93307. As a result of this decision, the work RVUs for CPT code 93325 will be maintained for CY 2008 at the 2007 work value of 0.07. The cardiology community has indicated to the RUC and CMS that the newly bundled CPT code represents the first of a series of coding changes they intend to propose over the course of the next year. These changes would result in the bundling of CPT code 93325 and other echocardiography codes to reflect the utilization of ultrasound services that are routinely performed together when providing care to a patient. We appreciate the initiative the cardiology community is taking on this issue, and we will reassess the echocardiography codes once this process is complete.

2. Anesthesia Coding (Part of 5-Year Review)

Although anesthesia services are paid under the PFS, under section 1848(b)(2)(B) of the Act, they are paid on the basis of an anesthesia code specific base unit and time units that vary based on the actual anesthesia time of the case. Since anesthesia services do not have a work RVU per code as do other medical and surgical services, a work value must be imputed for each anesthesia code. The imputed value is determined by multiplying the national average allowed charge for each anesthesia service by its anesthesia work share and dividing this amount by the general PFS conversion factor (CF). This places the work of the anesthesia service on the same relative value scale as all other physicians' services.

As discussed in the CY 2008 PFS proposed rule, in the second 5-Year Review of anesthesia work implemented in 2002, the AMA RUC and the

American Society of Anesthesiologists (ASA) used a building block approach to estimate the value of anesthesia work and compared this value to the imputed work value to determine whether the work of anesthesia services is properly valued. Under the building block approach, each anesthesia code was uniformly divided into five components; pre anesthesia, equipment and supply preparation, induction, post induction anesthesia, and post anesthesia. Work is determined for each of the five components and summed to calculate total anesthesia work for the anesthesia code. The imputed value for the anesthesia code is compared to the building block estimate of work in order to assess whether, and if so, to what extent, the anesthesia code is not properly valued.

The most significant component of work for the anesthesia service is the intensity for the post-induction anesthesia time. The ASA thought that the RUC significantly misvalued this component in the second 5-Year Review. In addition, the ASA was dissatisfied that the RUC did not extend the analysis from the 19 high volume anesthesia codes reviewed by the RUC to all anesthesia codes.

In the CY 2007 PFS final rule with comment period, we addressed the issue of the work of anesthesia services under the third 5-Year Review of work. As explained in that rule, we made very modest adjustments to the work of the 19 anesthesia codes surveyed and analyzed by the RUC in the second 5-Year Review of work. These adjustments were made recognizing that the work of the pre- and post-anesthesia service components was linked to certain E/M services. Since we accepted the AMA RUC's recommendations for increased work values for certain E/M codes for the third 5-Year Review of work, we recalculated the work of the 19 anesthesia services to incorporate these higher work values. The adjustment in work was reflected by increasing the anesthesia CF by less than 1 percent.

However, on the more significant issue of the valuation of work in the post induction anesthesia period, we took no action. Rather, in the CY 2007 PFS final rule with comment period, we asked the RUC to review and consider this issue as part of the third 5-Year Review of work. We also asked the RUC to consider how increases in the work of pre- and post-anesthesia services could cause adjustments to the anesthesia services not specifically reviewed by the ASA and the RUC.

In January 2007, the ASA requested the AMA RUC to review the undervaluation of the work of the post-induction anesthesia period and to consider also an analytic approach, based on linear regression analysis, which could be used to evaluate the work of the entire anesthesia service. The linear regression model relates the work of the post-induction period time and the work of the entire anesthesia service to the base unit value for the anesthesia code. Under this model, the work of anesthesia services is undervalued by approximately 34 percent.

The RUC established an anesthesia workgroup to examine this proposal. The workgroup discussed this proposal extensively at its two teleconferences, prior to the April RUC meeting, and at the April RUC meeting itself. In May 2007, the AMA RUC, based on the analyses and recommendations of its workgroup, submitted a recommendation to CMS for a 32 percent increase in the work of anesthesia services.

The workgroup approved the ASA's use of the linear regression model to value only the work of the post-induction period time. In contrast to the ASA proposal, the workgroup considered an analytic approach different from the regression model developed by the ASA. This approach is based on a building block approach that could be used to evaluate the work of all anesthesia service components other than the post induction period time. For example, for pre-anesthesia time, the methodology is as shown in Table 15.

TABLE 15.—PRE-ANESTHESIA TIME

All Anesthesia codes with 3 base units—linked to the work of 99201.
All Anesthesia codes with 4 base units—linked to the blend of work for 99201 and 99202.
All Anesthesia codes with 5 to 15 base units—linked to the work of 99202.
All Anesthesia codes with 16 to 30 base units—linked to the work of 99252.

Note: The source of the link for work is the pre anesthesia valuation from the 19 surveyed anesthesia codes whose base units varied from 3 units to 25 units.

Similar approaches are used for each anesthesia component: Preparation time, induction period time, and post-anesthesia time. Systematically, codes with lower anesthesia base unit values have lower work values for each component of the building block approach than do codes with higher anesthesia base unit values. For the given building block component, the work value of that component is the same for all anesthesia services that have the same base unit value.

According to the workgroup's revised methodology which is extended from the 19 surveyed codes to all CPT anesthesia codes, the work of anesthesia services is undervalued by approximately 32 percent. Thus, based on the acceptance of the workgroup and the RUC's recommendation, an adjustment of approximately 25 percent would be applied to the anesthesia CF.

Increases in the work of anesthesia services would have to be offset by additional adjustments to the PFS BN adjustor for work. We estimated that the increase in the anesthesia CF would result in an additional 1.0 percent increase in the BN adjuster for work.

Other adjustments also affect the anesthesia CF. For example, an increase in anesthesia work may have implications for PE because indirect PEs are allocated based on the sum of work and direct PEs. When we ran the PE RVU program, there was a 1 percent decrease in the aggregate anesthesia PEs for CY 2008. Thus, an adjustment was made to the PE share of the anesthesia service of the CY 2008 anesthesia CF for this component.

We proposed to accept the RUC's recommendation and increase the work of anesthesia services by 32 percent.

Comment: Organizations and individual commenters supported our proposal and urged us to take action to implement this proposal in CY 2008. They commented that this proposal improves the valuation of the work of anesthesia services and will help ensure that Medicare beneficiaries have access to quality anesthesia care. One commenter indicated that three additional anesthesia codes, 00142, 00210 and 00562, have been identified as misvalued during the AMA RUC's evaluation of the work of anesthesia services. Both CMS and the AMA RUC agreed that the RUC would review the base units for 00142 at the September 2007 RUC meeting and that the other codes, as agreed by the ASA, would be referred to the CPT so that the codes descriptors could be clarified. The RUC reviewed and approved the ASA's request to support the current base unit value of four units for anesthesia code 00142.

Response: We have decided to accept the RUC's recommendation and increase the work of anesthesia services by 32 percent. We have also accepted the RUC's recommendation to maintain the value of four base units for anesthesia code 00142.

3. Budget Neutrality Adjustment

Due to the proposed work RVU changes for the additional codes from the 5-Year Review of Work RVUs and

the proposed increases in the work of anesthesia services, in the CY 2008 PFS proposed rule, we proposed to revise the work adjustor to maintain budget neutrality. Based upon the increases, the proposed revised work adjustor was estimated to be 0.8816. Further discussion of this work adjustor was included in the impact section of the CY 2008 PFS proposed rule (72 FR 38211 through 38220).

Comment: Several commenters recommended that we reconsider applying the BN adjustment associated with the 5-Year Review of work RVUs to the CF rather than the work RVUs.

Response: We appreciate the commenters' interest in this topic. However, this issue was fully addressed in the CY 2007 PFS final rule with comment period (71 FR 69735), and we made no further proposals regarding this issue in the CY 2008 PFS proposed rule. We continue to believe that it is most appropriate to apply the BN adjustment to work RVUs and refer the commenters to the CY 2007 PFS final rule for an explanation of our decision.

We note that as a result of the changes made in response to comments received and the work of the refinement panel, the separate work adjustor has changed from the proposed 0.8816. The separate work adjustor for CY 2008 will be 0.8806.

D. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Interim 2007 Codes

Although the RVUs in the CY 2007 PFS final rule with comment period were used to calculate 2007 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received comments on the following CPT codes.

Anticoagulation Management Codes

The CPT Editorial Panel created two anticoagulation management codes in February 2006: CPT code 99363, *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements),* and CPT code 99364, *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements).* The RUC reviewed the codes and recommended 1.65 work RVUs for code 99363 and 0.63 work RVUs for 99364. In the CY 2007 PFS final rule with comment period, we decided not to accept the RUC recommendation and decided that the services provided by 99363 and 99364 are bundled into existing E/M services. Hence, there is no separate payment under the PFS. Currently clinicians managing anticoagulation therapy may bill, if appropriate, the CPT code that best represents the level of outpatient E/M service provided on that day, including CPT code 99211.

Comment: We received comments from commenters who strongly disagree with our decision to continue to consider anticoagulation management codes to be bundled into the work of E/M codes and noted that these CPT codes recognize the important work of managing serious disease. The commenters also requested that we not finalize our decision to consider these services bundled but instead change their status to separately payable, covered services.

Response: We generally do not pay separately for disease-specific management services. We believe the services represented by CPT codes 99363 and 99364 are inherent in the services captured by the existing E/M codes. We will continue to recognize codes 99363 and 99364 as bundled services and continue to pay for E/M services as appropriate.

Medical Genetics and Genetic Counseling

CPT code 96040, *Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family,* was reviewed in the CY 2007 PFS final rule with comment period and assigned status B (bundled service).

Comment: Commenters disagree with the assigned status indicator of B (bundled service) for this service and urge CMS to reconsider its decision to make this a bundled service because they believe it is a separate and distinct procedure.

Response: The procedure does not contain any physician work and is a code that is designed to capture clinical labor time and PE. To the extent that this service is covered, we believe this service like other counseling services, is incorporated into existing E/M services, and therefore, will maintain the status assignment of B.

Home Ventilator Management

For CPT code 94005, *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more,* the RUC recommended 1.50 work RVUs. We assigned a status indicator of B (bundled service) to this service in the CY 2007 PFS final rule with comment period because: (1) The patient is not present when this service is rendered; and (2) we believe this service is captured in E/M services.

Comment: Commenters believe this service should not be bundled and recommend that this code be separately payable.

Response: We continue to believe this service should be assigned a status indicator of B (Bundled) for the reasons previously stated in the CY 2007 PFS final rule with comment period: (1) The patient is not present when the service is rendered; and (2) we believe this service is captured in the E/M services. (**Note:** The RUC-recommended RVUs for this code will be reflected in Addendum B.)

In the CY 2007 PFS final rule with comment period (70 FR 66370), we also responded to the RUC recommendations on the PE inputs for the new and revised CPT codes for 2007. In addition to PE comments discussed in section II.A.2. of this final rule with comment period, concerning PE inputs:

Comment: One commenter, representing a network of providers, requested that the PE inputs for CPT codes 35475 and 35476 be reviewed. These codes are used as the basis for the PE inputs for HCPCS codes G0392 and G0393 that were included in Addendum C. The commenter believes that the PE inputs have changed since the service was reviewed in 2004. The commenters also believed that items were missing from the PE database and included a list of these items.

Response: We suggest that the commenter work with the specialty group to determine if the PE inputs for CPT codes 35475 and 35476 should be reviewed by the RUC PE subcommittee. We have also reviewed the PE database regarding the missing PE items noted by the commenter and have verified that all PE inputs from CPT 35475 and 35476 have been crosswalked to G0392 and G0393, respectively.

Comment: One commenter, representing the specialty of dermatology, requested that the Unna

boot be removed from the PE database as a supply item and be assigned a HCPCS Q code so that it could be billed separately.

Response: This issue was specifically addressed in the CY 2007 PFS final rule with comment period (71 FR 69644 through 69645). We clarified that the policy we finalized relating to splint and cast supplies did not change the HCPCS Q-code descriptors or their pairing with certain CPT codes for payment purposes.

Comment: One commenter, representing the ophthalmology association, disagreed with our assessment that the specific topography equipment priced at $44,000 is not typically used with CPT code 92025, *Computerized corneal topography, unilateral or bilateral, with interpretation and report,* and questioned our substitution of the topography equipment priced at $13,495. The commenter pointed out that the $44,000 topography equipment is the only equipment that will provide the services of this procedure.

Response: We have reviewed the request from the commenter and agree that the $13,495 topography unit we assigned for CY 2007 should be replaced with the $44,000 equipment that is specifically designed for the procedure inherent to CPT code 92025.

Comment: One commenter, representing therapeutic radiology, requested that for CPT code 77371, *Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; multi-source Cobalt 60 based,* we treat the radiation source (Cobalt 60), as a direct PE rather than an indirect one. Since Cobalt 60 is: (1) Purchased by the physician; (2) exceeds the $500 threshold (price is $15,000); and, (3) is clearly attributable to the procedure; it meets the established criteria for treatment as a direct expense. The commenter indicated that this radiation source must be replaced monthly, requiring a useful life assignment of 0.08 years.

Response: Based on this comment, we have re-examined our assignment of the Cobalt 60 radiation source used in CPT code 77371 as indirect PE. While the radiation source may meet some of the criteria to be considered as a direct PE input for equipment (for example, that it is an expense to the physician and its price is above the $500 threshold), the commenter did not present information that is needed to verify the 1-month useful life that was requested. We lack the required evidence needed to determine the amount of viable radiation contained in the $15,000 source that is consumed through the provision of the radiation treatments versus the amount that was not utilized but could have been used, during the 1-month time period. This unused amount would be considered a wasted resource and cannot be accounted for as a direct PE input. Consequently, we will not include the Cobalt-60 radiation source as a direct PE input as the commenter requested.

E. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2008 (Includes Table titled ''American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2008 CPT Codes'')

One aspect of establishing RVUs for 2008 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 PFS (57 FR 55951) and in section III.B. of the CY 1997 PFS final rule (61 FR 59505), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for 169 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received RUC recommendations and agreed with the majority of the relative relationships reflected in the RUC values. In some instances, although we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes. That is, the work RVUs were adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use) for the family of codes.

We received approximately 7 recommendations from the Health Care Professional Advisory Committee (HCPAC).

Table 16: AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2008 CPT Codes lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2008. Table 16 includes the following information:

- A ''#'' identifies a new code for CY 2008.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the PC of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table.
- 2008 Work RVUs. This column establishes the interim 2008 work RVUs for physician work.

TABLE 16.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2008 CPT CODES

CPT [1] code	Mod	Descriptor	RUC recommendation	HCPAC recommendation	CMS decision	2008 work RVU
# 20555	.....	PLACE NDL MUSC/TIS FOR RT	6.00	.....	Agree	6.00
20660	.....	APPLY, REM FIXATION DEVICE	4.00	.....	Agree	4.00
20690	.....	APPLY BONE FIXATION DEVICE	8.65	.....	Agree	8.65
20692	.....	APPLY BONE FIXATION DEVICE	16.00	.....	Agree	16.00
# 20985 * ..	.....	CPTR–ASST DIR MS PX	2.50	.....	Agree	2.50

TABLE 16.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2008 CPT CODES—Continued

CPT [1] code	Mod	Descriptor	RUC recommendation	HCPAC recommendation	CMS decision	2008 work RVU
# 20986 * ..	.....	CPTR–ASST DIR MS PX IO IMG	Carrier Priced	.....	Agree	Carrier Priced.
# 20987 * ..	.....	CPTR–ASST DIR MS PX PRE IMG	Carrier Priced	.....	Agree	Carrier Priced.
# 21073	.....	MNPJ OF TMJ W/ANESTH	3.33	.....	Agree	3.33
# 22206	.....	CUT SPINE 3 COL, THOR	37.00	.....	Agree	37.00
# 22207	.....	CUT SPINE 3 COL, LUMB	36.50	.....	Agree	36.50
# 22208	.....	CUT SPINE 3 COL, ADDL SEG	9.66	.....	Agree	9.66
23515	.....	TREAT CLAVICLE FRACTURE	11.00	.....	Disagree	9.53
23585	.....	TREAT SCAPULA FRACTURE	16.25	.....	Disagree	14.07
23615	.....	TREAT HUMERUS FRACTURE	14.00	.....	Disagree	12.12
23616	.....	TREAT HUMERUS FRACTURE	21.00	.....	Disagree	18.19
23630	.....	TREAT HUMERUS FRACTURE	12.00	.....	Disagree	10.39
23670	.....	TREAT DISLOCATION/FRACTURE	14.00	.....	Disagree	12.12
23680	.....	TREAT DISLOCATION/FRACTURE	15.00	.....	Disagree	12.99
# 24357	.....	REPAIR ELBOW, PERC	5.32	.....	Agree	5.32
# 24358	.....	REPAIR ELBOW W/DEB, OPEN	6.54	.....	Agree	6.54
# 24359	.....	REPAIR ELBOW DEB/ATTCH OPEN	8.86	.....	Agree	8.86
24545	.....	TREAT HUMERUS FRACTURE	15.00	.....	Disagree	12.99
24546	.....	TREAT HUMERUS FRACTURE	17.01	.....	Disagree	14.73
24575	.....	TREAT HUMERUS FRACTURE	11.00	.....	Disagree	9.53
24579	.....	TREAT HUMERUS FRACTURE	13.00	.....	Disagree	11.26
24635	.....	TREAT ELBOW FRACTURE	10.00	.....	Disagree	8.64
24665	.....	TREAT RADIUS FRACTURE	Referred to CPT ..	.....	CPT	8.22
24666	.....	TREAT RADIUS FRACTURE	Referred to CPT ..	.....	CPT	9.74
24685	.....	TREAT ULNAR FRACTURE	9.50	.....	Disagree	8.21
25515	.....	TREAT FRACTURE OF RADIUS	10.00	.....	Disagree	8.64
25525	.....	TREAT FRACTURE OF RADIUS	12.00	.....	Disagree	10.37
25526	.....	TREAT FRACTURE OF RADIUS	15.00	.....	Disagree	12.96
25545	.....	TREAT FRACTURE OF ULNA	9.00	.....	Disagree	7.78
25574	.....	TREAT FRACTURE RADIUS & ULNA	10.00	.....	Disagree	8.64
25575	.....	TREAT FRACTURE RADIUS/ULNA	14.00	.....	Disagree	12.10
25628	.....	TREAT WRIST BONE FRACTURE	11.00	.....	Disagree	9.51
26615	.....	TREAT METACARPAL FRACTURE	8.00	.....	Disagree	6.91
26650	.....	TREAT THUMB FRACTURE	6.00	.....	Disagree	5.19
26665	.....	TREAT THUMB FRACTURE	9.00	.....	Disagree	7.78
26685	.....	TREAT HAND DISLOCATION	8.00	.....	Disagree	6.91
26715	.....	TREAT KNUCKLE DISLOCATION	7.95	.....	Disagree	6.87
26735	.....	TREAT FINGER FRACTURE, EACH	8.40	.....	Disagree	7.26
26746	.....	TREAT FINGER FRACTURE, EACH	11.10	.....	Disagree	9.59
26765	.....	TREAT FINGER FRACTURE, EACH	6.60	.....	Disagree	5.70
26785	.....	TREAT FINGER DISLOCATION	7.45	.....	Disagree	6.44
27248	.....	TREAT THIGH FRACTURE	12.83	.....	Disagree	10.64
# 27267	.....	CLTX THIGH FX	5.38	.....	Agree	5.38
# 27268	.....	CLTX THIGH FX W/MNPJ	7.00	.....	Agree	7.00
# 27269	.....	OPTX THIGH FX	18.75	.....	Agree	18.75
# 27416	.....	OSTEOCHONDRAL KNEE AUTOGRAFT	14.00	.....	Agree	14.00
27511	.....	TREATMENT OF THIGH FRACTURE	18.05	.....	Disagree	14.97
27513	.....	TREATMENT OF THIGH FRACTURE	23.04	.....	Disagree	19.11
27514	.....	TREATMENT OF THIGH FRACTURE	17.43	.....	Disagree	14.46
27519	.....	TREAT THIGH FX GROWTH PLATE	15.80	.....	Disagree	13.11
27535	.....	TREAT KNEE FRACTURE	16.00	.....	Disagree	13.27
27540	.....	TREAT KNEE FRACTURE	13.45	.....	Disagree	11.16
27556	.....	TREAT KNEE DISLOCATION	15.50	.....	Disagree	12.86
27557	.....	TREAT KNEE DISLOCATION	19.00	.....	Disagree	15.76
27558	.....	TREAT KNEE DISLOCATION	22.00	.....	Disagree	18.25
# 27726	.....	REPAIR FIBULA NONUNION	14.20	.....	Agree	14.20
27766	.....	OPTX MEDIAL ANKLE FX	8.50	.....	Disagree	7.73
# 27767	.....	CLTX POST ANKLE FX	2.50	.....	Agree	2.50
# 27768	.....	CLTX POST ANKLE FX W/MNPJ	5.00	.....	Agree	5.00
# 27769	.....	OPTX POST ANKLE FX	10.00	.....	Agree	10.00
27784	.....	TREATMENT OF FIBULA FRACTURE	10.45	.....	Disagree	9.51
27792	.....	TREATMENT OF ANKLE FRACTURE	10.50	.....	Disagree	9.55
27814	.....	TREATMENT OF ANKLE FRACTURE	11.50	.....	Disagree	10.46
27822	.....	TREATMENT OF ANKLE FRACTURE	12.12	.....	Disagree	11.03
27823	.....	TREATMENT OF ANKLE FRACTURE	14.26	.....	Disagree	12.98
27826	.....	TREAT LOWER LEG FRACTURE	12.00	.....	Disagree	10.92
27827	.....	TREAT LOWER LEG FRACTURE	16.00	.....	Disagree	14.56
27828	.....	TREAT LOWER LEG FRACTURE	20.00	.....	Disagree	18.20
27829	.....	TREAT LOWER LEG JOINT	9.50	.....	Disagree	8.64
27832	.....	TREAT LOWER LEG DISLOCATION	11.00	.....	Disagree	10.01

TABLE 16.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2008 CPT CODES—Continued

CPT [1] code	Mod	Descriptor	RUC recommendation	HCPAC recommendation	CMS decision	2008 work RVU
28415		TREAT HEEL FRACTURE	17.54		Disagree	15.96
28420		TREAT/GRAFT HEEL FRACTURE	19.00		Disagree	17.29
28445		TREAT ANKLE FRACTURE	17.07		Disagree	15.53
# 28446		OSTEOCHONDRAL TALUS AUTOGRFT	17.50		Agree	17.50
28465		TREAT MIDFOOT FRACTURE, EACH	9.50		Disagree	8.64
28485		TREAT METATARSAL FRACTURE	8.00		Disagree	7.28
28505		TREAT BIG TOE FRACTURE	8.00		Disagree	7.28
28525		TREAT TOE FRACTURE	6.00		Disagree	5.46
28555		REPAIR FOOT DISLOCATION	10.43		Disagree	9.49
28585		REPAIR FOOT DISLOCATION	12.00		Disagree	10.92
28615		REPAIR FOOT DISLOCATION	11.50		Disagree	10.46
28645		REPAIR TOE DISLOCATION	8.00		Disagree	7.28
28675		REPAIR OF TOE DISLOCATION	6.00		Disagree	5.46
# 29828*		ARTHROSCOPY BICEPS TENODESIS	13.00		Agree	13.00
# 29904		SUBTALAR ARTHRO W/FB RMVL	8.50		Agree	8.50
# 29905		SUBTALAR ARTHRO W/EXC	9.00		Agree	9.00
# 29906		SUBTALAR ARTHRO W/DEB	9.47		Agree	9.47
# 29907		SUBTALAR ARTHRO W/FUSION	12.00		Agree	12.00
31500		INSERT EMERGENCY AIRWAY	2.33		Agree	2.33
# 33257*		ABLATE ATRIA, LMTD, ADD-ON	9.63		Agree	9.63
# 33258*		ABLATE ATRIA, X10SV, ADD-ON	11.00		Agree	11.00
# 33259*		ABLATE ATRIA W/BYPASS ADD-ON	14.14		Agree	14.14
# 33864*		ASCENDING AORTIC GRAFT	60.00		Agree	60.00
# 34806*		ANEURYSM PRESS SENSOR ADD-ON	2.06		Agree	2.06
# 35523		ARTERY BYPASS GRAFT	24.00		Agree	24.00
36620		INSERTION CATHETER, ARTERY	1.15		Agree	1.15
# 41019		PLACE NEEDLES H&N FOR RT	8.84		Agree	8.84
43760		CHANGE GASTROSTOMY TUBE	0.90		Agree	0.90
# 49203		EXC ABD TUM 5 CM OR LESS	20.00		Agree	20.00
# 49204		EXC ABD TUM OVER 5 CM	26.00		Agree	26.00
# 49205		EXC ABD TUM OVER 10 CM	30.00		Agree	30.00
# 49440		PLACE GASTROSTOMY TUBE PERC	4.18		Agree	4.18
# 49441		PLACE DUOD/JEJ TUBE PERC	4.77		Agree	4.77
# 49442		PLACE CECOSTOMY TUBE PERC	4.00		Agree	4.00
# 49446		CHANGE G–TUBE TO G–J PERC	3.31		Agree	3.31
# 49450		REPLACE G/C TUBE PERC	1.36		Agree	1.36
# 49451		REPLACE DUOD/JEJ TUBE PERC	1.84		Agree	1.84
# 49452		REPLACE G–J TUBE PERC	2.86		Agree	2.86
# 49460		FIX G/COLON TUBE W/DEVICE	0.96		Agree	0.96
# 49465		FLUORO EXAM OF G/COLON TUBE	0.62		Agree	0.62
# 50385		CHANGE STENT VIA TRANSURETH	4.44		Agree	4.44
# 50386		REMOVE STENT VIA TRANSURETH	3.30		Agree	3.30
# 50593*		PERC CRYO ABLATE RENAL TUM	9.08		Agree	9.08
51797		INTRAABDOMINAL PRESSURE TEST	0.80		Agree	0.80
# 52649		PROSTATE LASER ENUCLEATION	17.16		Agree	17.16
# 55920		PLACE NEEDLES PELVIC FOR RT	8.31		Agree	8.31
57284		REPAIR PARAVAG DEFECT, OPEN	14.25		Agree	14.25
# 57285		REPAIR PARAVAG DEFECT, VAG	11.52		Agree	11.52
# 57423*		REPAIR PARAVAG DEFECT, LAP	16.00		Agree	16.00
# 58570*		TLH, UTERUS 250 G OR LESS	15.75		Agree	15.75
# 58571*		TLH W/T/O 250 G OR LESS	17.56		Agree	17.56
# 58572*		TLH, UTERUS OVER 250 G	19.96		Agree	19.96
# 58573*		TLH W/T/O UTERUS OVER 250 G	22.98		Agree	22.98
# 67041		VIT FOR MACULAR PUCKER	19.00		Agree	19.00
# 67042		VIT FOR MACULAR HOLE	22.13		Agree	22.13
# 67043		VIT FOR MEMBRANE DISSECT	22.94		Agree	22.94
# 67113		REPAIR RETINAL DETACH, CPLX	25.00		Agree	25.00
# 67229		TR RETINAL LES PRETERM INF	16.00		Agree	16.00
# 68816*		PROBE NL DUCT W/BALLOON	3.00		Agree	3.00
# 75557*	26	CARDIAC MRI FOR MORPH	2.35		Agree	2.35
# 75558*	26	CARDIAC MRI FLOW/VELOCITY	2.60		Agree (c)	2.60
# 75559*	26	CARDIAC MRI W/STRESS IMG	2.95		Agree	2.95
# 75560*	26	CARDIAC MRI FLOW/VEL/STRESS	3.00		Agree (c)	3.00
# 75561*	26	CARDIAC MRI FOR MORPH W/DYE	2.60		Agree	2.60
# 75562*	26	CARD MRI FLOW/VEL W/DYE	2.86		Agree (c)	2.86
# 75563*	26	CARD MRI W/STRESS IMG & DYE	3.00		Agree	3.00
# 75564*	26	HT MRI W/FLO/VEL/STRS & DYE	3.35		Agree (c)	3.35
78811*	26	PET IMAGE, LTD AREA	1.54		Agree	1.54
78812*	26	PET IMAGE, SKULL–THIGH	1.93		Agree	1.93

TABLE 16.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS' DECISIONS FOR NEW AND REVISED 2008 CPT CODES—Continued

CPT [1] code	Mod	Descriptor	RUC recommendation	HCPAC recommendation	CMS decision	2008 work RVU
78813 *	26	PET IMAGE, FULL BODY	2.00		Agree	2.00
78814 *	26	PET IMAGE W/CT, LMTD	2.20		Agree	2.20
78815 *	26	PET IMAGE W/CT, SKULL–THIGH	2.44		Agree	2.44
78816 *	26	PET IMAGE W/CT, FULL BODY	2.50		Agree	2.50
86486		SKIN TEST, NOS ANTIGEN	(a)		(a)*	0.00
88380 *		MICRODISSECTION, LASER	1.56		Agree	1.56
# 88381 *		MICRODISSECTION, MANUAL	1.18		Agree	1.18
# 90769 *		SC THER INFUSION, UP TO 1 HR	0.21		Agree	0.21
# 90770 *		SC THER INFUSION, ADDL HR	0.18		Agree	0.18
93503	26	INSERT/PLACE HEART CATHETER	2.91		Agree	2.91
# 93982 **		ANEURYSM PRESSURE SENS STUDY	0.30		Agree	0.30
95004		PERCUT ALLERGY SKIN TESTS	0.01		Agree	0.01
95024		ID ALLERGY TEST, DRUG/BUG	0.01		Agree	0.01
95027		ID ALLERGY TITRATE–AIRBORNE	0.01		Agree	0.01
# 95980 *		IO ANAL GAST N–STIM INIT	0.80		Agree	0.80
# 95981 *		IO ANAL GAST N–STIM SUBSQ	0.30		Agree	0.30
# 95982 *		IO GA N–STIM SUBSQ W/REPROG	0.65		Agree	0.65
# 96125		COGNITIVE TEST BY HC PRO		1.70	Agree	1.70
# 98966 *		HC PRO PHONE CALL 5–10 MIN		0.25	Agree (c)	0.25
# 98967 *		HC PRO PHONE CALL 11–20 MIN		0.50	Agree (c)	0.50
# 98968 *		HC PRO PHONE CALL 21–30 MIN		0.75	Agree (c)	0.75
# 98969		ONLINE SERVICE BY HC PRO		Carrier Priced	Agree (c)	Carrier Priced.
# 99174		OCULAR PHOTOSCREENING	(a)		(a)*	0.00
# 99366		TEAM CONF W/PAT BY HC PRO		0.82	Agree (b)	0.82
# 99367		TEAM CONF W/O PAT BY PHYS	1.10		Agree (b)	1.10
# 99368		TEAM CONF W/O PAT BY HC PRO		0.72	Agree (b)	0.72
# 99406		BEHAV CHNG SMOKING 3–10 MIN	0.24		Agree	0.24
# 99407		BEHAV CHNG SMOKING < 10 MIN	0.50		Agree	0.50
# 99408		AUDIT/DAST, 15–30 MIN	0.65		Agree (c)	0.65
# 99409		AUDIT/DAST, OVER 30 MIN	1.30		Agree (c)	1.30
# 99441 *		PHONE E/M BY PHYS 5–10 MIN	0.25		Agree (c)	0.25
# 99442 *		PHONE E/M BY PHYS 11–20 MIN	0.50		Agree (c)	0.50
# 99443 *		PHONE E/M BY PHYS 21–30 MIN	0.75		Agree (c)	0.75
# 99444		ONLINE E/M BY PHYS	Carrier Priced		Agree (c)	Carrier Priced.
# 99477		INIT DAY HOSP NEONATE CARE	7.00		Agree	7.00

New CPT code.
[1] All CPT codes copyright 2007 AMA.
* New Code for Re-Examination at the next 5-Year Review.
** Denotes restricted coverage of code.
(a) No RUC work RVU recommendation.
(a) * See code discussion in Section F, Discussion of Codes and RUC/HCPAC Recommendations.
(b) RUC-recommended work RVU accepted but coverage status of code is Bundled.
(c) RUC-recommended work RVU accepted but coverage status of code is Noncovered.

Table 17: AMA RUC Anesthesia Recommendations and CMS Decisions for New and Revised 2008 CPT Codes lists the new or revised CPT codes for anesthesia and their base units that will be interim in CY 2008. Table 17 includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table.
- 2008 Base Units. This column establishes the CY 2007 base units for these services.

TABLE 17.—AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED/REVIEWED CPT CODES

* CPT [1] code	Description	RUC recommendation	CMS decision	2008 base units
## 00142	ANESTH, LENS SURGERY	4.00	Agree	4.00
# 01935	ANESTH, PERC IMG DX SP PROC	5.00	Agree	5.00
# 01936	ANESTH, PERC IMG TX SP PROC	5.00	Agree	5.00

[1] All CPT codes copyright 2007 AMA.

New CPT code.
Note: CPT code 00142 is neither a new nor revised code for 2008. However, the RUC reviewed the base unit values for this code for 2008 and recommended that the value be maintained.

F. Discussion of Codes and RUC/HCPAC Recommendations

The following is a summary of our rationale for not accepting particular RUC work RVUs. It is arranged by type of service in CPT order. This summary refers only to work RVUs.

1. Internal Fixation Codes—Shoulder/Elbow (CPT codes 23515, 23585, 23615, 23616, 23680, 23670, 23680, 24545, 24546, 24575 and 24579), Elbow/Hand (CPT codes 24635, 24685, 25515, 25525, 25526, 25545, 25574, 25575, 25628, 26615, 26650, 26665, 26685, 26715, 26735, 26746, 26765, 26785), Hip and Knee (CPT codes 27248, 27511, 27513, 27514, 27519, 27535, 27540, 27556, 27557 and 27558) and Foot and Ankle (CPT codes 27766, 27784, 27792, 27814, 27822, 27823, 27826, 27827, 27828, 27829, 27832, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28555, 28585, 28615, 28645 and 28675)

These codes were originally part of the 5-Year Review of work RVUs and were referred to the CPT Editorial Panel by the RUC for further clarification because it was unclear whether the previous valuation for these codes included the situation when internal and external fixation is applied to the fracture site. The CPT Editorial Panel agreed that these codes needed to be clarified and removed reference to external fixation from these codes. As a result of this editorial change, the RUC reexamined these families of codes and recommended increased work RVUs. The RUC recommended 11.00 work RVUs for CPT code 23515; 16.25 work RVUs for CPT code 25385; 14.00 work RVUs for CPT code 23615; 21.00 work RVUs for CPT code 23616; 12.00 work RVUs for CPT code 23680; 14.00 work RVUs for CPT code 23670; 15.00 work RVUs for CPT code 23680; 15.00 work RVUs for CPT code 24545; 17.01 work RVUs for CPT code 24546; 11.00 work RVUs for CPT code 24575; 13.00 work RVUs for CPT code 24579; 10.00 work RVUs for CPT code 24635; 9.50 work RVUs for CPT code 24685; 10.00 work RVUs for CPT code 25515; 12.00 work RVUs for CPT code 25525; 15.00 work RVUs for CPT code 25526; 9.00 work RVUs for CPT code 25545; 10.00 work RVUs for CPT code 25574; 14.00 work RVUs for CPT code 25575; 11.00 work RVUs for CPT code 25628; 8.00 work RVUs for CPT code 26615; 6.00 work RVUs for CPT code 26650; 9.00 work RVUs for CPT code 26665; 8.00 work RVUs for CPT code 26685; 7.95 work RVUs for CPT code 26715; 8.40 work RVUs for CPT code 26735; 11.10 work RVUs for CPT code 26746; 6.60 work RVUs for CPT code 26765; 7.45 work RVUs for CPT code 26785; 12.83 work RVUs for CPT code 27248; 18.05 work RVUs for CPT code 27511; 23.04 work RVUs for CPT code 27513; 17.43 work RVUs for CPT code 27514; 15.80 work RVUs for CPT code 27519; 16.00 work RVUs for CPT code 27535; 13.45 work RVUs for CPT code 27540; 15.50 work RVUs for CPT code 27556; 19.00 work RVUs for CPT code 27557; 22.00 work RVUs for CPT code 27558; 8.50 work RVUs for CPT code 27766; 10.45 work RVUs for CPT code 27784; 10.50 work RVUs for CPT code 27792; 11.50 work RVUs for CPT code 27814; 12.12 work RVUs for CPT code 27822; 14.26 work RVUs for CPT code 27823; 12.00 work RVUs for CPT code 27826; 16.00 work RVUs for CPT code 27827; 20.00 work RVUs for CPT code 27828; 9.50 work RVUs for CPT code 27829; 11.00 work RVUs for CPT code 27832; 17.54 work RVUs for CPT code 28415; 19.00 work RVUs for CPT code 28420; 17.07 work RVUs for CPT code 28445; 9.50 work RVUs for CPT code 28465; 8.00 work RVUs for CPT code 28485; 8.00 work RVUs for CPT code 28505; 6.00 work RVUs for CPT code 28525; 10.43 work RVUs for CPT code 28555; 12.00 work RVUs for CPT code 28585; 11.50 work RVUs for CPT code 28615; 8.00 work RVUs for CPT code 28645; and 6.00 work RVUs for CPT code 28675. Although we agree with the relationships, the increases in work RVUs reestablish the relativity of the services in these families and in doing so created BN issues. In order to retain BN within these families of codes, the work RVUs associated with each code had to be adjusted. That is, the work RVUs were adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for each family will be the same as the sum of the current work RVUs (weighted by projected frequency of use) for each family of codes. The adjusted work RVUs are as follows: 9.53 work RVUs for CPT code 23515; 14.07 work RVUs for CPT code 25385; 12.12 work RVUs for CPT code 23615; 18.19 work RVUs for CPT code 23616; 10.39 work RVUs for CPT code 23680; 12.12 work RVUs for CPT code 23670; 12.99 work RVUs for CPT code 23680; 12.99 work RVUs for CPT code 24545; 14.73 work RVUs for CPT code 24546; 9.53 work RVUs for CPT code 24575; 11.26 work RVUs for CPT code 24579; 8.64 work RVUs for CPT code 24635; 8.21 work RVUs for CPT code 24685; 8.64 work RVUs for CPT code 25515; 10.37 work RVUs for CPT code 25525; 12.96 work RVUs for CPT code 25526; 7.78 work RVUs for CPT code 25545; 8.64 work RVUs for CPT code 25574; 12.10 work RVUs for CPT code 25575; 9.51 work RVUs for CPT code 25628; 6.91 work RVUs for CPT code 26615; 5.19 work RVUs for CPT code 26650; 7.78 work RVUs for CPT code 26665; 6.91 work RVUs for CPT code 26685; 6.87 work RVUs for CPT code 26715; 7.26 work RVUs for CPT code 26735; 9.59 work RVUs for CPT code 26746; 5.70 work RVUs for CPT code 26765; 6.44 work RVUs for CPT code 26785; 10.64 work RVUs for CPT code 27248; 14.97 work RVUs for CPT code 27511; 19.11 work RVUs for CPT code 27513; 14.46 work RVUs for CPT code 27514; 13.11 work RVUs for CPT code 27519; 13.27 work RVUs for CPT code 27535; 11.16 work RVUs for CPT code 27540; 12.86 work RVUs for CPT code 27556; 15.76 work RVUs for CPT code 27557; 18.25 work RVUs for CPT code 27558; 7.73 work RVUs for CPT code 27766; 9.51 work RVUs for CPT code 27784; 9.55 work RVUs for CPT code 27792; 10.46 work RVUs for CPT code 27814; 11.03 work RVUs for CPT code 27822; 12.98 work RVUs for CPT code 27823; 10.92 work RVUs for CPT code 27826; 14.56 work RVUs for CPT code 27827; 18.20 work RVUs for CPT code 27828; 8.64 work RVUs for CPT code 27829; 10.01 work RVUs for CPT code 27832; 15.96 work RVUs for CPT code 28415; 17.29 work RVUs for CPT code 28420; 15.53 work RVUs for CPT code 28445; 8.64 work RVUs for CPT code 28465; 7.28 work RVUs for CPT code 28485; 7.28 work RVUs for CPT code 28505; 5.46 work RVUs for CPT code 28525; 9.49 work RVUs for CPT code 28555; 10.92 work RVUs for CPT code 28585; 10.46 work RVUs for CPT code 28615; 7.28 work RVUs for CPT code 28645; and 5.46 work RVUs for CPT code 28675.

2. Cardiac MRI Codes

Cardiac MRI services have evolved over the past decade from providing primarily anatomic information to providing both anatomic and physiologic information. We have had a national noncoverage determination in place for Magnetic Resonance Imaging (MRI) that provides blood flow measurement since March 1994. This NCD provides that CPT code 75556,

Cardiac magnetic resonance imaging for velocity flow, is not covered.

As a result of the technological changes in MRI scanning, the CPT Editorial Panel created eight new Cardiac MRI codes and deleted five existing Cardiac MRI codes. The new codes are: CPT code 75557, *Cardiac magnetic resonance imaging for morphology and function without contrast material;* CPT code 75558, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification;* CPT code 75559, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging;* CPT code 75560, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress;* CPT code 75561, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* CPT code 75562, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification;* CPT code 75563, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging;* and CPT code 75564, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress*. The RUC recommended 2.35 work RVUs for CPT code 75557; 2.60 work RVUs for CPT code 75558; 2.95 work RVUs for CPT code 75559; 3.00 work RVUs for CPT code 75560; 2.60 work RVUs for CPT code 75561; 2.86 work RVUs for CPT code 75562; 3.00 work RVUs for CPT code 75563; and 3.35 work RVUs for CPT code 75564.

The deleted codes are: CPT code 75552, *Cardiac magnetic resonance imaging for function, without contrast material;* CPT code 75553, *Cardiac magnetic resonance imaging for function, without contrast material with contrast material;* CPT code 75554, *Cardiac magnetic resonance imaging for function, with or without morphology; complete study;* CPT code 75555, *Cardiac magnetic resonance imaging for function, with or without morphology; limited study;* and CPT code 75556 *Cardiac magnetic resonance imaging for velocity flow mapping*.

Upon review of the new cardiac MRI codes, we recognize that four of the new codes incorporate blood flow measurement, which remains one of the nationally noncovered indications for MRI in the Medicare program. Due to a national non-coverage determination for MRI that provides blood flow measurement, CPT codes 75558, 75560, 75562 and 75564 will not be recognized by the Medicare program and have been assigned a status indicator of ''N'' (Noncovered) on the Medicare physician fee schedule. (Note: The RUC-recommended RVUs for these codes will be reflected in Addendum B.)

The remaining codes in this family (CPT codes 75557, 75559, 75561 and 75563) will be recognized as active on the Medicare PFS.

3. Skin Test, Unlisted Antigen

For CPT code 86486, *Skin test; unlisted antigen*, the RUC did not make a work RVU recommendation. During our 2007 public meeting for new clinical laboratory tests held in accordance with § 414.506, we received approximately four comments. The commenters indicated the code belongs in the skin test code series included in the PFS with a payment crosswalk to CPT code 86490 *Skin test; coccidioidomycosis*. We agree with the recommendations. We are assigning the code a status indicator of A (Active code). The status indicator does not mean that Medicare has made a national coverage determination regarding this service. Contractors may develop local coverage determinations. CPT also deleted predecessor CPT code 86586 effective January 1, 2008; thus, CPT code 86586 will be deleted from the 2008 clinical laboratory fee schedule.

4. Wireless Pressure Sensor Implantation and Study

For CPT code 93982, *Noninvasive physiologic study of implanted wireless pressure sensor in aneursymal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report*, the RUC recommended 0.30 work RVUs. We have assigned a status indicator of R (Restricted) to this service because the sensor used in this procedure is FDA approved for pressure interpretation at the time of an endovascular aneurysm repair only and is currently not FDA approved for the follow-up evaluation of pressure analysis in the office or outpatient setting once the patient is discharged from the hospital.

5. Non-Face-to-Face Physician and Qualified Healthcare Professional Services

For CPT code 98966, *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion;* CPT code 98967, *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion;* CPT code 98968, *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion;* CPT code 98969, *Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network;* CPT code 99441, *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion;* CPT code 99442, *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion;*

CPT code 99443, *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion;* and CPT code 99444, *Online evaluation and management service provided by a physician to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network*, the HCPAC recommended 0.25 work RVUs for CPT code 98966; 0.50 work RVUs for CPT code 98967; 0.75 work RVUs for CPT code 98968; carrier pricing for CPT code 98969; and the RUC recommended 0.25 work RVUs for CPT code 99441; 0.50 work RVUs for CPT code 99442; 0.75 work RVUs for CPT code 99443; and carrier pricing for CPT code 99444. We are assigning a status indicator of ''N'' (Non-covered service) to these services because: (1) These services are non-face-to-face; and (2) the code descriptor includes language that recognizes the provision of services to parties other than the beneficiary and for whom Medicare does not provide coverage (for example, guardian). (**Note**: The RUC or HCPAC recommended RVUs for these codes will be reflected in Addendum B.)

6. Team Conference

For CPT code 99366, *Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional;* CPT code 99367, *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician;* and CPT code 99368, *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional*, the HCPAC recommended 0.82 work RVUs for CPT code 99366; the RUC recommended 1.10 work RVUs for CPT code 99367; and the HCPAC recommended 0.72 work RVUs for CPT code 99368. We are assigning a status indicator of ''B'' (Bundled) to these services because to the extent that these services are covered, we believe these services like other counseling services are incorporated into existing E/M services. (**Note:** The RUC or HCPAC recommended RVUs for these codes will be reflected in Addendum B.)

7. Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening. They are CPT code 99408, *Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes*, and CPT code 99409, *Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes*.

The code descriptions for these CPT codes suggest that these CPT codes may describe services that include screening services. In general, screening services under Medicare are considered to be those services provided to beneficiaries in the absence of signs or symptoms of illness or injury; therefore, to the extent that the services described by these two CPT codes have a screening element, the screening component would not meet the statutory requirements for coverage under section 1862(a)(1)(A) of the Act. Screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Accordingly, we will not recognize these CPT codes that incorporate screening for payment under the PFS.

Instead, we have created two parallel G-codes to allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. The codes are HCPCS code G0396, *Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes* and HCPCS code G0397, *Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes*. We will instruct Medicare contractors to pay for these codes only when considered reasonable and necessary. We will also provide coding and payment instructions for these assessment and intervention services in the program instructions implementing the CY 2008 PFS.

We are assigning a status indicator of ''N'' (Noncovered) to CPT codes 99408 and 99409. However, the work RVUs and PE inputs for 99408 will be crosswalked to G0396 and the work RVUs and PE inputs for 99409 will be crosswalked to G0397.

8. Ocular Photoscreening

For CPT code 99174, *Ocular photoscreening with interpretation and report, bilateral*, the RUC did not provide a recommendation. We are assigning a status indicator of ''N'' (Noncovered) to this service because it is a screening service that is not covered under the Medicare statute.

G. Additional Coding Issues

1. Modifier −51 Exempt List

The CPT Editorial Panel reviewed all of the codes on the modifier −51 exempt list to identify which codes should be exempt from the multiple procedure payment reduction rules and which codes should be removed from the exemption list. We have reviewed all codes recommended for removal from the exemption list and agree with the CPT Editorial Panel's recommendations. We have updated payment modifiers where applicable.

2. New Codes for Re-Examination at the Next 5-Year Review

As part of its annual recommendations, the RUC includes a list identifying new CPT codes for reexamination at the next 5-Year Review of Work RVUs. New CPT codes that have been added to this list are identified with an asterisk (*) on Table 16: AMA RUC and HCPAC Recommendations and CMS' Decisions for New and Revised 2008 CPT Codes.

H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2008

We have developed a process for establishing interim PE RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the PE direct inputs (the staff time, supplies and equipment) associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs. The RUC recommendations on the PE inputs for the new and revised CY 2008 codes were submitted to us as interim recommendations. We have accepted, in the interim, the PE recommendations submitted by the RUC for the codes listed in Table 16: AMA RUC and HCPAC Recommendations and CMS' Decisions for New and Revised

2008 CPT Codes except as noted below in this section.

CPT Code Series 49450 Through 49465

In this series of nine G-, J-, and G-J Tubes CPT codes, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460 and 49465, we made revisions to the clinical labor time to conform to the RUC-established standard under which the time assigned to any one labor type for the ''intra'' time, based on the physician's time to perform the procedure, can not exceed 100 percent of the physician time. These revisions affected the service period times for the angio-tech/RT for each code. For each CPT code, the angio-tech/RT time to assist the physician in performing the procedure was allocated at 67 percent of the physician time and the angio-tech/RT time to assist the physician with image acquisition during the procedure was allocated the remaining 33 percent of the physician time.

We also made minor revisions to the supply list for this family of codes in order to match the number of requested needles with the number of syringes. We allocated one needle for each saline flush syringe and 1 additional needle to administer the lidocaine. Each needle was assigned the supply category ''SC029, needle, 18–27g'' to encompass both the 18g and 25g needles requested. In addition, we added a 10–12 ml syringe that could be used to administer the lidocaine.

CPT Code 50593

We disagreed with the RUC recommended number of renal cryoablation probes typically needed to perform this procedure. Instead of 4 probes, we believe that an average of 2.5 probes is typical to this procedure based on 2005 clinical data (collected at Karmonos Cancer Institute) that was included as an attachment to information provided by the manufacturer. Therefore, we have assigned 2.5 probes for renal cryoablation, at $1,175 each, for CPT 50593.

V. Physician Self-Referral Prohibition: Annual Update to List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

As specified in our regulations at § 411.351, the following services are DHS:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Annual Update to the Code List

1. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations or vaccines (§ 411.355(h)).

The Code List was last updated in the CY 2007 PFS final rule with comment period (71 FR 69624) and in a subsequent correction notice (72 FR 18909).

2. Response to Comments

We received only one public comment relating to the Code List that became effective January 1, 2007. The commenter was supportive of our additions and deletions.

3. Revisions Effective for 2008

The updated, comprehensive Code List effective January 1, 2008, appears as Addendum x in this final rule with comment period and is available on our Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp#TopOfPage.*

Tables 19 and 20 identify the additions and deletions, respectively, to the comprehensive Code List that was published in Addendum J of the CY 2007 PFS final rule (71 FR 70247 through 70251) and revised in a subsequent correction notice (72 FR 18909). Tables 19 and 20 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

The additions and deletions specified in Tables 19 and 20 are necessary to conform the Code List to the most recent publications of CPT and HCPCS and to changes in Medicare payment policies.

We will consider comments regarding the codes listed in Tables 19 and 20. Comments will be considered if we receive them by the date specified in the DATES section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

TABLE 19.—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1] HCPCS CODES

CLINICAL LABORATORY SERVICES	
[no additions]	
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES	
96125	Cognitive test by HC pro.
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
75557	Cardiac mri for morph.
75558	Cardiac mri flow/velocity.
75559	Cardiac mri w/stress img.
75560	Cardiac mri flow/vel/stress.
75561	Cardiac mri for morph w/dye.
75562	Card mri flow/vel w/dye.
75563	Card mri w/stress img & dye.
75564	Ht mri w/flo/vel/strs & dye.
A9501	Technetium TC-99m teboroxime.
A9509	Iodine I-123 sod iodide mil.
A9569	Technetium TC-99m auto WBC.
A9570	Indium In-111 auto WBC.
A9571	Indium In-111 auto platelet.

TABLE 19.—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT [1] HCPCS CODES—Continued

A9572	Indium In-111 pentetreotide.
A9576	Inj prohance multipack.
A9577	Inj multihance.
A9578	Inj multihance multipack.
A9579	Gad-base MR contrast NOS, 1ml.
Q9965	LOCM 100–199mg/ml iodine, 1ml.
Q9966	LOCM 200–299mg/ml iodine, 1ml.
Q9967	LOCM 300–399mg/ml iodine, 1ml.
RADIATION THERAPY SERVICES AND SUPPLIES	
0182T	HDR elect brachytherapy.
20555	Place ndl musc/tis for rt.
41019	Place needles h&n for rt.
55920	Place needles pelvic for rt.
C1716	Brachytx source, Gold 198.
C1717	Brachytx source, HDR Ir-192.
C1719	Brachytx source, Non-HDR Ir-192.
C2616	Brachytx source, Yttrium-9.
C2634	Brachytx source, HA, I-125.
C2635	Brachytx source, HA, P-13.
C2636	Brachytx linear source, P-13.
C2637	Brachytx, Ytterbium-169.
C2638	Brachytx, stranded, I-125.
C2639	Brachytx, non-stranded, I-125.
C2640	Brachytx, stranded, P-13.
C2641	Brachytx, non-stranded, P-13.
C2642	Brachytx, stranded, C-131.
C2643	Brachytx, non-stranded, C-131.
C2698	Brachytx, stranded, NOS.
C2699	Brachytx, non-stranded, NOS.
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[no additions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
90669	Pneumococcal vacc, ped <5.

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TABLE 20.—DELETIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT[1]/ HCPCS CODES

CLINICAL LABORATORY SERVICES
[no deletions]

TABLE 20.—DELETIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT[1]/ HCPCS CODES—Continued

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES
[no deletions]

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
75552	Heart mri for morph w/o dye.
75553	Heart mri for morph w/dye.
75554	Cardiac MRI/function.
75555	Cardiac MRI/limited study.
78609	Brain imaging (PET).
78615	Cerebral vascular flow image.
A9565	In111 pentetreotide.
Q9945	LOCM≤149mg/ml iodine, 1ml.
Q9946	LOCM 150–199mg/ml iodine, 1ml.
Q9947	LOCM 200–249mg/ml iodine, 1ml.
Q9948	LOCM 250–299mg/ml iodine, 1ml.
Q9949	LOCM 300–349mg/ml iodine, 1ml.
Q9950	LOCM 350–399mg/ml iodine, 1ml.
Q9952	Inj Gad-base MR contrast, 1ml.
RADIATION THERAPY SERVICES AND SUPPLIES	
[no deletions]	
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[no deletions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[no deletions]	

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VI. Physician Fee Schedule Update for CY 2008

A. Physician Fee Schedule Update

The PFS update is set under a formula specified in section 1848(d)(4) of the Act, as amended by the MIEA–TRHCA. Section 101 of the MIEA–TRHCA provided a 1 year increase in the CY 2007 conversion factor and specified that the conversion factor for CY 2008 must be computed as if the 1-year increase had never applied. Consistent with this requirement, the update for CY 2008 is equal to the product of 1 plus the CY 2007 update (as published in the CY 2007 PFS final rule with comment period (71 FR 69751)), 1 plus the percentage increase in the MEI (divided by 100), and 1 plus the UAF. As stated in the CY 2007 PFS final rule with comment period, if section 101 of the MIEA–TRHCA had not subsequently been enacted, the CY 2007 update would have been −5.0 percent (0.94953). For CY 2008, the MEI is equal to 1.8 percent (1.018). The UAF is −7.0 percent (0.930). The product of the published CY 2007 update (0.94953), MEI (1.018), and the UAF (0.930) equals the CY 2008 update of −10.1 percent (0.89896).

Our calculations of these figures are explained in this section.

B. The Percentage Change in the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is authorized by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes.

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has CY 2000 base year weights, is comprised of two broad categories: (1) Physician's own time; and (2) physician's PE.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

In the CY 2008 PFS proposed rule (72 FR 38190), we presented a listing of the cost categories with the associated cost weights. We also explained that the Bureau of Labor Statistics (BLS) has discontinued production and publication of the white collar

occupation employment cost index (ECI) series which was used as the price proxy for nonphysician benefits in the MEI. There was no other comparable published series that was a suitable replacement for the white collar benefit ECI. Therefore, a nationally recognized economic and financial forecasting firm, Global Insight, Inc. (GII), and CMS jointly developed a composite series which is composed of four published ECI series and weighted by November 2004 National Industry Specific Occupational Employment and Wage Estimates for NAICS 6211, Office of Physicians. We proposed to replace the ECI white collar benefit series with this composite benefit index effective for the CY 2008 MEI update (See the CY 2008 PFS proposed rule (72 FR 38190) for a more detailed explanation of the specific proposal). In addition, we also published a preliminary estimate of the expected MEI update.

Table 21 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2008 update. For CY 2008, the increase in the MEI is 1.8 percent, which includes a 1.4 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.7 percent increase in physician's own time and a 2.7 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 4.2 percent, and professional and technical wages, which increased 4.0 percent.

TABLE 21.—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CY 2008 [1]

Cost categories and price measures	CY 2000 weights [2]	CY 2008 percent changes
Medicare Economic Index Total, productivity adjusted [3]	N/A	1.8
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector [3 4]	N/A	1.4
Medicare Economic Index Total, without productivity adjustment [4]	100.000	3.2
1. Physician's Own Time [5]	52.466	3.7
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	4.0
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	2.7
2. Physician's Practice Expense [5]	47.534	2.7
a. Nonphysician Employee Compensation	18.653	3.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.6
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation [7]	4.845	3.7
b. Office Expense: Consumer Price Index for Urban Areas (CPI–U), housing	12.209	3.5
c. Drugs and Medical Materials and Supplies	4.319	2.9
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI–U, medical equipment and supplies (equally weighted)	2.011	1.0
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	4.2
d. Professional Liability Insurance: Professional liability insurance Premiums [6]	3.865	−0.8
e. Medical Equipment: PPI, medical instruments and equipment	2.055	−0.4
f. Other Expenses	6.433	2.6

[1] The rates of historical change are estimated for the 12-month period ending June 30, 2007, which is the period used for computing the CY 2008 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of August 31, 2007.

[2] The weights shown for the MEI components are the 2000 base year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] These numbers may not sum due to rounding and the multiplicative nature of their relationship.

[4] On March 23, 2006, Bureau of Labor Statistics introduced a new Multi Factor Productivity (MFP) series based on the 1997 NAICS classification system to replace its SIC based series published until 2005 (the last historical value was for 2002). The new series differs historically from the old MFP series and adds two new historical values through 2004. Therefore, we used the most recently available information (thru CY 2006) to develop the productivity adjustment for the CY 2008 update.

[5] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found on the BLS Web site at *http://stats.bls.gov.*

[6] Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2007).

[7] In April 2007, with their March 2007 publication, Bureau of Labor Statistics (BLS) discontinued production and publication of the white collar occupation employment cost index (ECI) series. CMS replaced this proxy with a composite benefit series. The historical percent changes for the non physician employee benefits match the BLS white collar benefit series through 2006Q4, and from 2007Q1 forward, the percent changes reflect those of the composite benefit series. For more detail on the composite benefit series see the CY 2008 PFS proposed rule (72 FR 38190).

Comment: Many commenters proposed that we should reduce the productivity adjustment to the MEI to 0.65 percentage points from the proposed productivity adjustment of 1.5 percentage points. They believe the MEI should be subject to the same productivity adjustment as the recommended productivity adjustment for hospital, hospice, and ambulance care providers, which they state was recommended in the President's Budget proposal. The commenters also note that it is not logical for CMS to believe that physician's productivity is increasing at twice the rate of other health care providers.

Response: We disagree that the productivity adjustment to the MEI should be changed based on the proposals made in the FY 2008 President's Budget.[4] The MEI has contained a productivity adjustment since its inception in 1973. The rationale for, and technical appropriateness of the current MEI productivity adjustment has been well documented in the **Federal Register** (for example, 67 FR 80020 through 80023). Moreover, we recently partnered with

[4] *http://www.whitehouse.gov/omb/budget/fy2008/hhs.html.*

the Assistant Secretary of Planning and Evaluation of the Department of Health and Human Services to sponsor an analysis of physician-specific productivity. The results of this effort were presented at a conference of stakeholders in October 2006. A highly respected panel of experts concluded that the use of the 10-year moving average for private, nonfarm business sector multifactor productivity was not an unreasonable proxy for physician-specific productivity. Papers from this research effort are expected to be published in the forthcoming Winter 2007/2008 edition of the *Health Care Financing Review*. We will continue to monitor, on an ongoing basis, the appropriateness of the use of this economy-wide measure of multifactor productivity for purposes of adjusting the MEI.

With respect to historical productivity achievement in other health care sectors, there is comparatively little on this topic in the literature. We intend to continue to research various health-related productivity measures and would welcome the provision of data or completed studies on this topic.

Comment: One commenter questioned why other providers receive a 0.65 percent adjustment while physicians face an adjustment of more than twice that amount.

Response: To date, there are no laws in place requiring productivity adjustments for other PPS-reimbursed providers such as hospitals, and skilled nursing facilities. However, the MEI has contained an explicit productivity adjustment since its inception in 1973. The rationale and technical appropriateness of the current MEI productivity adjustment was addressed in the CY 2003 PFS final rule with comment period (67 FR 80019).

Comment: Several commenters requested that we address the broader issue that the MEI only measures changes in the specific types of practice costs that existed in 1973. They note that inputs to the MEI are vastly different now than when the MEI was first developed in the 1970s, and suggest additional inputs may be needed to ensure that the current MEI adequately measures the costs of practicing medicine.

Response: We disagree with the commenters' claim that the MEI only measures changes in specific types of practice costs that existed in 1973. The current MEI is based on costs reported by physicians for the year 2000. The 2000-based cost weights are derived from the *2003 AMA Physician Socioeconomic Characteristics* publication (2003 Patient Care Physician Survey data), which measures physicians' earnings and overall PEs for 2000. This is the latest available data on the breakdown of physician expenses.

Although cost weights in the various market baskets do not tend to change dramatically over short periods of time, we do recognize that they can change over long periods of time. We are presently researching alternative data sources for a forthcoming rebasing of the MEI, including the potential use of an AMA-sponsored Physician Practice Information Survey that was fielded in 2007. We have also considered data from the Census Bureau's Business Expenditure Survey (BES). This survey is the most comprehensive source of periodic national industry statistics on major economic inputs by type. Data are published every 5 years for years ending in ''2'' and ''7''. Currently the most recent data is reported for 2002. We compared the cost weights we derived from the 2002 BES data for NAICS 6211, Offices of Physicians and found that the overall cost weights for compensation and all other costs are quite similar to the cost weights for the current MEI market basket as shown in Table 22. We are optimistic that the new data from AMA or the Census Bureau will be sufficiently robust for the purpose of updating the MEI's input cost weights.

TABLE 22.—A COMPARISON OF MAJOR COST CATEGORY MEI MARKET BASKET WEIGHTS USING AMA AND BES DATA

	MB 2000 weights (percent)	2002 BES (excluding capital) (percent)
Compensation ...	71.2	73.5
Other	28.8	26.5

Comment: Several commenters believe that the MEI does not adequately account for the costs related to the multitude of regulations and requirements that physicians must comply with in their practices. For example, they note that the physician quality reporting initiative (PQRI) has reduced productivity in physician's offices. Similarly, a commenter had concerns that employee wages used in the MEI formula do not capture the wages of highly skilled professionals such as nurse practitioners, physician assistants, certified nurse specialists, nurse midwives, therapists, computer professional, and other types of professional occupations.

Response: The current MEI cost weights are based on input costs reported by physicians for 2000, which would reflect changes in the distributions of the cost weights associated with new government-imposed regulatory requirements up to that point. These cost weights are derived from the *2003 AMA Physician Socioeconomic Characteristics* publication (2003 Patient Care Physician Survey data), which measures physicians' earnings and overall PEs for CY 2000. While we understand that more recent data would better measure relative input costs, we presently lack a viable alternative data source with which to compute new cost weights. The data used as the basis for the current MEI market basket cost weights represent the latest available data on physician expenses. As stated previously, we are awaiting the data from the 2007 AMA Physician Practice Information Survey and are hopeful that this source will be sufficiently robust for use in rebasing the cost weights found in the MEI. We would expect that any relative cost changes related to regulatory changes would be reflected in this new data.

Comment: One commenter suggested we should discontinue use of the MEI to measure physician input price pressures and switch to the same market basket update used by the hospital outpatient prospective payment system (OPPS).

Response: We disagree with the commenter that physicians and outpatient hospital departments face the same input costs.

The MEI reflects the cost structure and price changes associated with the inputs used in furnishing physicians' services while the hospital market basket reflects the cost structure and price changes associated with the inputs used in providing hospital services.

Comment: One commenter noted that input expenses for recruiting and employing trained personnel and other PEs in the physician's office are identical to those in a hospital.

Response: The expenses for trained personnel are captured in the PE portion of the MEI. These PE cost weights are derived from the *2003 AMA Physician Socioeconomic Characteristics* publication (2003 Patient Care Physician Survey data), which measures physicians' earnings and overall PEs for CY 2000. As indicated above in this section, while we understand that more recent data would better measure relative input costs, we presently lack a viable alternative data source with which to compute new cost weights. The data used as the basis for the current MEI market basket cost weights represent the latest available data on physician expenses. We are awaiting the

data from the 2007 AMA Physician Practice Information Survey and are hopeful that this source will be sufficiently robust for use in rebasing the cost weights found in the MEI. We would expect that any relative cost changes related to PE costs would be reflected in this new data.

Comment: One commenter disagreed with the price proxy used for office expenses in the MEI noting that the growth in office rents differ from apartment rents. The commenter also suggested that we get data from a contractor comparing the cost of building medical office space to that of residential living space.

Response: We agree that the construction costs of a physician's office differ from the construction costs of a residential dwelling; however, the cost category for office expenses is not designed to measure the changes in initial construction costs. Instead, we attempt to measure the rate of price changes related to a monthly office expense payment. The majority of monthly office expenses are related to rent or mortgage for commercial space. As we are not aware of a publicly-available proxy that measures the price changes in rental costs of commercial space, we use what we believe to be the best, technically appropriate alternative; the consumer price index (CPI) for housing. Other major office expenses, such as medical equipment, are broken out in greater detail. Once data is available for the next rebasing of the MEI, we will explore the feasibility of breaking office expenses into more comprehensive cost categories.

Comment: One commenter has concerns that the forecasts of the MEI have been and continue to be declining (from over 3 percent to below 2 percent) for the foreseeable future. The commenter would like for CMS to examine in more detail the assumptions of the price proxy forecasts produced by Global Insight Inc. (GII).

Response: It is important to note that the MEI update is based on historical data rather than on forecasted data. For example, the CY 2008 update is based on the actual measured price inflation through the second quarter of 2007. Since the MEI update is based on historical data, not on a forecast, the concern that GII's work does not involve forecasting the price proxies for compensation and PEs accurately is not relevant. Table 23 shows the MEI updates for the past 5 years and the current CY 2008 update. While the MEI update for CY 2003 through CY 2006 was closer to 3.0 percent, the MEI update for CY 2007 and CY 2008 is closer to 2.0 percent. These lower updates are not, however, a function of an incorrect forecast. The recent lower overall MEI updates are a function of both a deceleration in input price pressures and relatively higher gains in multifactor productivity.

TABLE 23.—MEI UPDATES FOR THE PAST 5 YEARS AND THE CURRENT CY 2008 UPDATE *

MEI final updates	Adjusted	Unadjusted	Productivity
CY 2003	3.0	3.8	0.8
CY 2004	2.9	3.8	0.9
CY 2005	3.1	4.0	0.9
CY 2006	2.8	3.8	1.0
CY 2007	2.1	3.5	1.3
CY 2008	1.8	3.2	1.4

* Prior to the update for CY 2003 the MEI was adjusted for Labor productivity rather than by private non-farm multifactor productivity.

Comment: One commenter stated that the only solution the commenter would support at this time would be a nationwide legislative solution that would provide additional funding for fair and equitable payment to Medicare participating physicians in *every* State.

Response: We do not have the administrative authority to make such a legislative change. More so, this comment is beyond the scope of the MEI proposals of the CY 2008 PFS proposed rule.

C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

Section 101 of the MIEA TRHCA provided a 1 year increase in the CY 2007 conversion factor. The provision specified that the CF for CY 2008 must be computed as if the 1 year increase for CY 2007 had never applied.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• *Cumulative Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2008 in this case), the current CY (that is, CY 2007) and the preceding CY (that is, CY 2006) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year are initially estimated and subsequently revised twice. The second revision occurs after the CY has ended

(that is, we are making the final revision to 2006 allowed expenditures in this final rule with comment). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 24 shows annual and cumulative allowed and actual expenditures for physicians' services from April 1, 1996 through the end of the current CY, including the short periods in 1999 when we transitioned to a CY system. Also shown is the SGR corresponding with each period. The calculation of the SGR is discussed in detail below in this section.

TABLE 24.—ANNUAL AND CUMULATIVE ALLOWED AND ACTUAL EXPENDITURES FOR PHYSICIANS' SERVICES FROM APRIL 1, 1996 THROUGH THE END OF THE CURRENT CALENDAR YEAR

Period	Annual allowed expenditures ($ in billions)	Annual actual expenditures ($ in billions)	Cumulative allowed expenditures ($ in billions)	Cumulative actual expenditures ($ in billions)	FY/CY SGR
4/1/96–3/31/97	[1] $48.9	$48.9	$48.9	$48.9	N/A
4/1/97–3/31/98	50.5	49.4	99.4	98.4	FY 1998=3.2%
4/1/98–3/31/99	52.6	50.5	152.0	148.9	FY 1999=4.2%
1/1/99–3/31/99	13.3	13.1	([2])	148.9	FY 1999=4.2%
4/1/99–12/31/99	42.1	39.5	([3])	188.4	FY 2000=6.9%
1/1/99–12/31/99	55.3	52.6	194.0	188.4	FY 1999/2000
1/1/00–12/31/00	59.3	58.1	253.4	246.5	CY 2000=7.3%
1/1/01–12/31/01	62.0	66.3	315.4	312.8	CY 2001=4.5%
1/1/02–12/31/02	67.2	70.9	382.6	383.7	CY 2002=8.3%
1/1/03–12/31/03	72.1	78.2	454.6	461.9	CY 2003=7.3%
1/1/04–12/31/04	76.8	87.1	531.5	549.0	CY 2004=6.6%
1/1/05–12/31/05	80.1	91.8	611.5	640.8	CY 2005=4.2%
1/1/06–12/31/06	81.3	93.4	692.8	734.2	CY 2006=1.5%
1/1/07–12/31/07	83.9	94.6	776.6	828.8	CY 2007=3.2%
1/1/08–12/31/08	83.8	NA	860.4	NA	CY 2008= 0.1%

[1] Allowed expenditures in the first year (April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: *http://www.cms.hhs.gov/SustainableGRatesConFact/*. We expect to update the Web site with the most current information later this month.
[2] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.
[3] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

Consistent with section 1848(d)(4)(E) of the Act, Table 24 includes our final revision of allowed expenditures for CY 2006, a recalculation of allowed expenditures for CY 2007, and our initial estimate of allowed expenditures for CY 2008. To determine the UAF for CY 2008, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2007 and the CY 2008 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2007 and CY 2008 SGRs and CY 2007 and CY 2008 allowed expenditures. Because we have incomplete actual expenditure data for CY 2007, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years.

We are using figures from Table 24 in the following statutory formula:

$$UAF_{08} = \frac{Target_{07} - Actual_{07}}{Actual_{07}} \times .75 + \frac{Target_{4/96-12/07} - Actual_{4/96-12/07}}{Actual_{07} \times SGR_{08}} \times .33$$

UAF_{08} = Update Adjustment Factor for CY 2008 = −26.7 percent
$Target_{07}$ = Allowed Expenditures for CY 2007 = $83.9 billion
$Actual_{07}$ = Estimated Actual Expenditures for CY 2007 = $94.6 billion
$Target_{4/96-12/07}$ = Allowed Expenditures from 4/1/1996–12/31/2007 = $776.6 billion
$Actual_{4/96-12/07}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2007 = $828.8 billion
SGR_{08} = −0.1 percent (0.999)

$$\frac{\$83.9 - \$94.6}{\$94.6} \times .75 + \frac{\$776.6 - \$828.8}{\$94.6 \times 0.999} \times .33 = -0.267$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. Since −0.267 is less than −0.070, the UAF for CY 2008 will be −0.070.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to −0.070 makes the UAF equal to 0.930.

VII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians'

services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real GDP per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2008 SGR, a revision to the CY 2007 SGR, and our final revision to the CY 2006 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, NPs, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- MNT services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device (70 FR 50940).

Telehealth services and the power mobility device related services were added because they meet the statutory criteria for services to be included in the SGR (that is, these services are commonly performed or furnished by a physician or in a physician's office) (70 FR 70305).

Summary of Comments on the Physician Update and the SGR

We appreciate the comments we received expressing concern about the negative update for CY 2008 and the SGR formula. These comments and our responses are summarized here.

Comment: The 2007 Medicare Trustees Report projected an approximate 10 percent reduction in payment for physicians' services in CY 2008 and about a 5 percent reduction in each subsequent year through CY 2016. The cumulative impact of the projected reductions from CY 2008 to CY 2016 is estimated to be about −40 percent. In contrast, the MEI increase over this same period is projected to be about 15 percent.

Commenters noted that Medicare reimbursement does not reflect the actual costs of delivering services to Medicare beneficiaries. The commenters stated the reimbursement system has been unstable, and physicians cannot plan for the future in an unpredictable reimbursement environment that fails to keep pace with the costs of labor and supplies. Commenters also stated that practitioners unable to absorb the sustained losses will refuse or limit Medicare patients, resulting in reduced access to care. Commenters believe that beneficiaries will be forced to seek care in inpatient settings, which will be more costly for Medicare, less efficient in delivering care, and yield worse health outcomes for beneficiaries.

Commenters recommended that the SGR be replaced with a more equitable and sustainable formula, such as an appropriate inflation rate linked to changes in the actual costs of medical practice. Many commenters suggested the MEI as an appropriate measure. Commenters requested that we assume the leadership in pushing the Congress to enact legislation preventing a negative update for CY 2008, and to replace the SGR with a more sustainable system.

Response: We understand the potential implications of more than 9 years of negative physician updates. We remain concerned regarding these trends, and we are closely monitoring physicians' participation in the Medicare program, as well as beneficiaries' access to care.

It is a top priority at CMS to transform Medicare from a passive payor to an active purchaser of high quality, efficient health care services. We are studying and implementing value based purchasing initiatives for Medicare payment systems, including physicians' services. In addition, the FY 2008 President's Budget supports budget neutral physician payment reform and states that ''an important component of improving quality is encouraging more efficient and high-quality physician services.'' (For further discussion of the President's FY 2008 Budget initiatives to improve the quality, efficiency and transparency of health care, see *http://www.whitehouse.gov/omb/budget/fy2008/hhs.html*.)

Ultimately, the formula for the SGR and the physician update are dictated by statute. We are required to follow this methodology when calculating the payment rates under the PFS. We look forward to working with the Congress, the physician community, and other interested parties as we continue to analyze appropriate alternatives to the current system that could ensure appropriate payments while promoting high quality care, without increasing Medicare costs.

Comment: Commenters noted that only physicians and other practitioners under the PFS face steep cuts under the SGR formula. The commenters also noted that other health care providers have payment updates that reflect the cost of inflation. Further, the commenters stated the approximately 10 percent cut in payment rates is in stark contrast to providers enrolled in Medicare Advantage (MA) plans, who are paid on average 112 percent above the cost of traditional Medicare.

Response: As noted previously, the formula for the SGR and the physician update are dictated by statute. We are required to follow this methodology when calculating the payment rates under the PFS. Other Medicare payment systems have their own update formulas.

Comment: Many commenters requested that we use our administrative authority to reduce the negative physician update for CY 2008. Many commenters stated that we are authorized to remove the cost of Medicare-covered physician-administered drugs from the SGR on a retrospective basis. They stated that we must also adjust the SGR target to reflect the impact of National and Local Coverage Decisions on physician spending. Commenters noted that the current formula does not account for costs and savings associated with new technologies. The commenters stated that if we make such administrative changes now, then the cost of legislation revising the payment methodology for physicians' services will drop, and the likelihood of Congressional action to fix the SGR permanently will increase. Commenters expressed frustration that these administrative adjustments have been requested numerous times, yet we have never implemented the changes.

Response: We indicated in the past (most recently in the CY 2007 PFS final rule with comment period (71 FR 69756)) that many of these administrative changes are statutorily difficult, and according to our current estimates, making such changes would not provide relief from the projected negative updates for the next several years. As indicated above in this section, we are working with the Congress and health professional organizations on potential reforms that would improve the effectiveness of the payment methodology for physicians without increasing overall Medicare costs.

Comment: Commenters noted that payment updates under the SGR are tied to the gross domestic product (GDP), which bears little relationship to Medicare beneficiaries' health care needs or physician practice costs. Commenters noted that medical needs of individual patients are not related to the growth of the overall economy, and beneficiaries' medical needs do not decline during economic downturns. Commenters stated that MEI is a better reflection than GDP of the growth in health care costs.

Response: As discussed in the CY 2007 PFS final rule with comment period (71 FR 69756), the percentage change in the MEI is one of the key components used to update the PFS CF. GDP is a general measure of economic growth. It is not intended to reflect factors specific to operating a medical practice because these factors are captured in the MEI. The statute requires that GDP be used as a component of the SGR, which is then used to calculate the target level of expenditures. Although both MEI and GDP are factors that affect the calculation of the CF, the MEI has a more direct and greater impact on the physician update than GDP.

Comment: Commenters stated that additional funds need to be added to the SGR allowed expenditures for all the ancillary costs associated with new benefits. New benefits adjust the target, but they generate other services whose costs are not added to the targeted allowed expenditures.

Response: As discussed in the CY 2007 PFS final rule with comment period (71 FR 69756 through 69757), our estimate of changes in expenditures arising from changes in laws and regulations includes induced spending impacts, when applicable and material. Our estimate of the additional expenditures associated with any new benefit, like all of the figures used to determine a particular year's SGR, is an estimate that will be revised based on subsequent data. A 2-year look back window allows adjustments to the estimates to reflect actual impacts. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates. (See below in this section for a discussion of all the new benefits that were considered in estimating the change in expenditures due to changes in law and regulation in 2006, 2007, and 2008.)

C. Preliminary Estimate of the SGR for 2008

Our preliminary estimate of the CY 2008 SGR is −0.1 percent. We first estimated the CY 2008 SGR in March 2007, and made the estimate available to the MedPAC and on our Web site. Table 25 shows the March 2007 estimate and our current estimates of the factors included in the CY 2008 SGR.

TABLE 25.—2008 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	2.0 percent (1.020)	1.9 percent (1.019).
Enrollment	−0.2 percent (0.998)	−0.7 percent (0.993).
Real Per Capita GDP	1.9 percent (1.019)	1.7 percent (1.017).
Law and Regulation	−1.5 percent (0.985)	−2.9 percent (0.971).
Total	2.2 percent (1.022)	−0.1 percent (0.999).

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.019 × 0.993 × 1.017 × 0.971 = 0.999). A more detailed explanation of each figure is provided in section VII.F.1 of this preamble.

D. Revised Sustainable Growth Rate for 2007

Our current estimate of the CY 2007 SGR is 3.2 percent. Table 26 shows our preliminary estimate of the CY 2007 SGR that was published in the CY 2007 PFS final rule with comment period (71 FR 69757) and our current estimate.

TABLE 26.—2007 SGR CALCULATION

Statutory factors	Estimate from CY 2006 final rule	Current estimate
Fees	2.2 percent (1.022)	1.9 percent (1.019).
Enrollment	−0.9 percent (0.991)	−2.6 percent (0.974).
Real Per Capita GDP	2.0 percent (1.020)	1.9 percent (1.019).
Law and Regulation	−1.5 percent (0.985)	2.0 percent (1.020).
Total	1.8 percent (1.018)	3.2 percent (1.032).

A more detailed explanation of each figure is provided in section VIII.F.2 of this preamble.

E. Final Sustainable Growth Rate for 2006

The SGR for 2006 is 1.5 percent. Table 27 shows our preliminary estimate of the 2006 SGR from the CY 2006 PFS final rule with comment period (70 FR 70309), our revised estimate from the CY 2007 PFS final rule with comment period (71 FR 69757) and the final figures determined using the best available data as of September 1, 2007.

TABLE 27.—2006 SGR CALCULATION

Statutory factors	Estimate from CY 2006 final rule	Estimate from CY 2007 final rule	Final
Fees	2.7 percent (1.027)	2.2 percent (1.022)	2.1 percent (1.021).
Enrollment	−3.1 percent (0.969)	−2.2 percent (0.978)	−2.6 percent (0.974).
Real Per Capita GDP	2.2 percent (1.022)	2.1 percent (1.021)	2.1 percent (1.021).
Law and Reg	0.0 percent (1.000)	0.0 percent (1.000)	0.0 percent (1.000).
Total	1.7 percent (1.017)	2.1 percent (1.021)	1.5 percent (1.015).

A more detailed explanation of each figure is provided in section VIII.F.3.

F. Calculation of CY 2008, CY 2007, and CY 2006 Sustainable Growth Rates

1. Detail on the CY 2008 SGR

All of the figures used to determine the CY 2008 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2008

This factor is calculated as a weighted-average of the CY 2008 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 80.4 percent of total allowed charges included in the SGR in CY 2008 and are updated using the MEI. The MEI for CY 2008 is 1.8 percent. Diagnostic laboratory tests are estimated to represent approximately 7.6 percent of Medicare allowed charges included in the SGR for CY 2008. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U). However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from CY 2004 through CY 2008.

Drugs are estimated to represent 12.0 percent of Medicare allowed charges included in the SGR in CY 2008. We estimated a weighted average change in fees for drugs included in the SGR (using the ASP + 6 percent pricing methodology) of 4.0 percent for CY 2008.

Table 28 shows the weighted average of the MEI, laboratory, and drug price changes for CY 2008.

TABLE 28.—WEIGHTED AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2008

	Weight	Update
Physician	0.804	1.8
Laboratory	0.076	0.0
Drugs	0.120	4.0

TABLE 28.—WEIGHTED AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2008—Continued

	Weight	Update
Weighted-average	1.000	1.9

We estimate that the weighted average increase in fees for physicians' services in CY 2008 under the SGR (before applying any legislative adjustments) will be 1.9 percent.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees From CY 2007 to CY 2008

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2007 to CY 2008. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. OACT estimates that the average number of Medicare Part B fee-for-service enrollees will decrease by 0.7 percent from CY 2007 to CY 2008. Table 29 illustrates how this figure was determined.

TABLE 29.—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES
[(Excluding beneficiaries enrolled in MA plans) from CY 2007 to CY 2008]

	2007	2008
Overall	40.726 million	41.480 million.
Medicare Advantage (MA)	7.890 million	8.888 million.
Net	32.836 million	32.592 million.
Percent Increase		−0.7 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in Medicare Advantage (MA) plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2008 becomes known.

• Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2008

We estimate that the growth in real GDP per capita from CY 2007 to CY 2008 will be 1.7 percent (based on the 10-year average GDP over the 10-years of 1999–2008). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in 2008.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2008 Compared With CY 2007

The statutory and regulatory provisions that will affect expenditures in CY 2008 relative to CY 2007 are estimated to have an impact on expenditures of −2.9 percent. These provisions include the expiration of the MMA provisions for the work GPCI floor and HPSA bonuses, the DRA provision reducing payments for imaging services, and the MIEA–TRHCA provisions regarding the conversion factor and the 2007 PQRI reporting bonuses payable in 2008. The details of these provisions are discussed elsewhere in this final rule with comment.

2. Detail on the 2007 SGR

A more detailed discussion of our revised estimates of the four elements of the 2007 SGR follows.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2007

This factor was calculated as a weighted-average of the 2007 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the PFS account for approximately 82.5 percent of total allowed charges included in the SGR in CY 2007. These services were updated using the CY 2007 MEI of 2.1 percent. We estimate that diagnostic laboratory tests represent approximately 7.3 percent of total allowed charges included in the SGR in CY 2007. Medicare payments for these tests are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from CY 2004 through CY 2008. We estimate that drugs represent 10.2 percent of Medicare-allowed charges included in the SGR in CY 2007. We estimate a weighted-average change in fees for drugs included in the SGR of 1.3 percent for CY 2007.

Table 30 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2007.

TABLE 30.—WEIGHTED AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2007

	Weight	Update
Physician	0.825	2.1
Laboratory	0.073	0.0
Drugs	0.102	1.3
Weighted-average	1.000	1.9

After taking into account the elements described in Table 30, we estimate that the weighted-average increase in fees for physicians' services in 2007 under the SGR (before applying any legislative adjustments) will be 1.9 percent. Our estimate of this factor in the CY 2007 PFS final rule with comment period was 2.2 percent. The decrease in the estimate is due to the availability of some actual data.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2006 to CY 2007

OACT estimates that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) decreased by 2.6 percent in CY 2007. Table 31 illustrates how we determined this figure.

TABLE 31.—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES
[(Excluding beneficiaries enrolled in MA plans) from CY 2006 to CY 2007]

	2006	2007
Overall	40.271 million	40.726 million.
Medicare Advantage (MA)	6.550 million	7.890 million.
Net	33.721 million	32.836 million.
Percent Increase		−2.6 percent.

OACT's estimate of the −2.6 percentage change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2007 compared to CY 2006, is lower than our original estimate of −0.9 percent in the CY 2007 PFS final rule with comment period (71 FR 69758). While our current projection based on data from 8 months of 2007 is lower than our original estimate of −0.9 percent when we had no actual data, it is still possible that

our final estimate of this figure will be different once we have complete information on CY 2007 fee-for-service enrollment.

• Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in CY 2007

We estimate that the growth in real GDP per capita will be 1.9 percent for CY 2007 (based on the 10-year average GDP over the 10 years of CY 1998 through CY 2007). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2007 economic performance becomes available to us in 2008.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or regulations in CY 2007 Compared With CY 2006

The statutory and regulatory provisions that will affect expenditures in CY 2007 relative to CY 2006 are estimated to have an impact on expenditures of 2.0 percent. These provisions include the DRA provisions adding the AAA ultrasound test to the Welcome to Medicare visit as a preventive benefit and reducing payments for imaging services. Also included is the MIEA–TRHCA 1-year adjustment to the conversion factor. The details of these provisions are discussed elsewhere in this final rule with comment.

3. Detail on the CY 2006 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2006 SGR follows.

• Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2006

This factor was calculated as a weighted average of the CY 2006 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the PFS accounted for approximately 83.8 percent of total Medicare-allowed charges included in the SGR for CY 2006 and are updated using the MEI. The MEI for CY 2006 was 2.8 percent. Diagnostic laboratory tests represented approximately 7.2 percent of total CY 2006 Medicare allowed charges included in the SGR and are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from CY 2004 through CY 2008. Drugs represented approximately 9.1 percent of total Medicare-allowed charges included in the SGR for CY 2006. We estimate a weighted-average change in fees for drugs included in the SGR of −2.8 percent for 2006. Table 32 shows the weighted average of the MEI, laboratory, and drug price changes for CY 2006.

TABLE 32.—WEIGHTED AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2006

	Weight	Update
Physician	0.838	2.8
Laboratory	0.072	0.0
Drugs	0.091	−2.8
Weighted-average	1.000	2.1

After taking into account the elements described in Table 32, we estimate that the weighted-average increase in fees for physicians' services in CY 2006 under the SGR (before applying any legislative adjustments) was 2.1 percent. This figure is a final one based on complete data for CY 2006.

• Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2005 to CY 2006

We estimate the decrease in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2005 to CY 2006 was 2.6 percent. Our calculation of this factor is based on complete data from CY 2006. Table 33 illustrates the calculation of this factor.

TABLE 33.—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES

[(Excluding beneficiaries enrolled in MA plans) from CY 2005 to CY 2006]

	2005	2006
Overall	39.698 million	40.271 million.
Medicare Advantage (MA)	5.084 million	6.550 million.
Net	34.615 million	33.721 million.
Percent Increase		−2.6 percent.

• Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2006

We estimate that the growth in real per capita GDP was 2.1 percent in 2006 (based on the 10-year average GDP over the 10 years of CY 1997 through CY 2006). This figure is a final one based on complete data for CY 2006.

• Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2006 Compared With CY 2005

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2006 relative to CY 2005 is less than 0.05 percent. These provisions include the expiration of the temporary higher payments to physicians in Alaska, the new power wheelchair code for physicians, and the IVIG pre-administration fee.

VIII. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2008

The CY 2008 PFS CF will be $34.0682. The CY 2008 national average anesthesia CF is $16.3176. Both CFs will be subject to a separate, independent BN adjustor, as described below.

A. Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the PFS CF is equal to the CF for the previous year timesplied by the update determined under section 1848(d)(4) of the Act, as amended by the MIEA–TRHCA. Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied.

The PFS update for CY 2008 is determined by timesplying the CY 2007 conversion factor update that would have occurred in the absence of the MIEA–TRHCA (as published in 71 FR 69760), the estimated MEI, and the

estimated update adjustment factor, as shown in Table 34 (0.89896 = 0.94953 × 1.018 × 0.930). To determine the estimated CY 2008 CF, the Pre-MIEA–TRHCA CY 2007 CF update is applied to the CY 2006 CF of $37.8975 to produce the Pre-MIEA–TRHCA CY 2007 CF of $35.9848. Then applying the estimated MEI for CY 2008 and the estimated UAF for CY 2008 to the Pre-MIEA–TRHCA CY 2007 a CF produces an estimated CF for CY 2008 of $34.0682. We illustrate the calculation for the 2008 PFS CF in Table 34.

TABLE 34.—CALCULATION OF THE CY 2008 CONVERSION FACTOR

CY 2006 Conversion Factor	$37.8975.
Pre-MIEA–TRHCA CY 2007 CF Update	−5.0 percent (0.94953).
CY 2007 Pre-MIEA–TRHCA Conversion Factor	$35.9848.
2008 MEI	1.8 percent (1.018).
2008 Update adjustment factor	−7.0 percent (0.930).
CY 2008 Update	−5.3 percent (0.94674).
CY 2008 Conversion Factor Update	−10.1 percent (0.89896).
CY 2008 Conversion Factor	$34.0682.

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN.

The 5-Year Review of work RVUs, including the refinement to the work RVU changes for the additional codes and the increases in the work of anesthesia services, would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the CF or RVUs. As discussed in section IV.C.3 of this final rule with comment period, we are applying the following BN adjustor to the work RVUs in order to calculate payment for a service:

2008 Work Adjustor: 11.94 percent (0.8806)

Payment for services under the PFS will be calculated as follows:

Payment = [(RVU work × BN adjustor (round product to two decimal places) × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF

B. Anesthesia Fee Schedule Conversion Factor

We calculate the physician anesthesia CF similar to the general PFS CF in Table 34. As noted, section 101 of the TRCHA provided for a 1-year increase in the CY 2007 conversion factor and specified the conversion factor for 2008 must be computed as if the 1-year increase had never applied. The PFS update for CY 2008 is determined by timesplying the CY 2007 conversion factor that would have occurred in the absence of TRCHA by the estimated MEI and the estimated update adjustment factor for 2008.

Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF to simulate changes to RVUs. We modeled the resource based PE methodology using imputed anesthesia RVUs that were made comparable to other PFS services. The 2008 adjustment factor in Table 35 includes the combined effect of the PE adjustment, the increase in work of anesthesia services under the recent five year review and the BN adjustment.

We illustrate the calculation for the 2008 anesthesia CF in Table 35.

TABLE 35.—CALCULATION FOR THE 2008 ANESTHESIA CONVERSION FACTOR

CY 2006 Anesthesia Conversion Factor	$17.7663.
Pre-TRHCA CY 2007 CF Update	−5.0 percent (0.94953).
2007 Combined Adjustment for PE and BN	0.9089.
CY 2007 Pre-TRHCA Anesthesia Conversion Factor	$15.3328.
2008 MEI	1.8 percent (1.018).
2008 Update adjustment factor	−7.0 percent (0.930).
CY 2008 Anesthesia CF after MEI and 2008 Adjustment Factor	$14.5162.
2008 Combined Adjustment for PE and BN	1.1250.
CY 2008 Anesthesia Conversion Factor	$16.3307.

IX. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2008 is 1.8 percent.

Therefore, for CY 2007, the payment amount for HCPCS code Q3014, Telehealth originating site facility fee, is 80 percent of the lesser of the actual charge or $23.35. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 36.

TABLE 36.—THE MEDICARE TELEHEALTH ORIGINATING SITE FACILITY FEE AND MEI INCREASE BY THE APPLICABLE TIME PERIOD

Facility fee	MEI increase (percent)	Period
$20.00	N/A	10/01/2001–12/31/2002
$20.60	3.0	01/01/2003–12/31/2003
$21.20	2.9	01/01/2004–12/31/2004
$21.86	3.1	01/01/2005–12/31/2005
$22.47	2.8	01/01/2006–12/31/2006
$22.94	2.1	01/01/2007–12/31/2007
$23.35	1.8	01/01/2008–12/31/2008

X. Provisions of the Final Rule

The provisions of this final rule with comment restate the provisions of the CY 2008 PFS proposed rule, except as noted elsewhere in the preamble.

XI. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for CMS to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the RUC recommendations for valuing these services. By reviewing these RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with providing the services. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each carrier establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

In addition, we ordinarily publish a notice of proposed rulemaking in the **Federal Register** and provide a period for public comment before we make final the provisions of the notice. We can waive this procedure, however, if we find good cause that notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice issued. We find it unnecessary to undertake notice and comment rulemaking in this instance for the ambulance inflation factor because the law specifies the method of computation of annual updates, and we have no discretion in this matter. Further, we are merely applying the update method specified in statute and regulation. Therefore, under 5 U.S.C. 553(b)(B), for good cause, we waive notice and comment procedures for this ambulance inflation factor update.

XII. Collection of Information Requirements

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This final rule with comment period does not contain any new information collection requirements. However, we are republishing the discussion of the information collection requirements as it appeared in the CY 2008 PFS

proposed rule (72 FR 38122). We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements.

Independent Diagnostic Testing Facility (§ 410.33)

Section 410.33(g)(2) states that an independent diagnostic testing facility (IDTF) should provide complete and accurate information on its Medicare enrollment application. In addition, an IDTF is required to notify its designated fee-for-service contractor within 30-days of any changes in ownership, changes of location, changes in general supervision, and any adverse legal actions. The notification must be made on the Medicare enrollment application. All of the changes to the enrollment application must be reported within 90 days.

The aforementioned requirements are not new. The burden associated with completing the Medicare enrollment application is currently approved under OMB control number 0938–0685. The collection has an expiration date of April 30, 2009.

Section 410.33(g)(6) states the comprehensive liability insurance requirements for IDTFs. Specifically, § 410.33(g)(6)(1) states they must have a comprehensive insurance policy to notify the CMS designated contractor, in writing, of any policy changes or cancellations. The burden associated with this requirement is the time and effort necessary to draft and submit the written notification to the CMS designated contractor. While this requirement is subject to the PRA, we believe it is exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). This information will be collected on case by case basis.

Section 410.33(g)(8) requires an IDTF to answer, document, maintain documentation of beneficiaries questions and responses to beneficiary complaints at the physical site of the IDTF. Sections 410.33(g)(8) (i through iii) list the minimum amount of documentation needed to comply with this requirement. The burden associated with these requirements is the time and effort associated with responding to beneficiary questions and complaints, documenting the actions taken in response to the questions and complaints, and maintaining the documentation. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(b)(2). The burden associated with documenting and maintaining the documentation of the corrective actions is a usual and customary business practice. The time, effort, and financial resources necessary to comply this information collection requirement would be incurred by persons in the normal course of their activities (for example, in compiling and maintaining business records) and is not subject to the PRA.

Basis of Payment (§ 414.707)

Section 414.707(c) states that effective January 1, 2008, each request for payment for anti-anemia drugs furnished to treat anemia resulting from the treatment of cancer must report the beneficiary's most recent hemoglobin or hematocrit level. The burden associated with this requirement is the time and effort associated with obtaining the most recent hemoglobin or hematocrit levels and documenting it on the request for payment. The requirement and its associated burden are not subject to the PRA under 5 CFR 1320.3(h)(5). The interpretation of biological analyses of body fluids, tissues, or other specimens, or the identification or classification of such specimens is not subject to the PRA.

Term of Contract (§ 414.914)

Section 414.914(h) states that the approved CAP vendor must verify drug administration prior to the collection of any applicable cost sharing amount. As part of the verification process, § 414.914(h)(1) through (2) states lists the documentation that is required as part of the verification process. Section 414.914(h)(3) states that the approved CAP vendor must provide this information to CMS or the beneficiary upon request.

The burden associated with the requirements in § 414.914(1) through (3) is the time and effort needed to verify the drug administration. When obtaining written verification, the CAP vendor must document the elements listed in § 414.914(h)(1)(i) through (vi). When obtaining verbal verification, the CAP vendor must document the elements listed in § 414.914(h)(2)(i) through (ii). We believe the requirements and their associated burden are not subject to the PRA; they are part of the CAP vendor's usual and customary business practices as stipulated under 5 CFR 1320.3(h)(5).

In addition, § 414.914(h)(3) imposes both recordkeeping and reporting requirements. We believe that the burden associated with the recordkeeping requirement imposed by § 414.914(h)(3) is not subject to the PRA under 5 CFR 1320.3(c)(4) because it would affect less than 10 persons.

The reporting requirement places burden on the CAP vendor to provide the information listed in § 414.914(h)(1–2) to a beneficiary upon request. We estimate that the CAP vendor will receive 72 requests per year from beneficiaries. We believe it will take 15 minutes per request for the vendor to provide this information to the beneficiary. The total annual burden associated with this requirement is 1080 minutes or 18 burden hours. However, we believe this information collection requirement and the associated burden is not subject to the PRA as defined in 5 CFR 1320.3(c)(4) because it would affect less than 10 persons.

Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (§ 414.930)

Section 414.930(b) states the process for listing compendia for determining medically-accepted uses of drugs and biologicals in anti-cancer treatment. We will annually provide an annual opportunity to request changes to the list of compendia. As stated in § 414.930(c)(1), CMS will review a complete written request that is submitted in writing, electronically or via hard copy. A complete written request must contain the following information as stated in § 414.930(c)(1)(i) through (vi): Full name and contact information for the requestor; full identification of the compendium in question; a complete written copy of the compendium in question; the specific action requested of CMS; supporting documentation for the requested action; address a single compendium per request.

The burden associated with the requirements contained in § 414.930(b) through (c) is the time and effort required to draft and submit to CMS a complete written request for changes to the list of compendia. While these requirements are subject to the PRA, we believe the burden is exempt under 5 CFR 1320.3(c)(4) because it would affect less than 10 persons or entities. There are only 6 compendia that could reasonably be expected to be the subject of a request, so 6 requests is a likely maximum.

Signature Requirements (§ 424.36)

Section 424.36(a) requires the beneficiary's signature on a claim for payment of services unless the beneficiary has died or the provisions of § 424.36(b), (c), or (d) apply. Section 424.36(b) states that if the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed by one of the parties specified in § 424.36(b)(1) through (5). Proposed

§ 424.36(b)(6) states that, for emergency ambulance transport services, if certain conditions and documentation requirements are met, an ambulance provider or supplier would be permitted to sign the claim on behalf of the beneficiary. Specifically, § 424.36(b)(6)(ii)(A) through (C) lists the documentation that would be required, all of which would have to be maintained by the ambulance provider or supplier in its files for a period of at least 4 years from the date of service. An ambulance provider or supplier would be required to obtain a signed, contemporaneous statement from an ambulance employee present during transport of the patient that, at the time the service was provided, the beneficiary was physically or mentally incapable of signing the claim and that none of the other qualified parties listed in § 424.36(b)(1) through (5) were available or willing to sign the claim on behalf of the beneficiary.

The ambulance provider or supplier would also be required to maintain documentation of the date and time that the beneficiary was transported and the name and location of the facility that received the beneficiary. In addition, the ambulance provider or supplier would be required to obtain and maintain a signed contemporaneous statement from a representative of the facility that received the beneficiary. The statement would have to contain the name of the beneficiary and the date and time the beneficiary was received at the facility.

The burden associated with the recordkeeping requirements contained in § 424.36(b)(6) is the time and effort associated with drafting, obtaining, and maintaining written statements from both employees of the ambulance provider or supplier transporting the beneficiary and employees of the facility receiving the beneficiary. We estimate that 9,000 ambulance providers or suppliers will comply with these requirements. We estimate that it will take no more than five minutes for each provider or supplier to comply with the recordkeeping requirements. Based on the best available data at this time, we estimate the total annual burden associated with the requirements in § 424.36(b)(6) to be 541,667 hours nationwide. The annual total number of burden hours was arrived at by multiplying five minutes by the total estimated number of emergency ambulance transports of 6,500,000. We note that the total number of burden hours may be overstated, because not every beneficiary who receives emergency ambulance transport services is unable to sign the claim. However, we also note that the 6.5 million figure for emergency transports is the estimated number of ALS1-emergency and BLS-emergency ambulance claims processed by Part B carriers, incurred in 2006 and processed through April of 2007, and thus does not include the number of emergency ambulance transport services billed to fiscal intermediaries by ambulance providers (which number is not available to us). In any event, we believe our proposal will benefit ambulance providers and suppliers by allowing them an alternative procedure for submitting claims to Medicare. In the absence of the proposed procedure for signing claims on behalf of beneficiaries for emergency ambulance transport services, ambulance suppliers and providers would be required to track down beneficiaries after the emergency transport services have been rendered, in an attempt to have the beneficiary sign the claim. Moreover, such attempts may prove fruitless, thereby preventing the ambulance suppliers and providers from submitting the claim to Medicare.

Additional Information Collection Requirements

This final rule with comment period imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule with comment period 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 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. As stated in section II.F.1.a of the preamble, the ASP reporting requirements are set forth in section 1927(b) of the Act.

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)

In section II.F.2.d of the preamble, we propose to revise the CAP physician election agreement. In conjunction with post-payment review process, we are revising the CAP physician election agreement to reflect the physician's obligation to provide medical records to assist with claims review. The CAP physician election agreement is currently approved under 0938–0955 with an expiration date of August 31, 2009. Under a separate notice, we will make the revised instrument available for public comment prior to submitting the revised information collection request to OMB for approval.

Section II.F.2.f of the preamble discusses details of the competitive acquisition program. Each year, physicians are given the option to elect to obtain Medicare Part B drugs and biologicals through the CAP. In addition, physicians are also given an opportunity to select an approved CAP vendor. The burden associated with these election requirements is the time and effort necessary for a physician to make an election and notify CMS. The burden associated with election requirements for participating in the CAP and selecting an approved CAP vendor is subject to the PRA. However, it is currently approved under OMB control numbers 0938–0955 and 0938–0987 with expiration dates of August 31, 2009 and April 30, 2009, respectively.

Section II.F.2.g. of the preamble also discusses the exigent circumstances exception for leaving the CAP outside of the annual election process. A physician may request a release from the CAP within the first 60 days of his or her participation if he or she can show that CAP participation imposes a burden on the practice, or later if he or she can show that a change in circumstances that was not known to the practice previously results in a burden to the practice. Specifically, the physician must submit a release request to the CAP-designated carrier.

While this burden is subject to the PRA, we believe it is exempt under 5 CFR 1320.3(h)(6). Facts or opinions collected from a single person or entity are not subject to the PRA. The aforementioned information collection request will be reviewed individually on a case by cases basis.

If the designated carrier receives an exigent circumstance removal request related to the approved CAP vendor's service, it is required to refer the physician to his or her approved CAP vendor within 1 business day of its receipt of the request. As part of the grievance process, the CAP vendor will try to work with the physician to address their concerns with respect to participation in the program. The designated carrier can alternatively continue to investigate, and within 2

business days of its receipt of the request, can request a single 2-business day extension (after which it must submit findings and a recommendation to CMS), submit findings and a recommendation to CMS that the physician be permitted to terminate his or her CAP participation, or submit findings and a recommendation to CMS that the physician not be permitted to terminate his or her CAP participation.

Requests from physicians will be reviewed by CAP vendors on an individual, case by case basis. We will continue to monitor the process. If we believe that we will receive 10 or more requests, we will submit an information collection request to OMB.

Physician Quality Reporting Initiative (PQRI)

Section II.U.1.a 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 eligible professionals to submit data pertaining to certain quality measures. As stated in section II.U.1.a, eligible professionals, for the purpose of the quality reporting system, include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, and qualified speech-language pathologists. As also stated in section II.U.1.a, this is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive a bonus incentive payment.

Specifically, to qualify to receive a bonus incentive payment for satisfactory reporting of quality data on covered professional services furnished in 2007, an eligible professional must submit data on 1, 2, or 3 measures selected from the 74 PQRI 2007 quality measures. The minimum number of measures each professional must report in order to qualify for the bonus payment is determined by how many available measures are applicable to the services that professional furnishes to Medicare beneficiaries. For a majority of the eligible professionals, the requirement, per 1848(k) of the Act, will be that they satisfactorily report on at least three measures. An eligible professional could meet the satisfactory reporting requirement, and thus be eligible for the bonus incentive payment, by reporting fewer than three measures only if his or her practice has fewer than three applicable measures. The quality measures are posted and available for download on the CMS Web site at *http://www.cms.hhs.gov/pqri.*

The burden associated with this requirement is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. In addition, they 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.

In 2007, the PQRI will collect quality-data codes exclusively as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. There will be no new forms and no modifications to the existing transaction or form in support of 2007 PQRI. CMS also does not anticipate changes to the 837–P or CMS Form 1500 for 2008.

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 2008. 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.

TABLE 37.—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Total annual burden (hours)
Preamble section II.F.1	0938–0921	120	480	17,760
Preamble section II.F.2.f	0938–0955	12	12	480
§ 410.33	0938–0685	400,000	400,000	1,000,000
§ 424.36	0938–New	9,000	6,500,000	541,667
Total				1,579,907

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: William N. Parham, III, CMS–1385–FC, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, [CMS–1385–P], *carolyn_lovett@omb.eop.gov.* Fax (202) 395 6974.

XIII. 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.

XIV. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which

merely reassigns responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any one year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). As indicated in more detail below in this regulatory impact analysis, we estimate that the PFS provisions included in this final rule with comment period rule will redistribute more than $100 million in 1 year. We are considering this final rule with comment period rule to be economically significant because its provisions are estimated to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this final rule with comment period is a major rule and we have prepared a regulatory impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include 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, 2003.) 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 furnish to Medicare beneficiaries are included in the list of CAP drugs, whether the physician chooses to obtain drugs administered to Medicare beneficiaries through the CAP. The CAP provisions in this final rule with comment period 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. Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status or by having revenues of $31.5 million or less in any year. We consider a substantial number of entities to be affected if the rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 915 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this final rule with comment period will have a 0.9 percent increase in overall payments to nonprofit ESRD facilities relative to current overall payments. The analysis and discussion provided in this section, as well as elsewhere in this final rule with comment period, complies with the RFA requirements.

For the e-prescribing provisions, physician practices and independent pharmacies are considered small entities.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule with comment period constitutes our regulatory flexibility analysis for the remaining provisions.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule with comment period that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule with comment period would have minimal impact on small hospitals located in rural areas. Of the 202 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 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $127 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments. Medicare beneficiaries are considered to be part of the private sector for this purpose. A discussion concerning the impact of this rule on beneficiaries is found later in this section.

We have examined this final rule with comment period in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we use to minimize the burden on small entities. As indicated elsewhere in this final rule with comment period, we are making a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this final rule with comment period. The relevant sections of this final rule with comment period contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work and PE RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN. 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 discussed in section IV.D.3 of the CY 2007 PFS final rule with comment period (71 FR 69735), we carefully reviewed the comments received concerning the BN adjustment needed to offset the $4 billion impact of changes in work RVUs resulting from the 5-Year Review. To meet the requirements set forth in section 1848(c)(2)(B)(ii)(II) of the Act, we implemented a BN adjustor of 0.8994 or 10.1 percent to be applied to the work RVUs.

Subsequent to the publication of the CY 2007 PFS final rule with comment period and the announcement of the 0.8994 BN adjustment to the work RVUs, the AMA RUC supplied work RVU recommendations on additional CPT codes from the 5-Year Review and recommendations for an increase in the work of anesthesia services. As stated in the CY 2007 PFS final rule with comment period, these additional codes are still considered part of the 5-Year Review. The impact of these additional recommendations and increases in the work of anesthesia services on the BN adjustment must be accounted for by revising the current work adjustor of 0.8994. The work adjustor for CY 2008, based upon the final work RVUs for these additional CPT codes and increases in the work of anesthesia services, is approximately 0.8806. Table 38 shows the specialty-level impact of the work and PE RVU changes.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2007 with payment rates for CY 2008 using CY 2006 Medicare utilization for all years. To the extent that there are year to year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 38. 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 38 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 38.

- 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 furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Work RVU Changes for additional changes in work RVUs from the 5-Year Review.
- Impact of PE RVU changes. The impact is shown for both 2008 which is the second year of the 4-year transition using the new methodology and the fully implemented 2010 PE RVUs.
- Combined impact of the finalized work RVUs and PE RVUs for both 2008 and the fully implemented 2010 PE RVUs.

TABLE 38.—COMBINED TOTAL ALLOWED CHARGE IMPACT FOR WORK AND PRACTICE EXPENSE RVU CHANGES

Specialty	Allowed charges (mil)	Impact of work RVU changes (percent)	Impact of PE RVU changes (percent)		Combined impact of PE and work changes*	
			2008 (PE trans. year 2) (percent)	2010 (PE full implement.) (percent)	2008 (PE trans. year 2) (percent)	2010 (PE full implement.) (percent)
TOTAL	$76,551	0	0	0	0	0
ALLERGY/IMMUNOLOGY	173	1	1	3	2	4
ANESTHESIOLOGY	1,579	15	−1	−3	14	12
CARDIAC SURGERY	396	−1	−1	−2	−2	−3
CARDIOLOGY	7,519	−1	−1	−3	−2	−4
COLON AND RECTAL SURGERY	122	−1	1	2	0	2
CRITICAL CARE	199	−1	0	0	−1	−2
DERMATOLOGY	2,248	−1	2	7	2	7
EMERGENCY MEDICINE	2,203	−2	0	−1	−2	−2
ENDOCRINOLOGY	350	−1	0	0	−1	−1
FAMILY PRACTICE	5,060	0	0	1	0	1
GASTROENTEROLOGY	1,750	−1	1	4	0	3
GENERAL PRACTICE	974	0	0	0	0	0
GENERAL SURGERY	2,309	−1	0	0	−1	0
GERIATRICS	147	3	0	1	3	4
HAND SURGERY	80	−1	−1	−3	−2	−4
HEMATOLOGY/ONCOLOGY	1,917	−1	0	0	−1	−1
INFECTIOUS DISEASE	504	−1	0	1	−1	0
INTERNAL MEDICINE	9,981	1	0	0	0	0
INTERVENTIONAL RADIOLOGY	244	−1	−1	−3	−2	−4
NEPHROLOGY	1,664	−1	−1	−4	−3	−5
NEUROLOGY	1,398	−1	0	−1	−1	−2
NEUROSURGERY	576	−1	−1	−2	−2	−3
NUCLEAR MEDICINE	78	−1	5	14	4	14

TABLE 38.—COMBINED TOTAL ALLOWED CHARGE IMPACT FOR WORK AND PRACTICE EXPENSE RVU CHANGES—Continued

Specialty	Allowed charges (mil)	Impact of work RVU changes (percent)	Impact of PE RVU changes (percent)		Combined impact of PE and work changes*	
			2008 (PE trans. year 2) (percent)	2010 (PE full implement.) (percent)	2008 (PE trans. year 2) (percent)	2010 (PE full implement.) (percent)
OBSTETRICS/GYNECOLOGY	628	−1	0	−1	−1	−1
OPHTHALMOLOGY	4,664	2	−1	−3	1	−1
ORTHOPEDIC SURGERY	3,248	−1	0	−1	−1	−2
OTOLARNGOLOGY	913	2	−1	−3	1	−1
PATHOLOGY	948	−1	−1	−3	−2	−4
PEDIATRICS	74	0	0	0	0	0
PHYSICAL MEDICINE	784	1	−1	−2	−1	−2
PLASTIC SURGERY	272	−1	0	1	−1	0
PSYCHIATRY	1,099	−1	1	2	0	1
PULMONARY DISEASE	1,691	−1	0	1	−1	0
RADIATION ONCOLOGY	1,612	−1	1	2	0	1
RADIOLOGY	5,245	−1	1	2	0	1
RHEUMATOLOGY	494	−1	0	−1	−1	−2
THORACIC SURGERY	436	−1	−1	−2	−2	−3
UROLOGY	2,033	−1	0	0	−1	−1
VASCULAR SURGERY	641	−1	0	0	−1	−1
AUDIOLOGIST	31	26	−14	−43	12	−17
CHIROPRACTOR	725	−1	−1	−2	−2	−3
CLINICAL PSYCHOLOGIST	531	−1	−2	−6	−3	−7
CLINICAL SOCIAL WORKER	354	−1	−2	−5	−3	−6
NURSE ANESTHETIST	608	22	0	0	22	21
NURSE PRACTITIONER	796	2	0	1	2	3
OPTOMETRY	790	4	0	−1	4	3
ORAL/MAXILLOFACIAL SURGERY	37	−1	1	3	1	3
PHYSICAL/OCCUPATIONAL THERAPY	1,391	−1	1	4	1	4
PHYSICIAN ASSISTANT	600	0	0	1	0	0
PODIATRY	1,575	0	2	5	2	5
DIAGNOSTIC TESTING FACILITY	1,191	0	0	1	0	1
INDEPENDENT LABORATORY	1,087	0	3	10	3	10
PORTABLE X-RAY SUPPLIER	81	0	2	7	2	7

* Components may not sum to total due to rounding.

2. Adjustments for Payments for Imaging Services

Section 1848(c)(2)(B)(iv)(II) of the Act as added by section 5102 of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) exempts the estimated savings from the application of the OPPS based payment limitation on PFS imaging services from the PFS BN requirement. We estimate that the combined impact of the current BN exemptions instituted by such section, the addition of 6 codes to the list of services subject to the DRA OPPS cap (discussed in section II.E.1.), and the payment revisions to OPPS cap amounts would result in no measurable changes in the specialty specific impacts of the DRA provisions with the exception of vascular surgery in CY 2008.

3. Combined Impact

Table 39 shows the specialty-level impact of the work and PE RVU changes, section 5102 of the DRA (including the additional 6 services that were added to the list of services subject to the DRA OPPS cap and the revision to OPPS payment amounts), and our most recent estimate (−10.1 percent) of the CY 2008 Medicare PFS update. Additionally, the impacts in this final rule with comment period rule reflect the use of updated physician time data from the AMA–RUC.

As indicated in Table 39, our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2007 with payment rates for CY 2008 using CY 2006 Medicare utilization crosswalked to 2008 services. To the extent that there are year-to-year changes in the volume and mix of services furnished by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 39. 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 furnishes.

Table 39 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 39.

- 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 furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of the CY 2008 Work and PE RVU changes using the methodology finalized in the CY 2007 PFS final rule with comment period and the revised data sources discussed in this final rule with comment period.
- Impact of section 5102 of the DRA: The CY 2008 percentage decrease in allowed charges attributed to section 5102 of the DRA with the addition of six codes to the OPPS cap list and revisions to the OPPS payment amounts.

• Combined impact of the finalized work and PE RVUs, section 5102 of the DRA and the addition of six codes to the OPPS cap list, and the revisions to OPPS payment amounts.

• CY 2008 Update: The percentage decrease in allowed charges attributed to the estimated CY 2008 PFS conversion factor update of −10.1 percent.

• Combined impact with CY 2008 update: The CY 2008 percentage decrease in allowed charges attributed to the impact of the work and PE RVU changes, section 5102 of the DRA (plus six additions to OPPS cap list), revisions to OPPS payment amounts, and the CY 2008 update.

TABLE 39.—COMBINED CY 2008 TOTAL ALLOWED CHARGE IMPACT FOR THE REMAINING 5-YEAR REVIEW OF WORK RVUS AND PRACTICE EXPENSE CHANGES, OPPS IMAGING CAP, AND THE CY 2008 UPDATE

Specialty	Allowed charges (mil)	Impact of work and PE RVU changes * (percent)	Impact of DRA 5102 (percent)	Combined impact RVU and DRA 5102 ** (percent)	CY 2008 update (percent)	Combined impact with CY 2008 update ** (percent)
TOTAL	$76,551	0	0	0	−10	−10
ALLERGY/IMMUNOLOGY	173	2	0	2	−10	−8
ANESTHESIOLOGY	1,579	14	0	14	−10	4
CARDIAC SURGERY	396	−2	0	−2	−10	−12
CARDIOLOGY	7,519	−2	0	−2	−10	−12
COLON AND RECTAL SURGERY	122	0	0	0	−10	−10
CRITICAL CARE	199	−1	0	−1	−10	−11
DERMATOLOGY	2,248	2	0	2	−10	−8
EMERGENCY MEDICINE	2,203	−2	0	−2	−10	−12
ENDOCRINOLOGY	350	−1	0	−1	−10	−11
FAMILY PRACTICE	5,060	0	0	0	−10	−10
GASTROENTEROLOGY	1,750	0	0	0	−10	−10
GENERAL PRACTICE	974	0	0	0	−10	−10
GENERAL SURGERY	2,309	−1	0	−1	−10	−11
GERIATRICS	147	3	0	3	−10	−7
HAND SURGERY	80	−2	0	−2	−10	−12
HEMATOLOGY/ONCOLOGY	1,917	−1	0	−1	−10	−11
INFECTIOUS DISEASE	504	−1	0	−1	−10	−11
INTERNAL MEDICINE	9,981	0	0	0	−10	−10
INTERVENTIONAL RADIOLOGY	244	−2	0	−2	−10	−12
NEPHROLOGY	1,664	−3	0	−3	−10	−13
NEUROLOGY	1,398	−1	0	−1	−10	−11
NEUROSURGERY	576	−2	0	−2	−10	−12
NUCLEAR MEDICINE	78	4	0	5	−10	−5
OBSTETRICS/GYNECOLOGY	628	−1	0	−1	−10	−11
OPHTHALMOLOGY	4,664	1	0	1	−10	−9
ORTHOPEDIC SURGERY	3,248	−1	0	−1	−10	−11
OTOLARNGOLOGY	913	1	0	1	−10	−9
PATHOLOGY	948	−2	0	−2	−10	−12
PEDIATRICS	74	0	0	0	−10	−10
PHYSICAL MEDICINE	784	−1	0	−1	−10	−11
PLASTIC SURGERY	272	−1	0	−1	−10	−11
PSYCHIATRY	1,099	0	0	0	−10	−10
PULMONARY DISEASE	1,691	−1	0	−1	−10	−11
RADIATION ONCOLOGY	1,612	0	0	0	−10	−10
RADIOLOGY	5,245	0	0	0	−10	−10
RHEUMATOLOGY	494	−1	0	−1	−10	−11
THORACIC SURGERY	436	−2	0	−2	−10	−12
UROLOGY	2,033	−1	0	−1	−10	−11
VASCULAR SURGERY	641	−1	−1	−1	−10	−11
AUDIOLOGIST	31	12	0	12	−10	2
CHIROPRACTOR	725	−2	0	−2	−10	−12
CLINICAL PSYCHOLOGIST	531	−3	0	−3	−10	−13
CLINICAL SOCIAL WORKER	354	−3	0	−3	−10	−13
NURSE ANESTHETIST	608	22	0	22	−10	12
NURSE PRACTITIONER	796	2	0	2	−10	−8
OPTOMETRY	790	4	0	4	−10	−6
ORAL/MAXILLOFACIAL SURGERY	37	1	0	1	−10	−9
PHYSICAL/OCCUPATIONAL THERAPY	1,391	1	0	1	−10	−9
PHYSICIAN ASSISTANT	600	0	0	0	−10	−10
PODIATRY	1,575	2	0	2	−10	−8
DIAGNOSTIC TESTING FACILITY	1,191	0	0	0	−10	−10
INDEPENDENT LABORATORY	1,087	3	0	3	−10	−7
PORTABLE X-RAY SUPPLIER	81	2	0	2	−10	−8

* PE changes are CY 2008 second year transition changes. For fully implemented CY 2010 PE changes see Table 1.
** Components may not sum to total due to rounding.

Table 40 shows the estimated impact on total payments for selected high volume procedures of all of the changes discussed previously. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE refer to Addendum A of this final rule with comment period rule.

TABLE 40.—IMPACT OF FINAL RULE WITH COMMENT PERIOD AND ESTIMATED PHYSICIAN UPDATE ON 2008 PAYMENT FOR SELECTED PROCEDURES

CPT/HCPCS	MOD	Description	Facility			Non-facility		
			2007	2008	Percent change	2007	2008	Percent change
11721		Debride nail, 6 or more	$28.80	$24.53	−15	$39.03	$35.43	−9
17000		Destruct premalg lesion	44.72	41.56	−7	63.29	60.30	−5
27130		Total hip arthroplasty	1,360.52	1,194.77	−12	na	na	na
27244		Treat thigh fracture	1,100.92	963.11	−13	na	na	na
27447		Total knee arthroplasty	1,464.74	1,283.35	−12	na	na	na
33533		CABG, arterial, single	1,908.52	1,658.44	−13	na	na	na
35301		Rechanneling of artery	1,071.74	934.49	−13	na	na	na
43239		Upper GI endoscopy, biopsy	155.00	140.36	−9	325.16	294.01	−10
66821		After cataract laser surgery	253.53	222.81	−12	270.97	237.80	−12
66984		Cataract surg w/iol, 1 stage	641.98	560.08	−13	na	na	na
67210		Treatment of retinal lesion	556.34	487.86	−12	580.59	507.96	−13
71010		Chest x-ray	na	na	na	26.15	22.83	−13
71010	26	Chest x-ray	8.72	7.84	−10	8.72	7.84	−10
77056		Mammogram, both breasts	na	na	na	97.40	93.35	−4
77056	26	Mammogram, both breasts	41.31	37.48	−9	41.31	37.48	−9
77057		Mammogram, screening	na	na	na	81.86	73.93	−10
77057	26	Mammogram, screening	33.35	30.32	−9	33.35	30.32	−9
77427		Radiation tx management, x5	176.22	158.42	−10	176.22	158.42	−10
78465	26	Heart image (3d), multiple	73.14	66.43	−9	73.14	66.43	−9
88305	26	Tissue exam by pathologist	37.90	32.36	−15	37.90	32.36	−15
90801		Psy dx interview	129.99	112.08	−14	145.15	131.50	−9
90862		Medication management	44.72	39.18	−12	50.40	46.67	−7
90935		Hemodialysis, one evaluation	67.46	58.26	−14	na	na	na
92012		Eye exam established pat	34.11	38.50	13	61.77	62.69	1
92014		Eye exam & treatment	55.71	59.28	6	91.33	90.96	0
92980		Insert intracoronary stent	795.85	720.88	−9	na	na	na
93000		Electrocardiogram, complete	24.63	20.78	−16	24.63	20.78	−16
93010		Electrocardiogram report	8.34	7.50	−10	8.34	7.50	−10
93015		Cardiovascular stress test	104.22	93.01	−11	104.22	93.01	−11
93307	26	Echo exam of heart	46.99	42.24	−10	46.99	42.24	−10
93510	26	Left heart catheterization	242.92	215.31	−11	242.92	215.31	−11
98941		Chiropractic manipulation	28.80	25.55	−11	33.35	29.64	−11
99203		Office/outpatient visit, new	67.08	58.60	−13	91.71	81.42	−11
99213		Office/outpatient visit, est	42.07	37.48	−11	59.50	53.15	−11
99214		Office/outpatient visit, est	66.32	58.60	−12	90.20	80.40	−11
99222		Initial hospital care	119.00	104.59	−12	na	na	na
99223		Initial hospital care	173.57	153.65	−11	na	na	na
99231		Subsequent hospital care	35.62	31.68	−11	na	na	na
99232		Subsequent hospital care	63.67	56.55	−11	na	na	na
99233		Subsequent hospital care	90.95	81.08	−11	na	na	na
99236		Observ/hosp same date	205.40	179.20	−13	na	na	na
99239		Hospital discharge day	94.74	83.13	−12	na	na	na
99243		Office consultation	93.23	83.13	−11	122.41	109.36	−11
99244		Office consultation	145.91	130.14	−11	179.26	160.12	−11
99253		Inpatient consultation	108.77	97.09	−11	na	na	na
99254		Inpatient consultation	156.52	140.02	−11	na	na	na
99283		Emergency dept visit	60.64	52.81	−13	na	na	na
99284		Emergency dept visit	110.28	97.44	−12	na	na	na
99291		Critical care, first hour	208.82	182.61	−13	256.19	224.17	−12
99292		Critical care, addtl 30 min	104.60	91.64	−12	114.45	100.16	−12
99348		Home visit, est patient	na	na	na	66.32	68.14	2
99350		Home visit, est patient	na	na	na	150.83	139.34	−8
G0008		Admin influenza virus vac	na	na	na	18.95	18.40	−3
G0317		ESRD related svs 4+mo 20+yrs	283.09	245.29	−13	283.09	245.29	−13

B. Geographic Practice Cost Index Changes

Section 1848(e)(1)(A) of the Act requires that payments under the Medicare physician fee schedule vary among payment areas only to the extent that area costs vary as reflected by the area GPCIs. The GPCIs measure area cost differences in the three components of the physician fee schedule: Physician work, PEs (employee wages, rent, medical supplies, and equipment), and malpractice insurance. Section 1848(e)(1)(C) of the Act requires that the GPCIs be reviewed and, if necessary, revised at least every 3 years. The first GPCI revision occurred in 1993. The second revision was implemented in 1998, the next in 2001, and the last in 2005. We are implementing the next GPCI update in this rule and the 2008 updated, budget neutralized values are shown in Addendum E. These values reflect the removal of the 1.000 floor on physician work as mandated by the MIEA-TRHCA law of December 2006. As required by law, the GPCIs are phased in over a two year period; therefore the 2008 GPCI values are calculated as one-half the difference between the fully implemented 2007 GPCIs and the fully implemented 2009 (updated) GPCIs.

An estimate of the overall effects of GPCI changes on fee schedule area payments can be demonstrated by a comparison of area geographic adjustment factors (GAFs). The GAFs are a weighted composite of each area's work, PE, and malpractice expense GPCIs using the national GPCI cost share weights. While we do not actually use the GAFs in computing the fee schedule payment for a specific service, they are useful in comparing overall area costs and payments. The actual effect on payment for any actual service will deviate from the GAF to the extent that the services proportions of work, PE, and malpractice expense RVUs differ from those of the GAF. The GAFs reflect the removal of the 1.000 floor on physician work as mandated by the MIEA-TRHCA law of December 2006.

The most significant positive changes occur in seven payment localities where the GAF moves up between 5.91 percent (Rest of Maine) and 2.05 percent (Ventura, Calif.). Nineteen payment localities show an increase in GAF of between 1.99 percent (Rest of Texas) to 1.05 percent (New Hampshire). Twenty-two payment localities have increases of less than 1 percent.

The Detroit, Michigan payment locality shows a drop in the GAF value of 4.32 percent, the largest, and eight other payment localities (including Santa Clara, California, Atlanta, Georgia, Fort Worth, Texas, and Chicago, Illinois) decrease between 3.8 percent and 2.16 percent in the GAF value. Fourteen payment localities show decreases between 1.10 percent (Rest of Michigan) and 1.92 percent (Miami, Florida). Twenty-two payment localities show decreases between 0.01 percent (Anaheim, California) and 0.90 percent (Seattle, Washington).

Increases or decreases in GPCI values do not necessarily reflect increases or decreases in the actual costs associated with a specific locality, but rather reflect the relative costs compared to a national average. As an example, when rents go up in Wisconsin or Ohio, the index for California or New York goes down, even if actual costs for California or New York stay the same or even increase. Other factors also play a part in the overall GPCI picture. We do not have sufficient data to undertake a sensitivity analysis of exact elements of the change but we can make some generalized assumptions. For example, the changes in GAF values for several areas of California reflect significant changes in the malpractice GPCIs; and, a lowering of the PE GPCI in many urban settings is offset by increases in the PE GPCI of more rural settings.

The 2008 GPCIs are budget neutralized so the update does not result in an increase in spending as a result of the changes.

C. Telehealth

In section II.D of this rule, we are adding neurobehavioral status exam as represented by HCPCS code 96116 to the list of telehealth services. To date, Medicare expenditures for telehealth services have been extremely low. For instance, in CY 2006, the *total* Medicare payment amount for telehealth services (including the originating site facility fee) was approximately $2 million. Moreover, previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures. For example, the psychiatric diagnostic interview examination (as described by CPT code 90801) was added to the list of Medicare telehealth services in CY 2003. The addition of CPT code 90801 resulted in an increase in Medicare payment amounts of approximately $100,000 in CY 2006.

The neurobehavioral status exam (CPT code 96116) includes an initial assessment and evaluation of the mental status for a psychiatric patient. In this regard, the neurobehavioral status exam is similar to the psychiatric diagnostic interview examination (CPT code 90801). However, the utilization rate of psychiatric diagnostic interview examination is much greater than the neurobehavioral status exam. For instance, in CY 2006, the total allowed services for CPT code 90801 was approximately 1.3 million while total allowed services for neurobehavioral status exam in CY 2006 was approximately 105,000. Because utilization of neurobehavioral status exam is substantially less than the psychiatric diagnostic interview examination, we believe the budgetary impact of adding neurobehavioral status exam to the list of Medicare telehealth services will be even less than the previously added psychiatric diagnostic interview examination.

While we believe that addition of this service to the telehealth service list will enable more beneficiaries to access to these services, we do not anticipate that this change will have a significant budgetary impact on the Medicare program.

D. Payment for Covered Outpatient Drugs and Biologicals

1. ASP Issues

The issues discussed in section II.F.1. with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures. However, we believe the policies we are adopting will assist in clarifying existing policy with respect to ASP payment.

2. CAP issues

This final rule describes a significant change in how CAP drug claims are paid due to the implementation of section 108(a)(2) of the MIEA–TRHCA. This rule also addresses comments and finalizes regulations on certain approaches to refining the CAP that seek to improve service by improving compliance, increasing flexibility, and increasing choices available to participating CAP physicians. The finalized CAP provisions will also have a potential impact on entities that are involved in the dispensing or distribution of drugs, that plan to become approved CAP vendors, or are approved CAP vendors. Changes associated with section 108(a)(2) of the MIEA–TRHCA, especially the provision for payment to vendors upon receipt of a claim, will almost certainly be perceived as a positive step. Other finalized changes seek to improve service by improving compliance and increasing flexibility under the CAP. At this time, we anticipate that these changes will result in no significant additional cost savings or increases

associated with the CAP, relative to the ASP payment system.

E. Clinical Laboratory Fee Schedule Issues

As discussed in section II.G of this final rule, we are adopting § 414.509 for establishing payment for a new clinical diagnostic laboratory paid under the Medicare Part B clinical laboratory fee schedule. Also, we are clarifying dates in § 414.502 and § 414.508. These changes will not increase or decrease payments for current clinical diagnostic laboratory tests. For newly developed tests, we will permit an opportunity for the public to request a reconsideration of a payment amount. Because any new laboratory tests to undergo a reconsideration request of a payment amount are unknown to us at the current time, we do not have any data to estimate the impact. However, we anticipate that the reconsideration process will apply to fewer than five new tests per year so that no significant additional costs to the clinical laboratory payment system will occur.

F. Provisions Related to Payment for Renal Dialysis Services Furnished by End State Renal Disease (ESRD) Facilities

The ESRD-related provisions in this final rule are discussed in section II.H. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2007 payments) to estimated payments under the revisions to the composite rate payment system as discussed in II.H. of this final rule with comment period (2008 payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and projected payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2007 payments and projected 2008 payments.

ESRD providers were grouped into the categories based on characteristics furnished in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2007 update of CY 2006 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Due to data limitations, we are unable to estimate current 2007 payments and projected 2008 payments for 153 of the 4,813 ESRD facilities that billed for ESRD dialysis treatments in CY 2006.

Table 41 shows the impact of this year's changes to CY 2008 payments to hospital-based and independent ESRD facilities. The first column of Table 41 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 change to the wage index floor as it affects the composite rate payments to ESRD facilities for CY 2008. The fourth column compares aggregate ESRD wage adjusted composite rate payments in the third year of the transition (CY 2008) using the CY 2008 wage index with a 0.80 floor compared to aggregate ESRD wage adjusted composite rate payments in the third year of the transition (CY 2008) using the CY 2008 wage index with a 0.75 floor. Note that the fourth column only includes the effect of the change to the wage index floor and does not include the effects of other wage index changes, such as, moving from the second to third year of the transition and updated wage index values from CY 2007 to CY 2008.

The fifth column shows the effect of all changes to the ESRD wage index for CY 2008 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 third year of the transition (CY 2008) to aggregate ESRD wage adjusted composite rate payments in the second year of the transition (CY 2007). In the third year of the transition (CY 2008), ESRD facilities receive 75 percent of the CBSA wage adjusted composite rate and 25 percent of the MSA wage adjusted composite rate. In the second year of the transition, ESRD facilities receive 50 percent of the CBSA wage adjusted composite rate and 50 percent of the MSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2008 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 decreases shown among census regions is primarily due to reducing the wage index floor, as there were areas in these areas with wage index values below the reduced floor.

The sixth column shows the overall effect of the changes in composite rate payments to ESRD providers. The overall effect is measured as the difference between the projected CY 2008 payment with all changes in this final rule and CY 2007 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 2006 claims. The projected CY 2008 payment is the transition year 3 wage-adjusted composite rate for each provider (with the 15.5 percent drug add-on) times dialysis treatments from CY 2006 claims. The CY 2007 current payment is the transition year 2 wage-adjusted composite rate for each provider (with the current 14.9 percent drug add-on) times dialysis treatments from CY 2006 claims.

The overall impact to ESRD providers in aggregate is 0.5 percent. This increase corresponds to the 0.5 percent increase 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 0.5 percent increase to the drug add-on.

TABLE 41.—IMPACT OF CY 2008 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	4,660	35.5	0.0	0.0	0.5
Independent	4,101	31.8	0.0	−0.1	0.5
Hospital Based	559	3.7	0.0	0.5	1.0
By Facility Size					
Less than 5000 treatments	1,650	4.7	−0.1	−0.3	0.3

TABLE 41.—IMPACT OF CY 2008 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]
5000 to 9999 treatments	1,800	13.0	0.0	0.0	0.5
Greater than 9999 treatments	1,210	17.7	0.0	0.1	0.6
Type of Ownership					
Profit	3,745	28.9	0.0	−0.1	0.4
Nonprofit	915	6.5	0.0	0.3	0.9
By Geographic Location					
Rural	1,261	7.3	−0.4	−0.6	0.0
Urban	3,399	28.1	0.1	0.1	0.7
By Region					
New England	141	1.1	0.1	1.4	2.0
Middle Atlantic	553	4.5	0.1	0.5	1.0
East North Central	727	5.7	0.1	−0.6	−0.1
West North Central	358	1.9	0.1	−0.3	0.3
South Atlantic	1,063	8.1	0.0	0.0	0.6
East South Central	365	2.6	−0.5	−1.4	−0.8
West South Central	646	5.0	−0.1	−0.7	−0.2
Mountain	254	1.6	0.1	0.3	0.8
Pacific	523	4.4	0.1	1.4	2.0
Puerto Rico	30	0.4	−2.1	−3.0	−2.5

[1] This column shows the effect of the wage index floor changes on ESRD providers. Composite rate payments computed using the CY 2008 wage index with a 0.80 floor are compared to composite rate payments using the CY 2008 wage index with a 0.75 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 CY 2008 wage index changes.

[3] This column shows the percent change between CY 2008 and CY 2007 composite rate payments to ESRD facilities. The CY 2008 payments include the CY 2008 wage adjusted composite rate, and the 15.5% drug add-on times treatments The CY 2007 payments to ESRD facilities includes the CY 2007 wage adjusted composite rate and the 14.9% drug add-on times treatments.

G. IDTF Changes

We believe that our provisions regarding IDTFs as discussed in section II.I. of this final rule with comment period would have no budgetary impact. However, we believe that these changes are necessary to ensure that only legitimate IDTFs are enrolled into the program. In addition, we believe that the IDTF provisions contained in this final rule will help ensure that beneficiaries receive quality care. Therefore, we expect to have an impact on an unknown number of persons and entities who will be denied enrollment into the Medicare program.

H. CORF Issues

The revisions to the CORF regulations discussed in section II.K. update the regulations for consistency with the PFS payment rules. These revisions will help to clarify payment for CORF services and are expected to have minimal impact on Medicare expenditures.

I. Compendia for Determination of Medically-Accepted Indications for Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen.

We anticipate that the changes related to the compendia discussed in section II.L. of this final rule with comment period will have a negligible cost to the Medicare program. The changes will enable CMS to respond quickly should changes in the number and quality of the compendia indicate a need to amend the list.

J. Physician Self-Referral Provisions

We anticipate that our provisions in section II.M. of this final rule with comment period for the reassignment and anti-markup provisions, and the physician self-referral provisions will result in savings to the program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any certainty the extent of these savings to the Medicare program.

K. Beneficiary Signature for Ambulance Transport Services

We believe that our provision in section II.N. of this final rule with comment period for allowing the ambulance provider or supplier to sign the claim on behalf of the beneficiary with respect to emergency transport services, provided that certain conditions are satisfied, will have no budget impact.

L. Update to Fee Schedules for Class III DME for CYs 2007 and 2008

In section II.O. of this final rule with comment period, we discuss the update to the fee schedules for class III DME for CYs 2007 and 2008. Total allowed charges for class III devices in 2005 were $71 million. Accordingly, with a zero percent increase for DME, other than class III devices, for 2005 and 2006 and with the establishment of an update for 2007 of zero percent for class III devices, rather than 4.3 percent based on the CPI–U, this results in a savings to the Medicare program of approximately $2 million in FY 2007, $4 million in FY 2008, $4 million in FY 2009, $5 million in FY 2010, $5 million in FY 2011, and $5 million in FY 2012.

M. Therapy Services

In section II.R.2., we are changing the certification requirement for the plan of care, for outpatient physical therapy, occupational therapy and speech-language pathology services from every 30 days to an appropriate length, based on the patient's needs, limited to 90 days. As we stated in the proposed rule, analysis of Medicare claims data shows negative or no impact for this change and this was also supported by commenters. In most cases, the appropriate length of treatment will be

less than 30 days. Certification of the appropriate length of treatment will discourage the practice of billing for re-evaluations prior to recertification regardless of need.

The 30-day recertification allows treatment under a plan of care for 30 days after initial certification, regardless of the appropriate length of treatment. The initial certification cannot assure that a physician reviews the plan or follows the patient's progress.

We will review the utilization of therapy services after a 2-year trial to assess any changes that might be related to certification of a plan of care for an appropriate length of treatment. At that time, if we determine that this change has caused an increase in inappropriate utilization, we will reconsider the 30-day certification requirement.

N. TRHCA 101(b) Physician Quality Reporting Initiative

As discussed section II.S.1. of this rule, the final 2008 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, 2007, measures that the Secretary proposes as appropriate for eligible professionals to use to submit data to the Secretary in 2008. We also expect to address registry- and EHR-based data submission on a test basis in 2008, as discussed in section II.T.1. of this rule. Although there may be some cost incurred for maintaining the measures and their associated code sets, and for enhancing an existing clinical data warehouse to accommodate the registry- and EHR-based data submission, we do not anticipate a significant cost impact on the Medicare program.

O. TRHCA 101(d) Physician Assistance and Quality Initiative Fund

As discussed in section II.S.5. of this final rule with comment period, section 101(d) of the MIEA–TRHCA created the Physician Assistance and Quality Initiative Fund (PAQI) which provides $1.35 billion for physician payment and quality improvement initiatives. The legislation directs the Secretary to provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire $1.35 billion for payment for physicians' services furnished during 2008. As discussed in section II.S.5. of this final rule with comment period, we will scale aggregate payments to physicians in a manner such that Medicare would pay $1.35 billion during CY 2009 for measures reported for services furnished during CY 2008. We are unable to provide an exact percentage for the bonus payment, but we anticipate that the bonus payments will be approximately 1.5 percent of allowed charges for participating professionals (and we do not expect that the ultimate percentage amount would exceed 2 percent). We also note that the Transitional Medical Assistance, Abstinence Education, and Qualifying Individual Programs Extension Act of 2007 (Pub. L. 110–90) provided an additional $325 million to be used as a part of the PAQI Fund for payment with regard to services furnished in 2009 and $60,000,000 for payment with respect to physicians' services furnished on or after January 1, 2013.

P. TRHCA 110 Reporting of Anemia Quality Indicators

As discussed in section II.S.2. of this final rule with comment period, there are no program cost savings or increased expenditures associated with this change; however, we expect that the regulation will have a positive impact on patient care.

Q. Amendment of the Exemption From NCPDP SCRIPT Standard for Computer-Generated Facsimile Transmissions Under Medicare Part D

The amendment of the exemption for computer-generated fax transactions under Medicare Part D is discussed in section II.R.3. of this rule. E-prescribing is voluntary for providers and pharmacies. This amendment only affects providers and pharmacies that already conduct e-prescribing using products that generate faxes rather than SCRIPT transactions.

We believe that providers and pharmacies that are now e-prescribing using products that generate faxes generally already possess the hardware necessary to e-prescribe. Many would need to obtain software upgrades to send and receive the SCRIPT transaction. This software will generally be available to providers through automatic version upgrades built into annual software vendor maintenance fees. However, providers currently using software that cannot be upgraded to generate SCRIPT transactions would need to purchase and install new e-prescribing software or revert to sending paper fax transactions to pharmacies.

Dispensers that currently e-prescribe but have not established the connectivity necessary to receive and send SCRIPT transactions would need to connect to a network, and may need to install software upgrades, which will generally be covered under annual fees. Because pharmacies customarily bear the cost of transaction fees for the SCRIPT transactions they receive and send, these costs would increase as the rate of e-prescribing increases.

The amendment of this exemption will have indirect benefits in that it will help to encourage e-prescribing using electronic data interchange, which will ultimately result in improved patient safety. We also will continue to allow computer-generated faxes as a fallback in cases of temporary/transient transmission failures and communications problems.

Because of the voluntary nature of e-prescribing for physicians and pharmacies, the relatively small number of entities currently e-prescribing, and the minimal nature of the anticipated costs, we believe this provision does not constitute a major rule for purposes of this analysis.

R. Revisions to Payment Policies Under the Ambulance Fee Schedule and the Ambulance Inflation Factor Update for CY 2008

For the purposes of the RFA, ambulance providers and suppliers are considered to be small entities. Removing the requirement that the AIF be published annually via **Federal Register** notice has no monetary impact on small entities or small businesses. It merely allows for the earlier dissemination of necessary information to the ambulance industry, the Medicare contractors, and the general public.

We estimate that the total program expenditure for CY 2007 for ambulance services covered by the Medicare program is approximately $5.2 billion. Application of an AIF of 2.7 percent will result in an additional total program expenditure for CY 2008 of approximately $140 million over CY 2007 expenditures.

S. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, 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 final rule with comment period that would have an effect on beneficiaries. In general, we believe these changes, particularly the implementation of the PQRI with its continuing focus on measuring, submitting, and analyzing quality data, will have a positive impact and improve

the quality and value of care furnished to Medicare beneficiaries.

We do not believe that beneficiaries will experience drug access issues as a result of the changes with respect to Part B drugs and CAP.

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 calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2008, total cost sharing (coinsurance and deductible) per Part B enrollee associated with physician fee schedule services is estimated to be $590. In addition, the portion of the 2008 standard monthly Part B premium attributable to PFS services is estimated to be $38.60.

To illustrate this point, as shown in Table 40, the 2007 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is $91.71 which means that currently a beneficiary is responsible for 20 percent of this amount, or $18.34. Based on this final rule with comment period, the 2008 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 40, is $81.42 which means that, in 2008, the beneficiary coinsurance for this service would be $16.28.

Policies discussed in this rule that do affect overall spending, such as the additions to the list of codes that are subject to section 5102 of the DRA imaging provisions, 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 42, we have prepared an accounting statement showing the classification of the expenditures associated with this final rule with comment period. This estimate includes the incurred benefit impact associated with the estimated CY 2008 PFS update, shown in this final rule with comment period, based on the 2007 Trustees Report baseline. All estimated impacts are classified as transfers.

TABLE 42.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR CY 2008

[In billions]

Category	Transfers
Annualized Monetized Transfers.	−$6.0.
From Whom To Whom?	Federal Government to physicians, other practitioners and suppliers who receive payment under the Medicare Physician Fee Schedule; ESRD Medicare Providers; ambulance suppliers, DME suppliers, and Medicare suppliers billing for Part B drugs.

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

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 414

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

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Health Professionals, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant programs—health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS

■ 1. The authority citation for part 409 continues to read as follows:

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

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

■ 2. Section 409.17 is added to read as follows:

§ 409.17 Physical therapy, occupational therapy, and speech-language pathology services.

(a) *General rules.* (1) Except as specified in paragraph (a)(1)(ii) of 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 part 484 of this chapter.

(2) Physical therapy, occupational therapy or speech-language pathology services must be furnished under a plan that meets the requirements of paragraphs (b) through (d) of this section, or plan requirements specific to the payment policy under which the services are rendered, if applicable.

(b) *Establishment of the plan.* The plan must be established before treatment begins by one of the following:

(1) A physician.

(2) A nurse practitioner, a clinical nurse specialist or a physician assistant.

(3) The physical therapist furnishing the physical therapy services.

(4) A speech-language pathologist furnishing the speech-language pathology services.

(5) An occupational therapist furnishing the occupational therapy services.

(c) *Content of the plan.* The plan:

(1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and

(2) Indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan are implemented in accordance with hospital policies and procedures.

Subpart C—Posthospital SNF Care

■ 3. Section 409.23 is amended by adding paragraph (c) to read as follows:

§ 409.23 Physical, occupational, and speech therapy.

* * * * *

(c) Except as specified in paragraph (c)(1)(ii) of this section, physical therapy, occupational therapy or speech-language pathology services must be furnished—

(1) By qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants or speech-language pathologists as defined in part 484 of this chapter

(2) In accordance with a plan that meets the requirements of § 409.17(b) through (d) of this part.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 4. 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

§ 410.32 [Amended]

■ 5. Section 410.32 is amended by—
■ A. Removing paragraph (a)(1).
■ B. Redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(1) and (a)(2).

■ 6. Section 410.33 is amended by—
■ A. Revising paragraphs (b)(1), (g)(2), (g)(3), (g)(6), and (g)(8).
■ B. Adding paragraphs (g)(15) and (i).

The revisions and addition read as follows:

§ 410.33 Independent diagnostic testing facility.

* * * * *

(b) * * *

(1) Each supervising physician must be limited to providing general supervision to no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

* * * * *

(g) * * *

(2) Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

(3) Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not considered an appropriate site.

(i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.

(ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

* * * * *

(6) Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a nonrelative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must—

(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

* * * * *

(8) Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

* * * * *

(15) With the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not include the following:

(i) Sharing a practice location with another Medicare-enrolled individual or organization;

(ii) Leasing or subleasing its operations or its practice location to another Medicare-enrolled individual or organization; or

(iii) Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.

* * * * *

(i) *Effective date of billing privileges.* The filing date of the Medicare enrollment application is the date that the Medicare contractor receives a signed provider enrollment application that it is able to process to approval. The effective date of billing privileges for a

newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or

(2) The date the IDTF first started furnishing services at its new practice location.

■ 7. Section 410.43 is amended by revising paragraph (a)(3)(ii) to read as follows:

§ 410.43 Partial hospitalization services: Conditions and exclusions.

(a) * * *

(3) * * *

(ii) Occupational therapy requiring the skills of a qualified occupational therapist, provided by an occupational therapist, or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant as specified in part 484 of this chapter.

■ 8. Section 410.59 is amended by revising the introductory text to paragraph (a) to read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for an occupational therapist or an appropriately supervised occupational therapy assistant but only under the following conditions:

* * * * *

■ 9. Section 410.60 is amended by revising the introductory text of paragraph (a) to read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

* * * * *

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for a physical therapist or an appropriately supervised physical therapist assistant but only under the following conditions:

* * * * *

§ 410.61 [Amended]

■ 10. Section 410.61 is amended by removing paragraph (e).

■ 11. 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, and neurobehavioral status exam furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

Subpart D—Comprehensive Outpatient Rehabilitation Facility (CORF) Services

■ 12. Section 410.100 is amended by—

■ A. Revising the introductory text and paragraphs (a), (e), and (h).

■ B. Removing paragraph (i).

■ C. Redesignating paragraphs (j), (k), (l), and (m) to (i), (j), (k), and (l) respectively.

■ D. Revising new paragraphs (i), (j), (k), and (l).

The revisions read as follows:

§ 410.100 Included services.

Subject to the conditions and limitations set forth in § 410.102 and § 410.105, CORF services means the following services furnished to an outpatient of the CORF by personnel that meet the qualifications set forth in § 485.70 of this chapter. Payment for CORF services are made in accordance with § 414.1105.

(a) *Physician's services.* CORF facility physician services are administrative in nature and include consultation with and medical supervision of nonphysician staff, participation in plan of treatment reviews and patient care review conferences, and other medical and facility administration activities. Diagnostic and therapeutic services furnished to an individual CORF patient by a physician in a CORF facility are not CORF physician services. These services, if covered, are physician services under § 410.20 with payment for these services made to the physician in accordance with part 414 subpart B.

* * * * *

(e) *Respiratory therapy services.* (1) Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

(2) Respiratory therapy services include the following:

(i) Application of techniques for support of oxygenation and ventilation of the patient.

(ii) Therapeutic use and monitoring of gases, mists, and aerosols and related equipment.

(iii) Bronchial hygiene therapy.

(iv) Pulmonary rehabilitation techniques to develop strength and endurance of respiratory muscles and other techniques to increase respiratory function, such as graded activity services; these services include physiologic monitoring and patient education.

* * * * *

(h) *Social and psychological services.* 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.

(i) *Nursing care services.* Nursing care services include nursing services provided by a registered nurse that are prescribed by a physician and are specified in or directly related to the rehabilitation treatment plan and necessary for the attainment of the rehabilitation goals of the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment.

(j) *Drugs and biologicals.* These are drugs and biologicals that are the following:

(1) Prescribed by a physician and administered by or under the supervision of a physician or by a registered professional nurse; and

(2) Not excluded from Medicare Part B payment for reasons specified in § 410.29.

(k) *Supplies and durable medical equipment.* Supplies and durable medical equipment include the following:

(1) Disposable supplies.

(2) Durable medical equipment of the type specified in § 410.38 (except for renal dialysis systems) for a patient's use outside the CORF, whether purchased or rented.

(l) *Home environment evaluation.* A home environment evaluation—

(1) Is a single home visit to evaluate the potential impact of the home situation on the patient's rehabilitation goals.

(2) Requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

■ 13. Section 410.105 is amended by revising paragraphs (b)(3)(i), (b)(3)(ii), (c)(1) introductory text, and (c)(2) to read as follows:

§ 410.105 Requirements for coverage of CORF services.

* * * * *

(b) * * *

(3) * * *

(i) 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.

(ii) The single home environment evaluation visit specified in § 410.100(m) is also covered.

(c) * * *

(1) The service must be furnished under a written plan of treatment that—

(i) * * *

(ii) 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, and indicates the other CORF services to be furnished that relate directly to such rehabilitation goals.

(2) The plan must be reviewed at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy and speech-language pathology services by a facility physician or the referring physician who, when appropriate, consults with the professional personnel providing the services.

* * * * *

Subpart G—Medical Nutrition Therapy

■ 14. Section 410.132 is amended by revising paragraph (a) to read as follows:

§ 410.132 Medical nutrition therapy.

(a) *Conditions for coverage of MNT services.* Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the treating physician. Except as provided at § 410.78, services covered consist of face-to-face nutritional assessments and interventions in accordance with nationally-accepted dietary or nutritional protocols.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

Subpart A—General Exclusions and Exclusion of Particular Services

■ 16. Section 411.15 is amended by—

■ A. Revising paragraph (a)(1).

■ B. Adding paragraphs (k)(13) and (k)(14).

The revision and additions read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, initial preventive physical exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, or diabetes screening tests that meet the criteria specified in paragraphs (k)(6) through (k)(14) of this section.

* * * * *

(k) * * *

(13) In the case of cardiovascular disease screening tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease, subject to the conditions specified in § 410.17 of this chapter.

(14) In the case of diabetes screening tests furnished to an individual at risk for diabetes for the purpose of the early detection of that disease, subject to the conditions specified in § 410.18 of this chapter.

* * * * *

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

■ 17. Section 411.351 is amended by revising the definition of ''entity'' to read as follows:

§ 411.351 Definitions.

* * * * *

Entity means—

* * * * *

(3) For purposes of this subpart, ''entity'' does not include a physician's practice when it bills Medicare for the technical component or professional component of a diagnostic test for which the anti-markup provision is applicable in accordance with § 414.50 of this chapter and section 30.2.9 of the CMS Internet-only Manual, publication 100–04, Claims Processing Manual, Chapter 1 (general billing requirements).

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

■ 19. Section 413.1 is amended by—

■ A. Removing paragraphs (a)(2)(iv) and (vi).

■ B. Redesignating paragraphs (a)(2)(v) and (vii) as paragraphs (a)(2)(iv) and (v), respectively.

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

■ 20. Section 413.184 is amended by revising the section heading as set forth below:

§ 413.184 Payment exception: Pediatric patient mix.

* * * * *

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

■ 21. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart B—Physicians and Other Practitioners

■ 22. Section 414.50 is revised to 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.* (1) The services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act), if a physician or other supplier bills for the technical component or professional component of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control as described in § 413.17 of this chapter) and the diagnostic test is 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 technical component or professional component of the diagnostic test may not exceed the lowest of the following amounts:

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

(ii) The billing physician or other supplier's actual charge.

(iii) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

(2) The following requirements are applicable for purposes of paragraph (a) of this section:

(i) The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

(ii) An ''outside supplier'' is 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 or other supplier under a reassignment that meets the requirements of § 424.80.

(iii) The ''office of the billing physician or other supplier'' is medical office space where the physician or other supplier regularly furnishes patient care. 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 space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally.

(b) *Restriction on payment.* (1) The billing physician or other supplier must identify the performing supplier and indicate the performing supplier's net charge for the test. If the billing physician or other supplier fails to provide this information, CMS makes no payment to the billing physician or other supplier and the billing physician or other supplier may not bill the beneficiary.

(2) Physicians and other suppliers that accept Medicare assignment may bill beneficiaries for only the applicable deductibles and coinsurance.

(3) Physicians and other suppliers that do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

■ 23. 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), individual medical nutrition therapy, and neurobehavioral status exam furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

Subpart G—Payment for New Clinical Diagnostic Laboratory Tests

■ 24. Section § 414.502 is amended by adding the definition, ''New test'' in alphabetical order to read as follows:

§ 414.502 Definitions.

* * * * *

New test means any clinical diagnostic laboratory test for which a new or substantially revised Healthcare Common Procedure Coding System Code is assigned on or after January 1, 2005.

■ 25. Section 414.506 is amended by revising the introductory text to read as follows:

§ 414.506 Procedures for public consultation for payment for a new clinical diagnostic laboratory test.

For a new test, CMS determines the basis for and amount of payment after performance of the following:

* * * * *

■ 26. Section 414.508 is amended by revising paragraph (b)(3) to read as follows:

§ 414.508 Payment for a new clinical diagnostic laboratory test.

* * * * *

(b) * * *

(3) For a new test for which a new or substantially revised HCPCS code was assigned on or before December 31, 2007, after the first year of gapfilling, CMS determines whether the carrier-specific amounts will pay for the test appropriately. If CMS determines that the carrier-specific amounts will not pay for the test appropriately, CMS may crosswalk the test.

■ 27. Section 414.509 is added to read as follows:

§ 414.509 Reconsideration of basis for and amount of payment for a new clinical diagnostic laboratory test.

For a new test for which a new or substantially revised HCPCS code was assigned on or after January 1, 2008, the following reconsideration procedures apply:

(a) *Reconsideration of basis for payment.* (1) CMS will receive reconsideration requests in written format for 60 days after making a determination of the basis for payment under § 414.506(d)(2) regarding whether CMS should reconsider the basis for payment and why a different basis for payment would be more appropriate. If a requestor recommends that the basis for payment should be changed from gapfilling to crosswalking, the requestor may also recommend the code or codes to which to crosswalk the new test.

(2)(i) A requestor that submitted a request under paragraph (a)(1) of this section may also present its reconsideration request at the public meeting convened under § 414.506(c), provided that the requestor requests an opportunity to present at the public meeting as part of its written submission under paragraph (a)(1) of this section.

(ii) If the requestor presents its reconsideration request at the public meeting convened under § 414.506(c), members of public may comment on the reconsideration request verbally at the public meeting and may submit written comments after the public meeting (within the timeframe for public comments established by CMS).

(3) Considering reconsideration requests and other comments received, CMS may reconsider its determination of the basis for payment. As the result of such a reconsideration, CMS may change the basis for payment from crosswalking to gapfilling or from gapfilling to crosswalking.

(4) If the basis for payment is revised as the result of a reconsideration, the new basis for payment is final and is not subject to further reconsideration.

(b) *Reconsideration of amount of payment*—(1) *Crosswalking.* (i) For 60 days after making a determination under § 414.506(d)(2) of the code or codes to which a new test will be crosswalked, CMS receives reconsideration requests in written format regarding whether CMS should reconsider its determination and the recommended code or codes to which to crosswalk the new test.

(ii)(A) A requestor that submitted a request under paragraph (b)(1)(i) of this section may also present its reconsideration request at the public meeting convened under § 414.506(c), provided that the requestor requests an opportunity to present at the public meeting as part of its written submission under paragraph (b)(1)(i) of this section.

(B) If a requestor presents its reconsideration request at the public meeting convened under § 414.506(c), members of public may comment on the reconsideration request verbally at the public meeting and may submit written comments after the public meeting (within the timeframe for public comments established by CMS).

(iii) Considering comments received, CMS may reconsider its determination of the amount of payment. As the result of such a reconsideration, CMS may change the code or codes to which the new test is crosswalked.

(iv) If CMS changes the basis for payment from gapfilling to crosswalking as a result of a reconsideration, the crosswalked amount of payment is not subject to reconsideration.

(2) *Gapfilling.* (i) By April 30 of the year after CMS makes a determination under § 414.506(d)(2) or § 414.509(a)(3) that the basis for payment for a new test will be gapfilling, CMS posts interim carrier-specific amounts on the CMS Web site.

(ii) For 60 days after CMS posts interim carrier-specific amounts on the CMS Web site, CMS will receive public comments in written format regarding the interim carrier-specific amounts.

(iii) After considering the public comments, CMS will post final carrier-specific amounts on the CMS Web site.

(iv) For 30 days after CMS posts final carrier-specific amounts on the CMS Web site, CMS will receive reconsideration requests in written format regarding whether CMS should reconsider the final payment amounts and the appropriate national limitation amount for the new test.

(v) Considering reconsideration requests received, CMS may reconsider its determination of the amount of payment. As the result of a reconsideration, CMS may revise the national limitation amount for the new test.

(3) For both gapfilled and crosswalked new tests, if CMS revises the amount of payment as the result of a reconsideration, the new amount of payment is final and is not subject to further reconsideration.

(c) *Effective date.* If CMS changes a determination as the result of a reconsideration, the new determination regarding the basis for or amount of payment is effective January 1 of the year following reconsideration. Claims for services with dates of service prior to the effective date will not be reopened or otherwise reprocessed.

(d) *Jurisdiction for Reconsideration Decisions.* Jurisdiction for reconsidering a determination rests exclusively with the Secretary. A decision whether to reconsider a determination is committed to the discretion of the Secretary. A decision not to reconsider an initial determination is not subject to administrative or judicial review.

■ 28. Section 414.510 is amended by—

■ A. Revising the section heading to read as set forth below.

■ B. Revising the introductory text.

The revisions read as follows:

§ 414.510 Laboratory date of service for clinical laboratory and pathology specimens.

The date of service for either a clinical laboratory test or the technical component of physician pathology service is as follows:

* * * * *

Subpart H—Fee Schedule for Ambulance Services

§ 414.620 [Amended]

■ 29. In § 414.620, the phrase ''notice in the **Federal Register** without opportunity for prior comment'' is removed and the phrase ''CMS by instruction and on the CMS Web site'' is added in its place.

Subpart I—Payment for Drugs and Biologicals

■ 30. Section 414.707 is amended by adding paragraph (c) to read as follows:

§ 414.707 Basis of payment

* * * * *

(c) *Mandatory reporting of anemia quality indicators.* The following provisions are effective January 1, 2008:

(1) Each request for payment for anti-anemia drugs furnished to treat anemia resulting from the treatment of cancer must report the beneficiary's most recent hemoglobin or hematocrit level;

(2) Each request for payment for use of erythropoiesis stimulating agents must report the beneficiary's most recent hemoglobin or hematocrit level.

Subpart K—Payment for Drugs and Biologicals Under Part B

■ 31. Section 414.904 is amended by revising paragraph (d)(3) to read as follows:

§ 414.904 Average sales price as the basis for payment.

* * * * *

(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 CY 2005, 2006, 2007 or 2008, 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.

* * * * *

■ 32. Section 414.908 is amended by—

■ A. Revising paragraphs (a)(2)(iv), (a)(3)(x), and (a)(3)(xi).

■ B. Adding paragraph (a)(2)(v).

■ C. Removing paragraph (a)(5).

The revisions and addition read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(2) * * *

(iv) The approved CAP vendor refuses to ship to the participating CAP physician because the conditions of § 414.914(i) have been met (if this subparagraph (a)(2)(iv) applies, the physician can withdraw from the CAP category for the remainder of the year immediately upon notice to CMS and the approved CAP vendor); or

(v) Other exigent circumstances defined by CMS are present, including—

(A) If, up to and including 60 days after the effective date of the physician's CAP election agreement, the participating CAP physician submits a written request to the designated carrier to terminate the CAP election agreement

because CAP participation imposes a burden on the physician's practice. The written request must document the burden. The designated carrier will process the participating CAP physician's request and CMS will approve or deny the request under the dispute resolution process as specified under § 414.917 of this subpart.

(B) If, more than 60 days after the effective date of the physician's CAP election agreement, the participating CAP physician submits a written request to the designated carrier to terminate the CAP election agreement because, based on a change in circumstances of which the participating CAP physician was not previously aware, CAP participation imposes a burden on the physician's practice. The written request must document the burden. The designated carrier will process the participating CAP physician's request and CMS will approve or deny the request under the dispute resolution process as specified under § 414.917 of this subpart.

(3) * * *

(x) Agrees to file the Medicare claim within 30 calendar days of the date of drug administration.

(xi) Agrees to submit documentation such as medical records or certification, as necessary, to support payment for a CAP drug;

* * * * *

■ 33. Section 414.914 is amended by—

■ A. Redesignating paragraph (h) as (i)

■ B. Adding new paragraph (h).

■ C. Revising new paragraphs (i)(1) and (2).

■ D. Removing the reference ''§ 414.914(h)'' in paragraph (f)(12) and adding in its place the reference ''§ 414.914(i)''.

■ E. Revising new paragraph (i)(5).

The addition and revision read as follows:

§ 414.914 Terms of contract.

* * * * *

(h) The approved CAP vendor must verify drug administration prior to collection of any applicable cost sharing amount.

(1) The approved CAP vendor documents, in writing, the following information necessary to verify drug administration:

(i) Beneficiary name.

(ii) Health insurance number.

(iii) Expected date of administration.

(iv) Actual date of administration.

(v) Identity of the participating CAP physician.

(vi) Prescription order number.

(vii) Identity of the individuals who supply and receive the information.

(viii) Dosage supplied.

(ix) Dosage administered.

* * * * *

(2) If the information is obtained verbally, the approved CAP vendor must also maintain the following information:

(i) The identities of individuals who exchanged the information.

(ii) The date and time that the information was obtained.

(3) The approved CAP vendor must provide this information to CMS or the beneficiary upon request.

(i) * * *

(1) Subsequent to receipt of payment by Medicare, or the verification of drug administration by the participating CAP physician, the approved CAP vendor must bill any applicable supplemental insurance policies.

(2) An approved CAP vendor that has received payment from the designated carrier for CAP drugs that have not been administered must promptly refund payment for such drugs to the designated carrier and must refund any coinsurance and deductible collected from the beneficiary and his or her supplemental insurer.

* * * * *

(5) For purposes of paragraph (i) of this section delivery means postmark date, or the date the coinsurance bill or notice was presented to the beneficiary by the participating CAP physician on behalf of the approved CAP vendor.

(i) Except as specified in paragraph (i)(5)(ii) of this section, if after 45 days from delivery of the approved CAP vendor's bill to the beneficiary, the beneficiary's cost-sharing obligation remains unpaid, the approved CAP vendor may refuse further shipments to the participating CAP physician for that beneficiary.

(ii) If the beneficiary has requested cost-sharing assistance within 45 days of receiving delivery of the approved CAP vendor's bill, provisions of paragraphs (i)(6), (i)(7), or (i)(8) of this section, apply.

■ 34. Section 414.916 is amended by revising paragraph (c)(1) to read as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(c) * * *

(1) *Right to a reconsideration.* A participating CAP physician dissatisfied with a determination that his or her CAP election agreement has been suspended by CMS or a determination under § 414.917(d) denying the participating CAP physician's request to terminate participation in the CAP under § 414.908(a)(v) is entitled to a reconsideration as provided in this subpart.

* * * * *

■ 35. Section 414.917 is amended by—

■ A. Revising the section heading as set forth below.

■ B. Adding paragraph (d).

The revision and addition 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.

* * * * *

(d) *CAP participating physicians' exigent circumstances provision.* The following process must be completed for participating CAP physicians' requests to terminate their participation in the program under exigent circumstances provisions described in § 414.908(a)(2)(v):

(1) The designated carrier must—

(i) Determine whether a request to terminate CAP participation was related to approved CAP vendor service, and if so, forward the issue to the approved CAP vendor's grievance process within 1 business day of the receipt of the request; or

(ii) Continue to investigate, consistent with § 414.916(b)(2) of this chapter, and within 2 business days of receipt, do any of the following:

(A) Request a single, 2-business day extension. No later than the end of any 2-business day extension, the designated carrier must make findings and a recommendation as provided in subparagraph (B) or (C).

(B) Submit a recommendation and relevant findings to CMS that the requesting participating CAP physician be permitted to terminate his or her participation in the CAP.

(C) Submit a recommendation and relevant findings to CMS that the requesting participating CAP physician not be permitted to terminate his or her participation in the CAP.

(ii) In the case of a request made under § 414.908(a)(2)(v)(B), the designated carrier also shall include in its recommendation its finding with respect to whether the request is based on a change in circumstances of which the participating CAP physician was previously unaware.

(2) CMS will consider the carrier's findings and recommendation and may also make its own findings. As a result, CMS will—

(i) Approve or deny the request to terminate participation in the CAP within 2 business days of receipt of the recommendation.

(ii) Communicate the decision to the appropriate Medicare contractors and the participating CAP physician.

(3) A denial of the participating CAP physician's request to terminate participation in the CAP must include written notification of the right to request reconsideration under § 414.916(c).

(4) Upon termination of participation in the CAP a physician must—

(i) Continue to submit claims for drugs supplied and administered under the CAP prior to the effective date of the physician's termination from the CAP consistent with § 414.908(a) until all such claims are timely submitted.

(ii) Return any unused CAP drugs that had not been administered to the beneficiary prior to the effective date of the physician's termination from the CAP to the approved CAP vendor consistent with applicable law and regulation and any agreement with the approved CAP vendor.

(iii) Cooperate in any post-payment review activities on claims submitted under the CAP, as required under section 1847B(a)(3) of the Act.

(5) An approved CAP vendor that has billed and been paid for CAP drugs that have not been administered must refund any payments made by CMS or the beneficiary and his or her supplemental insurer in accordance with § 414.914(h)(3)(i)(2) of this chapter.

■ 36. Section 414.930 is added to subpart K to read as follows:

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

(a) *Definition.* For purposes of this section, *compendium* means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anti-cancer treatment. A compendium includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases. A compendium is indexed by drug or biological.

(b) *Process for listing compendia for determining medically-accepted uses of drugs and biologicals in anti-cancer treatment.* (1) The CMS process—

(i) Receives formal written requests for changes to the list of compendia during a 30 day window beginning January 15 each year.

(ii) Publishes a listing of the timely, complete requests by March 15th and solicits public comment on the requests for 30 days. The listing identifies the requestor and the requested action.

(iii) Considers a compendium's attainment of the MedCAC (Medicare Evidence Development and Coverage Advisory Committee, previously known as the MCAC—Medicare Coverage Advisory Committee) recommended desirable characteristics of compendia (including explicit listing and recommendations) in reviewing requests. CMS may consider additional reasonable factors.

(iv) Considers a compendium's grading of evidence used in making recommendations regarding off-label uses and the process by which the compendium grades the evidence.

(v) Publishes its decision no later than 90 days after the close of the public comment period.

(2) *Exception.* In addition to the annual process outlined in paragraph (b)(1) of this section, CMS may internally generate a request for changes to the list of compendia at any time.

(c) *Written request for review.* (1) CMS will review a complete, written request that is submitted in writing, electronically or via hard copy (no duplicate submissions) and includes the following:

(i) The full name and contact information of the requestor.

(ii) The full identification of the compendium that is the subject of the request, including name, publisher, edition if applicable, date of publication, and any other information needed for the accurate and precise identification of the specific compendium.

(iii) A complete written copy of the compendium that is the subject of the request.

(iv) The specific action that is requested of CMS.

(v) Materials that the requestor must submit for CMS review in support of the requested action.

(vi) A single compendium as its subject.

(d) CMS may at its discretion combine and consider multiple requests that refer to the same compendium.

(e) For the purposes of this section, publication by CMS may be accomplished by posting on the CMS Web site.

■ 37. Subpart M is added to read as follows:

Subpart M—Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) Services

§ 414.1100 Basis and Scope.

This subpart implements sections 1834(k)(1) and (k)(3) of the Act by specifying the payment methodology for comprehensive outpatient rehabilitation facility services covered under Part B of Title XVIII of the Act that are described at section 1861(cc)(1) of the Act.

§ 414.1105 Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) Services.

(a) *Payment under the physician fee schedule.* Except as otherwise specified under paragraphs (b), (c), (d), and (e) of this section payment for CORF services, as defined under § 410.100 of this chapter, is paid the lesser of 80 percent of the following:

(1) The actual charge for the item or service; or

(2) The nonfacility amount determined under the physician fee schedule established under section 1848(b) of the Act for the item or service.

(b) *Payment for physician services.* No separate payment for physician services that are CORF services under § 410.100(a) of this chapter will be made.

(c) *Payment for supplies and durable medical equipment, prosthetic and orthotic devices, and drugs and biologicals.* Supplies and durable medical equipment that are CORF services under § 410.100(l) of this chapter, prosthetic device services that are CORF services under § 410.100(f), orthotic devices that are CORF services under § 410.100(g) of this chapter and drugs and biologicals that are CORF services under § 410.100(k) of this chapter are paid the lesser of 80 percent of the following:

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (d); or

(2) The amount determined under the DMEPOS fee schedule established under part 414 subparts D and F for the item or the single payment amount established under the DMEPOS competitive bidding program provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (d).

(d) *Payment for drugs and biologicals.* Drugs and biologicals that are CORF services under § 410.100(j) of this chapter, are paid the lesser of 80 percent of the following:

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (c); or

(2) The amount determined using the same methodology for drugs (as defined

in § 414.704 of this chapter) described in section 1842(o)(1) of the Act provided that payment for such *drug* is not included in the payment amount for other CORF services paid under paragraphs (a) or (c).

(e) *Payment for CORF services when no fee schedule amount for the service.* If there is no fee schedule amount established for a CORF service, payment for the item or service will be the lesser of 80 percent of:

(i) The actual charge for the service provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

(ii) The amount determined under the fee schedule established for a comparable service as specified by the Secretary provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

■ 38. 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

■ 39. Section 415.130 is amended by revising paragraph (d) to read as follows:

§ 415.130 Conditions for payment: Physician pathology services.

* * * * *

(d) *Physician pathology services furnished by an independent laboratory.* The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before December 31, 2007, may be paid to the laboratory by the carrier under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section. 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. For services furnished on or after January 1, 2008, the date of service policy in § 414.510 of this chapter applies for the technical component of specimens for physician pathology services.

PART 418—HOSPICE CARE

■ 40. The authority citation for part 418 continues to read as follows:

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

Subpart E—Condition of Participation: Other Services

■ 41. Section 418.92 is amended by revising paragraph (a) to read as follows:

§ 418.92 Condition of participation—Physical therapy, occupational therapy, and speech-language pathology.

(a) Physical therapy, occupational therapy, and speech-language pathology services must be—

(1) Available, and when provided, offered in a manner consistent with accepted standards of practice; and

(2) Furnished by personnel who meet the qualifications specified in part 484 of this chapter.

* * * * *

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

■ 42. The authority citation for part 423 continues to read as follows:

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

Subpart D—Cost Control and Quality Improvement Requirements

■ 43. Section 423.160 is amended by—

■ A. Revising paragraph (a)(3)(i).

■ B. Redesignating paragraphs (a)(3)(ii) and (iii) to (a)(3)(iii) and (iv), respectively.

■ C. Adding new paragraph (a)(3)(ii).

The revision and addition reads as follows:

§ 423.160 Standards for electronic prescribing.

(a) * * *

(3) * * *

(i) Entities transmitting prescriptions or prescription-related information by means of computer-generated facsimile are exempt from the requirement to use the NCPDP SCRIPT Standard adopted by this section in transmitting such prescriptions or prescription-related information until January 1, 2009;

(ii) After January 1, 2009, electronic transmission of prescriptions or prescription-related information by means of computer-generated facsimile is only permitted in instances of temporary/transient transmission failure and communication problems that would preclude the use of the NCPDP SCRIPT Standard adopted by this section.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 44. 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).

■ 45. The heading for subpart B is revised to read as set forth below.

Subpart B—Certification and Plan Requirements

■ 46. Section 424.24 is amended by revising paragraphs (c)(2) and (c)(4) to read as follows:

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

* * * * *

(c) * * *

(2) *Timing.* The initial certification must be obtained as soon as possible after the plan is established.

(4) *Recertification.* (i) *Timing.* Recertification is required at least every 90 days.

(ii) *Content.* When it is recertified, the plan or other documentation in the patient's record must indicate the continuing need for physical therapy, occupational therapy or speech-language pathology services.

(iii) *Signature.* The physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan must recertify the plan by signing the medical record.

* * * * *

■ 47. Section 424.27 is amended by revising paragraph (b)(1) to read as follows:

§ 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services

* * * * *

(b) * * *

(1) *Timing.* Recertification is required at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy, and speech-language pathology services based on review by a facility physician or the referring physician who, when appropriate, consults with the professional personnel who furnish the services.

* * * * *

■ 48. In § 424.32, paragraph (a)(3) is revised to read as follows:

§ 424.32 Basic requirements for all claims.

(a) * * *

(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

* * * * *

Subpart C—Claims for Payment

■ 49. Section 424.36 is amended by—

■ A. Revising paragraph (b)(5).

■ B. Adding paragraph (b)(6).

The revision and addition read as follows:

§ 424.36 Signature requirements.

* * * * *

(b) * * *

(5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished if the provider or nonparticipating hospital is unable to have the claim signed in accordance with paragraph (b)(1), (2), (3), or (4) of this section after making reasonable efforts to locate and obtain the signature of one of the individuals specified in paragraph (b)(1), (2), (3), or (4) of this section.

(6) An ambulance provider or supplier with respect to emergency ambulance transport services, if the following conditions and documentation requirements are met.

(i) None of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section was available or willing to sign the claim on behalf of the beneficiary at the time the service was provided;

(ii) The ambulance provider or supplier maintains in its files the following information and documentation for a period of at least four years from the date of service:

(A) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility, that, at the time the service was provided, the beneficiary was physically or mentally incapable of signing the claim and that none of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section were available or willing to sign the claim on behalf of the beneficiary, and

(B) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary, and

(C) Either of the following:

(*1*) A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility; or

(*2*) The requested information from a representative of the facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment. Secondary forms of verification include a copy of any of the following—

(*i*) The signed patient care/trip report;

(*ii*) The hospital registration/admissions sheet;

(*iii*) The patient medical record;

(*iv*) The hospital log; or

(*v*) Other internal hospital records.

* * * * *

Subpart F—Limitations on Assignment and Reassignment of Claims

■ 50. Section 424.80 is amended by adding paragraph (d)(3) to read as follows:

§ 424.80 Prohibition of reassignment of claims by suppliers.

* * * * *

(d) * * *

(3) *Reassignment of the technical or professional component of a diagnostic test.* If a physician or other supplier bills for the technical or professional component of a diagnostic test covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special rules set forth in section 1833(h)(5)(A) of the Act) following a reassignment from a physician or other supplier who performed the technical or professional component, the amount payable to the billing physician or other supplier may be subject to the limits specified in § 414.50 of this chapter.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

■ 51. The authority citation for part 482 continues to read as follows:

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

■ 52. Section 482.56 is amended by revising paragraphs (a)(2) and (b) to read as follows:

§ 482.56 Condition of participation: Rehabilitation services.

(a) * * *

(2) Physical therapy, occupational therapy, speech-language pathology or audiology services, if provided, must be provided by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists as defined in part 484 of this chapter.

(b) *Standard: Delivery of services.* Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record. The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of § 409.17

PART 484—HOME HEALTH SERVICES

■ 53. The authority citation for part 484 continues to read as follows:

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

Subpart A—General Provisions

■ 54. Section 484.4 is amended by revising the definitions of ''Occupational therapist,'' ''Occupational therapy assistant,'' ''Physical therapist,'' ''Physical therapist assistant'' and ''Speech language pathologist'' to read as follows:

§ 484.4 Personnel Qualifications.

* * * * *

Occupational therapist. A person who—

(a)(1) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;

(2) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and

(3) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(1) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing; or

(2) When licensure or other regulation does not apply—

(i) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and

(ii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc., (NBCOT).

(c) On or before January 1, 2008—

(1) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapist; and

(2) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) If educated outside the United States—

(1) Must meet both of the following:

(i) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by one of the following:

(A) The Accreditation Council for Occupational Therapy Education (ACOTE).

(B) Successor organizations of ACOTE.

(C) The World Federation of Occupational Therapists.

(D) A credentialing body approved by the American Occupational Therapy Association.

(ii) Successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(2) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.

Occupational therapy assistant. A person who—

(a) Meets all of the following:

(1) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing, unless licensure does apply.

(2) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education, (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.

(3) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(1) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the State in which practicing; or any qualifications defined by the State in which practicing, unless licensure does not apply; or

(2) Must meet both of the following:

(i) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association.

(ii) After January 1, 2010, meets the requirements in paragraph (a) of this section.

(c) After December 31, 1977 and on or before December 31, 2007—

(1) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or

(2) Completed the requirements to practice as an occupational therapy assistant applicable in the State in which practicing.

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapy assistant; and

(2) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) If educated outside the United States, on or after January 1, 2008—

(1) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by—

(i) The Accreditation Council for Occupational Therapy Education (ACOTE).

(ii) Its successor organizations.

(iii) The World Federation of Occupational Therapists.

(iv) By a credentialing body approved by the American Occupational Therapy Association; and

(2) Successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

Physical therapist. A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:

(a)(1) Graduated after successful completion of one of a physical therapist eduction program approved by one of the following:

(i) The Commission on Accreditation in Physical Therapy Education (CAPTE).

(ii) Successor organizations of CAPTE.

(iii) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.

(2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.

(b) On or before December 31, 2009—

(1) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or

(2) Meets both of the following:

(i) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.

(ii) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.

(c) Before January 1, 2008—

(1) Graduated from a physical therapy curriculum approved by one of the following:

(i) The American Physical Therapy Association.

(ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.

(iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

(d) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:

(1) Has 2 years of appropriate experience as a physical therapist.

(2) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) Before January 1, 1966—

(1) Was admitted to membership by the American Physical Therapy Association;

(2) Was admitted to registration by the American Registry of Physical Therapists; and

(3) Graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.

(f) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.

(g) If trained outside the United States before January 1, 2008, meets the following requirements:

(1) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.

(2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

Physical therapist assistant. A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:

(a)(1)(i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and

(ii) Passed a national examination for physical therapist assistants.

(b) On or before December 31, 2009, meets one of the following:

(1) Is licensed, or otherwise regulated in the State in which practicing.

(2) In States where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January 1, 2010, meets the requirements of paragraph (a) of this definition.

(c) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college-level program approved by the American Physical Therapy Association.

(d) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

* * * * *

Speech-language pathologist. A person who meets either of the following requirements:

(a) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association.

(b) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 55. 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

■ 56. Section 485.51 is amended by—

■ A. Revising paragraph (a).

■ B. Adding paragraph (c).

The revision and addition read as follows:

§ 485.51 Definition.

* * * * *

(a) Is established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician except as provided in paragraph (c) of this section;

* * * * *

(c) *Exception.* May provide influenza, pneumococcal and Hepatitis B vaccines provided the applicable conditions of coverage under § 410.58 and § 410.63 of this chapter are met.

■ 57. Section 485.70 is amended by revising paragraphs (c), (e), and (m) to read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in part 484 of this chapter.

* * * * *

(e) A physical therapist and a physical therapist assistant must meet the qualifications in part 484 of this chapter.

* * * * *

(m) A speech-language pathologist must meet the qualifications set forth in part 484 of this chapter.

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

■ 58. Section 485.635 is amended by adding paragraph (e) to read as follows:

§ 485.635 Condition of participation: Provision of services.

* * * * *

(e) Standard: Rehabilitation Therapy Services. Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided as direct services by staff qualified under State law, and consistent with the requirements for therapy services in 409.17.

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

Dated: October 23, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 31, 2007.

Michael O. Leavitt,

Secretary.

Addendum A:

Note: These addenda will not appear in the Code of Federal Regulations. Addendum A: Explanation and Use of Addendum B.

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2008. Addendum B contains the RVUs for work, non-facility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B—2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for: Alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

• An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

• Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example, a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D* = Deleted/discontinued code.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H* = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians'' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2008.

Note: The separate budget neutrality 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. *Year 2008 Transitional Non-facility practice expense RVUs.* These are the 2008 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. *Year 2008 Transitional facility practice expense RVUs.* These are the 2008 resource-based PE RVUs for facility settings.

10. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2008.

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 2008

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice 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
0066T		N	Ct colonography;screen	0.00	0.00	0.00	NA	NA	0.00	XXX
0066T	TC	N	Ct colonography;screen	0.00	0.00	0.00	NA	NA	0.00	XXX
0066T	26	N	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	NA	NA	0.00	XXX
0067T	TC	C	Ct colonography;dx	0.00	0.00	0.00	NA	NA	0.00	XXX
0067T	26	C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	13.15	15.58	NA	NA	0.13	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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

[1] CPT codes and descriptions only are copyright 2007 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 B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0144T		C	CT heart wo dye; qual calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0144T	TC	C	CT heart wo dye; qual calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0144T	26	C	CT heart wo dye; qual calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0145T		C	CT heart w/wo dye funct	0.00	0.00	0.00	NA	NA	0.00	XXX
0145T	TC	C	CT heart w/wo dye funct	0.00	0.00	0.00	NA	NA	0.00	XXX
0145T	26	C	CT heart w/wo dye funct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0146T		C	CCTA w/wo dye	0.00	0.00	0.00	NA	NA	0.00	XXX
0146T	TC	C	CCTA w/wo dye	0.00	0.00	0.00	NA	NA	0.00	XXX
0146T	26	C	CCTA w/wo dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0147T		C	CCTA w/wo, quan calcium	0.00	0.00	0.00	NA	NA	0.00	XXX
0147T	TC	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	NA	NA	0.00	XXX
0147T	26	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0148T		C	CCTA w/wo, strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0148T	TC	C	CCTA w/wo, strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0148T	26	C	CCTA w/wo, strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0149T		C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0149T	TC	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	NA	NA	0.00	XXX
0149T	26	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0150T		C	CCTA w/wo, disease strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0150T	TC	C	CCTA w/wo, disease strxr	0.00	0.00	0.00	NA	NA	0.00	XXX
0150T	26	C	CCTA w/wo, disease strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0151T		C	CT heart funct add-on	0.00	0.00	0.00	NA	NA	0.00	XXX
0151T	TC	C	CT heart funct add-on	0.00	0.00	0.00	NA	NA	0.00	XXX
0151T	26	C	CT heart funct add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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
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

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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
10021		A	Fna w/o image	1.27	2.18	2.17	0.37	0.46	0.10	XXX
10022		A	Fna w/image	1.27	2.15	2.35	0.41	0.41	0.08	XXX
10040		A	Acne surgery	1.19	1.33	1.17	0.98	0.88	0.05	010
10060		A	Drainage of skin abscess	1.19	1.50	1.35	1.08	1.01	0.12	010
10061		A	Drainage of skin abscess	2.42	2.06	1.94	1.51	1.50	0.26	010
10080		A	Drainage of pilonidal cyst	1.19	2.68	2.89	1.10	1.10	0.11	010
10081		A	Drainage of pilonidal cyst	2.47	3.48	3.77	1.45	1.47	0.24	010
10120		A	Remove foreign body	1.23	1.95	2.06	0.94	0.95	0.12	010
10121		A	Remove foreign body	2.71	3.51	3.51	1.65	1.72	0.33	010
10140		A	Drainage of hematoma/fluid	1.55	2.26	2.01	1.29	1.29	0.19	010
10160		A	Puncture drainage of lesion	1.22	1.85	1.72	1.07	1.08	0.14	010
10180		A	Complex drainage, wound	2.27	3.25	3.11	1.80	1.89	0.35	010
11000		A	Debride infected skin	0.60	0.72	0.65	0.16	0.19	0.07	000
11001		A	Debride infected skin add-on	0.30	0.23	0.23	0.08	0.10	0.04	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	NA	3.20	3.55	0.67	000
11005		A	Debride abdom wall	14.24	NA	NA	3.78	4.67	0.96	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	3.95	4.40	1.28	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	1.29	1.66	0.61	ZZZ
11010		A	Debride skin, fx	4.19	6.80	6.83	2.34	2.48	0.66	010
11011		A	Debride skin/muscle, fx	4.94	7.03	7.59	2.01	2.18	0.74	000
11012		A	Debride skin/muscle/bone, fx	6.87	9.00	10.55	3.10	3.47	1.16	000
11040		A	Debride skin, partial	0.50	0.68	0.60	0.16	0.18	0.06	000
11041		A	Debride skin, full	0.60	0.72	0.69	0.19	0.26	0.10	000
11042		A	Debride skin/tissue	0.80	0.95	0.96	0.24	0.34	0.13	000
11043		A	Debride tissue/muscle	3.04	3.50	3.44	2.60	2.59	0.32	010
11044		A	Debride tissue/muscle/bone	4.11	4.84	4.64	3.58	3.66	0.43	010
11055		R	Trim skin lesion	0.43	0.81	0.68	0.11	0.14	0.05	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.88	0.76	0.16	0.19	0.07	000
11057		R	Trim skin lesions, over 4	0.79	0.99	0.86	0.20	0.25	0.10	000
11100		A	Biopsy, skin lesion	0.81	1.88	1.56	0.38	0.38	0.03	000
11101		A	Biopsy, skin add-on	0.41	0.41	0.37	0.20	0.19	0.02	ZZZ
11200		A	Removal of skin tags	0.79	1.23	1.13	0.90	0.83	0.04	010
11201		A	Remove skin tags add-on	0.29	0.16	0.16	0.11	0.12	0.02	ZZZ
11300		A	Shave skin lesion	0.51	1.19	1.09	0.21	0.21	0.03	000
11301		A	Shave skin lesion	0.85	1.51	1.31	0.38	0.38	0.04	000
11302		A	Shave skin lesion	1.05	1.76	1.53	0.48	0.47	0.05	000
11303		A	Shave skin lesion	1.24	2.03	1.80	0.55	0.53	0.07	000
11305		A	Shave skin lesion	0.67	1.06	0.96	0.20	0.24	0.07	000
11306		A	Shave skin lesion	0.99	1.42	1.26	0.38	0.40	0.07	000
11307		A	Shave skin lesion	1.14	1.70	1.49	0.47	0.48	0.07	000
11308		A	Shave skin lesion	1.41	1.70	1.57	0.49	0.54	0.13	000
11310		A	Shave skin lesion	0.73	1.38	1.24	0.31	0.32	0.04	000
11311		A	Shave skin lesion	1.05	1.64	1.43	0.48	0.48	0.05	000
11312		A	Shave skin lesion	1.20	1.92	1.67	0.56	0.55	0.06	000
11313		A	Shave skin lesion	1.62	2.18	1.99	0.73	0.72	0.10	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.87	1.88	1.94	0.93	0.91	0.06	010
11401		A	Exc tr-ext b9+marg 0.6–1 cm	1.25	2.19	2.12	1.15	1.08	0.10	010
11402		A	Exc tr-ext b9+marg 1.1–2 cm	1.42	2.40	2.31	1.21	1.14	0.13	010
11403		A	Exc tr-ext b9+marg 2.1–3 cm	1.81	2.55	2.47	1.56	1.44	0.17	010
11404		A	Exc tr-ext b9+marg 3.1–4 cm	2.08	2.85	2.78	1.63	1.51	0.21	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.47	3.53	3.30	2.10	1.87	0.32	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.00	1.83	1.79	0.93	0.93	0.09	010
11421		A	Exc h-f-nk-sp b9+marg 0.6–1	1.44	2.21	2.14	1.16	1.13	0.13	010
11422		A	Exc h-f-nk-sp b9+marg 1.1–2	1.65	2.43	2.34	1.53	1.43	0.16	010
11423		A	Exc h-f-nk-sp b9+marg 2.1–3	2.03	2.67	2.62	1.66	1.55	0.20	010
11424		A	Exc h-f-nk-sp b9+marg 3.1–4	2.45	2.97	2.89	1.77	1.68	0.25	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.04	3.59	3.53	2.31	2.20	0.44	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.02	2.00	2.10	1.31	1.31	0.08	010
11441		A	Exc face-mm b9+marg 0.6–1 cm	1.50	2.38	2.35	1.55	1.52	0.13	010
11442		A	Exc face-mm b9+marg 1.1–2 cm	1.74	2.64	2.59	1.66	1.61	0.16	010
11443		A	Exc face-mm b9+marg 2.1–3 cm	2.31	2.88	2.90	1.84	1.83	0.22	010
11444		A	Exc face-mm b9+marg 3.1–4 cm	3.16	3.31	3.39	2.10	2.14	0.30	010
11446		A	Exc face-mm b9+marg > 4 cm	4.75	4.09	4.06	2.68	2.73	0.43	010
11450		A	Removal, sweat gland lesion	3.14	5.12	5.07	2.41	2.22	0.34	090
11451		A	Removal, sweat gland lesion	4.35	6.37	6.49	2.91	2.73	0.53	090
11462		A	Removal, sweat gland lesion	2.92	5.32	5.21	2.47	2.24	0.32	090
11463		A	Removal, sweat gland lesion	4.35	6.52	6.67	2.94	2.81	0.54	090
11470		A	Removal, sweat gland lesion	3.66	5.47	5.26	2.62	2.44	0.40	090
11471		A	Removal, sweat gland lesion	4.81	6.50	6.60	3.01	2.88	0.58	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.58	2.74	2.69	1.14	1.05	0.10	010
11601		A	Exc tr-ext mlg+marg 0.6–1 cm	2.02	3.44	3.07	1.51	1.36	0.12	010
11602		A	Exc tr-ext mlg+marg 1.1–2 cm	2.22	3.84	3.33	1.69	1.47	0.12	010
11603		A	Exc tr-ext mlg+marg 2.1–3 cm	2.77	4.05	3.56	1.87	1.60	0.16	010
11604		A	Exc tr-ext mlg+marg 3.1–4 cm	3.12	4.33	3.85	1.93	1.66	0.20	010
11606		A	Exc tr-ext mlg+marg > 4 cm	4.97	5.49	4.77	2.46	2.10	0.36	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	2.85	2.72	1.19	1.07	0.09	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6–1	2.03	3.50	3.10	1.54	1.39	0.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1–2	2.36	3.90	3.43	1.75	1.57	0.14	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1–3	3.06	4.11	3.72	1.95	1.76	0.20	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1–4	3.57	4.43	4.08	2.08	1.93	0.27	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	4.96	4.79	2.32	2.36	0.45	010
11640		A	Exc face-mm malig+marg 0.5 <	1.62	3.05	2.85	1.29	1.20	0.11	010
11641		A	Exc face-mm malig+marg 0.6–1	2.12	3.63	3.33	1.61	1.57	0.16	010
11642		A	Exc face-mm malig+marg 1.1–2	2.57	4.04	3.72	1.84	1.77	0.19	010
11643		A	Exc face-mm malig+marg 2.1–3	3.37	4.28	4.04	2.11	2.04	0.26	010
11644		A	Exc face-mm malig+marg 3.1–4	4.29	5.07	4.87	2.46	2.46	0.37	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.21	5.90	5.83	3.13	3.30	0.61	010
11719		R	Trim nail(s)	0.17	0.38	0.31	0.04	0.06	0.02	000
11720		A	Debride nail, 1–5	0.32	0.47	0.40	0.08	0.10	0.04	000
11721		A	Debride nail, 6 or more	0.54	0.55	0.49	0.14	0.17	0.07	000
11730		A	Removal of nail plate	1.10	1.33	1.18	0.28	0.36	0.14	000
11732		A	Remove nail plate, add-on	0.57	0.54	0.49	0.15	0.18	0.07	ZZZ
11740		A	Drain blood from under nail	0.37	0.80	0.67	0.43	0.39	0.04	000
11750		A	Removal of nail bed	2.40	2.95	2.56	1.88	1.82	0.22	010
11752		A	Remove nail bed/finger tip	3.48	4.06	3.52	2.77	2.88	0.35	010
11755		A	Biopsy, nail unit	1.31	2.02	1.79	0.76	0.76	0.14	000
11760		A	Repair of nail bed	1.60	3.40	3.01	1.43	1.61	0.21	010
11762		A	Reconstruction of nail bed	2.91	3.70	3.29	1.68	2.01	0.36	010
11765		A	Excision of nail fold, toe	0.71	2.67	2.23	1.01	0.88	0.08	010
11770		A	Removal of pilonidal lesion	2.63	3.45	3.47	1.52	1.51	0.33	010
11771		A	Removal of pilonidal lesion	5.98	6.63	6.14	3.69	3.50	0.74	090
11772		A	Removal of pilonidal lesion	7.23	8.03	7.76	5.55	5.31	0.89	090
11900		A	Injection into skin lesions	0.52	0.92	0.78	0.25	0.23	0.02	000
11901		A	Added skin lesions injection	0.80	1.01	0.83	0.39	0.37	0.03	000
11920		R	Correct skin color defects	1.61	2.34	3.02	1.09	1.09	0.24	000
11921		R	Correct skin color defects	1.93	2.66	3.31	1.25	1.26	0.29	000
11922		R	Correct skin color defects	0.49	0.92	1.03	0.22	0.24	0.07	ZZZ
11950		R	Therapy for contour defects	0.84	0.88	1.01	0.36	0.37	0.06	000
11951		R	Therapy for contour defects	1.19	0.90	1.19	0.36	0.43	0.11	000
11952		R	Therapy for contour defects	1.69	1.63	1.74	0.77	0.72	0.16	000
11954		R	Therapy for contour defects	1.85	1.79	2.11	0.77	0.83	0.25	000
11960		A	Insert tissue expander(s)	11.01	NA	NA	10.56	10.47	1.31	090
11970		A	Replace tissue expander	7.86	NA	NA	6.16	6.15	1.05	090
11971		A	Remove tissue expander(s)	3.21	7.39	8.25	4.01	3.90	0.32	090
11975		N	Insert contraceptive cap	1.48	1.53	1.47	0.34	0.45	0.17	XXX
11976		R	Removal of contraceptive cap	1.78	1.72	1.72	0.47	0.58	0.21	000
11977		N	Removal/reinsert contra cap	3.30	1.98	2.13	0.76	1.01	0.37	XXX
11980		A	Implant hormone pellet(s)	1.48	1.07	1.07	0.49	0.51	0.13	000
11981		A	Insert drug implant device	1.48	1.89	1.79	0.58	0.63	0.12	XXX
11982		A	Remove drug implant device	1.78	2.02	1.98	0.70	0.76	0.17	XXX
11983		A	Remove/insert drug implant	3.30	2.63	2.46	1.32	1.39	0.23	XXX
12001		A	Repair superficial wound(s)	1.72	1.73	1.86	0.73	0.75	0.15	010
12002		A	Repair superficial wound(s)	1.88	1.80	1.92	0.84	0.87	0.17	010
12004		A	Repair superficial wound(s)	2.26	2.08	2.20	0.92	0.96	0.21	010
12005		A	Repair superficial wound(s)	2.88	2.52	2.67	1.06	1.13	0.27	010
12006		A	Repair superficial wound(s)	3.68	3.06	3.22	1.30	1.40	0.35	010
12007		A	Repair superficial wound(s)	4.13	3.35	3.58	1.46	1.64	0.45	010
12011		A	Repair superficial wound(s)	1.78	1.91	2.02	0.76	0.77	0.16	010
12013		A	Repair superficial wound(s)	2.01	2.06	2.17	0.89	0.91	0.18	010
12014		A	Repair superficial wound(s)	2.48	2.29	2.43	0.98	1.02	0.23	010
12015		A	Repair superficial wound(s)	3.21	2.79	2.96	1.12	1.18	0.29	010
12016		A	Repair superficial wound(s)	3.94	3.17	3.36	1.28	1.40	0.37	010
12017		A	Repair superficial wound(s)	4.72	NA	NA	1.52	1.71	0.47	010
12018		A	Repair superficial wound(s)	5.54	NA	NA	1.92	2.09	0.64	010
12020		A	Closure of split wound	2.64	3.69	3.75	1.75	1.84	0.30	010
12021		A	Closure of split wound	1.86	1.85	1.83	1.33	1.37	0.24	010
12031		A	Layer closure of wound(s)	2.17	3.89	3.09	1.77	1.36	0.17	010
12032		A	Layer closure of wound(s)	2.49	5.21	4.52	2.28	2.04	0.16	010
12034		A	Layer closure of wound(s)	2.94	4.61	3.90	1.99	1.72	0.25	010
12035		A	Layer closure of wound(s)	3.44	5.29	5.24	2.11	2.13	0.39	010
12036		A	Layer closure of wound(s)	4.06	5.40	5.48	2.23	2.39	0.55	010

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
12037		A	Layer closure of wound(s)	4.68	5.98	6.04	2.63	2.80	0.66	010
12041		A	Layer closure of wound(s)	2.39	3.87	3.20	1.77	1.45	0.19	010
12042		A	Layer closure of wound(s)	2.76	4.49	3.88	2.12	1.79	0.17	010
12044		A	Layer closure of wound(s)	3.16	5.40	4.31	1.95	1.77	0.27	010
12045		A	Layer closure of wound(s)	3.65	5.03	5.14	2.06	2.17	0.41	010
12046		A	Layer closure of wound(s)	4.26	5.65	6.08	2.29	2.52	0.54	010
12047		A	Layer closure of wound(s)	4.66	6.49	6.41	2.66	2.87	0.58	010
12051		A	Layer closure of wound(s)	2.49	4.11	3.69	1.92	1.68	0.20	010
12052		A	Layer closure of wound(s)	2.81	4.86	4.04	2.56	1.99	0.17	010
12053		A	Layer closure of wound(s)	3.14	5.38	4.31	2.12	1.82	0.23	010
12054		A	Layer closure of wound(s)	3.47	5.42	4.49	2.05	1.84	0.30	010
12055		A	Layer closure of wound(s)	4.44	6.01	5.24	2.09	2.11	0.45	010
12056		A	Layer closure of wound(s)	5.25	6.56	6.65	2.58	2.81	0.59	010
12057		A	Layer closure of wound(s)	5.97	7.75	6.94	2.93	3.34	0.56	010
13100		A	Repair of wound or lesion	3.14	4.42	4.23	2.46	2.38	0.26	010
13101		A	Repair of wound or lesion	3.93	5.94	5.30	2.97	2.83	0.26	010
13102		A	Repair wound/lesion add-on	1.24	1.35	1.26	0.53	0.55	0.13	ZZZ
13120		A	Repair of wound or lesion	3.32	4.58	4.36	2.57	2.46	0.26	010
13121		A	Repair of wound or lesion	4.36	6.71	5.78	3.64	3.21	0.25	010
13122		A	Repair wound/lesion add-on	1.44	1.37	1.44	0.58	0.60	0.15	ZZZ
13131		A	Repair of wound or lesion	3.80	5.01	4.68	2.88	2.78	0.26	010
13132		A	Repair of wound or lesion	6.48	7.88	6.89	4.95	4.55	0.32	010
13133		A	Repair wound/lesion add-on	2.19	1.87	1.76	0.98	1.00	0.18	ZZZ
13150		A	Repair of wound or lesion	3.82	4.72	4.79	2.72	2.74	0.34	010
13151		A	Repair of wound or lesion	4.46	5.51	5.15	3.22	3.18	0.31	010
13152		A	Repair of wound or lesion	6.34	7.53	6.78	3.91	3.97	0.40	010
13153		A	Repair wound/lesion add-on	2.38	2.05	1.99	1.03	1.08	0.24	ZZZ
13160		A	Late closure of wound	11.84	NA	NA	7.02	7.09	1.54	090
14000		A	Skin tissue rearrangement	6.83	8.94	8.39	6.04	5.75	0.59	090
14001		A	Skin tissue rearrangement	9.60	11.01	10.21	7.48	7.27	0.82	090
14020		A	Skin tissue rearrangement	7.66	10.02	9.31	6.88	6.70	0.64	090
14021		A	Skin tissue rearrangement	11.18	12.45	11.21	8.65	8.46	0.81	090
14040		A	Skin tissue rearrangement	8.44	10.19	9.49	6.98	7.09	0.62	090
14041		A	Skin tissue rearrangement	12.67	13.56	12.07	9.34	9.00	0.73	090
14060		A	Skin tissue rearrangement	9.07	9.68	9.23	7.17	7.30	0.68	090
14061		A	Skin tissue rearrangement	13.67	14.82	13.21	10.17	9.83	0.76	090
14300		A	Skin tissue rearrangement	13.26	13.51	12.32	9.44	9.30	1.16	090
14350		A	Skin tissue rearrangement	10.82	NA	NA	6.89	7.01	1.34	090
15002		A	Wnd prep, ch/inf, trk/arm/lg	3.65	4.21	4.21	1.68	1.68	0.49	000
15003		A	Wnd prep, ch/inf addl 100 cm	0.80	0.90	0.90	0.26	0.26	0.11	ZZZ
15004		A	Wnd prep ch/inf, f/n/hf/g	4.58	4.87	4.87	2.01	2.01	0.62	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.24	1.24	0.52	0.52	0.22	ZZZ
15040		A	Harvest cultured skin graft	2.00	3.93	4.24	1.05	1.09	0.24	000
15050		A	Skin pinch graft	5.37	7.62	7.26	5.00	5.05	0.57	090
15100		A	Skin splt grft, trnk/arm/leg	9.74	9.76	11.17	6.67	7.24	1.28	090
15101		A	Skin splt grft t/a/l, add-on	1.72	2.47	3.10	0.85	1.01	0.24	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.88	8.74	9.70	6.36	6.68	1.31	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	0.87	1.08	0.62	0.70	0.26	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.19	9.22	9.22	6.73	7.04	1.15	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.19	1.38	0.86	0.99	0.33	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	10.96	11.34	11.03	7.45	7.61	1.16	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.43	3.96	1.29	1.57	0.36	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.41	7.95	8.90	5.57	5.95	0.97	090
15131		A	Derm autograft t/a/l add-on	1.50	0.65	0.86	0.48	0.56	0.21	ZZZ
15135		A	Derm autograft face/nck/hf/g	10.91	9.48	9.67	7.04	7.58	1.23	090
15136		A	Derm autograft, f/n/hf/g add	1.50	0.66	0.77	0.51	0.59	0.20	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.30	7.04	7.74	5.75	6.10	1.14	090
15151		A	Cult epiderm grft t/a/l addl	2.00	0.88	1.09	0.67	0.76	0.28	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.05	1.30	0.84	0.95	0.35	ZZZ
15155		A	Cult epiderm graft, f/n/hf/g	10.05	7.65	7.73	6.30	6.63	1.05	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.15	1.35	0.94	1.09	0.36	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.33	1.55	1.03	1.19	0.39	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	4.01	3.92	2.60	2.48	0.55	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.60	0.64	0.46	0.54	0.19	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	4.46	4.94	3.14	3.57	0.82	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.04	1.07	0.79	0.89	0.29	ZZZ
15200		A	Skin full graft, trunk	8.97	9.90	9.65	6.34	6.27	0.98	090
15201		A	Skin full graft trunk add-on	1.32	2.02	2.29	0.47	0.54	0.19	ZZZ
15220		A	Skin full graft sclp/arm/leg	7.95	10.45	9.82	6.69	6.68	0.84	090
15221		A	Skin full graft add-on	1.19	2.00	2.16	0.50	0.53	0.16	ZZZ
15240		A	Skin full grft face/genit/hf	10.15	12.03	11.11	8.89	8.42	0.92	090
15241		A	Skin full graft add-on	1.86	2.54	2.49	0.81	0.86	0.23	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
15260	.....	A	Skin full graft een & lips	11.39	13.00	11.60	9.33	8.95	0.69	090
15261	.....	A	Skin full graft add-on	2.23	2.97	2.83	1.15	1.28	0.21	ZZZ
15300	.....	A	Apply skinallogrft, t/arm/lg	4.65	3.44	3.32	2.15	2.19	0.49	090
15301	.....	A	Apply sknallogrft t/a/l addl	1.00	0.46	0.46	0.32	0.36	0.14	ZZZ
15320	.....	A	Apply skin allogrft f/n/hf/g	5.36	3.78	3.70	2.35	2.44	0.58	090
15321	.....	A	Aply sknallogrft f/n/hfg add	1.50	0.69	0.69	0.51	0.55	0.21	ZZZ
15330	.....	A	Aply acell alogrft t/arm/leg	3.99	3.49	3.34	2.14	2.18	0.49	090
15331	.....	A	Aply acell grft t/a/l add-on	1.00	0.49	0.47	0.36	0.38	0.14	ZZZ
15335	.....	A	Apply acell graft, f/n/hf/g	4.50	3.32	3.39	2.01	2.22	0.55	090
15336	.....	A	Aply acell grft f/n/hf/g add	1.43	0.74	0.71	0.51	0.54	0.20	ZZZ
15340	.....	A	Apply cult skin substitute	3.76	3.68	3.84	2.64	2.69	0.41	010
15341	.....	A	Apply cult skin sub add-on	0.50	0.64	0.62	0.13	0.17	0.06	ZZZ
15360	.....	A	Apply cult derm sub, t/a/l	3.93	4.85	4.66	3.53	3.31	0.43	090
15361	.....	A	Aply cult derm sub t/a/l add	1.15	0.50	0.54	0.32	0.39	0.14	ZZZ
15365	.....	A	Apply cult derm sub f/n/hf/g	4.21	4.21	4.38	3.09	3.14	0.46	090
15366	.....	A	Apply cult derm f/hf/g add	1.45	0.67	0.68	0.47	0.53	0.17	ZZZ
15400	.....	A	Apply skin xenograft, t/a/l	4.38	4.99	4.50	3.76	3.88	0.47	090
15401	.....	A	Apply skn xenogrft t/a/l add	1.00	1.01	1.45	0.33	0.39	0.14	ZZZ
15420	.....	A	Apply skin xgraft, f/n/hf/g	4.89	5.43	5.10	4.17	3.98	0.52	090
15421	.....	A	Apply skn xgrft f/n/hf/g add	1.50	1.16	1.24	0.48	0.55	0.21	ZZZ
15430	.....	A	Apply acellular xenograft	5.93	6.60	6.75	6.05	6.33	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	10.08	10.69	6.27	6.51	1.34	090
15572	.....	A	Form skin pedicle flap	9.94	9.78	9.63	6.66	6.55	1.20	090
15574	.....	A	Form skin pedicle flap	10.52	10.54	10.61	7.03	7.41	1.20	090
15576	.....	A	Form skin pedicle flap	9.24	9.66	9.70	6.51	6.70	0.87	090
15600	.....	A	Skin graft	1.95	5.31	6.45	2.75	2.90	0.27	090
15610	.....	A	Skin graft	2.46	5.56	5.12	3.04	3.23	0.35	090
15620	.....	A	Skin graft	3.62	6.47	7.12	3.90	3.89	0.35	090
15630	.....	A	Skin graft	3.95	7.07	7.05	4.31	4.23	0.34	090
15650	.....	A	Transfer skin pedicle flap	4.64	7.27	7.20	4.38	4.29	0.42	090
15731	.....	A	Forehead flap w/vasc pedicle	14.12	11.89	11.89	9.33	9.33	1.28	090
15732	.....	A	Muscle-skin graft, head/neck	19.70	14.64	16.34	11.09	11.65	2.00	090
15734	.....	A	Muscle-skin graft, trunk	19.62	15.68	16.89	11.84	12.10	2.62	090
15736	.....	A	Muscle-skin graft, arm	16.92	13.39	15.80	9.59	10.40	2.46	090
15738	.....	A	Muscle-skin graft, leg	18.92	13.76	15.86	10.18	10.95	2.66	090
15740	.....	A	Island pedicle flap graft	11.57	13.56	11.84	9.41	8.83	0.63	090
15750	.....	A	Neurovascular pedicle graft	12.73	NA	NA	8.85	8.94	1.42	090
15756	.....	A	Free myo/skin flap microvasc	36.74	NA	NA	18.55	19.55	4.62	090
15757	.....	A	Free skin flap, microvasc	36.95	NA	NA	17.85	19.71	3.90	090
15758	.....	A	Free fascial flap, microvasc	36.70	NA	NA	17.56	19.56	4.24	090
15760	.....	A	Composite skin graft	9.68	10.41	10.21	7.05	7.15	0.85	090
15770	.....	A	Derma-fat-fascia graft	8.73	NA	NA	6.63	6.66	1.05	090
15775	.....	R	Hair transplant punch grafts	3.95	2.88	3.55	1.23	1.26	0.52	000
15776	.....	R	Hair transplant punch grafts	5.53	4.85	5.10	2.14	2.47	0.72	000
15780	.....	A	Abrasion treatment of skin	8.50	11.23	11.37	6.52	7.38	0.67	090
15781	.....	A	Abrasion treatment of skin	4.91	8.67	7.79	5.64	5.50	0.34	090
15782	.....	A	Abrasion treatment of skin	4.36	8.70	9.28	4.96	5.75	0.34	090
15783	.....	A	Abrasion treatment of skin	4.33	7.91	7.39	4.96	4.57	0.28	090
15786	.....	A	Abrasion, lesion, single	2.05	3.89	3.62	1.24	1.28	0.11	010
15787	.....	A	Abrasion, lesions, add-on	0.33	0.83	0.96	0.08	0.12	0.04	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	9.45	8.08	4.12	3.60	0.11	090
15789	.....	R	Chemical peel, face, dermal	4.91	9.42	8.75	5.83	5.31	0.20	090
15792	.....	R	Chemical peel, nonfacial	1.86	8.97	8.03	4.58	4.51	0.13	090
15793	.....	A	Chemical peel, nonfacial	3.82	8.09	7.19	4.90	4.64	0.19	090
15819	.....	A	Plastic surgery, neck	10.45	NA	NA	6.68	6.93	0.97	090
15820	.....	A	Revision of lower eyelid	6.09	6.39	6.68	5.19	5.38	0.40	090
15821	.....	A	Revision of lower eyelid	6.66	6.56	6.95	5.28	5.49	0.45	090
15822	.....	A	Revision of upper eyelid	4.51	5.23	5.53	4.09	4.29	0.37	090
15823	.....	A	Revision of upper eyelid	8.12	7.38	7.61	6.10	6.27	0.50	090
15824	.....	R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825	.....	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826	.....	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828	.....	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829	.....	R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15830	.....	R	Exc skin abd	16.90	NA	NA	9.81	9.81	2.93	090
15832	.....	A	Excise excessive skin tissue	12.65	NA	NA	8.27	8.30	1.66	090
15833	.....	A	Excise excessive skin tissue	11.70	NA	NA	7.50	7.85	1.49	090
15834	.....	A	Excise excessive skin tissue	11.97	NA	NA	8.15	7.92	1.61	090
15835	.....	A	Excise excessive skin tissue	12.79	NA	NA	7.85	7.69	1.60	090
15836	.....	A	Excise excessive skin tissue	10.41	NA	NA	6.82	6.80	1.34	090
15837	.....	A	Excise excessive skin tissue	9.37	8.67	8.61	5.78	6.57	1.18	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
15838		A	Excise excessive skin tissue	8.07	NA	NA	5.44	5.75	0.58	090
15839		A	Excise excessive skin tissue	10.32	9.75	9.29	6.46	6.42	1.22	090
15840		A	Graft for face nerve palsy	14.76	NA	NA	8.91	9.44	1.32	090
15841		A	Graft for face nerve palsy	25.69	NA	NA	13.52	14.25	2.55	090
15842		A	Flap for face nerve palsy	40.68	NA	NA	20.86	21.88	4.94	090
15845		A	Skin and muscle repair, face	14.04	NA	NA	8.35	8.83	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	1.20	1.38	0.18	0.24	0.05	XXX
15851		A	Removal of sutures	0.86	1.33	1.50	0.24	0.27	0.06	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.25	0.29	0.09	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.64	0.71	0.27	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.15	NA	NA	5.34	5.45	1.04	090
15922		A	Removal of tail bone ulcer	10.23	NA	NA	7.16	7.18	1.42	090
15931		A	Remove sacrum pressure sore	9.96	NA	NA	5.56	5.62	1.25	090
15933		A	Remove sacrum pressure sore	11.60	NA	NA	7.30	7.57	1.52	090
15934		A	Remove sacrum pressure sore	13.54	NA	NA	7.72	7.87	1.79	090
15935		A	Remove sacrum pressure sore	15.58	NA	NA	9.17	9.74	2.10	090
15936		A	Remove sacrum pressure sore	13.04	NA	NA	7.41	7.81	1.77	090
15937		A	Remove sacrum pressure sore	15.00	NA	NA	8.93	9.37	2.07	090
15940		A	Remove hip pressure sore	10.11	NA	NA	5.80	5.99	1.31	090
15941		A	Remove hip pressure sore	12.24	NA	NA	8.42	8.93	1.66	090
15944		A	Remove hip pressure sore	12.27	NA	NA	8.13	8.36	1.65	090
15945		A	Remove hip pressure sore	13.57	NA	NA	8.80	9.22	1.85	090
15946		A	Remove hip pressure sore	23.80	NA	NA	13.69	14.03	3.17	090
15950		A	Remove thigh pressure sore	7.91	NA	NA	5.40	5.40	1.04	090
15951		A	Remove thigh pressure sore	11.41	NA	NA	7.33	7.59	1.49	090
15952		A	Remove thigh pressure sore	12.14	NA	NA	7.45	7.60	1.60	090
15953		A	Remove thigh pressure sore	13.39	NA	NA	8.22	8.61	1.80	090
15956		A	Remove thigh pressure sore	16.59	NA	NA	9.54	10.15	2.22	090
15958		A	Remove thigh pressure sore	16.55	NA	NA	10.42	10.72	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	0.79	0.23	0.25	0.08	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.11	1.20	0.56	0.57	0.08	000
16025		A	Dress/debrid p-thick burn, m	1.85	1.57	1.67	0.86	0.91	0.19	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.08	2.13	1.02	1.07	0.24	000
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.22	1.40	0.46	000
16036		A	Escharotomy; add'l incision	1.50	NA	NA	0.46	0.53	0.20	ZZZ
17000		A	Destruct premalg lesion	0.62	1.41	1.19	0.74	0.64	0.03	010
17003		A	Destruct premalg les, 2–14	0.07	0.10	0.11	0.03	0.05	0.01	ZZZ
17004		A	Destroy premlg lesions 15+	1.82	2.44	2.37	1.38	1.48	0.11	010
17106		A	Destruction of skin lesions	4.62	4.69	4.64	3.28	3.30	0.35	090
17107		A	Destruction of skin lesions	9.19	6.97	7.08	4.94	5.20	0.63	090
17108		A	Destruction of skin lesions	13.22	8.86	9.06	6.38	7.02	0.54	090
17110		A	Destruct b9 lesion, 1–14	0.67	1.79	1.70	0.88	0.79	0.05	010
17111		A	Destruct lesion, 15 or more	0.94	2.25	1.96	1.11	0.96	0.05	010
17250		A	Chemical cautery, tissue	0.50	1.32	1.27	0.38	0.36	0.06	000
17260		A	Destruction of skin lesions	0.93	1.41	1.34	0.71	0.69	0.04	010
17261		A	Destruction of skin lesions	1.19	2.49	2.05	1.07	0.95	0.05	010
17262		A	Destruction of skin lesions	1.60	2.83	2.36	1.27	1.14	0.06	010
17263		A	Destruction of skin lesions	1.81	3.06	2.56	1.37	1.23	0.07	010
17264		A	Destruction of skin lesions	1.96	3.27	2.74	1.43	1.28	0.08	010
17266		A	Destruction of skin lesions	2.36	3.50	3.00	1.59	1.40	0.09	010
17270		A	Destruction of skin lesions	1.34	2.43	2.06	1.10	0.98	0.05	010
17271		A	Destruction of skin lesions	1.51	2.66	2.22	1.22	1.10	0.06	010
17272		A	Destruction of skin lesions	1.79	2.97	2.48	1.36	1.24	0.07	010
17273		A	Destruction of skin lesions	2.07	3.21	2.71	1.49	1.35	0.08	010
17274		A	Destruction of skin lesions	2.61	3.60	3.08	1.74	1.59	0.10	010
17276		A	Destruction of skin lesions	3.22	3.88	3.41	1.97	1.82	0.16	010
17280		A	Destruction of skin lesions	1.19	2.36	1.98	1.03	0.92	0.05	010
17281		A	Destruction of skin lesions	1.74	2.73	2.32	1.33	1.21	0.07	010
17282		A	Destruction of skin lesions	2.06	3.14	2.64	1.49	1.36	0.08	010
17283		A	Destruction of skin lesions	2.66	3.55	3.05	1.76	1.62	0.11	010
17284		A	Destruction of skin lesions	3.23	3.97	3.44	2.02	1.89	0.13	010
17286		A	Destruction of skin lesions	4.45	4.44	4.06	2.49	2.46	0.23	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.70	10.70	3.05	3.05	0.24	000
17312		A	Mohs addl stage	3.30	6.88	6.88	1.62	1.62	0.13	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	9.87	9.87	2.73	2.73	0.22	000
17314		A	Mohs, addl stage, t/a/l	3.06	6.37	6.37	1.50	1.50	0.12	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
17315		A	Mohs surg, addl block	0.87	1.14	1.14	0.43	0.43	0.03	ZZZ
17340		A	Cryotherapy of skin	0.76	0.35	0.36	0.38	0.37	0.05	010
17360		A	Skin peel therapy	1.44	1.86	1.65	1.01	0.94	0.06	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1.91	1.95	0.26	0.29	0.08	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.25	0.14	0.14	0.04	ZZZ
19020		A	Incision of breast lesion	3.74	6.62	6.48	3.03	2.85	0.45	090
19030		A	Injection for breast x-ray	1.53	2.66	2.76	0.54	0.52	0.09	000
19100		A	Bx breast percut w/o image	1.27	2.08	2.08	0.33	0.37	0.16	000
19101		A	Biopsy of breast, open	3.20	4.37	4.43	1.78	1.85	0.39	010
19102		A	Bx breast percut w/image	2.00	3.46	3.64	0.68	0.67	0.14	000
19103		A	Bx breast percut w/device	3.69	10.09	10.79	1.19	1.21	0.30	000
19105		A	Cryosurg ablate fa, each	3.69	46.46	46.46	0.99	0.99	0.30	000
19110		A	Nipple exploration	4.35	6.06	5.93	3.09	2.98	0.57	090
19112		A	Excise breast duct fistula	3.72	6.22	6.14	3.12	2.90	0.48	090
19120		A	Removal of breast lesion	5.84	5.08	4.81	3.36	3.21	0.73	090
19125		A	Excision, breast lesion	6.59	5.55	5.16	3.64	3.46	0.80	090
19126		A	Excision, addl breast lesion	2.93	NA	NA	0.75	0.87	0.38	ZZZ
19260		A	Removal of chest wall lesion	17.60	NA	NA	10.14	10.64	2.14	090
19271		A	Revision of chest wall	21.86	NA	NA	15.81	16.87	2.63	090
19272		A	Extensive chest wall surgery	24.82	NA	NA	16.95	17.93	3.00	090
19290		A	Place needle wire, breast	1.27	2.89	2.87	0.45	0.43	0.07	000
19291		A	Place needle wire, breast	0.63	1.14	1.17	0.22	0.21	0.04	ZZZ
19295		A	Place breast clip, percut	0.00	2.28	2.48	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	85.92	105.62	1.19	1.36	0.36	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.44	0.54	0.17	ZZZ
19298		A	Place breast rad tube/caths	6.00	21.99	32.06	2.10	2.26	0.43	000
19300		A	Removal of breast tissue	5.20	8.05	7.59	3.85	3.62	0.69	090
19301		A	Partical mastectomy	10.00	NA	NA	4.62	4.02	0.79	090
19302		A	P-mastectomy w/ln removal	13.88	NA	NA	6.14	6.23	1.80	090
19303		A	Mast, simple, complete	15.67	NA	NA	6.99	6.00	1.18	090
19304		A	Mast, subq	7.81	NA	NA	4.93	4.84	1.04	090
19305		A	Mast, radical	17.23	NA	NA	8.11	8.03	1.93	090
19306		A	Mast, rad, urban type	17.85	NA	NA	8.71	8.47	2.08	090
19307		A	Mast, mod rad	17.95	NA	NA	8.76	8.48	2.13	090
19316		A	Suspension of breast	10.98	NA	NA	6.94	7.22	1.64	090
19318		A	Reduction of large breast	15.91	NA	NA	9.90	10.53	2.93	090
19324		A	Enlarge breast	6.65	NA	NA	4.46	4.67	0.84	090
19325		A	Enlarge breast with implant	8.52	NA	NA	6.40	6.46	1.33	090
19328		A	Removal of breast implant	6.35	NA	NA	4.99	5.00	0.91	090
19330		A	Removal of implant material	8.39	NA	NA	5.95	5.99	1.26	090
19340		A	Immediate breast prosthesis	6.32	NA	NA	2.81	2.96	1.06	ZZZ
19342		A	Delayed breast prosthesis	12.40	NA	NA	8.92	8.92	1.84	090
19350		A	Breast reconstruction	8.99	9.88	11.86	6.58	6.87	1.41	090
19355		A	Correct inverted nipple(s)	8.37	7.40	8.82	4.67	4.68	0.92	090
19357		A	Breast reconstruction	20.57	NA	NA	15.37	15.49	2.94	090
19361		A	Breast reconstr w/lat flap	23.17	NA	NA	16.78	14.60	2.93	090
19364		A	Breast reconstruction	42.40	NA	NA	22.15	22.84	6.24	090
19366		A	Breast reconstruction	21.70	NA	NA	9.90	10.73	3.25	090
19367		A	Breast reconstruction	26.59	NA	NA	15.17	15.93	4.04	090
19368		A	Breast reconstruction	33.61	NA	NA	18.01	18.46	5.54	090
19369		A	Breast reconstruction	31.02	NA	NA	16.31	17.35	4.51	090
19370		A	Surgery of breast capsule	8.99	NA	NA	6.78	6.84	1.29	090
19371		A	Removal of breast capsule	10.42	NA	NA	7.68	7.75	1.62	090
19380		A	Revise breast reconstruction	10.21	NA	NA	7.60	7.65	1.44	090
19396		A	Design custom breast implant	2.17	4.53	2.80	1.28	1.13	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	2.78	2.74	1.52	1.63	0.25	010
20005		A	Incision of deep abscess	3.55	3.66	3.58	2.01	2.13	0.46	010
20100		A	Explore wound, neck	10.33	NA	NA	3.58	4.02	1.21	010
20101		A	Explore wound, chest	3.22	6.59	6.26	1.53	1.57	0.44	010
20102		A	Explore wound, abdomen	3.95	6.94	7.20	1.84	1.87	0.49	010
20103		A	Explore wound, extremity	5.31	7.80	8.19	2.78	3.09	0.75	010
20150		A	Excise epiphyseal bar	14.60	NA	NA	7.64	7.33	2.04	090
20200		A	Muscle biopsy	1.46	3.09	3.06	0.69	0.72	0.23	000
20205		A	Deep muscle biopsy	2.35	3.82	3.85	1.10	1.14	0.33	000
20206		A	Needle biopsy, muscle	0.99	5.22	5.86	0.57	0.60	0.07	000
20220		A	Bone biopsy, trocar/needle	1.27	2.71	3.63	0.68	0.73	0.08	000
20225		A	Bone biopsy, trocar/needle	1.87	11.99	18.21	1.02	1.07	0.22	000
20240		A	Bone biopsy, excisional	3.25	NA	NA	2.02	2.29	0.44	010
20245		A	Bone biopsy, excisional	8.77	NA	NA	5.74	6.15	1.31	010

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
20250		A	Open bone biopsy	5.16	NA	NA	3.63	3.56	1.02	010
20251		A	Open bone biopsy	5.69	NA	NA	3.84	4.00	1.15	010
20500		A	Injection of sinus tract	1.25	1.34	1.80	0.88	1.20	0.12	010
20501		A	Inject sinus tract for x-ray	0.76	2.36	2.64	0.27	0.26	0.04	000
20520		A	Removal of foreign body	1.87	2.60	2.76	1.45	1.61	0.21	010
20525		A	Removal of foreign body	3.51	7.11	8.12	2.21	2.41	0.51	010
20526		A	Ther injection, carp tunnel	0.94	0.81	0.89	0.41	0.46	0.13	000
20550		A	Inj tendon sheath/ligament	0.75	0.63	0.67	0.28	0.25	0.09	000
20551		A	Inj tendon origin/insertion	0.75	0.64	0.66	0.29	0.31	0.08	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.58	0.65	0.24	0.22	0.05	000
20553		A	Inject trigger points, =/> 3	0.75	0.64	0.73	0.26	0.24	0.04	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.18	2.18	0.43	000
20600		A	Drain/inject, joint/bursa	0.66	0.66	0.66	0.31	0.33	0.08	000
20605		A	Drain/inject, joint/bursa	0.68	0.74	0.75	0.32	0.34	0.08	000
20610		A	Drain/inject, joint/bursa	0.79	1.06	1.01	0.40	0.41	0.11	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.70	0.70	0.32	0.34	0.10	000
20615		A	Treatment of bone cyst	2.30	2.71	3.11	1.41	1.63	0.20	010
20650		A	Insert and remove bone pin	2.25	2.46	2.41	1.45	1.50	0.31	010
20660		A	Apply, rem fixation device	4.00	1.50	2.27	1.50	1.55	0.59	000
20661		A	Application of head brace	5.14	NA	NA	6.04	5.47	1.14	090
20662		A	Application of pelvis brace	6.26	NA	NA	4.80	5.16	0.56	090
20663		A	Application of thigh brace	5.62	NA	NA	4.85	4.84	0.94	090
20664		A	Halo brace application	9.86	NA	NA	7.80	7.42	1.75	090
20665		A	Removal of fixation device	1.33	1.37	1.76	0.98	1.16	0.19	010
20670		A	Removal of support implant	1.76	6.62	9.07	1.67	1.88	0.28	010
20680		A	Removal of support implant	5.90	8.13	8.46	4.06	3.89	0.56	090
20690		A	Apply bone fixation device	8.65	NA	NA	4.91	3.71	0.59	090
20692		A	Apply bone fixation device	16.00	NA	NA	9.79	6.78	1.05	090
20693		A	Adjust bone fixation device	5.97	NA	NA	4.49	4.96	0.98	090
20694		A	Remove bone fixation device	4.20	5.31	6.22	3.52	3.78	0.71	090
20802		A	Replantation, arm, complete	42.30	NA	NA	13.22	17.08	3.82	090
20805		A	Replant forearm, complete	51.14	NA	NA	17.97	26.13	4.85	090
20808		A	Replantation hand, complete	62.77	NA	NA	30.31	36.25	6.88	090
20816		A	Replantation digit, complete	31.74	NA	NA	16.35	27.06	4.53	090
20822		A	Replantation digit, complete	26.42	NA	NA	15.05	24.81	4.19	090
20824		A	Replantation thumb, complete	31.74	NA	NA	16.19	26.36	4.62	090
20827		A	Replantation thumb, complete	27.24	NA	NA	14.73	25.59	3.67	090
20838		A	Replantation foot, complete	42.56	NA	NA	14.01	18.14	1.12	090
20900		A	Removal of bone for graft	5.77	9.22	8.82	4.90	5.28	0.94	090
20902		A	Removal of bone for graft	7.98	NA	NA	5.98	6.43	1.30	090
20910		A	Remove cartilage for graft	5.41	NA	NA	4.56	4.87	0.71	090
20912		A	Remove cartilage for graft	6.42	NA	NA	4.94	5.37	0.69	090
20920		A	Removal of fascia for graft	5.42	NA	NA	4.33	4.28	0.66	090
20922		A	Removal of fascia for graft	6.84	7.56	7.54	4.99	4.93	0.70	090
20924		A	Removal of tendon for graft	6.59	NA	NA	4.97	5.42	1.04	090
20926		A	Removal of tissue for graft	5.70	NA	NA	4.49	4.62	0.87	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	0.68	0.80	0.43	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.08	1.26	0.54	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.15	1.35	0.64	ZZZ
20950		A	Fluid pressure, muscle	1.26	4.23	5.53	0.88	0.93	0.20	000
20955		A	Fibula bone graft, microvasc	40.02	NA	NA	18.53	21.39	4.90	090
20956		A	Iliac bone graft, microvasc	40.93	NA	NA	20.31	22.52	7.03	090
20957		A	Mt bone graft, microvasc	42.33	NA	NA	15.87	17.40	7.07	090
20962		A	Other bone graft, microvasc	39.21	NA	NA	21.29	23.90	6.57	090
20969		A	Bone/skin graft, microvasc	45.11	NA	NA	21.09	23.85	4.80	090
20970		A	Bone/skin graft, iliac crest	44.26	NA	NA	20.89	23.13	6.62	090
20972		A	Bone/skin graft, metatarsal	44.19	NA	NA	14.92	17.74	5.32	090
20973		A	Bone/skin graft, great toe	46.95	NA	NA	14.15	19.64	5.56	090
20974		A	Electrical bone stimulation	0.62	0.98	0.83	0.48	0.51	0.11	000
20975		A	Electrical bone stimulation	2.60	NA	NA	1.46	1.58	0.51	000
20979		A	Us bone stimulation	0.62	0.61	0.71	0.20	0.27	0.09	000
20982		A	Ablate, bone tumor(s) perq	7.27	79.99	94.74	2.68	2.83	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	6.29	6.69	1.11	090
21015		A	Resection of facial tumor	5.59	NA	NA	4.30	4.65	0.70	090
21025		A	Excision of bone, lower jaw	11.07	12.54	12.39	8.74	9.04	1.32	090
21026		A	Excision of facial bone(s)	5.54	8.82	8.34	5.93	6.12	0.60	090

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21029		A	Contour of face bone lesion	8.26	9.55	9.46	6.52	6.76	0.94	090
21030		A	Excise max/zygoma b9 tumor	4.80	7.19	6.76	4.68	4.85	0.54	090
21031		A	Remove exostosis, mandible	3.26	5.91	5.54	3.47	3.54	0.48	090
21032		A	Remove exostosis, maxilla	3.28	6.04	5.69	3.36	3.43	0.47	090
21034		A	Excise max/zygoma mlg tumor	17.17	13.92	14.92	10.11	11.38	1.72	090
21040		A	Excise mandible lesion	4.80	7.19	6.79	4.64	4.68	0.54	090
21044		A	Removal of jaw bone lesion	12.61	NA	NA	8.10	8.73	1.12	090
21045		A	Extensive jaw surgery	18.13	NA	NA	10.78	11.56	1.52	090
21046		A	Remove mandible cyst complex	13.97	NA	NA	11.48	11.69	1.86	090
21047		A	Excise lwr jaw cyst w/repair	19.83	NA	NA	10.21	11.82	2.13	090
21048		A	Remove maxilla cyst complex	14.47	NA	NA	11.38	11.75	1.77	090
21049		A	Excis uppr jaw cyst w/repair	19.08	NA	NA	10.28	11.65	1.59	090
21050		A	Removal of jaw joint	11.54	NA	NA	8.20	8.82	1.47	090
21060		A	Remove jaw joint cartilage	10.91	NA	NA	7.19	7.89	1.38	090
21070		A	Remove coronoid process	8.50	NA	NA	6.26	6.68	1.27	090
21073		A	Mnpj of tmj w/anesth	3.33	5.50	5.50	2.31	2.31	0.43	090
21076		A	Prepare face/oral prosthesis	13.40	8.01	10.18	4.68	7.34	2.00	010
21077		A	Prepare face/oral prosthesis	33.70	18.42	24.86	11.82	18.90	4.56	090
21079		A	Prepare face/oral prosthesis	22.31	13.95	17.72	8.09	12.62	3.16	090
21080		A	Prepare face/oral prosthesis	25.06	16.14	20.31	9.01	14.18	3.75	090
21081		A	Prepare face/oral prosthesis	22.85	15.01	18.65	8.40	12.94	3.21	090
21082		A	Prepare face/oral prosthesis	20.84	14.89	17.11	8.26	11.99	3.12	090
21083		A	Prepare face/oral prosthesis	19.27	14.89	16.83	7.77	11.10	2.89	090
21084		A	Prepare face/oral prosthesis	22.48	16.83	19.63	8.94	13.31	2.19	090
21085		A	Prepare face/oral prosthesis	8.99	6.92	7.60	3.51	5.14	1.27	010
21086		A	Prepare face/oral prosthesis	24.88	12.90	18.31	8.44	13.93	3.72	090
21087		A	Prepare face/oral prosthesis	24.88	13.03	18.15	8.54	13.86	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	090
21100		A	Maxillofacial fixation	4.56	14.86	13.19	5.53	5.13	0.34	090
21110		A	Interdental fixation	5.80	13.04	11.30	9.73	9.04	0.72	090
21116		A	Injection, jaw joint x-ray	0.81	2.52	3.42	0.23	0.28	0.06	000
21120		A	Reconstruction of chin	4.99	9.64	10.11	6.64	7.06	0.60	090
21121		A	Reconstruction of chin	7.70	10.63	10.18	7.58	7.70	0.90	090
21122		A	Reconstruction of chin	8.59	NA	NA	8.45	8.53	1.07	090
21123		A	Reconstruction of chin	11.22	NA	NA	7.03	8.91	1.40	090
21125		A	Augmentation, lower jaw bone	10.68	63.93	59.56	6.42	7.37	0.79	090
21127		A	Augmentation, lower jaw bone	12.24	84.93	63.85	7.49	8.47	1.52	090
21137		A	Reduction of forehead	10.12	NA	NA	7.43	7.58	1.32	090
21138		A	Reduction of forehead	12.73	NA	NA	7.78	8.65	1.75	090
21139		A	Reduction of forehead	14.90	NA	NA	6.98	9.02	1.18	090
21141		A	Reconstruct midface, lefort	19.27	NA	NA	11.85	12.75	2.36	090
21142		A	Reconstruct midface, lefort	19.98	NA	NA	10.07	11.44	2.39	090
21143		A	Reconstruct midface, lefort	20.75	NA	NA	11.80	13.05	1.66	090
21145		A	Reconstruct midface, lefort	23.64	NA	NA	12.96	13.43	2.85	090
21146		A	Reconstruct midface, lefort	24.54	NA	NA	9.17	12.25	3.10	090
21147		A	Reconstruct midface, lefort	26.14	NA	NA	14.29	14.67	1.85	090
21150		A	Reconstruct midface, lefort	25.78	NA	NA	16.90	16.83	2.56	090
21151		A	Reconstruct midface, lefort	28.84	NA	NA	11.60	17.27	2.31	090
21154		A	Reconstruct midface, lefort	31.05	NA	NA	17.87	20.49	2.49	090
21155		A	Reconstruct midface, lefort	34.98	NA	NA	18.15	21.02	6.66	090
21159		A	Reconstruct midface, lefort	42.90	NA	NA	15.12	22.09	8.20	090
21160		A	Reconstruct midface, lefort	46.95	NA	NA	23.21	25.33	4.14	090
21172		A	Reconstruct orbit/forehead	28.07	NA	NA	13.73	13.74	3.56	090
21175		A	Reconstruct orbit/forehead	33.43	NA	NA	13.51	15.65	4.84	090
21179		A	Reconstruct entire forehead	22.53	NA	NA	11.21	12.66	2.81	090
21180		A	Reconstruct entire forehead	25.46	NA	NA	12.98	14.18	3.49	090
21181		A	Contour cranial bone lesion	10.18	NA	NA	6.82	7.14	1.32	090
21182		A	Reconstruct cranial bone	32.45	NA	NA	15.26	17.18	2.81	090
21183		A	Reconstruct cranial bone	35.57	NA	NA	19.20	20.01	4.48	090
21184		A	Reconstruct cranial bone	38.49	NA	NA	15.61	18.77	5.72	090
21188		A	Reconstruction of midface	22.97	NA	NA	15.63	17.24	1.70	090
21193		A	Reconst lwr jaw w/o graft	18.65	NA	NA	9.80	11.23	2.24	090
21194		A	Reconst lwr jaw w/graft	21.54	NA	NA	12.12	12.93	2.03	090
21195		A	Reconst lwr jaw w/o fixation	18.88	NA	NA	13.06	13.94	1.64	090
21196		A	Reconst lwr jaw w/fixation	20.55	NA	NA	13.93	14.81	2.08	090
21198		A	Reconstr lwr jaw segment	15.48	NA	NA	11.88	12.29	1.44	090
21199		A	Reconstr lwr jaw w/advance	16.62	NA	NA	7.56	8.34	1.39	090
21206		A	Reconstruct upper jaw bone	15.36	NA	NA	10.88	11.75	1.33	090
21208		A	Augmentation of facial bones	11.15	33.14	27.73	8.00	8.79	1.09	090
21209		A	Reduction of facial bones	7.58	12.19	11.49	7.39	7.72	0.90	090
21210		A	Face bone graft	11.40	43.44	34.15	7.63	8.49	1.30	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
21215		A	Lower jaw bone graft	11.94	86.03	63.95	7.96	8.66	1.53	090
21230		A	Rib cartilage graft	11.06	NA	NA	7.01	7.52	1.29	090
21235		A	Ear cartilage graft	7.31	10.10	9.97	6.18	6.29	0.61	090
21240		A	Reconstruction of jaw joint	15.77	NA	NA	9.43	10.73	2.25	090
21242		A	Reconstruction of jaw joint	14.32	NA	NA	9.01	10.25	1.79	090
21243		A	Reconstruction of jaw joint	24.03	NA	NA	14.14	15.78	3.26	090
21244		A	Reconstruction of lower jaw	13.35	NA	NA	11.51	11.80	1.25	090
21245		A	Reconstruction of jaw	12.88	14.20	14.30	8.61	9.23	1.19	090
21246		A	Reconstruction of jaw	12.78	NA	NA	7.42	8.23	1.35	090
21247		A	Reconstruct lower jaw bone	24.05	NA	NA	12.69	15.01	2.84	090
21248		A	Reconstruction of jaw	12.54	12.60	12.36	7.51	8.45	1.55	090
21249		A	Reconstruction of jaw	18.57	15.72	16.22	9.61	11.15	2.49	090
21255		A	Reconstruct lower jaw bone	18.14	NA	NA	14.03	15.08	2.39	090
21256		A	Reconstruction of orbit	17.42	NA	NA	9.57	10.69	1.50	090
21260		A	Revise eye sockets	17.74	NA	NA	12.95	12.85	0.97	090
21261		A	Revise eye sockets	33.78	NA	NA	14.74	19.48	3.43	090
21263		A	Revise eye sockets	30.72	NA	NA	14.03	16.55	2.63	090
21267		A	Revise eye sockets	20.45	NA	NA	16.03	17.90	1.71	090
21268		A	Revise eye sockets	26.78	NA	NA	13.13	16.66	3.66	090
21270		A	Augmentation, cheek bone	10.52	11.15	11.39	5.90	6.57	0.72	090
21275		A	Revision, orbitofacial bones	11.65	NA	NA	7.15	7.65	1.29	090
21280		A	Revision of eyelid	6.92	NA	NA	5.66	5.79	0.42	090
21282		A	Revision of eyelid	4.11	NA	NA	4.16	4.32	0.26	090
21295		A	Revision of jaw muscle/bone	1.82	NA	NA	2.23	2.38	0.16	090
21296		A	Revision of jaw muscle/bone	4.67	NA	NA	5.43	5.16	0.34	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	1.99	2.14	0.11	0.13	0.05	000
21315		A	Treatment of nose fracture	1.78	4.71	4.47	1.78	1.83	0.14	010
21320		A	Treatment of nose fracture	1.86	4.29	4.10	1.36	1.49	0.18	010
21325		A	Treatment of nose fracture	4.07	NA	NA	6.97	7.79	0.31	090
21330		A	Treatment of nose fracture	5.68	NA	NA	7.62	8.66	0.56	090
21335		A	Treatment of nose fracture	8.91	NA	NA	8.47	9.04	0.74	090
21336		A	Treat nasal septal fracture	6.56	NA	NA	8.66	9.13	0.55	090
21337		A	Treat nasal septal fracture	3.26	6.14	6.13	3.56	3.56	0.28	090
21338		A	Treat nasoethmoid fracture	6.76	NA	NA	9.92	11.97	0.82	090
21339		A	Treat nasoethmoid fracture	8.39	NA	NA	9.82	11.86	0.96	090
21340		A	Treatment of nose fracture	11.33	NA	NA	7.24	7.82	1.15	090
21343		A	Treatment of sinus fracture	14.11	NA	NA	12.79	14.12	1.47	090
21344		A	Treatment of sinus fracture	21.36	NA	NA	13.05	14.77	2.44	090
21345		A	Treat nose/jaw fracture	8.87	10.48	10.16	6.55	6.86	0.92	090
21346		A	Treat nose/jaw fracture	11.29	NA	NA	10.82	11.51	1.21	090
21347		A	Treat nose/jaw fracture	13.37	NA	NA	11.73	13.96	1.47	090
21348		A	Treat nose/jaw fracture	17.36	NA	NA	10.99	11.05	2.49	090
21355		A	Treat cheek bone fracture	4.32	5.90	6.07	3.25	3.36	0.34	010
21356		A	Treat cheek bone fracture	4.70	6.97	7.04	4.05	4.30	0.46	010
21360		A	Treat cheek bone fracture	7.03	NA	NA	5.39	5.66	0.74	090
21365		A	Treat cheek bone fracture	16.52	NA	NA	9.09	9.95	1.70	090
21366		A	Treat cheek bone fracture	18.44	NA	NA	10.50	10.91	2.50	090
21385		A	Treat eye socket fracture	9.46	NA	NA	7.13	7.70	0.97	090
21386		A	Treat eye socket fracture	9.46	NA	NA	6.00	6.53	0.97	090
21387		A	Treat eye socket fracture	10.00	NA	NA	7.44	8.20	1.08	090
21390		A	Treat eye socket fracture	11.07	NA	NA	7.01	7.40	0.90	090
21395		A	Treat eye socket fracture	14.62	NA	NA	8.33	8.68	1.44	090
21400		A	Treat eye socket fracture	1.44	2.70	2.66	1.96	1.92	0.15	090
21401		A	Treat eye socket fracture	3.57	7.03	7.51	3.04	3.27	0.38	090
21406		A	Treat eye socket fracture	7.31	NA	NA	5.29	5.68	0.73	090
21407		A	Treat eye socket fracture	8.91	NA	NA	5.92	6.39	0.94	090
21408		A	Treat eye socket fracture	12.67	NA	NA	7.44	8.16	1.44	090
21421		A	Treat mouth roof fracture	5.80	12.45	10.89	9.20	8.75	0.73	090
21422		A	Treat mouth roof fracture	8.62	NA	NA	7.04	7.56	0.99	090
21423		A	Treat mouth roof fracture	10.71	NA	NA	7.39	8.36	1.27	090
21431		A	Treat craniofacial fracture	7.74	NA	NA	10.83	10.18	0.70	090
21432		A	Treat craniofacial fracture	8.76	NA	NA	6.81	7.43	0.81	090
21433		A	Treat craniofacial fracture	26.13	NA	NA	12.13	14.26	2.79	090
21435		A	Treat craniofacial fracture	20.02	NA	NA	11.07	11.88	1.99	090
21436		A	Treat craniofacial fracture	30.01	NA	NA	13.13	15.67	3.10	090
21440		A	Treat dental ridge fracture	3.28	10.06	8.58	7.45	6.80	0.38	090
21445		A	Treat dental ridge fracture	6.04	12.27	11.01	8.46	8.41	0.78	090
21450		A	Treat lower jaw fracture	3.55	10.50	8.94	7.71	7.29	0.33	090
21451		A	Treat lower jaw fracture	5.46	12.97	11.16	9.67	9.03	0.63	090
21452		A	Treat lower jaw fracture	2.29	12.02	12.52	6.05	5.33	0.27	090
21453		A	Treat lower jaw fracture	6.40	14.80	12.76	11.64	11.18	0.74	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
21454		A	Treat lower jaw fracture	7.17	NA	NA	5.72	5.99	0.82	090
21461		A	Treat lower jaw fracture	9.07	41.68	33.06	12.80	12.73	0.98	090
21462		A	Treat lower jaw fracture	10.77	42.97	35.28	13.40	13.05	1.27	090
21465		A	Treat lower jaw fracture	12.88	NA	NA	8.11	8.96	1.50	090
21470		A	Treat lower jaw fracture	17.24	NA	NA	10.17	11.09	1.97	090
21480		A	Reset dislocated jaw	0.61	1.52	1.64	0.18	0.18	0.06	000
21485		A	Reset dislocated jaw	4.58	12.09	10.15	9.10	8.38	0.51	090
21490		A	Repair dislocated jaw	12.71	NA	NA	8.12	8.90	1.97	090
21495		A	Treat hyoid bone fracture	6.55	NA	NA	10.47	9.44	0.46	090
21497		A	Interdental wiring	4.45	12.21	10.33	9.34	8.49	0.50	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.87	6.55	6.49	3.52	3.67	0.43	090
21502		A	Drain chest lesion	7.43	NA	NA	4.56	5.09	0.97	090
21510		A	Drainage of bone lesion	6.06	NA	NA	4.80	5.23	0.80	090
21550		A	Biopsy of neck/chest	2.08	4.35	3.97	1.78	1.75	0.16	010
21555		A	Remove lesion, neck/chest	4.40	5.78	5.65	3.43	3.31	0.56	090
21556		A	Remove lesion, neck/chest	5.63	NA	NA	4.14	4.12	0.65	090
21557		A	Remove tumor, neck/chest	8.91	NA	NA	4.51	4.93	1.08	090
21600		A	Partial removal of rib	7.14	NA	NA	5.96	5.85	0.99	090
21610		A	Partial removal of rib	15.76	NA	NA	8.89	8.88	3.08	090
21615		A	Removal of rib	10.31	NA	NA	5.16	5.92	1.45	090
21616		A	Removal of rib and nerves	12.54	NA	NA	6.51	7.26	1.87	090
21620		A	Partial removal of sternum	7.16	NA	NA	4.76	5.36	0.98	090
21627		A	Sternal debridement	7.18	NA	NA	5.54	5.92	1.02	090
21630		A	Extensive sternum surgery	19.01	NA	NA	10.34	11.09	2.59	090
21632		A	Extensive sternum surgery	19.51	NA	NA	9.42	10.26	2.66	090
21685		A	Hyoid myotomy & suspension	14.89	NA	NA	8.76	9.36	1.06	090
21700		A	Revision of neck muscle	6.23	NA	NA	4.39	4.41	0.32	090
21705		A	Revision of neck muscle/rib	9.83	NA	NA	4.35	4.97	1.43	090
21720		A	Revision of neck muscle	5.72	NA	NA	4.10	3.28	0.91	090
21725		A	Revision of neck muscle	7.10	NA	NA	5.14	5.29	1.21	090
21740		A	Reconstruction of sternum	17.47	NA	NA	8.20	8.35	2.37	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	11.35	NA	NA	5.31	5.71	1.63	090
21800		A	Treatment of rib fracture	0.98	1.36	1.35	1.43	1.38	0.09	090
21805		A	Treatment of rib fracture	2.80	NA	NA	3.27	3.23	0.38	090
21810		A	Treatment of rib fracture(s)	6.92	NA	NA	5.37	5.17	0.94	090
21820		A	Treat sternum fracture	1.31	1.82	1.82	1.89	1.83	0.16	090
21825		A	Treat sternum fracture	7.65	NA	NA	5.37	5.88	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	4.43	3.86	1.88	1.67	0.14	010
21925		A	Biopsy soft tissue of back	4.54	5.34	5.25	3.36	3.30	0.60	090
21930		A	Remove lesion, back or flank	5.06	6.04	5.88	3.77	3.58	0.66	090
21935		A	Remove tumor, back	18.38	NA	NA	8.44	9.03	2.48	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.57	NA	NA	8.35	8.61	1.74	090
22015		A	I&d, p-spine, l/s/ls	12.46	NA	NA	8.33	8.58	1.72	090
22100		A	Remove part of neck vertebra	10.80	NA	NA	8.19	7.86	2.14	090
22101		A	Remove part, thorax vertebra	10.88	NA	NA	8.11	7.93	1.91	090
22102		A	Remove part, lumbar vertebra	10.88	NA	NA	7.92	8.01	1.88	090
22103		A	Remove extra spine segment	2.34	NA	NA	0.90	1.05	0.44	ZZZ
22110		A	Remove part of neck vertebra	13.80	NA	NA	9.11	9.14	2.77	090
22112		A	Remove part, thorax vertebra	13.87	NA	NA	9.02	9.15	2.53	090
22114		A	Remove part, lumbar vertebra	13.87	NA	NA	9.00	9.13	2.64	090
22116		A	Remove extra spine segment	2.32	NA	NA	0.89	1.03	0.50	ZZZ
22206		A	Cut spine 3 col, thor	37.00	NA	NA	17.71	17.71	6.23	090
22207		A	Cut spine 3 col, lumb	36.50	NA	NA	17.59	17.59	6.07	090
22208		A	Cut spine 3 col, addl seg	9.66	3.72	3.72	3.72	3.72	2.07	ZZZ
22210		A	Revision of neck spine	25.13	NA	NA	14.54	14.97	5.46	090
22212		A	Revision of thorax spine	20.74	NA	NA	12.44	12.85	3.91	090
22214		A	Revision of lumbar spine	20.77	NA	NA	12.53	13.17	3.92	090
22216		A	Revise, extra spine segment	6.03	NA	NA	2.32	2.73	1.29	ZZZ
22220		A	Revision of neck spine	22.69	NA	NA	13.35	13.48	5.08	090
22222		A	Revision of thorax spine	22.84	NA	NA	10.46	10.79	4.13	090
22224		A	Revision of lumbar spine	22.84	NA	NA	12.89	13.55	4.19	090
22226		A	Revise, extra spine segment	6.03	NA	NA	2.28	2.68	1.29	ZZZ
22305		A	Treat spine process fracture	2.08	2.15	2.23	1.80	1.86	0.39	090
22310		A	Treat spine fracture	3.69	2.98	2.89	2.50	2.42	0.50	090
22315		A	Treat spine fracture	9.91	9.88	9.78	7.43	7.38	1.86	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	NA	13.25	13.31	5.30	090
22319		A	Treat odontoid fx w/graft	25.15	NA	NA	13.45	14.07	6.05	090
22325		A	Treat spine fracture	19.62	NA	NA	12.13	12.10	3.88	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
22326		A	Treat neck spine fracture	20.64	NA	NA	12.02	12.36	4.43	090
22327		A	Treat thorax spine fracture	20.52	NA	NA	12.32	12.34	3.99	090
22328		A	Treat each add spine fx	4.60	NA	NA	1.76	2.01	0.94	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	1.10	1.02	0.36	010
22520		A	Percut vertebroplasty thor	9.17	43.78	52.71	4.58	4.84	1.72	010
22521		A	Percut vertebroplasty lumb	8.60	44.96	50.45	4.36	4.65	1.60	010
22522		A	Percut vertebroplasty add'l	4.30	NA	NA	1.51	1.59	0.82	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	NA	4.67	5.28	1.72	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	NA	4.52	5.11	1.60	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.69	1.98	0.82	ZZZ
22526		A	Idet, single level	6.07	46.67	46.67	2.04	2.04	1.16	010
22527		A	Idet, 1 or more levels	3.03	40.35	40.35	0.70	0.70	0.58	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	NA	13.77	14.29	4.35	090
22533		A	Lat lumbar spine fusion	24.61	NA	NA	13.56	13.57	3.16	090
22534		A	Lat thor/lumb, add'l seg	5.99	NA	NA	2.28	2.65	1.25	ZZZ
22548		A	Neck spine fusion	26.86	NA	NA	14.92	15.36	5.61	090
22554		A	Neck spine fusion	17.54	NA	NA	10.64	11.49	4.46	090
22556		A	Thorax spine fusion	24.50	NA	NA	12.95	13.83	4.35	090
22558		A	Lumbar spine fusion	23.33	NA	NA	11.42	12.35	3.16	090
22585		A	Additional spinal fusion	5.52	NA	NA	2.05	2.42	1.25	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	NA	13.07	13.19	4.79	090
22595		A	Neck spinal fusion	20.44	NA	NA	12.63	12.73	4.41	090
22600		A	Neck spine fusion	17.20	NA	NA	11.19	11.19	3.73	090
22610		A	Thorax spine fusion	17.08	NA	NA	10.81	11.11	3.53	090
22612		A	Lumbar spine fusion	23.38	NA	NA	12.49	13.34	4.47	090
22614		A	Spine fusion, extra segment	6.43	NA	NA	2.45	2.90	1.38	ZZZ
22630		A	Lumbar spine fusion	21.89	NA	NA	12.53	13.06	4.73	090
22632		A	Spine fusion, extra segment	5.22	NA	NA	1.99	2.32	1.16	ZZZ
22800		A	Fusion of spine	19.30	NA	NA	11.15	11.96	3.76	090
22802		A	Fusion of spine	31.91	NA	NA	15.98	17.78	6.17	090
22804		A	Fusion of spine	37.30	NA	NA	18.11	20.40	7.00	090
22808		A	Fusion of spine	27.31	NA	NA	14.05	15.17	4.93	090
22810		A	Fusion of spine	31.30	NA	NA	14.90	16.62	5.15	090
22812		A	Fusion of spine	34.00	NA	NA	17.37	18.71	5.30	090
22818		A	Kyphectomy, 1–2 segments	34.18	NA	NA	16.61	17.73	6.47	090
22819		A	Kyphectomy, 3 or more	39.18	NA	NA	18.86	19.45	7.67	090
22830		A	Exploration of spinal fusion	11.13	NA	NA	7.05	7.50	2.30	090
22840		A	Insert spine fixation device	12.52	NA	NA	4.77	5.63	2.79	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	NA	4.79	5.64	2.75	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	5.15	5.88	2.86	ZZZ
22844		A	Insert spine fixation device	16.42	NA	NA	6.40	7.57	3.19	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	4.48	5.27	2.86	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	4.66	5.49	2.96	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	5.19	6.10	3.00	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	2.33	2.76	1.15	ZZZ
22849		A	Reinsert spinal fixation	19.08	NA	NA	10.16	10.94	3.90	090
22850		A	Remove spine fixation device	9.74	NA	NA	6.40	6.69	2.05	090
22851		A	Apply spine prosth device	6.70	NA	NA	2.54	2.95	1.49	ZZZ
22852		A	Remove spine fixation device	9.29	NA	NA	6.17	6.48	1.90	090
22855		A	Remove spine fixation device	15.77	NA	NA	9.17	9.41	3.52	090
22857		R	Lumbar artif diskectomy	26.93	NA	NA	14.80	14.80	3.56	090
22862		R	Revise lumbar artif disc	32.43	NA	NA	10.06	10.06	5.36	090
22865		R	Remove lumb artif disc	31.55	NA	NA	9.86	9.86	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	3.53	3.38	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	7.88	8.20	3.73	4.07	0.68	090
23020		A	Release shoulder joint	9.24	NA	NA	6.48	7.02	1.54	090
23030		A	Drain shoulder lesion	3.44	6.28	6.83	2.40	2.65	0.57	010
23031		A	Drain shoulder bursa	2.76	6.51	7.18	2.21	2.47	0.46	010
23035		A	Drain shoulder bone lesion	9.04	NA	NA	6.45	7.35	1.47	090
23040		A	Exploratory shoulder surgery	9.63	NA	NA	6.74	7.30	1.60	090
23044		A	Exploratory shoulder surgery	7.48	NA	NA	5.51	5.97	1.24	090
23065		A	Biopsy shoulder tissues	2.28	2.95	2.72	1.74	1.68	0.20	010
23066		A	Biopsy shoulder tissues	4.21	7.75	7.71	3.61	3.79	0.63	090
23075		A	Removal of shoulder lesion	2.41	3.70	3.68	1.72	1.75	0.34	010
23076		A	Removal of shoulder lesion	7.77	NA	NA	5.32	5.43	1.13	090
23077		A	Remove tumor of shoulder	18.08	NA	NA	9.60	9.90	2.34	090
23100		A	Biopsy of shoulder joint	6.09	NA	NA	4.99	5.32	1.04	090
23101		A	Shoulder joint surgery	5.63	NA	NA	4.53	4.93	0.96	090
23105		A	Remove shoulder joint lining	8.36	NA	NA	6.09	6.60	1.42	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
23106		A	Incision of collarbone joint	6.02	NA	NA	4.78	5.24	0.99	090
23107		A	Explore treat shoulder joint	8.75	NA	NA	6.25	6.82	1.49	090
23120		A	Partial removal, collar bone	7.23	NA	NA	5.47	5.96	1.23	090
23125		A	Removal of collar bone	9.52	NA	NA	6.39	6.97	1.62	090
23130		A	Remove shoulder bone, part	7.63	NA	NA	6.07	6.60	1.30	090
23140		A	Removal of bone lesion	7.01	NA	NA	4.90	5.06	1.08	090
23145		A	Removal of bone lesion	9.28	NA	NA	6.49	6.96	1.49	090
23146		A	Removal of bone lesion	7.96	NA	NA	5.91	6.51	1.35	090
23150		A	Removal of humerus lesion	8.79	NA	NA	6.25	6.58	1.32	090
23155		A	Removal of humerus lesion	10.72	NA	NA	7.25	7.78	1.81	090
23156		A	Removal of humerus lesion	8.99	NA	NA	6.28	6.83	1.50	090
23170		A	Remove collar bone lesion	7.10	NA	NA	5.00	5.51	1.12	090
23172		A	Remove shoulder blade lesion	7.20	NA	NA	5.51	5.90	1.01	090
23174		A	Remove humerus lesion	9.90	NA	NA	7.17	7.76	1.65	090
23180		A	Remove collar bone lesion	8.85	NA	NA	6.41	7.70	1.47	090
23182		A	Remove shoulder blade lesion	8.47	NA	NA	6.42	7.48	1.37	090
23184		A	Remove humerus lesion	9.76	NA	NA	6.92	8.12	1.63	090
23190		A	Partial removal of scapula	7.36	NA	NA	5.31	5.74	1.17	090
23195		A	Removal of head of humerus	10.24	NA	NA	6.91	7.32	1.71	090
23200		A	Removal of collar bone	12.69	NA	NA	7.11	7.92	1.94	090
23210		A	Removal of shoulder blade	13.16	NA	NA	7.80	8.40	2.03	090
23220		A	Partial removal of humerus	15.36	NA	NA	9.14	9.98	2.49	090
23221		A	Partial removal of humerus	18.41	NA	NA	10.61	11.16	3.06	090
23222		A	Partial removal of humerus	25.44	NA	NA	13.33	14.55	3.95	090
23330		A	Remove shoulder foreign body	1.87	3.35	3.52	1.51	1.70	0.24	010
23331		A	Remove shoulder foreign body	7.51	NA	NA	5.83	6.31	1.27	090
23332		A	Remove shoulder foreign body	12.23	NA	NA	7.96	8.64	2.03	090
23350		A	Injection for shoulder x-ray	1.00	2.73	3.09	0.35	0.34	0.06	000
23395		A	Muscle transfer,shoulder/arm	18.29	NA	NA	11.20	12.03	2.94	090
23397		A	Muscle transfers	16.62	NA	NA	9.54	10.45	2.74	090
23400		A	Fixation of shoulder blade	13.73	NA	NA	8.54	9.30	2.30	090
23405		A	Incision of tendon & muscle	8.43	NA	NA	5.92	6.42	1.45	090
23406		A	Incise tendon(s) & muscle(s)	10.90	NA	NA	6.90	7.62	1.88	090
23410		A	Repair rotator cuff, acute	12.63	NA	NA	7.77	8.59	2.17	090
23412		A	Repair rotator cuff, chronic	13.55	NA	NA	8.15	9.02	2.32	090
23415		A	Release of shoulder ligament	10.09	NA	NA	6.58	7.28	1.74	090
23420		A	Repair of shoulder	14.75	NA	NA	9.70	10.27	2.32	090
23430		A	Repair biceps tendon	10.05	NA	NA	6.77	7.43	1.74	090
23440		A	Remove/transplant tendon	10.53	NA	NA	6.77	7.51	1.83	090
23450		A	Repair shoulder capsule	13.58	NA	NA	8.17	9.00	2.33	090
23455		A	Repair shoulder capsule	14.55	NA	NA	8.55	9.49	2.50	090
23460		A	Repair shoulder capsule	15.68	NA	NA	9.36	10.36	2.67	090
23462		A	Repair shoulder capsule	15.60	NA	NA	9.07	9.91	2.60	090
23465		A	Repair shoulder capsule	16.16	NA	NA	9.49	10.33	2.77	090
23466		A	Repair shoulder capsule	15.55	NA	NA	9.99	10.67	2.47	090
23470		A	Reconstruct shoulder joint	17.75	NA	NA	10.11	11.18	2.99	090
23472		A	Reconstruct shoulder joint	22.47	NA	NA	12.14	13.27	3.67	090
23480		A	Revision of collar bone	11.42	NA	NA	7.29	8.03	1.95	090
23485		A	Revision of collar bone	13.79	NA	NA	8.20	9.04	2.34	090
23490		A	Reinforce clavicle	12.04	NA	NA	6.74	7.72	1.47	090
23491		A	Reinforce shoulder bones	14.40	NA	NA	8.71	9.71	2.47	090
23500		A	Treat clavicle fracture	2.13	2.64	2.76	2.71	2.62	0.30	090
23505		A	Treat clavicle fracture	3.74	4.01	4.21	3.61	3.73	0.61	090
23515		A	Treat clavicle fracture	9.53	NA	NA	7.00	6.77	1.28	090
23520		A	Treat clavicle dislocation	2.21	2.77	2.81	2.84	2.79	0.34	090
23525		A	Treat clavicle dislocation	3.67	4.16	4.35	3.64	3.79	0.46	090
23530		A	Treat clavicle dislocation	7.37	NA	NA	5.30	5.62	1.20	090
23532		A	Treat clavicle dislocation	8.08	NA	NA	6.01	6.49	1.38	090
23540		A	Treat clavicle dislocation	2.28	2.66	2.76	2.73	2.55	0.29	090
23545		A	Treat clavicle dislocation	3.32	3.74	3.96	3.26	3.31	0.35	090
23550		A	Treat clavicle dislocation	7.48	NA	NA	5.54	5.95	1.25	090
23552		A	Treat clavicle dislocation	8.70	NA	NA	6.25	6.78	1.46	090
23570		A	Treat shoulder blade fx	2.28	2.78	2.89	2.92	2.91	0.36	090
23575		A	Treat shoulder blade fx	4.12	4.59	4.73	4.08	4.19	0.59	090
23585		A	Treat scapula fracture	14.07	NA	NA	8.50	8.07	1.54	090
23600		A	Treat humerus fracture	3.00	4.07	4.31	3.65	3.60	0.48	090
23605		A	Treat humerus fracture	4.94	5.38	5.76	4.59	4.85	0.84	090
23615		A	Treat humerus fracture	12.12	NA	NA	8.05	8.44	1.62	090
23616		A	Treat humerus fracture	18.19	NA	NA	10.45	12.29	3.70	090
23620		A	Treat humerus fracture	2.46	3.41	3.51	3.14	3.06	0.40	090
23625		A	Treat humerus fracture	3.99	4.44	4.69	3.91	4.09	0.67	090
23630		A	Treat humerus fracture	10.39	NA	NA	7.36	7.00	1.27	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
23650		A	Treat shoulder dislocation	3.44	3.29	3.53	2.82	2.79	0.30	090
23655		A	Treat shoulder dislocation	4.64	NA	NA	4.15	4.16	0.69	090
23660		A	Treat shoulder dislocation	7.55	NA	NA	5.68	6.03	1.29	090
23665		A	Treat dislocation/fracture	4.54	4.85	5.09	4.26	4.49	0.71	090
23670		A	Treat dislocation/fracture	12.12	NA	NA	7.92	7.37	1.36	090
23675		A	Treat dislocation/fracture	6.13	6.12	6.47	5.13	5.48	1.01	090
23680		A	Treat dislocation/fracture	12.99	NA	NA	8.23	8.16	1.76	090
23700		A	Fixation of shoulder	2.54	NA	NA	1.90	2.04	0.44	010
23800		A	Fusion of shoulder joint	14.59	NA	NA	8.86	9.63	2.36	090
23802		A	Fusion of shoulder joint	18.17	NA	NA	11.20	10.68	2.71	090
23900		A	Amputation of arm & girdle	20.57	NA	NA	10.41	11.06	3.19	090
23920		A	Amputation at shoulder joint	16.03	NA	NA	9.21	9.56	2.47	090
23921		A	Amputation follow-up surgery	5.61	NA	NA	4.85	4.96	0.78	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.96	4.98	5.65	1.98	2.14	0.43	010
23931		A	Drainage of arm bursa	1.81	4.35	5.13	1.75	1.96	0.28	010
23935		A	Drain arm/elbow bone lesion	6.27	NA	NA	5.09	5.50	1.05	090
24000		A	Exploratory elbow surgery	5.99	NA	NA	4.75	5.08	0.97	090
24006		A	Release elbow joint	9.62	NA	NA	6.59	7.17	1.50	090
24065		A	Biopsy arm/elbow soft tissue	2.10	4.15	3.68	1.92	1.83	0.17	010
24066		A	Biopsy arm/elbow soft tissue	5.26	8.26	8.60	3.92	4.02	0.80	090
24075		A	Remove arm/elbow lesion	3.96	7.18	7.26	3.26	3.33	0.56	090
24076		A	Remove arm/elbow lesion	6.36	NA	NA	4.59	4.72	0.95	090
24077		A	Remove tumor of arm/elbow	11.95	NA	NA	6.85	7.29	1.73	090
24100		A	Biopsy elbow joint lining	4.98	NA	NA	4.09	4.30	0.85	090
24101		A	Explore/treat elbow joint	6.19	NA	NA	5.04	5.49	1.03	090
24102		A	Remove elbow joint lining	8.15	NA	NA	5.80	6.33	1.33	090
24105		A	Removal of elbow bursa	3.67	NA	NA	4.02	4.20	0.61	090
24110		A	Remove humerus lesion	7.46	NA	NA	5.65	6.15	1.28	090
24115		A	Remove/graft bone lesion	10.00	NA	NA	4.32	5.76	1.68	090
24116		A	Remove/graft bone lesion	12.11	NA	NA	7.67	8.37	2.06	090
24120		A	Remove elbow lesion	6.71	NA	NA	5.17	5.55	1.10	090
24125		A	Remove/graft bone lesion	8.02	NA	NA	5.99	6.07	1.06	090
24126		A	Remove/graft bone lesion	8.50	NA	NA	6.00	6.51	1.16	090
24130		A	Removal of head of radius	6.31	NA	NA	5.12	5.57	1.04	090
24134		A	Removal of arm bone lesion	10.10	NA	NA	6.90	7.87	1.64	090
24136		A	Remove radius bone lesion	8.29	NA	NA	5.76	6.49	1.38	090
24138		A	Remove elbow bone lesion	8.33	NA	NA	6.48	7.13	1.34	090
24140		A	Partial removal of arm bone	9.43	NA	NA	6.57	7.83	1.51	090
24145		A	Partial removal of radius	7.70	NA	NA	5.64	6.84	1.25	090
24147		A	Partial removal of elbow	7.69	NA	NA	6.28	7.43	1.30	090
24149		A	Radical resection of elbow	15.92	NA	NA	10.76	11.19	2.35	090
24150		A	Extensive humerus surgery	13.70	NA	NA	8.49	9.24	2.33	090
24151		A	Extensive humerus surgery	16.08	NA	NA	9.68	10.59	2.60	090
24152		A	Extensive radius surgery	10.24	NA	NA	6.16	6.94	1.48	090
24153		A	Extensive radius surgery	11.73	NA	NA	4.87	5.22	0.74	090
24155		A	Removal of elbow joint	11.97	NA	NA	7.41	7.90	1.93	090
24160		A	Remove elbow joint implant	7.89	NA	NA	5.82	6.35	1.30	090
24164		A	Remove radius head implant	6.34	NA	NA	4.89	5.33	1.03	090
24200		A	Removal of arm foreign body	1.78	2.74	3.07	1.36	1.49	0.20	010
24201		A	Removal of arm foreign body	4.61	7.79	8.80	3.66	3.94	0.72	090
24220		A	Injection for elbow x-ray	1.31	2.66	3.14	0.46	0.45	0.08	000
24300		A	Manipulate elbow w/anesth	3.86	NA	NA	5.16	5.43	0.65	090
24301		A	Muscle/tendon transfer	10.26	NA	NA	6.83	7.50	1.66	090
24305		A	Arm tendon lengthening	7.51	NA	NA	5.65	6.18	1.15	090
24310		A	Revision of arm tendon	6.03	NA	NA	4.73	5.15	0.96	090
24320		A	Repair of arm tendon	10.74	NA	NA	7.02	7.27	1.74	090
24330		A	Revision of arm muscles	9.67	NA	NA	6.63	7.25	1.60	090
24331		A	Revision of arm muscles	10.83	NA	NA	6.94	7.81	1.78	090
24332		A	Tenolysis, triceps	7.77	NA	NA	5.91	6.34	1.23	090
24340		A	Repair of biceps tendon	7.96	NA	NA	5.96	6.47	1.36	090
24341		A	Repair arm tendon/muscle	9.24	NA	NA	7.52	7.71	1.36	090
24342		A	Repair of ruptured tendon	10.74	NA	NA	7.06	7.79	1.86	090
24343		A	Repr elbow lat ligmnt w/tiss	8.99	NA	NA	6.98	7.56	1.43	090
24344		A	Reconstruct elbow lat ligmnt	14.97	NA	NA	9.95	10.73	2.37	090
24345		A	Repr elbw med ligmnt w/tissu	8.99	NA	NA	6.93	7.47	1.44	090
24346		A	Reconstruct elbow med ligmnt	14.97	NA	NA	10.03	10.68	2.34	090
24357		A	Repair elbow, perc	5.32	NA	NA	4.72	5.15	0.87	090
24358		A	Repair elbow w/deb, open	6.54	NA	NA	5.27	5.73	1.07	090
24359		A	Repair elbow deb/attch open	8.86	NA	NA	6.19	6.19	1.41	090
24360		A	Reconstruct elbow joint	12.53	NA	NA	7.84	8.65	2.06	090
24361		A	Reconstruct elbow joint	14.27	NA	NA	8.75	9.66	2.19	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
24362		A	Reconstruct elbow joint	15.18	NA	NA	5.73	7.88	2.61	090
24363		A	Replace elbow joint	22.47	NA	NA	12.16	12.93	3.02	090
24365		A	Reconstruct head of radius	8.51	NA	NA	5.96	6.58	1.41	090
24366		A	Reconstruct head of radius	9.25	NA	NA	6.30	6.92	1.52	090
24400		A	Revision of humerus	11.19	NA	NA	7.49	8.17	1.93	090
24410		A	Revision of humerus	14.96	NA	NA	9.24	9.77	2.58	090
24420		A	Revision of humerus	13.58	NA	NA	8.50	9.52	2.18	090
24430		A	Repair of humerus	15.07	NA	NA	9.22	9.48	2.22	090
24435		A	Repair humerus with graft	14.74	NA	NA	9.80	10.34	2.28	090
24470		A	Revision of elbow joint	8.81	NA	NA	5.65	6.68	1.48	090
24495		A	Decompression of forearm	8.30	NA	NA	6.41	7.57	1.18	090
24498		A	Reinforce humerus	12.16	NA	NA	7.66	8.46	2.07	090
24500		A	Treat humerus fracture	3.29	4.45	4.64	3.80	3.74	0.50	090
24505		A	Treat humerus fracture	5.25	5.83	6.21	4.87	5.13	0.89	090
24515		A	Treat humerus fracture	11.97	NA	NA	8.03	8.71	2.03	090
24516		A	Treat humerus fracture	12.07	NA	NA	7.64	8.37	2.03	090
24530		A	Treat humerus fracture	3.57	4.73	4.97	4.00	4.02	0.57	090
24535		A	Treat humerus fracture	6.96	6.81	7.32	5.86	6.24	1.18	090
24538		A	Treat humerus fracture	9.63	NA	NA	7.18	7.94	1.64	090
24545		A	Treat humerus fracture	12.99	NA	NA	8.27	8.36	1.83	090
24546		A	Treat humerus fracture	14.73	NA	NA	9.10	10.20	2.74	090
24560		A	Treat humerus fracture	2.87	4.11	4.29	3.43	3.31	0.44	090
24565		A	Treat humerus fracture	5.64	5.93	6.27	5.04	5.28	0.93	090
24566		A	Treat humerus fracture	8.86	NA	NA	6.79	7.47	1.30	090
24575		A	Treat humerus fracture	9.53	NA	NA	6.96	7.68	1.87	090
24576		A	Treat humerus fracture	2.94	4.41	4.58	3.71	3.71	0.46	090
24577		A	Treat humerus fracture	5.87	6.03	6.48	5.08	5.46	0.95	090
24579		A	Treat humerus fracture	11.26	NA	NA	7.74	8.28	2.03	090
24582		A	Treat humerus fracture	9.89	NA	NA	8.17	8.64	1.48	090
24586		A	Treat elbow fracture	15.64	NA	NA	9.31	10.27	2.65	090
24587		A	Treat elbow fracture	15.65	NA	NA	9.31	10.16	2.53	090
24600		A	Treat elbow dislocation	4.28	3.86	4.36	3.28	3.39	0.50	090
24605		A	Treat elbow dislocation	5.50	NA	NA	4.91	5.13	0.89	090
24615		A	Treat elbow dislocation	9.72	NA	NA	6.55	7.18	1.60	090
24620		A	Treat elbow fracture	7.07	NA	NA	5.48	5.87	1.07	090
24635		A	Treat elbow fracture	8.64	NA	NA	6.55	10.29	2.29	090
24640		A	Treat elbow dislocation	1.22	1.52	1.68	0.83	0.81	0.12	010
24650		A	Treat radius fracture	2.22	3.42	3.60	2.99	2.87	0.35	090
24655		A	Treat radius fracture	4.48	5.18	5.56	4.40	4.59	0.70	090
24665		A	Treat radius fracture	8.22	NA	NA	6.51	7.01	1.41	090
24666		A	Treat radius fracture	9.74	NA	NA	6.95	7.50	1.62	090
24670		A	Treat ulnar fracture	2.60	3.72	3.91	3.15	3.11	0.41	090
24675		A	Treat ulnar fracture	4.79	5.37	5.68	4.57	4.77	0.81	090
24685		A	Treat ulnar fracture	8.21	NA	NA	6.51	7.01	1.52	090
24800		A	Fusion of elbow joint	11.27	NA	NA	6.88	7.81	1.63	090
24802		A	Fusion/graft of elbow joint	14.18	NA	NA	8.02	9.20	2.38	090
24900		A	Amputation of upper arm	10.04	NA	NA	6.41	6.73	1.53	090
24920		A	Amputation of upper arm	10.02	NA	NA	6.03	6.48	1.61	090
24925		A	Amputation follow-up surgery	7.19	NA	NA	4.94	5.51	1.14	090
24930		A	Amputation follow-up surgery	10.72	NA	NA	6.19	6.71	1.68	090
24931		A	Amputate upper arm & implant	13.32	NA	NA	5.07	5.40	1.90	090
24935		A	Revision of amputation	16.30	NA	NA	10.46	9.24	2.14	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.44	NA	NA	3.98	5.42	0.55	090
25001		A	Incise flexor carpi radialis	3.68	NA	NA	3.94	4.08	0.55	090
25020		A	Decompress forearm 1 space	5.97	NA	NA	6.94	8.25	0.93	090
25023		A	Decompress forearm 1 space	13.69	NA	NA	11.32	13.12	2.04	090
25024		A	Decompress forearm 2 spaces	10.62	NA	NA	7.08	7.27	1.36	090
25025		A	Decompress forearm 2 spaces	17.77	NA	NA	9.69	9.83	1.83	090
25028		A	Drainage of forearm lesion	5.30	NA	NA	6.19	7.17	0.81	090
25031		A	Drainage of forearm bursa	4.18	NA	NA	3.49	5.70	0.63	090
25035		A	Treat forearm bone lesion	7.54	NA	NA	5.62	9.60	1.24	090
25040		A	Explore/treat wrist joint	7.41	NA	NA	5.39	6.34	1.15	090
25065		A	Biopsy forearm soft tissues	2.01	4.33	3.77	1.98	1.94	0.15	010
25066		A	Biopsy forearm soft tissues	4.18	NA	NA	3.83	5.45	0.64	090
25075		A	Removal forearm lesion subcu	3.78	NA	NA	3.31	4.60	0.55	090
25076		A	Removal forearm lesion deep	4.97	NA	NA	4.11	6.82	0.74	090
25077		A	Remove tumor, forearm/wrist	9.90	NA	NA	6.17	9.13	1.42	090
25085		A	Incision of wrist capsule	5.55	NA	NA	4.61	5.86	0.85	090
25100		A	Biopsy of wrist joint	3.94	NA	NA	3.77	4.52	0.59	090
25101		A	Explore/treat wrist joint	4.74	NA	NA	4.35	5.12	0.75	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
25105	.....	A	Remove wrist joint lining	5.91	NA	NA	4.97	6.13	0.92	090
25107	.....	A	Remove wrist joint cartilage	7.50	NA	NA	6.24	7.28	0.99	090
25109	.....	A	Excise tendon forearm/wrist	6.81	NA	NA	5.23	5.23	0.96	090
25110	.....	A	Remove wrist tendon lesion	3.96	NA	NA	3.62	5.33	0.62	090
25111	.....	A	Remove wrist tendon lesion	3.44	NA	NA	3.61	4.15	0.53	090
25112	.....	A	Reremove wrist tendon lesion	4.58	NA	NA	4.07	4.66	0.70	090
25115	.....	A	Remove wrist/forearm lesion	9.89	NA	NA	7.33	10.68	1.31	090
25116	.....	A	Remove wrist/forearm lesion	7.38	NA	NA	6.18	9.66	1.11	090
25118	.....	A	Excise wrist tendon sheath	4.42	NA	NA	4.14	4.94	0.68	090
25119	.....	A	Partial removal of ulna	6.10	NA	NA	5.06	6.33	0.96	090
25120	.....	A	Removal of forearm lesion	6.16	NA	NA	5.09	8.58	1.00	090
25125	.....	A	Remove/graft forearm lesion	7.55	NA	NA	5.68	9.26	1.06	090
25126	.....	A	Remove/graft forearm lesion	7.62	NA	NA	5.86	9.43	1.27	090
25130	.....	A	Removal of wrist lesion	5.32	NA	NA	4.72	5.57	0.80	090
25135	.....	A	Remove & graft wrist lesion	6.96	NA	NA	5.62	6.56	1.02	090
25136	.....	A	Remove & graft wrist lesion	6.03	NA	NA	5.09	5.84	1.03	090
25145	.....	A	Remove forearm bone lesion	6.43	NA	NA	5.21	8.63	1.01	090
25150	.....	A	Partial removal of ulna	7.27	NA	NA	5.53	6.86	1.14	090
25151	.....	A	Partial removal of radius	7.57	NA	NA	5.64	9.18	1.18	090
25170	.....	A	Extensive forearm surgery	11.34	NA	NA	7.36	11.25	1.78	090
25210	.....	A	Removal of wrist bone	6.01	NA	NA	5.04	5.91	0.88	090
25215	.....	A	Removal of wrist bones	8.02	NA	NA	6.02	7.39	1.19	090
25230	.....	A	Partial removal of radius	5.28	NA	NA	4.49	5.32	0.79	090
25240	.....	A	Partial removal of ulna	5.22	NA	NA	4.46	5.70	0.81	090
25246	.....	A	Injection for wrist x-ray	1.45	2.73	3.08	0.53	0.50	0.09	000
25248	.....	A	Remove forearm foreign body	5.20	NA	NA	4.04	6.28	0.72	090
25250	.....	A	Removal of wrist prosthesis	6.66	NA	NA	5.27	5.68	1.01	090
25251	.....	A	Removal of wrist prosthesis	9.70	NA	NA	6.74	7.33	1.26	090
25259	.....	A	Manipulate wrist w/anesthes	3.86	NA	NA	5.15	5.43	0.62	090
25260	.....	A	Repair forearm tendon/muscle	7.89	NA	NA	6.37	9.84	1.19	090
25263	.....	A	Repair forearm tendon/muscle	7.90	NA	NA	6.09	9.67	1.18	090
25265	.....	A	Repair forearm tendon/muscle	9.96	NA	NA	7.10	10.70	1.47	090
25270	.....	A	Repair forearm tendon/muscle	6.06	NA	NA	4.97	8.49	0.95	090
25272	.....	A	Repair forearm tendon/muscle	7.10	NA	NA	5.48	9.13	1.11	090
25274	.....	A	Repair forearm tendon/muscle	8.82	NA	NA	6.37	9.99	1.36	090
25275	.....	A	Repair forearm tendon sheath	8.82	NA	NA	6.48	7.02	1.31	090
25280	.....	A	Revise wrist/forearm tendon	7.28	NA	NA	5.55	9.09	1.08	090
25290	.....	A	Incise wrist/forearm tendon	5.34	NA	NA	4.50	9.74	0.82	090
25295	.....	A	Release wrist/forearm tendon	6.61	NA	NA	5.29	8.72	1.00	090
25300	.....	A	Fusion of tendons at wrist	8.88	NA	NA	6.65	7.55	1.26	090
25301	.....	A	Fusion of tendons at wrist	8.47	NA	NA	6.18	7.12	1.29	090
25310	.....	A	Transplant forearm tendon	8.26	NA	NA	5.93	9.48	1.21	090
25312	.....	A	Transplant forearm tendon	9.70	NA	NA	6.70	10.32	1.41	090
25315	.....	A	Revise palsy hand tendon(s)	10.56	NA	NA	7.10	10.74	1.58	090
25316	.....	A	Revise palsy hand tendon(s)	12.76	NA	NA	7.81	12.01	1.75	090
25320	.....	A	Repair/revise wrist joint	12.38	NA	NA	9.86	10.62	1.61	090
25332	.....	A	Revise wrist joint	11.60	NA	NA	7.60	8.39	1.84	090
25335	.....	A	Realignment of hand	13.25	NA	NA	8.30	9.94	1.93	090
25337	.....	A	Reconstruct ulna/radioulnar	11.44	NA	NA	8.62	9.85	1.61	090
25350	.....	A	Revision of radius	8.97	NA	NA	6.34	10.15	1.46	090
25355	.....	A	Revision of radius	10.41	NA	NA	6.74	10.67	1.74	090
25360	.....	A	Revision of ulna	8.62	NA	NA	6.23	10.05	1.41	090
25365	.....	A	Revise radius & ulna	12.77	NA	NA	8.17	11.90	2.16	090
25370	.....	A	Revise radius or ulna	13.93	NA	NA	9.00	12.53	2.29	090
25375	.....	A	Revise radius & ulna	13.41	NA	NA	8.36	12.39	2.27	090
25390	.....	A	Shorten radius or ulna	10.58	NA	NA	7.06	10.82	1.65	090
25391	.....	A	Lengthen radius or ulna	14.14	NA	NA	8.66	12.60	2.22	090
25392	.....	A	Shorten radius & ulna	14.44	NA	NA	8.90	12.43	2.11	090
25393	.....	A	Lengthen radius & ulna	16.42	NA	NA	9.55	13.56	2.77	090
25394	.....	A	Repair carpal bone, shorten	10.71	NA	NA	6.94	7.50	1.59	090
25400	.....	A	Repair radius or ulna	11.16	NA	NA	7.26	11.22	1.83	090
25405	.....	A	Repair/graft radius or ulna	14.87	NA	NA	8.92	13.09	2.33	090
25415	.....	A	Repair radius & ulna	13.66	NA	NA	8.79	12.64	2.18	090
25420	.....	A	Repair/graft radius & ulna	16.89	NA	NA	9.92	14.09	2.62	090
25425	.....	A	Repair/graft radius or ulna	13.58	NA	NA	8.48	14.93	2.09	090
25426	.....	A	Repair/graft radius & ulna	16.31	NA	NA	9.19	12.86	2.55	090
25430	.....	A	Vasc graft into carpal bone	9.57	NA	NA	7.03	7.18	1.27	090
25431	.....	A	Repair nonunion carpal bone	10.75	NA	NA	7.15	7.77	1.91	090
25440	.....	A	Repair/graft wrist bone	10.56	NA	NA	6.89	8.14	1.63	090
25441	.....	A	Reconstruct wrist joint	13.15	NA	NA	8.10	9.05	2.08	090
25442	.....	A	Reconstruct wrist joint	10.98	NA	NA	7.50	8.19	1.53	090
25443	.....	A	Reconstruct wrist joint	10.52	NA	NA	7.21	7.99	1.37	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
25444		A	Reconstruct wrist joint	11.28	NA	NA	7.43	8.23	1.72	090
25445		A	Reconstruct wrist joint	9.76	NA	NA	6.69	7.34	1.55	090
25446		A	Wrist replacement	17.16	NA	NA	9.98	10.94	2.48	090
25447		A	Repair wrist joint(s)	10.95	NA	NA	7.86	8.26	1.61	090
25449		A	Remove wrist joint implant	14.80	NA	NA	8.95	9.81	2.22	090
25450		A	Revision of wrist joint	7.94	NA	NA	3.84	7.01	1.36	090
25455		A	Revision of wrist joint	9.57	NA	NA	6.84	8.85	0.96	090
25490		A	Reinforce radius	9.61	NA	NA	6.57	10.15	1.43	090
25491		A	Reinforce ulna	10.03	NA	NA	6.78	10.62	1.60	090
25492		A	Reinforce radius and ulna	12.52	NA	NA	8.33	11.81	2.15	090
25500		A	Treat fracture of radius	2.51	3.30	3.44	2.86	2.79	0.35	090
25505		A	Treat fracture of radius	5.30	5.82	6.18	4.98	5.20	0.90	090
25515		A	Treat fracture of radius	8.64	NA	NA	6.46	6.96	1.59	090
25520		A	Treat fracture of radius	6.35	5.69	6.27	5.14	5.60	1.08	090
25525		A	Treat fracture of radius	10.37	NA	NA	7.41	8.70	2.13	090
25526		A	Treat fracture of radius	12.96	NA	NA	8.68	11.09	2.20	090
25530		A	Treat fracture of ulna	2.15	3.48	3.62	2.97	2.92	0.34	090
25535		A	Treat fracture of ulna	5.22	5.57	5.79	4.83	5.06	0.89	090
25545		A	Treat fracture of ulna	7.78	NA	NA	6.23	6.94	1.53	090
25560		A	Treat fracture radius & ulna	2.50	3.36	3.53	2.85	2.73	0.35	090
25565		A	Treat fracture radius & ulna	5.71	5.90	6.30	4.92	5.17	0.93	090
25574		A	Treat fracture radius & ulna	8.64	NA	NA	6.55	6.87	1.21	090
25575		A	Treat fracture radius/ulna	12.10	NA	NA	8.36	8.93	1.82	090
25600		A	Treat fracture radius/ulna	2.69	3.68	3.88	3.17	3.07	0.42	090
25605		A	Treat fracture radius/ulna	7.02	6.86	7.04	6.13	6.17	1.00	090
25606		A	Treat fx distal radial	8.10	NA	NA	6.69	7.82	1.26	090
25607		A	Treat fx rad extra-articul	9.35	NA	NA	7.19	7.19	1.36	090
25608		A	Treat fx rad intra-articul	10.86	NA	NA	7.79	7.79	1.84	090
25609		A	Treat fx radial 3+ frag	14.12	NA	NA	9.65	9.65	2.38	090
25622		A	Treat wrist bone fracture	2.68	3.90	4.08	3.35	3.23	0.41	090
25624		A	Treat wrist bone fracture	4.62	5.63	5.96	4.77	4.92	0.76	090
25628		A	Treat wrist bone fracture	9.51	NA	NA	6.84	7.33	1.37	090
25630		A	Treat wrist bone fracture	2.94	3.75	3.96	3.25	3.09	0.45	090
25635		A	Treat wrist bone fracture	4.47	5.11	5.53	4.34	4.12	0.74	090
25645		A	Treat wrist bone fracture	7.31	NA	NA	5.55	6.09	1.20	090
25650		A	Treat wrist bone fracture	3.12	3.84	4.07	3.44	3.31	0.45	090
25651		A	Pin ulnar styloid fracture	5.68	NA	NA	5.15	5.31	0.86	090
25652		A	Treat fracture ulnar styloid	7.92	NA	NA	6.16	6.58	1.21	090
25660		A	Treat wrist dislocation	4.84	NA	NA	4.32	4.51	0.58	090
25670		A	Treat wrist dislocation	7.98	NA	NA	5.81	6.40	1.28	090
25671		A	Pin radioulnar dislocation	6.32	NA	NA	5.53	5.84	1.00	090
25675		A	Treat wrist dislocation	4.75	4.71	5.18	3.99	4.32	0.62	090
25676		A	Treat wrist dislocation	8.17	NA	NA	6.13	6.71	1.34	090
25680		A	Treat wrist fracture	6.08	NA	NA	4.38	4.56	0.78	090
25685		A	Treat wrist fracture	9.97	NA	NA	6.62	7.21	1.60	090
25690		A	Treat wrist dislocation	5.58	NA	NA	4.85	5.17	0.88	090
25695		A	Treat wrist dislocation	8.40	NA	NA	6.00	6.54	1.32	090
25800		A	Fusion of wrist joint	9.95	NA	NA	6.79	7.94	1.57	090
25805		A	Fusion/graft of wrist joint	11.59	NA	NA	7.67	8.96	1.81	090
25810		A	Fusion/graft of wrist joint	11.75	NA	NA	8.03	8.97	1.68	090
25820		A	Fusion of hand bones	7.52	NA	NA	6.41	7.12	1.22	090
25825		A	Fuse hand bones with graft	9.54	NA	NA	7.65	8.44	1.41	090
25830		A	Fusion, radioulnar jnt/ulna	10.69	NA	NA	10.57	12.49	1.55	090
25900		A	Amputation of forearm	9.46	NA	NA	6.73	9.64	1.30	090
25905		A	Amputation of forearm	9.48	NA	NA	6.06	9.17	1.40	090
25907		A	Amputation follow-up surgery	7.98	NA	NA	5.77	8.76	1.10	090
25909		A	Amputation follow-up surgery	9.20	NA	NA	6.32	9.30	1.44	090
25915		A	Amputation of forearm	17.38	NA	NA	5.97	12.42	2.94	090
25920		A	Amputate hand at wrist	8.92	NA	NA	6.59	7.21	1.35	090
25922		A	Amputate hand at wrist	7.54	NA	NA	6.27	6.66	1.12	090
25924		A	Amputation follow-up surgery	8.70	NA	NA	6.12	7.10	1.32	090
25927		A	Amputation of hand	8.98	NA	NA	8.65	10.16	1.27	090
25929		A	Amputation follow-up surgery	7.71	NA	NA	5.66	5.77	1.14	090
25931		A	Amputation follow-up surgery	7.93	NA	NA	8.32	9.89	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	4.06	4.81	1.52	1.57	0.18	010
26011		A	Drainage of finger abscess	2.21	6.24	7.53	1.96	2.14	0.33	010
26020		A	Drain hand tendon sheath	4.97	NA	NA	4.74	5.05	0.73	090
26025		A	Drainage of palm bursa	4.99	NA	NA	4.46	4.78	0.76	090
26030		A	Drainage of palm bursa(s)	6.16	NA	NA	5.00	5.36	0.92	090
26034		A	Treat hand bone lesion	6.49	NA	NA	5.57	5.96	1.01	090
26035		A	Decompress fingers/hand	11.14	NA	NA	8.12	7.99	1.47	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
26037	.....	A	Decompress fingers/hand	7.48	NA	NA	5.49	5.91	1.13	090
26040	.....	A	Release palm contracture	3.38	NA	NA	3.60	3.82	0.53	090
26045	.....	A	Release palm contracture	5.62	NA	NA	4.88	5.26	0.93	090
26055	.....	A	Incise finger tendon sheath	3.00	9.04	11.69	3.82	3.88	0.43	090
26060	.....	A	Incision of finger tendon	2.85	NA	NA	3.05	3.28	0.45	090
26070	.....	A	Explore/treat hand joint	3.73	NA	NA	3.05	3.21	0.48	090
26075	.....	A	Explore/treat finger joint	3.83	NA	NA	3.37	3.57	0.53	090
26080	.....	A	Explore/treat finger joint	4.36	NA	NA	4.32	4.58	0.66	090
26100	.....	A	Biopsy hand joint lining	3.71	NA	NA	3.66	3.89	0.54	090
26105	.....	A	Biopsy finger joint lining	3.75	NA	NA	3.68	3.95	0.59	090
26110	.....	A	Biopsy finger joint lining	3.57	NA	NA	3.60	3.82	0.53	090
26115	.....	A	Removal hand lesion subcut	3.92	9.83	11.46	4.23	4.49	0.59	090
26116	.....	A	Removal hand lesion, deep	5.61	NA	NA	5.30	5.65	0.84	090
26117	.....	A	Remove tumor, hand/finger	8.62	NA	NA	6.18	6.62	1.26	090
26121	.....	A	Release palm contracture	7.61	NA	NA	5.92	6.44	1.17	090
26123	.....	A	Release palm contracture	10.63	NA	NA	8.21	8.53	1.43	090
26125	.....	A	Release palm contracture	4.60	NA	NA	1.87	2.15	0.70	ZZZ
26130	.....	A	Remove wrist joint lining	5.48	NA	NA	4.88	5.11	0.94	090
26135	.....	A	Revise finger joint, each	7.02	NA	NA	5.47	5.96	1.07	090
26140	.....	A	Revise finger joint, each	6.23	NA	NA	5.16	5.60	0.92	090
26145	.....	A	Tendon excision, palm/finger	6.38	NA	NA	5.18	5.62	0.97	090
26160	.....	A	Remove tendon sheath lesion	3.46	9.03	10.70	3.94	4.03	0.49	090
26170	.....	A	Removal of palm tendon, each	4.82	NA	NA	4.37	4.65	0.69	090
26180	.....	A	Removal of finger tendon	5.24	NA	NA	4.71	5.06	0.78	090
26185	.....	A	Remove finger bone	6.32	NA	NA	5.73	5.88	0.81	090
26200	.....	A	Remove hand bone lesion	5.56	NA	NA	4.55	4.95	0.88	090
26205	.....	A	Remove/graft bone lesion	7.82	NA	NA	5.85	6.37	1.20	090
26210	.....	A	Removal of finger lesion	5.21	NA	NA	4.73	5.08	0.79	090
26215	.....	A	Remove/graft finger lesion	7.16	NA	NA	5.54	5.92	0.98	090
26230	.....	A	Partial removal of hand bone	6.38	NA	NA	4.95	5.43	1.01	090
26235	.....	A	Partial removal, finger bone	6.24	NA	NA	4.94	5.38	0.95	090
26236	.....	A	Partial removal, finger bone	5.37	NA	NA	4.57	4.95	0.81	090
26250	.....	A	Extensive hand surgery	7.61	NA	NA	5.71	6.07	1.07	090
26255	.....	A	Extensive hand surgery	12.80	NA	NA	8.28	8.82	1.69	090
26260	.....	A	Extensive finger surgery	7.09	NA	NA	5.46	5.82	1.01	090
26261	.....	A	Extensive finger surgery	9.28	NA	NA	6.72	6.44	1.14	090
26262	.....	A	Partial removal of finger	5.72	NA	NA	4.74	5.04	0.88	090
26320	.....	A	Removal of implant from hand	4.02	NA	NA	3.79	4.05	0.59	090
26340	.....	A	Manipulate finger w/anesth	2.62	NA	NA	4.60	4.74	0.39	090
26350	.....	A	Repair finger/hand tendon	6.07	NA	NA	9.52	12.06	0.93	090
26352	.....	A	Repair/graft hand tendon	7.75	NA	NA	10.06	12.70	1.13	090
26356	.....	A	Repair finger/hand tendon	10.22	NA	NA	13.70	16.03	1.21	090
26357	.....	A	Repair finger/hand tendon	8.65	NA	NA	10.35	12.99	1.33	090
26358	.....	A	Repair/graft hand tendon	9.22	NA	NA	10.94	13.79	1.38	090
26370	.....	A	Repair finger/hand tendon	7.17	NA	NA	9.50	12.30	1.12	090
26372	.....	A	Repair/graft hand tendon	8.89	NA	NA	10.53	13.52	1.40	090
26373	.....	A	Repair finger/hand tendon	8.29	NA	NA	10.16	13.10	1.23	090
26390	.....	A	Revise hand/finger tendon	9.31	NA	NA	9.20	11.24	1.40	090
26392	.....	A	Repair/graft hand tendon	10.38	NA	NA	11.16	13.94	1.57	090
26410	.....	A	Repair hand tendon	4.68	NA	NA	7.63	9.78	0.73	090
26412	.....	A	Repair/graft hand tendon	6.37	NA	NA	8.62	10.94	0.97	090
26415	.....	A	Excision, hand/finger tendon	8.40	NA	NA	7.46	9.62	0.98	090
26416	.....	A	Graft hand or finger tendon	9.44	NA	NA	9.04	11.81	0.79	090
26418	.....	A	Repair finger tendon	4.33	NA	NA	8.14	10.23	0.67	090
26420	.....	A	Repair/graft finger tendon	6.83	NA	NA	8.80	11.21	1.07	090
26426	.....	A	Repair finger/hand tendon	6.21	NA	NA	5.11	9.13	0.95	090
26428	.....	A	Repair/graft finger tendon	7.28	NA	NA	9.25	11.55	1.09	090
26432	.....	A	Repair finger tendon	4.07	NA	NA	6.78	8.52	0.64	090
26433	.....	A	Repair finger tendon	4.61	NA	NA	7.01	8.90	0.72	090
26434	.....	A	Repair/graft finger tendon	6.15	NA	NA	7.93	9.73	0.93	090
26437	.....	A	Realignment of tendons	5.88	NA	NA	7.81	9.68	0.89	090
26440	.....	A	Release palm/finger tendon	5.07	NA	NA	8.48	10.95	0.75	090
26442	.....	A	Release palm & finger tendon	9.50	NA	NA	11.81	13.87	1.20	090
26445	.....	A	Release hand/finger tendon	4.36	NA	NA	8.23	10.68	0.65	090
26449	.....	A	Release forearm/hand tendon	8.34	NA	NA	7.27	11.52	1.06	090
26450	.....	A	Incision of palm tendon	3.71	NA	NA	5.19	6.26	0.59	090
26455	.....	A	Incision of finger tendon	3.68	NA	NA	5.15	6.21	0.58	090
26460	.....	A	Incise hand/finger tendon	3.50	NA	NA	5.11	6.12	0.55	090
26471	.....	A	Fusion of finger tendons	5.79	NA	NA	7.79	9.51	0.88	090
26474	.....	A	Fusion of finger tendons	5.38	NA	NA	7.60	9.49	0.76	090
26476	.....	A	Tendon lengthening	5.24	NA	NA	7.35	9.14	0.79	090
26477	.....	A	Tendon shortening	5.21	NA	NA	7.57	9.31	0.81	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
26478		A	Lengthening of hand tendon	5.86	NA	NA	7.78	9.80	0.90	090
26479		A	Shortening of hand tendon	5.80	NA	NA	7.73	9.64	0.92	090
26480		A	Transplant hand tendon	6.76	NA	NA	9.65	12.34	1.02	090
26483		A	Transplant/graft hand tendon	8.36	NA	NA	10.22	12.85	1.26	090
26485		A	Transplant palm tendon	7.77	NA	NA	10.07	12.71	1.15	090
26489		A	Transplant/graft palm tendon	9.74	NA	NA	10.82	11.43	1.26	090
26490		A	Revise thumb tendon	8.48	NA	NA	8.87	10.84	1.21	090
26492		A	Tendon transfer with graft	9.70	NA	NA	9.82	11.71	1.40	090
26494		A	Hand tendon/muscle transfer	8.54	NA	NA	9.23	11.10	1.28	090
26496		A	Revise thumb tendon	9.66	NA	NA	9.57	11.40	1.45	090
26497		A	Finger tendon transfer	9.64	NA	NA	9.52	11.54	1.41	090
26498		A	Finger tendon transfer	14.07	NA	NA	11.65	13.90	2.11	090
26499		A	Revision of finger	9.05	NA	NA	8.84	10.94	1.35	090
26500		A	Hand tendon reconstruction	6.02	NA	NA	7.74	9.59	0.90	090
26502		A	Hand tendon reconstruction	7.20	NA	NA	8.32	10.17	1.13	090
26508		A	Release thumb contracture	6.07	NA	NA	7.80	9.73	0.98	090
26510		A	Thumb tendon transfer	5.49	NA	NA	7.63	9.48	0.79	090
26516		A	Fusion of knuckle joint	7.21	NA	NA	8.30	10.26	1.10	090
26517		A	Fusion of knuckle joints	8.96	NA	NA	8.99	11.24	1.41	090
26518		A	Fusion of knuckle joints	9.15	NA	NA	8.96	11.17	1.35	090
26520		A	Release knuckle contracture	5.36	NA	NA	8.86	11.37	0.80	090
26525		A	Release finger contracture	5.39	NA	NA	8.88	11.42	0.81	090
26530		A	Revise knuckle joint	6.76	NA	NA	5.41	5.77	1.04	090
26531		A	Revise knuckle with implant	7.99	NA	NA	6.16	6.64	1.17	090
26535		A	Revise finger joint	5.30	NA	NA	4.09	3.91	0.71	090
26536		A	Revise/implant finger joint	6.44	NA	NA	9.24	9.44	0.96	090
26540		A	Repair hand joint	6.49	NA	NA	8.05	9.96	0.99	090
26541		A	Repair hand joint with graft	8.69	NA	NA	9.11	11.25	1.28	090
26542		A	Repair hand joint with graft	6.84	NA	NA	8.19	10.11	1.02	090
26545		A	Reconstruct finger joint	6.99	NA	NA	8.45	10.29	1.05	090
26546		A	Repair nonunion hand	10.53	NA	NA	11.42	13.22	1.44	090
26548		A	Reconstruct finger joint	8.10	NA	NA	8.80	10.82	1.20	090
26550		A	Construct thumb replacement	21.54	NA	NA	14.53	16.05	2.46	090
26551		A	Great toe-hand transfer	48.23	NA	NA	17.15	24.79	7.98	090
26553		A	Single transfer, toe-hand	47.92	NA	NA	27.34	25.01	2.42	090
26554		A	Double transfer, toe-hand	56.73	NA	NA	35.78	36.65	9.44	090
26555		A	Positional change of finger	16.94	NA	NA	13.99	16.08	2.49	090
26556		A	Toe joint transfer	49.43	NA	NA	18.03	25.67	2.58	090
26560		A	Repair of web finger	5.43	NA	NA	6.65	8.22	0.85	090
26561		A	Repair of web finger	10.98	NA	NA	9.50	10.92	1.45	090
26562		A	Repair of web finger	16.40	NA	NA	8.76	12.95	2.24	090
26565		A	Correct metacarpal flaw	6.80	NA	NA	8.15	10.07	1.00	090
26567		A	Correct finger deformity	6.88	NA	NA	8.11	10.03	1.04	090
26568		A	Lengthen metacarpal/finger	9.15	NA	NA	10.69	13.05	1.49	090
26580		A	Repair hand deformity	19.50	NA	NA	9.73	11.68	2.29	090
26587		A	Reconstruct extra finger	14.36	NA	NA	8.01	8.61	1.53	090
26590		A	Repair finger deformity	18.51	NA	NA	12.41	13.17	2.78	090
26591		A	Repair muscles of hand	3.30	NA	NA	6.21	7.91	0.48	090
26593		A	Release muscles of hand	5.38	NA	NA	7.79	9.46	0.78	090
26596		A	Excision constricting tissue	9.02	NA	NA	7.48	8.15	1.43	090
26600		A	Treat metacarpal fracture	2.48	3.83	3.72	3.49	3.07	0.30	090
26605		A	Treat metacarpal fracture	2.92	4.08	4.32	3.50	3.58	0.49	090
26607		A	Treat metacarpal fracture	5.40	NA	NA	4.88	5.58	0.87	090
26608		A	Treat metacarpal fracture	5.43	NA	NA	5.22	5.74	0.88	090
26615		A	Treat metacarpal fracture	6.91	NA	NA	6.01	5.66	0.86	090
26641		A	Treat thumb dislocation	4.01	4.03	4.30	3.40	3.46	0.39	090
26645		A	Treat thumb fracture	4.47	4.60	4.88	3.92	4.05	0.67	090
26650		A	Treat thumb fracture	5.19	NA	NA	4.88	5.78	0.94	090
26665		A	Treat thumb fracture	7.78	NA	NA	6.31	6.46	0.90	090
26670		A	Treat hand dislocation	3.74	3.62	3.94	3.03	2.99	0.39	090
26675		A	Treat hand dislocation	4.71	5.25	5.36	4.51	4.49	0.77	090
26676		A	Pin hand dislocation	5.60	NA	NA	5.56	6.12	0.91	090
26685		A	Treat hand dislocation	6.91	NA	NA	5.97	6.05	1.09	090
26686		A	Treat hand dislocation	8.06	NA	NA	6.07	6.48	1.24	090
26700		A	Treat knuckle dislocation	3.74	3.30	3.53	2.93	2.89	0.35	090
26705		A	Treat knuckle dislocation	4.26	4.74	5.04	4.04	4.17	0.66	090
26706		A	Pin knuckle dislocation	5.19	NA	NA	4.70	4.89	0.81	090
26715		A	Treat knuckle dislocation	6.87	NA	NA	5.99	5.75	0.91	090
26720		A	Treat finger fracture, each	1.70	2.58	2.68	2.30	2.18	0.24	090
26725		A	Treat finger fracture, each	3.39	4.08	4.42	3.41	3.45	0.53	090
26727		A	Treat finger fracture, each	5.30	NA	NA	5.18	5.70	0.84	090
26735		A	Treat finger fracture, each	7.26	NA	NA	6.12	5.84	0.95	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
26740	.....	A	Treat finger fracture, each	1.99	3.01	3.07	2.71	2.71	0.31	090
26742	.....	A	Treat finger fracture, each	3.90	4.26	4.62	3.56	3.72	0.58	090
26746	.....	A	Treat finger fracture, each	9.59	NA	NA	7.19	6.38	0.91	090
26750	.....	A	Treat finger fracture, each	1.74	2.25	2.36	2.26	2.14	0.22	090
26755	.....	A	Treat finger fracture, each	3.15	3.74	4.08	2.94	2.97	0.42	090
26756	.....	A	Pin finger fracture, each	4.46	NA	NA	4.86	5.29	0.71	090
26765	.....	A	Treat finger fracture, each	5.70	NA	NA	5.47	4.93	0.66	090
26770	.....	A	Treat finger dislocation	3.07	2.92	3.17	2.54	2.48	0.27	090
26775	.....	A	Treat finger dislocation	3.78	4.62	4.90	3.88	3.84	0.54	090
26776	.....	A	Pin finger dislocation	4.87	NA	NA	4.98	5.49	0.77	090
26785	.....	A	Treat finger dislocation	6.44	NA	NA	5.77	5.15	0.68	090
26820	.....	A	Thumb fusion with graft	8.33	NA	NA	8.96	11.10	1.30	090
26841	.....	A	Fusion of thumb	7.21	NA	NA	8.76	10.99	1.18	090
26842	.....	A	Thumb fusion with graft	8.37	NA	NA	9.01	11.19	1.32	090
26843	.....	A	Fusion of hand joint	7.67	NA	NA	8.56	10.45	1.15	090
26844	.....	A	Fusion/graft of hand joint	8.86	NA	NA	9.15	11.25	1.33	090
26850	.....	A	Fusion of knuckle	7.03	NA	NA	8.26	10.23	1.06	090
26852	.....	A	Fusion of knuckle with graft	8.59	NA	NA	9.13	11.01	1.22	090
26860	.....	A	Fusion of finger joint	4.76	NA	NA	7.53	9.35	0.73	090
26861	.....	A	Fusion of finger jnt, add-on	1.74	NA	NA	0.70	0.81	0.27	ZZZ
26862	.....	A	Fusion/graft of finger joint	7.44	NA	NA	8.66	10.50	1.10	090
26863	.....	A	Fuse/graft added joint	3.89	NA	NA	1.58	1.85	0.56	ZZZ
26910	.....	A	Amputate metacarpal bone	7.67	NA	NA	8.27	9.74	1.16	090
26951	.....	A	Amputation of finger/thumb	5.85	NA	NA	8.39	9.27	0.71	090
26952	.....	A	Amputation of finger/thumb	6.37	NA	NA	7.90	9.78	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	6.20	6.70	1.22	090
26991	.....	A	Drainage of pelvis bursa	6.97	8.61	9.88	4.88	5.15	1.11	090
26992	.....	A	Drainage of bone lesion	13.37	NA	NA	8.41	9.39	2.17	090
27000	.....	A	Incision of hip tendon	5.66	NA	NA	4.51	4.90	0.98	090
27001	.....	A	Incision of hip tendon	7.05	NA	NA	5.22	5.66	1.24	090
27003	.....	A	Incision of hip tendon	7.70	NA	NA	5.72	6.10	1.12	090
27005	.....	A	Incision of hip tendon	9.96	NA	NA	6.48	7.15	1.73	090
27006	.....	A	Incision of hip tendons	9.99	NA	NA	6.75	7.36	1.70	090
27025	.....	A	Incision of hip/thigh fascia	12.66	NA	NA	8.20	8.37	1.85	090
27030	.....	A	Drainage of hip joint	13.54	NA	NA	8.03	8.83	2.27	090
27033	.....	A	Exploration of hip joint	13.99	NA	NA	8.39	9.15	2.33	090
27035	.....	A	Denervation of hip joint	17.23	NA	NA	8.52	9.87	2.16	090
27036	.....	A	Excision of hip joint/muscle	14.18	NA	NA	8.91	9.45	2.27	090
27040	.....	A	Biopsy of soft tissues	2.89	5.19	5.21	1.87	1.94	0.27	010
27041	.....	A	Biopsy of soft tissues	10.07	NA	NA	5.73	6.18	1.35	090
27047	.....	A	Remove hip/pelvis lesion	7.51	7.02	7.06	4.49	4.63	1.03	090
27048	.....	A	Remove hip/pelvis lesion	6.44	NA	NA	4.60	4.70	0.92	090
27049	.....	A	Remove tumor, hip/pelvis	15.20	NA	NA	8.16	8.28	2.07	090
27050	.....	A	Biopsy of sacroiliac joint	4.65	NA	NA	3.01	3.71	0.60	090
27052	.....	A	Biopsy of hip joint	7.27	NA	NA	5.64	5.76	1.08	090
27054	.....	A	Removal of hip joint lining	9.09	NA	NA	6.49	6.91	1.47	090
27060	.....	A	Removal of ischial bursa	5.78	NA	NA	4.36	4.37	0.80	090
27062	.....	A	Remove femur lesion/bursa	5.66	NA	NA	4.60	4.89	0.93	090
27065	.....	A	Removal of hip bone lesion	6.44	NA	NA	4.99	5.21	1.01	090
27066	.....	A	Removal of hip bone lesion	11.06	NA	NA	7.43	7.93	1.80	090
27067	.....	A	Remove/graft hip bone lesion	14.57	NA	NA	8.83	9.74	1.85	090
27070	.....	A	Partial removal of hip bone	11.44	NA	NA	8.02	8.58	1.75	090
27071	.....	A	Partial removal of hip bone	12.25	NA	NA	8.47	9.29	1.93	090
27075	.....	A	Extensive hip surgery	36.77	NA	NA	16.13	17.66	5.66	090
27076	.....	A	Extensive hip surgery	24.25	NA	NA	12.82	13.66	3.71	090
27077	.....	A	Extensive hip surgery	42.54	NA	NA	19.92	21.29	6.14	090
27078	.....	A	Extensive hip surgery	14.54	NA	NA	8.81	9.37	2.23	090
27079	.....	A	Extensive hip surgery	14.91	NA	NA	8.00	8.77	1.95	090
27080	.....	A	Removal of tail bone	6.80	NA	NA	4.58	4.70	0.93	090
27086	.....	A	Remove hip foreign body	1.89	3.66	4.10	1.48	1.65	0.25	010
27087	.....	A	Remove hip foreign body	8.72	NA	NA	5.65	6.15	1.35	090
27090	.....	A	Removal of hip prosthesis	11.57	NA	NA	7.40	8.09	1.95	090
27091	.....	A	Removal of hip prosthesis	24.15	NA	NA	12.90	13.44	3.85	090
27093	.....	A	Injection for hip x-ray	1.30	3.15	3.80	0.47	0.48	0.13	000
27095	.....	A	Injection for hip x-ray	1.50	3.71	4.71	0.51	0.51	0.14	000
27096	.....	A	Inject sacroiliac joint	1.40	2.52	3.43	0.33	0.33	0.08	000
27097	.....	A	Revision of hip tendon	9.16	NA	NA	6.33	6.37	1.57	090
27098	.....	A	Transfer tendon to pelvis	9.20	NA	NA	4.91	5.96	0.95	090
27100	.....	A	Transfer of abdominal muscle	11.21	NA	NA	7.39	8.03	1.86	090
27105	.....	A	Transfer of spinal muscle	11.90	NA	NA	7.35	8.25	1.73	090
27110	.....	A	Transfer of iliopsoas muscle	13.63	NA	NA	8.27	8.69	2.19	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27111		A	Transfer of iliopsoas muscle	12.46	NA	NA	8.06	8.60	1.95	090
27120		A	Reconstruction of hip socket	19.10	NA	NA	10.81	11.32	3.09	090
27122		A	Reconstruction of hip socket	15.95	NA	NA	9.43	10.23	2.62	090
27125		A	Partial hip replacement	16.46	NA	NA	9.59	10.10	2.55	090
27130		A	Total hip arthroplasty	21.61	NA	NA	11.76	12.53	3.51	090
27132		A	Total hip arthroplasty	25.49	NA	NA	13.42	14.52	4.05	090
27134		A	Revise hip joint replacement	30.13	NA	NA	14.67	16.23	4.95	090
27137		A	Revise hip joint replacement	22.55	NA	NA	11.72	12.82	3.68	090
27138		A	Revise hip joint replacement	23.55	NA	NA	12.10	13.24	3.85	090
27140		A	Transplant femur ridge	12.66	NA	NA	7.87	8.64	2.12	090
27146		A	Incision of hip bone	18.72	NA	NA	10.68	11.40	2.97	090
27147		A	Revision of hip bone	21.87	NA	NA	12.00	12.62	3.58	090
27151		A	Incision of hip bones	23.92	NA	NA	12.87	10.41	3.92	090
27156		A	Revision of hip bones	26.03	NA	NA	13.71	14.88	4.22	090
27158		A	Revision of pelvis	20.89	NA	NA	11.51	11.23	3.17	090
27161		A	Incision of neck of femur	17.74	NA	NA	10.35	11.22	2.95	090
27165		A	Incision/fixation of femur	20.06	NA	NA	11.56	12.23	3.11	090
27170		A	Repair/graft femur head/neck	17.46	NA	NA	9.75	10.52	2.82	090
27175		A	Treat slipped epiphysis	9.29	NA	NA	5.16	5.91	1.46	090
27176		A	Treat slipped epiphysis	12.78	NA	NA	8.17	8.59	2.23	090
27177		A	Treat slipped epiphysis	15.94	NA	NA	9.63	10.26	2.62	090
27178		A	Treat slipped epiphysis	12.78	NA	NA	7.97	8.19	2.09	090
27179		A	Revise head/neck of femur	13.83	NA	NA	8.56	9.27	2.26	090
27181		A	Treat slipped epiphysis	15.98	NA	NA	9.73	9.96	1.57	090
27185		A	Revision of femur epiphysis	9.67	NA	NA	6.64	7.08	2.40	090
27187		A	Reinforce hip bones	14.09	NA	NA	8.68	9.50	2.38	090
27193		A	Treat pelvic ring fracture	5.98	4.62	4.85	4.75	4.92	0.96	090
27194		A	Treat pelvic ring fracture	10.08	NA	NA	6.60	7.12	1.65	090
27200		A	Treat tail bone fracture	1.87	2.07	2.15	2.22	2.19	0.28	090
27202		A	Treat tail bone fracture	7.25	NA	NA	4.90	10.88	1.06	090
27215		A	Treat pelvic fracture(s)	10.45	NA	NA	6.54	6.81	1.98	090
27216		A	Treat pelvic ring fracture	15.73	NA	NA	9.13	9.36	2.64	090
27217		A	Treat pelvic ring fracture	14.65	NA	NA	8.62	9.38	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	5.24	5.48	5.14	5.39	1.07	090
27222		A	Treat hip socket fracture	13.97	NA	NA	8.51	9.24	2.20	090
27226		A	Treat hip wall fracture	15.45	NA	NA	8.92	8.36	2.49	090
27227		A	Treat hip fracture(s)	25.21	NA	NA	13.37	14.38	4.06	090
27228		A	Treat hip fracture(s)	29.13	NA	NA	14.83	16.22	4.67	090
27230		A	Treat thigh fracture	5.69	4.93	5.22	4.86	4.98	0.95	090
27232		A	Treat thigh fracture	11.66	NA	NA	6.09	6.63	1.86	090
27235		A	Treat thigh fracture	12.88	NA	NA	7.97	8.71	2.12	090
27236		A	Treat thigh fracture	17.43	NA	NA	10.13	10.58	2.72	090
27238		A	Treat thigh fracture	5.64	NA	NA	4.65	4.89	0.89	090
27240		A	Treat thigh fracture	13.66	NA	NA	8.20	8.83	2.17	090
27244		A	Treat thigh fracture	17.08	NA	NA	9.61	10.45	2.78	090
27245		A	Treat thigh fracture	21.09	NA	NA	11.33	12.53	3.53	090
27246		A	Treat thigh fracture	4.75	3.91	4.18	3.94	4.18	0.81	090
27248		A	Treat thigh fracture	10.64	NA	NA	6.37	7.29	1.82	090
27250		A	Treat hip dislocation	7.21	NA	NA	4.29	4.45	0.62	090
27252		A	Treat hip dislocation	10.92	NA	NA	6.48	6.95	1.66	090
27253		A	Treat hip dislocation	13.46	NA	NA	8.16	8.97	2.25	090
27254		A	Treat hip dislocation	18.80	NA	NA	10.53	11.27	3.18	090
27256		A	Treat hip dislocation	4.25	2.52	3.02	1.41	1.74	0.46	010
27257		A	Treat hip dislocation	5.35	NA	NA	2.54	2.67	0.69	010
27258		A	Treat hip dislocation	16.04	NA	NA	9.47	10.17	2.65	090
27259		A	Treat hip dislocation	23.03	NA	NA	12.77	13.44	3.75	090
27265		A	Treat hip dislocation	5.12	NA	NA	3.94	4.36	0.63	090
27266		A	Treat hip dislocation	7.67	NA	NA	5.50	5.92	1.29	090
27267		A	Cltx thigh fx	5.38	NA	NA	4.39	4.39	0.89	090
27268		A	Cltx thigh fx w/mnpj	7.00	NA	NA	5.02	5.02	1.16	090
27269		A	Optx thigh fx	18.75	NA	NA	9.88	9.88	2.93	090
27275		A	Manipulation of hip joint	2.29	NA	NA	1.85	1.97	0.39	010
27280		A	Fusion of sacroiliac joint	14.49	NA	NA	8.87	9.56	2.54	090
27282		A	Fusion of pubic bones	11.71	NA	NA	7.77	7.88	1.87	090
27284		A	Fusion of hip joint	24.91	NA	NA	12.00	13.37	3.93	090
27286		A	Fusion of hip joint	24.97	NA	NA	12.60	14.19	3.13	090
27290		A	Amputation of leg at hip	24.38	NA	NA	12.10	13.07	3.44	090
27295		A	Amputation of leg at hip	19.54	NA	NA	9.57	10.44	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	8.19	9.13	4.64	4.89	1.04	090
27303		A	Drainage of bone lesion	8.52	NA	NA	5.99	6.48	1.43	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27305		A	Incise thigh tendon & fascia	6.09	NA	NA	4.68	4.93	1.01	090
27306		A	Incision of thigh tendon	4.66	NA	NA	4.07	4.39	0.85	090
27307		A	Incision of thigh tendons	5.97	NA	NA	4.74	5.06	1.04	090
27310		A	Exploration of knee joint	9.88	NA	NA	6.77	7.17	1.61	090
27323		A	Biopsy, thigh soft tissues	2.30	4.19	3.85	1.93	1.90	0.24	010
27324		A	Biopsy, thigh soft tissues	4.95	NA	NA	3.82	4.00	0.75	090
27325		A	Neurectomy, hamstring	7.09	NA	NA	4.99	4.96	1.09	090
27326		A	Neurectomy, popliteal	6.36	NA	NA	5.12	5.17	1.06	090
27327		A	Removal of thigh lesion	4.52	6.03	6.01	3.57	3.65	0.64	090
27328		A	Removal of thigh lesion	5.62	NA	NA	4.06	4.21	0.84	090
27329		A	Remove tumor, thigh/knee	15.68	NA	NA	8.46	8.74	2.15	090
27330		A	Biopsy, knee joint lining	5.02	NA	NA	4.26	4.41	0.86	090
27331		A	Explore/treat knee joint	5.93	NA	NA	4.79	5.16	1.02	090
27332		A	Removal of knee cartilage	8.34	NA	NA	6.12	6.62	1.43	090
27333		A	Removal of knee cartilage	7.43	NA	NA	5.68	6.17	1.26	090
27334		A	Remove knee joint lining	9.07	NA	NA	6.43	6.92	1.51	090
27335		A	Remove knee joint lining	10.43	NA	NA	7.01	7.61	1.75	090
27340		A	Removal of kneecap bursa	4.23	NA	NA	4.03	4.29	0.72	090
27345		A	Removal of knee cyst	5.98	NA	NA	4.88	5.25	1.00	090
27347		A	Remove knee cyst	6.58	NA	NA	5.25	5.34	0.98	090
27350		A	Removal of kneecap	8.54	NA	NA	6.24	6.74	1.41	090
27355		A	Remove femur lesion	7.89	NA	NA	5.80	6.29	1.32	090
27356		A	Remove femur lesion/graft	9.97	NA	NA	6.83	7.34	1.65	090
27357		A	Remove femur lesion/graft	11.02	NA	NA	7.47	8.08	1.96	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	1.81	2.16	0.82	ZZZ
27360		A	Partial removal, leg bone(s)	11.34	NA	NA	8.04	8.79	1.84	090
27365		A	Extensive leg surgery	17.93	NA	NA	10.40	11.04	2.80	090
27370		A	Injection for knee x-ray	0.96	2.99	3.36	0.36	0.34	0.08	000
27372		A	Removal of foreign body	5.12	8.30	9.17	4.04	4.36	0.84	090
27380		A	Repair of kneecap tendon	7.34	NA	NA	6.05	6.66	1.24	090
27381		A	Repair/graft kneecap tendon	10.64	NA	NA	7.56	8.32	1.80	090
27385		A	Repair of thigh muscle	8.00	NA	NA	6.30	6.96	1.36	090
27386		A	Repair/graft of thigh muscle	10.99	NA	NA	7.92	8.71	1.86	090
27390		A	Incision of thigh tendon	5.44	NA	NA	4.46	4.78	0.92	090
27391		A	Incision of thigh tendons	7.38	NA	NA	5.54	6.05	1.23	090
27392		A	Incision of thigh tendons	9.51	NA	NA	6.66	7.12	1.57	090
27393		A	Lengthening of thigh tendon	6.50	NA	NA	4.95	5.39	1.10	090
27394		A	Lengthening of thigh tendons	8.68	NA	NA	6.14	6.68	1.47	090
27395		A	Lengthening of thigh tendons	12.10	NA	NA	7.92	8.62	2.05	090
27396		A	Transplant of thigh tendon	8.04	NA	NA	5.82	6.41	1.34	090
27397		A	Transplants of thigh tendons	12.46	NA	NA	8.34	8.69	1.83	090
27400		A	Revise thigh muscles/tendons	9.21	NA	NA	6.51	6.88	1.31	090
27403		A	Repair of knee cartilage	8.51	NA	NA	6.02	6.60	1.44	090
27405		A	Repair of knee ligament	8.96	NA	NA	6.38	6.93	1.51	090
27407		A	Repair of knee ligament	10.71	NA	NA	6.82	7.57	1.79	090
27409		A	Repair of knee ligaments	13.57	NA	NA	8.25	9.10	2.25	090
27412		A	Autochondrocyte implant knee	24.53	NA	NA	13.64	14.22	4.36	090
27415		A	Osteochondral knee allograft	19.79	NA	NA	11.77	12.16	4.36	090
27416		A	Osteochondral knee autograft	14.00	NA	NA	8.38	8.38	2.32	090
27418		A	Repair degenerated kneecap	11.46	NA	NA	7.57	8.23	1.89	090
27420		A	Revision of unstable kneecap	10.14	NA	NA	6.90	7.50	1.72	090
27422		A	Revision of unstable kneecap	10.09	NA	NA	6.87	7.49	1.71	090
27424		A	Revision/removal of kneecap	10.12	NA	NA	6.89	7.49	1.71	090
27425		A	Lat retinacular release open	5.28	NA	NA	4.70	5.11	0.90	090
27427		A	Reconstruction, knee	9.67	NA	NA	6.69	7.24	1.63	090
27428		A	Reconstruction, knee	15.33	NA	NA	10.03	10.63	2.43	090
27429		A	Reconstruction, knee	17.24	NA	NA	11.25	11.83	2.71	090
27430		A	Revision of thigh muscles	10.04	NA	NA	6.84	7.41	1.70	090
27435		A	Incision of knee joint	10.68	NA	NA	7.58	8.03	1.70	090
27437		A	Revise kneecap	8.82	NA	NA	6.18	6.71	1.49	090
27438		A	Revise kneecap with implant	11.77	NA	NA	7.49	8.01	1.96	090
27440		A	Revision of knee joint	10.97	NA	NA	6.99	6.49	1.82	090
27441		A	Revision of knee joint	11.42	NA	NA	7.35	7.03	1.89	090
27442		A	Revision of knee joint	12.25	NA	NA	7.64	8.27	2.10	090
27443		A	Revision of knee joint	11.29	NA	NA	7.34	8.03	1.91	090
27445		A	Revision of knee joint	18.52	NA	NA	10.40	11.38	3.09	090
27446		A	Revision of knee joint	16.26	NA	NA	9.28	10.27	2.81	090
27447		A	Total knee arthroplasty	23.04	NA	NA	12.56	13.58	3.80	090
27448		A	Incision of thigh	11.48	NA	NA	7.31	7.95	1.95	090
27450		A	Incision of thigh	14.47	NA	NA	8.83	9.70	2.43	090
27454		A	Realignment of thigh bone	18.97	NA	NA	10.72	11.61	3.13	090
27455		A	Realignment of knee	13.24	NA	NA	8.30	9.09	2.25	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27457	.....	A	Realignment of knee	13.92	NA	NA	8.22	9.07	2.35	090
27465	.....	A	Shortening of thigh bone	18.44	NA	NA	10.28	10.25	2.48	090
27466	.....	A	Lengthening of thigh bone	17.13	NA	NA	10.05	10.94	2.78	090
27468	.....	A	Shorten/lengthen thighs	19.82	NA	NA	11.16	11.75	3.31	090
27470	.....	A	Repair of thigh	16.97	NA	NA	10.15	10.96	2.80	090
27472	.....	A	Repair/graft of thigh	18.57	NA	NA	10.63	11.65	3.08	090
27475	.....	A	Surgery to stop leg growth	8.82	NA	NA	6.19	6.70	1.36	090
27477	.....	A	Surgery to stop leg growth	10.03	NA	NA	6.59	7.16	1.74	090
27479	.....	A	Surgery to stop leg growth	13.04	NA	NA	8.84	9.24	2.79	090
27485	.....	A	Surgery to stop leg growth	9.02	NA	NA	6.21	6.80	1.53	090
27486	.....	A	Revise/replace knee joint	20.92	NA	NA	11.62	12.55	3.37	090
27487	.....	A	Revise/replace knee joint	26.91	NA	NA	13.97	15.25	4.40	090
27488	.....	A	Removal of knee prosthesis	17.40	NA	NA	10.24	10.96	2.75	090
27495	.....	A	Reinforce thigh	16.40	NA	NA	9.59	10.49	2.72	090
27496	.....	A	Decompression of thigh/knee	6.66	NA	NA	4.97	5.29	0.99	090
27497	.....	A	Decompression of thigh/knee	7.70	NA	NA	4.98	5.21	1.15	090
27498	.....	A	Decompression of thigh/knee	8.54	NA	NA	5.18	5.57	1.24	090
27499	.....	A	Decompression of thigh/knee	9.31	NA	NA	5.98	6.40	1.47	090
27500	.....	A	Treatment of thigh fracture	6.21	5.36	5.74	4.58	4.78	1.02	090
27501	.....	A	Treatment of thigh fracture	6.34	5.00	5.40	4.91	5.15	1.03	090
27502	.....	A	Treatment of thigh fracture	11.24	NA	NA	6.85	7.48	1.79	090
27503	.....	A	Treatment of thigh fracture	11.13	NA	NA	7.21	7.74	1.85	090
27506	.....	A	Treatment of thigh fracture	19.42	NA	NA	11.35	12.07	3.04	090
27507	.....	A	Treatment of thigh fracture	14.39	NA	NA	8.12	8.98	2.43	090
27508	.....	A	Treatment of thigh fracture	6.08	5.68	6.07	5.05	5.26	0.97	090
27509	.....	A	Treatment of thigh fracture	8.02	NA	NA	6.53	7.24	1.34	090
27510	.....	A	Treatment of thigh fracture	9.68	NA	NA	6.26	6.79	1.53	090
27511	.....	A	Treatment of thigh fracture	14.97	NA	NA	8.10	9.65	2.38	090
27513	.....	A	Treatment of thigh fracture	19.11	NA	NA	9.74	11.81	3.13	090
27514	.....	A	Treatment of thigh fracture	14.46	NA	NA	7.88	10.61	3.01	090
27516	.....	A	Treat thigh fx growth plate	5.45	5.71	6.03	5.07	5.29	0.81	090
27517	.....	A	Treat thigh fx growth plate	8.98	NA	NA	6.41	6.93	1.22	090
27519	.....	A	Treat thigh fx growth plate	13.11	NA	NA	7.38	9.48	2.56	090
27520	.....	A	Treat kneecap fracture	2.93	4.10	4.31	3.52	3.48	0.47	090
27524	.....	A	Treat kneecap fracture	10.25	NA	NA	6.93	7.58	1.75	090
27530	.....	A	Treat knee fracture	3.97	4.82	5.06	4.26	4.34	0.65	090
27532	.....	A	Treat knee fracture	7.43	6.39	6.87	5.62	6.03	1.26	090
27535	.....	A	Treat knee fracture	13.27	NA	NA	7.44	8.77	2.01	090
27536	.....	A	Treat knee fracture	17.19	NA	NA	10.19	10.89	2.74	090
27538	.....	A	Treat knee fracture(s)	4.95	5.51	5.82	4.89	5.04	0.84	090
27540	.....	A	Treat knee fracture	11.16	NA	NA	7.38	8.44	2.28	090
27550	.....	A	Treat knee dislocation	5.84	5.21	5.61	4.50	4.71	0.76	090
27552	.....	A	Treat knee dislocation	8.04	NA	NA	6.08	6.51	1.36	090
27556	.....	A	Treat knee dislocation	12.86	NA	NA	7.25	9.45	2.51	090
27557	.....	A	Treat knee dislocation	15.76	NA	NA	8.44	10.78	2.98	090
27558	.....	A	Treat knee dislocation	18.25	NA	NA	9.28	11.16	3.09	090
27560	.....	A	Treat kneecap dislocation	3.88	4.24	4.54	3.71	3.45	0.40	090
27562	.....	A	Treat kneecap dislocation	5.86	NA	NA	4.61	4.69	0.94	090
27566	.....	A	Treat kneecap dislocation	12.59	NA	NA	7.88	8.60	2.13	090
27570	.....	A	Fixation of knee joint	1.76	NA	NA	1.61	1.69	0.30	010
27580	.....	A	Fusion of knee	20.90	NA	NA	12.17	13.48	3.38	090
27590	.....	A	Amputate leg at thigh	13.35	NA	NA	6.01	6.34	1.75	090
27591	.....	A	Amputate leg at thigh	13.82	NA	NA	7.34	7.99	2.03	090
27592	.....	A	Amputate leg at thigh	10.86	NA	NA	5.45	5.81	1.45	090
27594	.....	A	Amputation follow-up surgery	7.17	NA	NA	4.72	4.94	1.02	090
27596	.....	A	Amputation follow-up surgery	11.15	NA	NA	5.97	6.39	1.57	090
27598	.....	A	Amputate lower leg at knee	11.08	NA	NA	6.19	6.60	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	3.79	4.16	0.86	090
27601	.....	A	Decompression of lower leg	5.94	NA	NA	4.17	4.51	0.80	090
27602	.....	A	Decompression of lower leg	7.71	NA	NA	4.29	4.71	1.10	090
27603	.....	A	Drain lower leg lesion	5.12	7.04	7.26	3.90	4.03	0.74	090
27604	.....	A	Drain lower leg bursa	4.51	6.48	6.28	3.42	3.69	0.69	090
27605	.....	A	Incision of achilles tendon	2.89	5.15	6.41	1.74	2.03	0.41	010
27606	.....	A	Incision of achilles tendon	4.15	NA	NA	2.62	2.99	0.69	010
27607	.....	A	Treat lower leg bone lesion	8.51	NA	NA	5.70	5.93	1.31	090
27610	.....	A	Explore/treat ankle joint	9.01	NA	NA	6.10	6.55	1.40	090
27612	.....	A	Exploration of ankle joint	8.01	NA	NA	5.17	5.63	1.13	090
27613	.....	A	Biopsy lower leg soft tissue	2.19	3.91	3.57	1.77	1.79	0.20	010
27614	.....	A	Biopsy lower leg soft tissue	5.71	7.75	7.44	3.93	4.18	0.78	090
27615	.....	A	Remove tumor, lower leg	12.93	NA	NA	7.27	8.33	1.84	090
27618	.....	A	Remove lower leg lesion	5.14	6.43	6.22	3.80	3.89	0.72	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27619		A	Remove lower leg lesion	8.47	9.99	9.75	5.27	5.61	1.25	090
27620		A	Explore/treat ankle joint	6.04	NA	NA	4.56	5.01	0.97	090
27625		A	Remove ankle joint lining	8.37	NA	NA	5.49	5.98	1.28	090
27626		A	Remove ankle joint lining	8.98	NA	NA	5.77	6.34	1.48	090
27630		A	Removal of tendon lesion	4.85	7.98	7.76	3.80	4.09	0.74	090
27635		A	Remove lower leg bone lesion	7.91	NA	NA	5.63	6.18	1.31	090
27637		A	Remove/graft leg bone lesion	10.17	NA	NA	6.90	7.59	1.66	090
27638		A	Remove/graft leg bone lesion	10.87	NA	NA	7.04	7.66	1.85	090
27640		A	Partial removal of tibia	12.10	NA	NA	7.46	8.88	1.89	090
27641		A	Partial removal of fibula	9.73	NA	NA	6.09	7.21	1.46	090
27645		A	Extensive lower leg surgery	14.78	NA	NA	8.73	10.38	2.42	090
27646		A	Extensive lower leg surgery	13.21	NA	NA	7.64	9.33	2.06	090
27647		A	Extensive ankle/heel surgery	12.85	NA	NA	6.54	7.07	1.76	090
27648		A	Injection for ankle x-ray	0.96	2.88	3.20	0.34	0.34	0.08	000
27650		A	Repair achilles tendon	9.94	NA	NA	6.15	6.83	1.59	090
27652		A	Repair/graft achilles tendon	10.64	NA	NA	6.44	7.23	1.72	090
27654		A	Repair of achilles tendon	10.32	NA	NA	5.98	6.56	1.58	090
27656		A	Repair leg fascia defect	4.62	7.95	8.24	3.58	3.67	0.69	090
27658		A	Repair of leg tendon, each	5.03	NA	NA	3.88	4.22	0.79	090
27659		A	Repair of leg tendon, each	6.99	NA	NA	4.67	5.16	1.09	090
27664		A	Repair of leg tendon, each	4.64	NA	NA	3.88	4.21	0.76	090
27665		A	Repair of leg tendon, each	5.46	NA	NA	4.32	4.64	0.89	090
27675		A	Repair lower leg tendons	7.24	NA	NA	4.67	5.20	1.11	090
27676		A	Repair lower leg tendons	8.61	NA	NA	5.72	6.23	1.37	090
27680		A	Release of lower leg tendon	5.79	NA	NA	4.16	4.63	0.93	090
27681		A	Release of lower leg tendons	6.94	NA	NA	5.09	5.50	1.15	090
27685		A	Revision of lower leg tendon	6.57	8.77	8.03	4.57	5.02	0.97	090
27686		A	Revise lower leg tendons	7.64	NA	NA	5.28	5.89	1.24	090
27687		A	Revision of calf tendon	6.30	NA	NA	4.47	4.89	1.00	090
27690		A	Revise lower leg tendon	8.96	NA	NA	5.37	5.86	1.33	090
27691		A	Revise lower leg tendon	10.28	NA	NA	6.65	7.20	1.64	090
27692		A	Revise additional leg tendon	1.87	NA	NA	0.71	0.82	0.32	ZZZ
27695		A	Repair of ankle ligament	6.58	NA	NA	4.87	5.37	1.05	090
27696		A	Repair of ankle ligaments	8.46	NA	NA	5.25	5.84	1.28	090
27698		A	Repair of ankle ligament	9.49	NA	NA	5.87	6.40	1.47	090
27700		A	Revision of ankle joint	9.54	NA	NA	5.20	5.44	1.30	090
27702		A	Reconstruct ankle joint	14.28	NA	NA	8.64	9.55	2.38	090
27703		A	Reconstruction, ankle joint	16.79	NA	NA	9.77	10.50	2.77	090
27704		A	Removal of ankle implant	7.69	NA	NA	5.61	5.60	1.27	090
27705		A	Incision of tibia	10.74	NA	NA	6.95	7.56	1.81	090
27707		A	Incision of fibula	4.67	NA	NA	4.48	4.71	0.76	090
27709		A	Incision of tibia & fibula	17.32	NA	NA	9.95	9.04	1.74	090
27712		A	Realignment of lower leg	15.67	NA	NA	9.44	10.09	2.48	090
27715		A	Revision of lower leg	15.36	NA	NA	9.03	9.89	2.50	090
27720		A	Repair of tibia	12.22	NA	NA	7.92	8.66	2.05	090
27722		A	Repair/graft of tibia	12.31	NA	NA	7.88	8.50	2.06	090
27724		A	Repair/graft of tibia	19.18	NA	NA	10.28	11.32	3.17	090
27725		A	Repair of lower leg	17.15	NA	NA	10.58	11.24	2.72	090
27726		A	Repair fibula nonunion	14.20	NA	NA	7.67	7.67	1.43	090
27727		A	Repair of lower leg	14.69	NA	NA	9.06	9.70	2.44	090
27730		A	Repair of tibia epiphysis	7.59	NA	NA	5.30	5.86	1.73	090
27732		A	Repair of fibula epiphysis	5.37	NA	NA	4.16	4.54	0.77	090
27734		A	Repair lower leg epiphyses	8.72	NA	NA	6.16	6.22	1.35	090
27740		A	Repair of leg epiphyses	9.49	NA	NA	6.60	7.29	1.62	090
27742		A	Repair of leg epiphyses	10.49	NA	NA	4.60	5.08	1.80	090
27745		A	Reinforce tibia	10.37	NA	NA	6.99	7.58	1.76	090
27750		A	Treatment of tibia fracture	3.26	4.32	4.54	3.73	3.79	0.55	090
27752		A	Treatment of tibia fracture	6.15	5.94	6.29	5.10	5.39	1.01	090
27756		A	Treatment of tibia fracture	7.33	NA	NA	5.75	6.10	1.17	090
27758		A	Treatment of tibia fracture	12.40	NA	NA	8.02	8.60	2.04	090
27759		A	Treatment of tibia fracture	14.31	NA	NA	8.66	9.48	2.39	090
27760		A	Cltx medial ankle fx	3.09	4.28	4.47	3.67	3.63	0.48	090
27762		A	Cltx med ankle fx w/mnpj	5.33	5.47	5.90	4.65	4.96	0.85	090
27766		A	Optx medial ankle fx	7.73	NA	NA	6.12	6.67	1.44	090
27767		A	Cltx post ankle fx	2.50	3.62	3.62	3.65	3.65	0.30	090
27768		A	Cltx post ankle fx w/mnpj	5.00	NA	NA	4.29	4.29	0.79	090
27769		A	Optx post ankle fx	10.00	NA	NA	6.07	6.07	1.45	090
27780		A	Treatment of fibula fracture	2.72	3.86	4.02	3.31	3.26	0.41	090
27781		A	Treatment of fibula fracture	4.47	4.87	5.18	4.26	4.45	0.73	090
27784		A	Treatment of fibula fracture	9.51	NA	NA	6.84	6.65	1.23	090
27786		A	Treatment of ankle fracture	2.91	4.05	4.25	3.43	3.38	0.46	090
27788		A	Treatment of ankle fracture	4.52	4.96	5.30	4.23	4.44	0.74	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27792		A	Treatment of ankle fracture	9.55	NA	NA	6.80	6.88	1.32	090
27808		A	Treatment of ankle fracture	2.91	4.39	4.59	3.70	3.70	0.46	090
27810		A	Treatment of ankle fracture	5.20	5.40	5.82	4.55	4.85	0.82	090
27814		A	Treatment of ankle fracture	10.46	NA	NA	7.23	7.89	1.86	090
27816		A	Treatment of ankle fracture	2.96	3.99	4.18	3.33	3.37	0.43	090
27818		A	Treatment of ankle fracture	5.57	5.41	5.89	4.44	4.80	0.82	090
27822		A	Treatment of ankle fracture	11.03	NA	NA	8.20	9.42	1.92	090
27823		A	Treatment of ankle fracture	12.98	NA	NA	8.93	10.19	2.26	090
27824		A	Treat lower leg fracture	3.20	3.65	3.85	3.47	3.51	0.45	090
27825		A	Treat lower leg fracture	6.60	5.78	6.19	4.75	5.07	1.02	090
27826		A	Treat lower leg fracture	10.92	NA	NA	8.20	8.51	1.47	090
27827		A	Treat lower leg fracture	14.56	NA	NA	10.17	11.47	2.44	090
27828		A	Treat lower leg fracture	18.20	NA	NA	11.56	12.74	2.82	090
27829		A	Treat lower leg joint	8.64	NA	NA	6.97	6.87	0.95	090
27830		A	Treat lower leg dislocation	3.85	4.09	4.24	3.56	3.70	0.54	090
27831		A	Treat lower leg dislocation	4.62	NA	NA	4.05	4.25	0.73	090
27832		A	Treat lower leg dislocation	10.01	NA	NA	6.83	6.50	1.03	090
27840		A	Treat ankle dislocation	4.65	NA	NA	3.65	3.70	0.46	090
27842		A	Treat ankle dislocation	6.34	NA	NA	4.85	4.98	1.00	090
27846		A	Treat ankle dislocation	10.16	NA	NA	6.76	7.34	1.71	090
27848		A	Treat ankle dislocation	11.56	NA	NA	7.31	8.51	1.95	090
27860		A	Fixation of ankle joint	2.36	NA	NA	1.68	1.83	0.39	010
27870		A	Fusion of ankle joint, open	15.21	NA	NA	9.07	9.79	2.37	090
27871		A	Fusion of tibiofibular joint	9.42	NA	NA	6.53	7.05	1.59	090
27880		A	Amputation of lower leg	15.24	NA	NA	6.64	6.88	1.76	090
27881		A	Amputation of lower leg	13.32	NA	NA	7.37	8.11	1.99	090
27882		A	Amputation of lower leg	9.67	NA	NA	4.90	5.69	1.29	090
27884		A	Amputation follow-up surgery	8.64	NA	NA	5.10	5.43	1.22	090
27886		A	Amputation follow-up surgery	9.88	NA	NA	5.65	6.08	1.40	090
27888		A	Amputation of foot at ankle	10.23	NA	NA	6.00	6.75	1.51	090
27889		A	Amputation of foot at ankle	10.72	NA	NA	5.43	5.95	1.46	090
27892		A	Decompression of leg	7.82	NA	NA	5.09	5.34	1.10	090
27893		A	Decompression of leg	7.78	NA	NA	5.12	5.29	1.10	090
27894		A	Decompression of leg	12.42	NA	NA	7.33	7.55	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	3.49	1.61	1.78	0.33	010
28002		A	Treatment of foot infection	5.78	6.67	5.83	3.57	3.67	0.61	010
28003		A	Treatment of foot infection	8.95	7.77	7.00	4.55	4.89	1.12	090
28005		A	Treat foot bone lesion	9.30	NA	NA	5.52	5.78	1.16	090
28008		A	Incision of foot fascia	4.50	6.17	5.36	3.00	3.10	0.57	090
28010		A	Incision of toe tendon	2.89	2.86	2.62	2.35	2.36	0.36	090
28011		A	Incision of toe tendons	4.19	3.79	3.55	3.03	3.16	0.59	090
28020		A	Exploration of foot joint	5.06	7.36	6.68	3.58	3.85	0.72	090
28022		A	Exploration of foot joint	4.72	6.92	6.06	3.33	3.59	0.62	090
28024		A	Exploration of toe joint	4.43	6.55	5.88	3.11	3.52	0.58	090
28035		A	Decompression of tibia nerve	5.14	7.27	6.56	3.54	3.81	0.70	090
28043		A	Excision of foot lesion	3.58	4.78	4.29	2.73	2.95	0.46	090
28045		A	Excision of foot lesion	4.77	7.02	6.20	3.24	3.42	0.63	090
28046		A	Resection of tumor, foot	10.55	10.36	9.56	5.76	6.11	1.36	090
28050		A	Biopsy of foot joint lining	4.30	6.94	5.91	3.29	3.44	0.60	090
28052		A	Biopsy of foot joint lining	3.98	6.30	5.60	2.87	3.15	0.53	090
28054		A	Biopsy of toe joint lining	3.49	6.25	5.48	2.79	3.01	0.46	090
28055		A	Neurectomy, foot	6.20	NA	NA	3.44	3.54	0.74	090
28060		A	Partial removal, foot fascia	5.29	7.07	6.27	3.54	3.70	0.70	090
28062		A	Removal of foot fascia	6.58	7.82	7.17	3.82	3.91	0.83	090
28070		A	Removal of foot joint lining	5.15	7.36	6.29	3.54	3.67	0.73	090
28072		A	Removal of foot joint lining	4.63	7.56	6.54	3.60	3.95	0.68	090
28080		A	Removal of foot lesion	4.65	7.66	6.38	4.19	3.93	0.47	090
28086		A	Excise foot tendon sheath	4.83	7.86	7.92	3.81	4.24	0.76	090
28088		A	Excise foot tendon sheath	3.90	7.00	6.37	3.19	3.54	0.61	090
28090		A	Removal of foot lesion	4.46	6.77	5.95	3.18	3.31	0.59	090
28092		A	Removal of toe lesions	3.69	6.46	5.84	2.98	3.25	0.49	090
28100		A	Removal of ankle/heel lesion	5.72	8.09	8.02	3.99	4.34	0.82	090
28102		A	Remove/graft foot lesion	7.80	NA	NA	4.84	5.39	1.14	090
28103		A	Remove/graft foot lesion	6.56	NA	NA	4.02	4.31	0.91	090
28104		A	Removal of foot lesion	5.17	7.23	6.35	3.46	3.69	0.70	090
28106		A	Remove/graft foot lesion	7.23	NA	NA	4.22	4.32	0.97	090
28107		A	Remove/graft foot lesion	5.62	7.69	7.11	3.66	3.93	0.74	090
28108		A	Removal of toe lesions	4.21	6.35	5.46	2.98	3.12	0.53	090
28110		A	Part removal of metatarsal	4.13	6.92	6.07	3.06	3.14	0.54	090
28111		A	Part removal of metatarsal	5.06	7.09	6.68	3.20	3.42	0.67	090
28112		A	Part removal of metatarsal	4.54	7.18	6.49	3.24	3.40	0.61	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
28113		A	Part removal of metatarsal	5.88	8.36	7.20	4.61	4.46	0.63	090
28114		A	Removal of metatarsal heads	11.61	13.38	12.49	8.29	8.33	1.42	090
28116		A	Revision of foot	8.94	9.44	8.11	5.34	5.25	1.03	090
28118		A	Removal of heel bone	6.02	7.92	7.08	4.02	4.18	0.84	090
28119		A	Removal of heel spur	5.45	7.21	6.31	3.57	3.65	0.70	090
28120		A	Part removal of ankle/heel	5.64	8.08	7.68	3.96	4.18	0.77	090
28122		A	Partial removal of foot bone	7.56	8.46	7.64	4.77	5.02	0.98	090
28124		A	Partial removal of toe	4.88	6.77	5.88	3.46	3.55	0.60	090
28126		A	Partial removal of toe	3.56	5.96	5.08	2.66	2.82	0.45	090
28130		A	Removal of ankle bone	9.30	NA	NA	6.15	6.43	1.26	090
28140		A	Removal of metatarsal	7.03	7.81	7.51	4.11	4.43	0.92	090
28150		A	Removal of toe	4.14	6.35	5.59	2.97	3.13	0.53	090
28153		A	Partial removal of toe	3.71	6.21	5.26	2.89	2.78	0.47	090
28160		A	Partial removal of toe	3.79	6.31	5.43	2.92	3.13	0.49	090
28171		A	Extensive foot surgery	9.85	NA	NA	5.25	5.34	1.33	090
28173		A	Extensive foot surgery	9.05	8.72	8.15	4.61	4.90	1.12	090
28175		A	Extensive foot surgery	6.17	7.14	6.42	3.62	3.66	0.73	090
28190		A	Removal of foot foreign body	1.98	4.01	3.70	1.34	1.41	0.22	010
28192		A	Removal of foot foreign body	4.69	6.71	6.09	3.19	3.41	0.61	090
28193		A	Removal of foot foreign body	5.79	7.33	6.47	3.63	3.77	0.73	090
28200		A	Repair of foot tendon	4.65	6.87	5.98	3.23	3.39	0.61	090
28202		A	Repair/graft of foot tendon	6.96	7.76	7.48	3.93	4.21	0.91	090
28208		A	Repair of foot tendon	4.42	6.69	5.75	3.18	3.24	0.58	090
28210		A	Repair/graft of foot tendon	6.41	7.62	6.91	3.93	3.97	0.81	090
28220		A	Release of foot tendon	4.58	6.41	5.54	3.07	3.25	0.57	090
28222		A	Release of foot tendons	5.67	6.92	6.08	3.34	3.73	0.69	090
28225		A	Release of foot tendon	3.70	6.01	5.14	2.71	2.81	0.46	090
28226		A	Release of foot tendons	4.58	6.88	5.83	3.25	3.49	0.58	090
28230		A	Incision of foot tendon(s)	4.28	6.26	5.46	2.87	3.27	0.55	090
28232		A	Incision of toe tendon	3.43	5.93	5.22	2.67	2.99	0.44	090
28234		A	Incision of foot tendon	3.43	6.29	5.48	3.05	3.20	0.44	090
28238		A	Revision of foot tendon	7.85	8.38	7.81	4.37	4.64	1.06	090
28240		A	Release of big toe	4.40	6.35	5.49	2.95	3.21	0.58	090
28250		A	Revision of foot fascia	5.97	7.55	6.58	3.82	3.97	0.82	090
28260		A	Release of midfoot joint	8.08	8.44	7.38	4.61	4.80	1.14	090
28261		A	Revision of foot tendon	12.91	10.66	9.63	6.33	6.81	1.57	090
28262		A	Revision of foot and ankle	17.01	15.52	14.53	9.72	10.31	2.60	090
28264		A	Release of midfoot joint	10.53	10.31	9.02	5.95	6.61	1.54	090
28270		A	Release of foot contracture	4.82	6.91	5.90	3.44	3.58	0.62	090
28272		A	Release of toe joint, each	3.84	5.83	5.00	2.65	2.75	0.46	090
28280		A	Fusion of toes	5.24	7.28	6.76	3.54	4.01	0.73	090
28285		A	Repair of hammertoe	4.65	6.70	5.78	3.34	3.38	0.59	090
28286		A	Repair of hammertoe	4.61	6.52	5.65	3.06	3.15	0.57	090
28288		A	Partial removal of foot bone	5.81	8.59	7.26	4.69	4.78	0.65	090
28289		A	Repair hallux rigidus	8.11	9.42	8.70	5.33	5.55	1.02	090
28290		A	Correction of bunion	5.72	8.18	7.21	3.96	4.34	0.82	090
28292		A	Correction of bunion	8.72	10.33	8.89	6.15	5.84	0.91	090
28293		A	Correction of bunion	11.10	14.46	12.60	6.91	6.50	1.13	090
28294		A	Correction of bunion	8.63	9.45	8.44	4.77	4.74	1.09	090
28296		A	Correction of bunion	9.31	9.57	8.86	4.79	5.10	1.19	090
28297		A	Correction of bunion	9.31	10.46	9.70	5.33	5.79	1.32	090
28298		A	Correction of bunion	8.01	9.29	8.25	4.59	4.79	1.05	090
28299		A	Correction of bunion	11.39	10.54	9.65	5.72	5.89	1.37	090
28300		A	Incision of heel bone	9.61	NA	NA	6.03	6.53	1.54	090
28302		A	Incision of ankle bone	9.62	NA	NA	6.21	6.54	1.42	090
28304		A	Incision of midfoot bones	9.29	9.55	8.74	5.08	5.40	1.27	090
28305		A	Incise/graft midfoot bones	10.63	NA	NA	5.78	6.25	1.27	090
28306		A	Incision of metatarsal	5.91	8.41	7.62	3.89	4.03	0.84	090
28307		A	Incision of metatarsal	6.39	9.27	10.14	4.33	4.81	0.90	090
28308		A	Incision of metatarsal	5.36	7.91	6.83	3.82	3.75	0.70	090
28309		A	Incision of metatarsals	13.96	NA	NA	7.68	7.81	2.05	090
28310		A	Revision of big toe	5.48	7.54	6.64	3.42	3.48	0.70	090
28312		A	Revision of toe	4.60	7.37	6.40	3.23	3.43	0.63	090
28313		A	Repair deformity of toe	5.06	7.26	6.27	3.60	4.21	0.73	090
28315		A	Removal of sesamoid bone	4.91	6.67	5.78	3.22	3.27	0.63	090
28320		A	Repair of foot bones	9.25	NA	NA	5.68	6.19	1.43	090
28322		A	Repair of metatarsals	8.41	9.74	9.45	5.31	5.82	1.27	090
28340		A	Resect enlarged toe tissue	7.04	8.09	7.26	4.07	4.15	0.84	090
28341		A	Resect enlarged toe	8.60	8.59	7.76	4.42	4.61	1.01	090
28344		A	Repair extra toe(s)	4.31	6.41	6.07	2.93	3.28	0.51	090
28345		A	Repair webbed toe(s)	5.98	7.61	6.90	3.78	4.23	0.80	090
28360		A	Reconstruct cleft foot	14.67	NA	NA	6.34	8.41	2.29	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
28400		A	Treatment of heel fracture	2.22	3.36	3.49	2.91	2.98	0.35	090
28405		A	Treatment of heel fracture	4.63	4.42	4.62	3.67	4.14	0.73	090
28406		A	Treatment of heel fracture	6.44	NA	NA	5.55	6.17	1.11	090
28415		A	Treat heel fracture	15.96	NA	NA	10.23	11.75	2.67	090
28420		A	Treat/graft heel fracture	17.29	NA	NA	10.27	11.59	2.81	090
28430		A	Treatment of ankle fracture	2.14	3.12	3.25	2.57	2.57	0.31	090
28435		A	Treatment of ankle fracture	3.45	3.98	3.93	3.26	3.50	0.55	090
28436		A	Treatment of ankle fracture	4.78	NA	NA	4.74	5.32	0.81	090
28445		A	Treat ankle fracture	15.53	NA	NA	9.48	10.25	2.59	090
28446		A	Osteochondral talus autogrft	17.50	NA	NA	10.34	10.34	2.45	090
28450		A	Treat midfoot fracture, each	1.95	2.91	3.01	2.41	2.44	0.28	090
28455		A	Treat midfoot fracture, each	3.15	3.74	3.58	3.10	3.26	0.44	090
28456		A	Treat midfoot fracture	2.75	NA	NA	3.72	3.94	0.44	090
28465		A	Treat midfoot fracture, each	8.64	NA	NA	6.06	6.18	1.10	090
28470		A	Treat metatarsal fracture	1.99	2.80	2.96	2.36	2.40	0.30	090
28475		A	Treat metatarsal fracture	2.97	3.13	3.23	2.51	2.86	0.44	090
28476		A	Treat metatarsal fracture	3.46	NA	NA	4.32	4.65	0.54	090
28485		A	Treat metatarsal fracture	7.28	NA	NA	5.56	5.50	0.83	090
28490		A	Treat big toe fracture	1.12	2.09	2.05	1.67	1.65	0.14	090
28495		A	Treat big toe fracture	1.62	2.46	2.32	1.86	1.96	0.20	090
28496		A	Treat big toe fracture	2.39	7.41	7.83	2.99	3.09	0.36	090
28505		A	Treat big toe fracture	7.28	8.45	8.27	4.81	4.36	0.56	090
28510		A	Treatment of toe fracture	1.12	1.68	1.60	1.61	1.57	0.14	090
28515		A	Treatment of toe fracture	1.50	2.22	2.06	1.82	1.86	0.18	090
28525		A	Treat toe fracture	5.46	8.11	7.81	4.31	3.87	0.49	090
28530		A	Treat sesamoid bone fracture	1.08	1.62	1.53	1.34	1.39	0.14	090
28531		A	Treat sesamoid bone fracture	2.51	6.54	6.90	2.42	2.24	0.34	090
28540		A	Treat foot dislocation	2.10	2.74	2.57	2.30	2.35	0.26	090
28545		A	Treat foot dislocation	2.51	3.43	2.88	2.81	2.57	0.37	090
28546		A	Treat foot dislocation	3.28	8.05	7.48	3.64	4.01	0.52	090
28555		A	Repair foot dislocation	9.49	10.80	10.35	6.29	5.98	1.04	090
28570		A	Treat foot dislocation	1.70	2.49	2.45	1.91	2.12	0.23	090
28575		A	Treat foot dislocation	3.38	4.41	4.06	3.71	3.71	0.56	090
28576		A	Treat foot dislocation	4.48	NA	NA	4.06	4.11	0.69	090
28585		A	Repair foot dislocation	10.92	11.56	9.44	6.96	6.40	1.25	090
28600		A	Treat foot dislocation	1.94	3.02	2.92	2.37	2.53	0.27	090
28605		A	Treat foot dislocation	2.78	3.89	3.50	3.27	3.19	0.40	090
28606		A	Treat foot dislocation	4.97	NA	NA	4.11	4.40	0.82	090
28615		A	Repair foot dislocation	10.46	NA	NA	8.13	8.08	1.30	090
28630		A	Treat toe dislocation	1.72	1.84	1.70	0.91	0.95	0.20	010
28635		A	Treat toe dislocation	1.93	2.27	2.15	1.33	1.43	0.26	010
28636		A	Treat toe dislocation	2.77	4.38	4.12	2.05	2.34	0.43	010
28645		A	Repair toe dislocation	7.28	8.33	6.64	4.61	3.94	0.57	090
28660		A	Treat toe dislocation	1.25	1.30	1.28	0.78	0.78	0.13	010
28665		A	Treat toe dislocation	1.94	1.82	1.62	1.32	1.37	0.26	010
28666		A	Treat toe dislocation	2.66	NA	NA	1.82	2.20	0.43	010
28675		A	Repair of toe dislocation	5.46	8.23	7.68	4.44	3.90	0.45	090
28705		A	Fusion of foot bones	20.12	NA	NA	10.64	11.54	3.09	090
28715		A	Fusion of foot bones	14.40	NA	NA	8.48	9.11	2.17	090
28725		A	Fusion of foot bones	11.97	NA	NA	6.82	7.52	1.87	090
28730		A	Fusion of foot bones	12.21	NA	NA	7.75	8.11	1.71	090
28735		A	Fusion of foot bones	12.03	NA	NA	6.96	7.39	1.69	090
28737		A	Revision of foot bones	10.83	NA	NA	6.06	6.43	1.47	090
28740		A	Fusion of foot bones	9.09	10.86	10.86	5.98	6.22	1.22	090
28750		A	Fusion of big toe joint	8.37	10.76	11.33	5.88	6.27	1.13	090
28755		A	Fusion of big toe joint	4.79	7.25	6.67	3.35	3.55	0.65	090
28760		A	Fusion of big toe joint	8.94	9.86	8.91	5.26	5.39	1.05	090
28800		A	Amputation of midfoot	8.65	NA	NA	5.00	5.40	1.15	090
28805		A	Amputation thru metatarsal	12.55	NA	NA	5.89	5.77	1.18	090
28810		A	Amputation toe & metatarsal	6.52	NA	NA	4.06	4.26	0.86	090
28820		A	Amputation of toe	4.89	7.64	7.59	3.55	3.66	0.61	090
28825		A	Partial amputation of toe	3.71	7.13	7.06	3.12	3.30	0.50	090
28890		A	High energy eswt, plantar f	3.36	4.56	5.14	2.20	2.14	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	4.00	3.48	1.64	1.69	0.41	000
29010		A	Application of body cast	2.06	4.38	3.83	1.62	1.70	0.45	000
29015		A	Application of body cast	2.41	3.61	3.29	1.56	1.58	0.28	000
29020		A	Application of body cast	2.11	3.81	3.49	1.41	1.41	0.28	000
29025		A	Application of body cast	2.40	4.04	3.59	1.76	1.81	0.44	000
29035		A	Application of body cast	1.77	3.70	3.65	1.48	1.53	0.28	000
29040		A	Application of body cast	2.22	3.28	2.87	1.34	1.42	0.36	000
29044		A	Application of body cast	2.12	3.57	3.77	1.47	1.69	0.35	000

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
29046		A	Application of body cast	2.41	4.49	3.86	1.91	2.00	0.42	000
29049		A	Application of figure eight	0.89	1.11	1.21	0.59	0.56	0.13	000
29055		A	Application of shoulder cast	1.78	2.82	2.90	1.23	1.35	0.30	000
29058		A	Application of shoulder cast	1.31	1.26	1.41	0.67	0.70	0.17	000
29065		A	Application of long arm cast	0.87	1.28	1.30	0.70	0.73	0.15	000
29075		A	Application of forearm cast	0.77	1.23	1.24	0.66	0.67	0.13	000
29085		A	Apply hand/wrist cast	0.87	1.26	1.27	0.68	0.66	0.14	000
29086		A	Apply finger cast	0.62	1.07	1.02	0.55	0.52	0.07	000
29105		A	Apply long arm splint	0.87	1.09	1.16	0.53	0.52	0.12	000
29125		A	Apply forearm splint	0.59	0.97	0.99	0.42	0.41	0.07	000
29126		A	Apply forearm splint	0.77	1.01	1.11	0.48	0.47	0.07	000
29130		A	Application of finger splint	0.50	0.43	0.45	0.18	0.18	0.06	000
29131		A	Application of finger splint	0.55	0.59	0.66	0.24	0.24	0.03	000
29200		A	Strapping of chest	0.65	0.60	0.66	0.34	0.34	0.04	000
29220		A	Strapping of low back	0.64	0.65	0.68	0.38	0.38	0.04	000
29240		A	Strapping of shoulder	0.71	0.68	0.76	0.40	0.38	0.06	000
29260		A	Strapping of elbow or wrist	0.55	0.67	0.70	0.37	0.35	0.05	000
29280		A	Strapping of hand or finger	0.51	0.67	0.73	0.37	0.35	0.03	000
29305		A	Application of hip cast	2.03	3.28	3.31	1.56	1.66	0.35	000
29325		A	Application of hip casts	2.32	3.33	3.43	1.58	1.77	0.40	000
29345		A	Application of long leg cast	1.40	1.66	1.71	0.94	1.00	0.24	000
29355		A	Application of long leg cast	1.53	1.62	1.66	0.93	1.03	0.26	000
29358		A	Apply long leg cast brace	1.43	2.01	2.03	0.91	1.00	0.25	000
29365		A	Application of long leg cast	1.18	1.58	1.62	0.85	0.90	0.20	000
29405		A	Apply short leg cast	0.86	1.19	1.20	0.65	0.68	0.14	000
29425		A	Apply short leg cast	1.01	1.22	1.22	0.65	0.70	0.15	000
29435		A	Apply short leg cast	1.18	1.52	1.54	0.81	0.87	0.20	000
29440		A	Addition of walker to cast	0.57	0.64	0.67	0.26	0.26	0.08	000
29445		A	Apply rigid leg cast	1.78	1.56	1.68	0.89	0.92	0.27	000
29450		A	Application of leg cast	2.08	1.59	1.53	0.90	0.99	0.27	000
29505		A	Application, long leg splint	0.69	1.07	1.12	0.45	0.45	0.08	000
29515		A	Application lower leg splint	0.73	0.96	0.91	0.46	0.46	0.09	000
29520		A	Strapping of hip	0.54	0.66	0.75	0.37	0.42	0.03	000
29530		A	Strapping of knee	0.57	0.65	0.72	0.36	0.35	0.05	000
29540		A	Strapping of ankle and/or ft	0.51	0.55	0.48	0.31	0.31	0.06	000
29550		A	Strapping of toes	0.47	0.56	0.49	0.30	0.29	0.06	000
29580		A	Application of paste boot	0.55	0.71	0.68	0.33	0.34	0.07	000
29590		A	Application of foot splint	0.76	0.59	0.55	0.26	0.27	0.09	000
29700		A	Removal/revision of cast	0.57	0.95	0.92	0.25	0.26	0.08	000
29705		A	Removal/revision of cast	0.76	0.76	0.79	0.36	0.37	0.13	000
29710		A	Removal/revision of cast	1.34	1.32	1.42	0.55	0.62	0.20	000
29715		A	Removal/revision of cast	0.94	1.20	1.18	0.43	0.42	0.09	000
29720		A	Repair of body cast	0.68	1.17	1.16	0.35	0.37	0.12	000
29730		A	Windowing of cast	0.75	0.74	0.77	0.34	0.34	0.12	000
29740		A	Wedging of cast	1.12	1.03	1.09	0.47	0.48	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.06	1.06	0.52	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	4.62	5.79	0.99	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	NA	5.69	6.65	1.38	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	NA	4.71	5.19	1.02	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	NA	9.35	10.25	2.50	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	NA	9.19	10.09	2.42	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.62	6.20	1.32	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	NA	5.17	5.70	1.22	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	NA	5.65	6.22	1.33	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	NA	5.57	6.13	1.28	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	NA	6.04	6.63	1.41	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	NA	6.53	7.03	1.42	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.63	6.19	1.32	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	NA	6.18	6.85	1.55	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	NA	9.31	10.41	2.67	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	NA	8.17	8.17	2.17	090
29830		A	Elbow arthroscopy	5.80	NA	NA	4.48	4.91	0.99	090
29834		A	Elbow arthroscopy/surgery	6.33	NA	NA	4.85	5.34	1.08	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	NA	4.96	5.42	1.13	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	NA	5.54	6.16	1.22	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	NA	5.06	5.59	1.19	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	NA	5.65	6.27	1.30	090
29840		A	Wrist arthroscopy	5.59	NA	NA	4.62	4.97	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	NA	4.80	5.21	0.92	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	NA	4.87	5.35	1.04	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	NA	5.59	6.03	0.99	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
29846		A	Wrist arthroscopy/surgery	6.80	NA	NA	5.11	5.58	1.07	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	NA	5.27	5.73	1.08	090
29848		A	Wrist endoscopy/surgery	6.24	NA	NA	5.27	5.44	0.86	090
29850		A	Knee arthroscopy/surgery	8.18	NA	NA	4.72	4.88	1.25	090
29851		A	Knee arthroscopy/surgery	13.08	NA	NA	8.21	9.00	2.35	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	NA	7.27	8.02	1.85	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	NA	8.69	9.67	2.40	090
29860		A	Hip arthroscopy, dx	8.85	NA	NA	6.24	6.60	1.36	090
29861		A	Hip arthroscopy/surgery	9.95	NA	NA	6.39	6.86	1.59	090
29862		A	Hip arthroscopy/surgery	10.97	NA	NA	7.57	8.06	1.62	090
29863		A	Hip arthroscopy/surgery	10.97	NA	NA	7.48	7.99	1.42	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	NA	9.46	10.40	2.40	090
29867		A	Allgrft implnt, knee w/scope	18.18	NA	NA	11.03	12.12	2.79	090
29868		A	Meniscal trnspl, knee w/scpe	24.89	NA	NA	13.79	15.29	4.36	090
29870		A	Knee arthroscopy, dx	5.11	NA	NA	4.18	4.53	0.85	090
29871		A	Knee arthroscopy/drainage	6.60	NA	NA	5.05	5.46	1.14	090
29873		A	Knee arthroscopy/surgery	6.09	NA	NA	5.59	6.08	1.04	090
29874		A	Knee arthroscopy/surgery	7.10	NA	NA	5.08	5.58	1.11	090
29875		A	Knee arthroscopy/surgery	6.36	NA	NA	4.88	5.37	1.09	090
29876		A	Knee arthroscopy/surgery	8.72	NA	NA	6.18	6.60	1.37	090
29877		A	Knee arthroscopy/surgery	8.15	NA	NA	5.97	6.36	1.28	090
29879		A	Knee arthroscopy/surgery	8.84	NA	NA	6.23	6.67	1.39	090
29880		A	Knee arthroscopy/surgery	9.30	NA	NA	6.42	6.89	1.47	090
29881		A	Knee arthroscopy/surgery	8.56	NA	NA	6.13	6.55	1.34	090
29882		A	Knee arthroscopy/surgery	9.45	NA	NA	6.45	6.84	1.50	090
29883		A	Knee arthroscopy/surgery	11.61	NA	NA	7.58	8.32	1.93	090
29884		A	Knee arthroscopy/surgery	8.13	NA	NA	5.96	6.33	1.27	090
29885		A	Knee arthroscopy/surgery	10.03	NA	NA	7.03	7.49	1.58	090
29886		A	Knee arthroscopy/surgery	8.34	NA	NA	6.03	6.44	1.30	090
29887		A	Knee arthroscopy/surgery	9.98	NA	NA	6.96	7.44	1.57	090
29888		A	Knee arthroscopy/surgery	14.14	NA	NA	8.26	9.23	2.42	090
29889		A	Knee arthroscopy/surgery	17.15	NA	NA	10.61	11.52	2.79	090
29891		A	Ankle arthroscopy/surgery	9.47	NA	NA	6.64	7.07	1.39	090
29892		A	Ankle arthroscopy/surgery	10.07	NA	NA	6.38	7.06	1.41	090
29893		A	Scope, plantar fasciotomy	6.08	8.83	7.56	4.66	4.32	0.63	090
29894		A	Ankle arthroscopy/surgery	7.26	NA	NA	4.72	5.09	1.15	090
29895		A	Ankle arthroscopy/surgery	7.04	NA	NA	4.51	4.99	1.11	090
29897		A	Ankle arthroscopy/surgery	7.23	NA	NA	4.81	5.35	1.17	090
29898		A	Ankle arthroscopy/surgery	8.38	NA	NA	5.24	5.71	1.28	090
29899		A	Ankle arthroscopy/surgery	15.21	NA	NA	9.20	9.87	2.41	090
29900		A	Mcp joint arthroscopy, dx	5.74	NA	NA	4.66	5.26	0.94	090
29901		A	Mcp joint arthroscopy, surg	6.45	NA	NA	5.09	5.68	1.06	090
29902		A	Mcp joint arthroscopy, surg	7.02	NA	NA	4.70	5.62	1.12	090
29904		A	Subtalar arthro w/fb rmvl	8.50	NA	NA	5.89	5.89	1.25	090
29905		A	Subtalar arthro w/exc	9.00	NA	NA	6.51	6.51	1.32	090
29906		A	Subtalar arthro w/deb	9.47	NA	NA	6.87	6.87	1.39	090
29907		A	Subtalar arthro w/fusion	12.00	NA	NA	7.86	7.86	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	4.01	4.04	1.34	1.36	0.12	010
30020		A	Drainage of nose lesion	1.45	4.16	3.72	1.39	1.43	0.12	010
30100		A	Intranasal biopsy	0.94	2.58	2.28	0.75	0.78	0.07	000
30110		A	Removal of nose polyp(s)	1.65	3.90	3.57	1.45	1.51	0.14	010
30115		A	Removal of nose polyp(s)	4.38	NA	NA	5.99	5.87	0.41	090
30117		A	Removal of intranasal lesion	3.20	18.15	15.64	4.91	4.77	0.26	090
30118		A	Removal of intranasal lesion	9.81	NA	NA	8.55	8.87	0.78	090
30120		A	Revision of nose	5.31	7.07	6.78	5.09	5.54	0.52	090
30124		A	Removal of nose lesion	3.14	NA	NA	3.68	3.64	0.25	090
30125		A	Removal of nose lesion	7.21	NA	NA	7.40	7.86	0.63	090
30130		A	Excise inferior turbinate	3.41	NA	NA	5.63	5.61	0.31	090
30140		A	Resect inferior turbinate	3.48	NA	NA	7.10	6.64	0.35	090
30150		A	Partial removal of nose	9.44	NA	NA	9.02	10.01	0.93	090
30160		A	Removal of nose	9.88	NA	NA	8.87	9.54	0.88	090
30200		A	Injection treatment of nose	0.78	2.02	1.82	0.67	0.70	0.06	000
30210		A	Nasal sinus therapy	1.10	2.51	2.30	1.27	1.29	0.09	010
30220		A	Insert nasal septal button	1.56	5.81	5.02	1.42	1.47	0.12	010
30300		A	Remove nasal foreign body	1.06	4.29	4.46	1.87	1.89	0.08	010
30310		A	Remove nasal foreign body	1.98	NA	NA	2.91	3.00	0.16	010
30320		A	Remove nasal foreign body	4.56	NA	NA	6.35	6.69	0.39	090
30400		R	Reconstruction of nose	10.58	NA	NA	13.90	14.69	1.04	090
30410		R	Reconstruction of nose	13.72	NA	NA	15.32	16.84	1.42	090
30420		R	Reconstruction of nose	16.62	NA	NA	15.82	16.86	1.46	090
30430		R	Revision of nose	7.96	NA	NA	13.24	14.62	0.77	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
30435		R	Revision of nose	12.45	NA	NA	15.42	17.38	1.22	090
30450		R	Revision of nose	19.38	NA	NA	16.88	19.38	1.97	090
30460		A	Revision of nose	10.24	NA	NA	7.48	8.71	1.03	090
30462		A	Revision of nose	20.12	NA	NA	14.64	17.44	2.54	090
30465		A	Repair nasal stenosis	12.20	NA	NA	11.07	11.52	1.06	090
30520		A	Repair of nasal septum	6.85	NA	NA	8.04	7.35	0.46	090
30540		A	Repair nasal defect	7.81	NA	NA	8.54	8.91	0.67	090
30545		A	Repair nasal defect	11.50	NA	NA	11.08	11.48	1.71	090
30560		A	Release of nasal adhesions	1.28	5.28	5.02	2.02	2.08	0.10	010
30580		A	Repair upper jaw fistula	6.76	8.13	7.95	4.69	5.24	0.89	090
30600		A	Repair mouth/nose fistula	6.07	7.67	7.59	4.18	4.60	0.70	090
30620		A	Intranasal reconstruction	6.04	NA	NA	8.66	8.75	0.57	090
30630		A	Repair nasal septum defect	7.18	NA	NA	7.73	7.83	0.61	090
30801		A	Ablate inf turbinate, superf	1.11	4.30	4.21	2.12	2.02	0.09	010
30802		A	Cauterization, inner nose	2.05	4.97	4.79	2.51	2.44	0.16	010
30901		A	Control of nosebleed	1.21	1.27	1.31	0.30	0.31	0.11	000
30903		A	Control of nosebleed	1.54	3.27	2.99	0.43	0.46	0.13	000
30905		A	Control of nosebleed	1.97	3.93	3.72	0.51	0.63	0.17	000
30906		A	Repeat control of nosebleed	2.45	4.28	4.08	0.76	0.98	0.20	000
30915		A	Ligation, nasal sinus artery	7.36	NA	NA	6.46	6.57	0.58	090
30920		A	Ligation, upper jaw artery	11.03	NA	NA	8.96	8.96	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	3.22	3.03	1.34	1.37	0.09	010
31002		A	Irrigation, sphenoid sinus	1.93	NA	NA	2.69	2.96	0.15	010
31020		A	Exploration, maxillary sinus	2.99	8.60	8.56	5.54	5.36	0.29	090
31030		A	Exploration, maxillary sinus	5.95	10.40	10.94	6.44	6.55	0.60	090
31032		A	Explore sinus, remove polyps	6.61	NA	NA	7.00	7.11	0.59	090
31040		A	Exploration behind upper jaw	9.66	NA	NA	7.37	8.59	0.87	090
31050		A	Exploration, sphenoid sinus	5.31	NA	NA	6.50	6.43	0.49	090
31051		A	Sphenoid sinus surgery	7.16	NA	NA	8.36	8.30	0.62	090
31070		A	Exploration of frontal sinus	4.32	NA	NA	6.18	6.06	0.38	090
31075		A	Exploration of frontal sinus	9.40	NA	NA	9.32	9.52	0.75	090
31080		A	Removal of frontal sinus	12.54	NA	NA	10.61	12.07	1.23	090
31081		A	Removal of frontal sinus	13.99	NA	NA	15.36	14.67	2.47	090
31084		A	Removal of frontal sinus	14.75	NA	NA	12.87	13.18	1.19	090
31085		A	Removal of frontal sinus	15.44	NA	NA	14.42	14.19	1.73	090
31086		A	Removal of frontal sinus	14.16	NA	NA	12.77	13.02	1.07	090
31087		A	Removal of frontal sinus	14.39	NA	NA	11.64	12.08	1.44	090
31090		A	Exploration of sinuses	10.88	NA	NA	13.40	12.97	0.94	090
31200		A	Removal of ethmoid sinus	5.03	NA	NA	7.43	8.32	0.29	090
31201		A	Removal of ethmoid sinus	8.49	NA	NA	8.99	9.08	0.82	090
31205		A	Removal of ethmoid sinus	10.47	NA	NA	9.51	10.69	0.67	090
31225		A	Removal of upper jaw	26.44	NA	NA	17.88	17.85	1.59	090
31230		A	Removal of upper jaw	30.56	NA	NA	19.48	19.41	1.78	090
31231		A	Nasal endoscopy, dx	1.10	3.59	3.49	0.77	0.82	0.09	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.26	4.28	1.12	1.30	0.20	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.64	4.77	1.26	1.49	0.26	000
31237		A	Nasal/sinus endoscopy, surg	2.98	4.90	5.05	1.39	1.63	0.28	000
31238		A	Nasal/sinus endoscopy, surg	3.26	4.82	5.03	1.48	1.79	0.27	000
31239		A	Nasal/sinus endoscopy, surg	9.23	NA	NA	6.42	7.21	0.62	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.27	1.50	0.24	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	1.93	2.39	0.45	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	2.69	3.40	0.73	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	1.49	1.80	0.33	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	2.20	2.74	0.55	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	3.31	4.21	0.92	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	1.69	2.07	0.39	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	1.91	2.36	0.46	000
31290		A	Nasal/sinus endoscopy, surg	18.50	NA	NA	9.04	10.54	1.40	010
31291		A	Nasal/sinus endoscopy, surg	19.45	NA	NA	9.53	11.00	1.69	010
31292		A	Nasal/sinus endoscopy, surg	15.79	NA	NA	8.05	9.33	1.21	010
31293		A	Nasal/sinus endoscopy, surg	17.36	NA	NA	8.68	10.02	1.28	010
31294		A	Nasal/sinus endoscopy, surg	20.20	NA	NA	9.66	11.26	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	14.57	14.77	1.17	090
31320		A	Diagnostic incision, larynx	5.62	NA	NA	10.14	10.22	0.46	090
31360		A	Removal of larynx	29.57	NA	NA	20.06	18.39	1.38	090
31365		A	Removal of larynx	38.47	NA	NA	22.97	21.66	1.98	090
31367		A	Partial removal of larynx	30.23	NA	NA	22.50	22.19	1.79	090
31368		A	Partial removal of larynx	33.85	NA	NA	24.58	25.03	2.21	090
31370		A	Partial removal of larynx	27.23	NA	NA	22.13	22.19	1.75	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
31375		A	Partial removal of larynx	25.73	NA	NA	21.14	20.75	1.63	090
31380		A	Partial removal of larynx	25.23	NA	NA	20.78	20.69	1.71	090
31382		A	Partial removal of larynx	28.23	NA	NA	22.68	22.14	1.68	090
31390		A	Removal of larynx & pharynx	42.17	NA	NA	25.96	25.16	2.24	090
31395		A	Reconstruct larynx & pharynx	43.46	NA	NA	28.50	28.39	2.49	090
31400		A	Revision of larynx	11.48	NA	NA	12.49	13.12	0.83	090
31420		A	Removal of epiglottis	11.32	NA	NA	8.58	9.06	0.83	090
31500		A	Insert emergency airway	2.33	NA	NA	0.42	0.48	0.17	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.21	0.25	0.05	000
31505		A	Diagnostic laryngoscopy	0.61	1.42	1.43	0.59	0.60	0.05	000
31510		A	Laryngoscopy with biopsy	1.92	3.22	3.26	1.00	1.12	0.16	000
31511		A	Remove foreign body, larynx	2.16	2.94	3.03	1.03	1.04	0.19	000
31512		A	Removal of larynx lesion	2.07	2.97	3.08	1.06	1.21	0.18	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.08	1.27	0.17	000
31515		A	Laryngoscopy for aspiration	1.80	3.19	3.37	0.88	0.97	0.14	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.21	1.38	0.20	000
31525		A	Dx laryngoscopy excl nb	2.63	3.45	3.54	1.23	1.44	0.21	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.25	1.48	0.21	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	1.40	1.63	0.26	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.09	1.27	0.19	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.25	1.48	0.22	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	1.45	1.70	0.29	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	1.58	1.93	0.29	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	1.44	1.72	0.26	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	1.57	1.91	0.29	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	1.76	2.15	0.33	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	1.89	2.34	0.37	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	2.51	2.99	0.37	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	3.43	4.20	0.78	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	2.15	2.65	0.43	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	2.32	2.84	0.49	000
31570		A	Laryngoscope w/vc inj	3.86	4.26	4.96	1.64	2.01	0.31	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	1.81	2.20	0.35	000
31575		A	Diagnostic laryngoscopy	1.10	1.69	1.80	0.76	0.82	0.09	000
31576		A	Laryngoscopy with biopsy	1.97	3.52	3.59	1.04	1.16	0.14	000
31577		A	Remove foreign body, larynx	2.47	3.37	3.56	1.17	1.35	0.21	000
31578		A	Removal of larynx lesion	2.84	3.99	4.13	1.34	1.43	0.23	000
31579		A	Diagnostic laryngoscopy	2.26	2.86	3.32	1.15	1.31	0.18	000
31580		A	Revision of larynx	14.46	NA	NA	13.82	14.86	1.00	090
31582		A	Revision of larynx	22.87	NA	NA	22.55	24.16	1.76	090
31584		A	Treat larynx fracture	20.35	NA	NA	15.26	16.70	1.72	090
31587		A	Revision of larynx	15.12	NA	NA	8.63	8.95	0.97	090
31588		A	Revision of larynx	14.62	NA	NA	12.50	13.05	1.06	090
31590		A	Reinnervate larynx	7.63	NA	NA	12.78	14.15	0.84	090
31595		A	Larynx nerve surgery	8.75	NA	NA	9.64	10.09	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	2.73	0.80	000
31601		A	Incision of windpipe	4.44	NA	NA	1.74	2.07	0.40	000
31603		A	Incision of windpipe	4.14	NA	NA	1.19	1.45	0.44	000
31605		A	Incision of windpipe	3.57	NA	NA	0.82	1.00	0.40	000
31610		A	Incision of windpipe	9.29	NA	NA	7.72	7.99	0.79	090
31611		A	Surgery/speech prosthesis	5.92	NA	NA	7.07	7.06	0.46	090
31612		A	Puncture/clear windpipe	0.91	1.09	1.09	0.26	0.30	0.08	000
31613		A	Repair windpipe opening	4.63	NA	NA	6.13	6.06	0.42	090
31614		A	Repair windpipe opening	8.47	NA	NA	9.57	9.14	0.58	090
31615		A	Visualization of windpipe	2.09	2.37	2.48	1.04	1.12	0.16	000
31620		A	Endobronchial us add-on	1.40	6.01	5.83	0.33	0.44	0.11	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.23	5.44	0.90	0.98	0.18	000
31623		A	Dx bronchoscope/brush	2.88	5.97	6.20	0.89	0.97	0.13	000
31624		A	Dx bronchoscope/lavage	2.88	5.33	5.55	0.89	0.97	0.13	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.48	5.64	1.01	1.11	0.18	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.95	6.98	1.10	1.20	0.18	000
31629		A	Bronchoscopy/needle bx, each	4.09	12.00	13.12	1.17	1.28	0.16	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.27	1.49	0.32	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.42	1.59	0.34	000
31632		A	Bronchoscopy/lung bx, add'l	1.03	0.85	0.83	0.24	0.27	0.18	ZZZ
31633		A	Bronchoscopy/needle bx add'l	1.32	0.99	0.95	0.31	0.35	0.16	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	5.19	5.65	1.13	1.28	0.24	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.34	1.55	0.31	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.41	0.48	0.13	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	1.54	1.76	0.22	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	1.53	1.80	0.46	000

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	1.49	1.68	0.35	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.04	1.13	0.20	000
31645		A	Bronchoscopy, clear airways	3.16	4.72	4.93	0.96	1.04	0.16	000
31646		A	Bronchoscopy, reclear airway	2.72	4.41	4.63	0.85	0.92	0.14	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.68	6.48	0.68	0.76	0.15	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.25	0.29	0.07	000
31717		A	Bronchial brush biopsy	2.12	5.84	7.04	0.72	0.75	0.14	000
31720		A	Clearance of airways	1.06	NA	NA	0.27	0.30	0.07	000
31725		A	Clearance of airways	1.96	NA	NA	0.41	0.49	0.14	000
31730		A	Intro, windpipe wire/tube	2.85	25.71	13.95	0.74	0.87	0.21	000
31750		A	Repair of windpipe	15.19	NA	NA	17.44	17.49	1.05	090
31755		A	Repair of windpipe	17.19	NA	NA	23.97	24.24	1.29	090
31760		A	Repair of windpipe	23.36	NA	NA	9.77	10.24	2.95	090
31766		A	Reconstruction of windpipe	31.58	NA	NA	11.68	12.66	4.53	090
31770		A	Repair/graft of bronchus	23.48	NA	NA	8.53	9.38	2.84	090
31775		A	Reconstruct bronchus	24.51	NA	NA	9.50	10.64	3.02	090
31780		A	Reconstruct windpipe	19.70	NA	NA	8.79	9.92	1.65	090
31781		A	Reconstruct windpipe	24.77	NA	NA	9.66	10.89	2.25	090
31785		A	Remove windpipe lesion	18.29	NA	NA	7.67	8.92	1.59	090
31786		A	Remove windpipe lesion	25.34	NA	NA	9.61	11.35	3.30	090
31800		A	Repair of windpipe injury	8.10	NA	NA	8.67	8.95	0.79	090
31805		A	Repair of windpipe injury	13.34	NA	NA	6.21	6.71	1.83	090
31820		A	Closure of windpipe lesion	4.58	5.85	5.76	3.26	3.45	0.38	090
31825		A	Repair of windpipe defect	6.98	7.44	7.55	4.47	4.92	0.53	090
31830		A	Revise windpipe scar	4.54	5.93	5.84	3.56	3.77	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	6.08	5.96	1.26	090
32036		A	Exploration of chest	12.21	NA	NA	6.29	6.36	1.43	090
32095		A	Biopsy through chest wall	10.06	NA	NA	5.10	5.23	1.22	090
32100		A	Exploration/biopsy of chest	16.08	NA	NA	7.00	7.41	2.24	090
32110		A	Explore/repair chest	25.15	NA	NA	9.87	10.29	3.22	090
32120		A	Re-exploration of chest	14.27	NA	NA	6.78	6.92	1.63	090
32124		A	Explore chest free adhesions	15.33	NA	NA	6.95	7.08	1.90	090
32140		A	Removal of lung lesion(s)	16.54	NA	NA	7.39	7.53	1.97	090
32141		A	Remove/treat lung lesions	27.10	NA	NA	10.17	8.86	2.01	090
32150		A	Removal of lung lesion(s)	16.70	NA	NA	7.50	7.55	2.01	090
32151		A	Remove lung foreign body	16.82	NA	NA	7.91	7.95	2.04	090
32160		A	Open chest heart massage	13.02	NA	NA	5.84	5.55	1.31	090
32200		A	Drain, open, lung lesion	18.48	NA	NA	8.76	8.68	2.14	090
32201		A	Drain, percut, lung lesion	3.99	19.84	20.27	1.42	1.36	0.24	000
32215		A	Treat chest lining	12.93	NA	NA	6.23	6.56	1.69	090
32220		A	Release of lung	26.41	NA	NA	11.90	12.42	3.57	090
32225		A	Partial release of lung	16.63	NA	NA	7.45	7.55	2.07	090
32310		A	Removal of chest lining	15.16	NA	NA	6.92	7.15	2.00	090
32320		A	Free/remove chest lining	27.04	NA	NA	11.44	11.79	3.52	090
32400		A	Needle biopsy chest lining	1.76	2.15	2.14	0.57	0.56	0.10	000
32402		A	Open biopsy chest lining	8.89	NA	NA	4.68	4.89	1.07	090
32405		A	Biopsy, lung or mediastinum	1.93	0.69	0.68	0.69	0.66	0.11	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.71	0.69	0.12	000
32421		A	Thoracentesis for aspiration	1.54	2.40	2.73	0.47	0.47	0.08	000
32422		A	Thoracentesis w/tube insert	2.19	2.87	3.04	1.03	1.04	0.12	000
32440		A	Removal of lung	27.17	NA	NA	10.91	11.90	3.69	090
32442		A	Sleeve pneumonectomy	56.37	NA	NA	18.71	16.73	3.85	090
32445		A	Removal of lung	63.60	NA	NA	22.77	18.41	3.72	090
32480		A	Partial removal of lung	25.71	NA	NA	10.18	11.12	3.50	090
32482		A	Bilobectomy	27.28	NA	NA	11.08	11.99	3.67	090
32484		A	Segmentectomy	25.30	NA	NA	9.56	10.47	3.04	090
32486		A	Sleeve lobectomy	42.80	NA	NA	14.60	13.92	3.52	090
32488		A	Completion pneumonectomy	42.83	NA	NA	15.56	14.67	3.81	090
32491		R	Lung volume reduction	25.09	NA	NA	10.42	11.52	2.99	090
32500		A	Partial removal of lung	24.48	NA	NA	10.26	11.30	3.26	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.33	1.43	0.65	ZZZ
32503		A	Resect apical lung tumor	31.61	NA	NA	12.08	13.57	4.38	090
32504		A	Resect apical lung tum/chest	36.41	NA	NA	13.46	15.06	5.09	090
32540		A	Removal of lung lesion	30.22	NA	NA	11.48	10.55	2.08	090
32550		A	Insert pleural cath	4.17	14.95	17.45	1.51	1.58	0.42	000
32551		A	Insertion of chest tube	3.29	NA	NA	0.97	1.16	0.43	000
32560		A	Treat lung lining chemically	2.19	5.05	5.75	0.58	0.64	0.23	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.06	2.21	0.80	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.22	2.37	0.87	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	2.74	2.88	1.14	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.05	3.25	1.25	000

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	2.57	2.74	1.00	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	2.97	3.15	1.22	000
32650		A	Thoracoscopy, surgical	10.77	NA	NA	5.24	6.00	1.58	090
32651		A	Thoracoscopy, surgical	18.70	NA	NA	7.69	7.46	1.87	090
32652		A	Thoracoscopy, surgical	29.00	NA	NA	11.13	10.63	2.73	090
32653		A	Thoracoscopy, surgical	18.09	NA	NA	7.45	7.21	1.89	090
32654		A	Thoracoscopy, surgical	20.44	NA	NA	7.95	7.74	1.63	090
32655		A	Thoracoscopy, surgical	16.09	NA	NA	6.88	7.06	1.90	090
32656		A	Thoracoscopy, surgical	13.18	NA	NA	5.95	6.94	1.90	090
32657		A	Thoracoscopy, surgical	12.85	NA	NA	5.97	6.82	2.00	090
32658		A	Thoracoscopy, surgical	11.65	NA	NA	5.50	6.42	1.70	090
32659		A	Thoracoscopy, surgical	11.86	NA	NA	5.79	6.62	1.62	090
32660		A	Thoracoscopy, surgical	17.69	NA	NA	7.58	8.53	2.09	090
32661		A	Thoracoscopy, surgical	13.27	NA	NA	6.05	6.91	1.93	090
32662		A	Thoracoscopy, surgical	14.91	NA	NA	6.63	7.73	2.18	090
32663		A	Thoracoscopy, surgical	24.56	NA	NA	9.39	10.07	2.73	090
32664		A	Thoracoscopy, surgical	14.22	NA	NA	5.61	6.62	2.33	090
32665		A	Thoracoscopy, surgical	21.45	NA	NA	8.56	8.34	2.16	090
32800		A	Repair lung hernia	15.59	NA	NA	6.92	7.16	1.99	090
32810		A	Close chest after drainage	14.83	NA	NA	6.97	7.24	1.94	090
32815		A	Close bronchial fistula	49.79	NA	NA	18.57	14.77	3.28	090
32820		A	Reconstruct injured chest	22.33	NA	NA	10.56	11.36	2.53	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	40.94	NA	NA	20.17	23.91	5.58	090
32852		A	Lung transplant with bypass	44.65	NA	NA	22.56	27.85	6.02	090
32853		A	Lung transplant, double	50.11	NA	NA	22.77	27.25	7.07	090
32854		A	Lung transplant with bypass	53.88	NA	NA	25.76	30.24	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	9.56	9.72	2.94	090
32905		A	Revise & repair chest wall	23.17	NA	NA	9.52	9.82	3.16	090
32906		A	Revise & repair chest wall	29.18	NA	NA	11.03	11.54	3.98	090
32940		A	Revision of lung	21.22	NA	NA	8.48	8.98	2.89	090
32960		A	Therapeutic pneumothorax	1.84	1.61	1.67	0.68	0.62	0.16	000
32997		A	Total lung lavage	7.31	NA	NA	1.83	1.87	0.55	000
32998		A	Perq rf ablate tx, pul tumor	5.68	70.18	70.18	1.98	1.98	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	1.04	0.91	0.14	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	1.12	0.97	0.15	000
33015		A	Incision of heart sac	8.44	NA	NA	5.15	5.05	0.65	090
33020		A	Incision of heart sac	14.87	NA	NA	6.37	6.57	1.80	090
33025		A	Incision of heart sac	13.65	NA	NA	5.84	6.09	1.81	090
33030		A	Partial removal of heart sac	22.27	NA	NA	9.11	9.31	2.84	090
33031		A	Partial removal of heart sac	25.30	NA	NA	9.57	9.80	3.14	090
33050		A	Removal of heart sac lesion	16.85	NA	NA	7.36	7.60	2.15	090
33120		A	Removal of heart lesion	27.33	NA	NA	10.55	11.06	3.70	090
33130		A	Removal of heart lesion	24.05	NA	NA	9.36	9.73	3.01	090
33140		A	Heart revascularize (tmr)	28.26	NA	NA	10.29	10.58	2.86	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.78	1.18	0.69	ZZZ
33202		A	Insert epicard eltrd, open	13.15	NA	NA	6.07	6.07	1.71	090
33203		A	Insert epicard eltrd, endo	13.92	NA	NA	6.13	6.13	1.39	090
33206		A	Insertion of heart pacemaker	7.31	NA	NA	5.12	4.79	0.52	090
33207		A	Insertion of heart pacemaker	8.00	NA	NA	5.22	4.94	0.59	090
33208		A	Insertion of heart pacemaker	8.72	NA	NA	5.65	5.21	0.56	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.66	1.45	0.18	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.59	1.45	0.21	000
33212		A	Insertion of pulse generator	5.51	NA	NA	3.70	3.53	0.43	090
33213		A	Insertion of pulse generator	6.36	NA	NA	4.21	3.96	0.45	090
33214		A	Upgrade of pacemaker system	7.78	NA	NA	5.36	5.12	0.58	090
33215		A	Reposition pacing-defib lead	4.89	NA	NA	3.48	3.33	0.37	090
33216		A	Insert lead pace-defib, one	5.81	NA	NA	4.54	4.37	0.36	090
33217		A	Insert lead pace-defib, dual	5.78	NA	NA	4.43	4.33	0.39	090
33218		A	Repair lead pace-defib, one	5.97	NA	NA	4.82	4.56	0.37	090
33220		A	Repair lead pace-defib, dual	6.05	NA	NA	4.78	4.52	0.37	090
33222		A	Revise pocket, pacemaker	5.01	NA	NA	4.30	4.29	0.42	090
33223		A	Revise pocket, pacing-defib	6.49	NA	NA	4.87	4.73	0.45	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	4.90	4.45	0.54	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	4.35	3.80	0.45	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	4.73	4.28	0.59	000
33233		A	Removal of pacemaker system	3.33	NA	NA	3.26	3.27	0.22	090
33234		A	Removal of pacemaker system	7.85	NA	NA	5.48	5.19	0.56	090
33235		A	Removal pacemaker electrode	9.93	NA	NA	7.23	7.02	0.73	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
33236		A	Remove electrode/thoracotomy	12.64	NA	NA	6.37	6.90	1.69	090
33237		A	Remove electrode/thoracotomy	13.75	NA	NA	8.01	7.89	1.59	090
33238		A	Remove electrode/thoracotomy	15.28	NA	NA	8.04	8.12	2.03	090
33240		A	Insert pulse generator	7.61	NA	NA	5.25	4.91	0.41	090
33241		A	Remove pulse generator	3.26	NA	NA	3.00	2.98	0.18	090
33243		A	Remove eltrd/thoracotomy	23.42	NA	NA	10.93	11.19	2.10	090
33244		A	Remove eltrd, transven	13.84	NA	NA	9.43	9.16	0.99	090
33249		A	Eltrd/insert pace-defib	15.02	NA	NA	10.15	9.25	0.77	090
33250		A	Ablate heart dysrhythm focus	25.78	NA	NA	10.88	10.94	3.19	090
33251		A	Ablate heart dysrhythm focus	28.80	NA	NA	10.95	11.30	3.60	090
33254		A	Ablate atria, lmtd	23.58	NA	NA	9.76	9.76	3.35	090
33255		A	Ablate atria w/o bypass, ext	28.91	NA	NA	11.36	11.36	3.94	090
33256		A	Ablate atria w/bypass, exten	34.77	NA	NA	13.11	13.11	4.95	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.46	5.46	0.89	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.98	5.98	1.09	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	7.79	7.79	1.78	ZZZ
33261		A	Ablate heart dysrhythm focus	28.80	NA	NA	11.68	11.72	3.46	090
33265		A	Ablate atria, lmtd, endo	23.58	NA	NA	9.76	9.76	3.35	090
33266		A	Ablate atria, x10sv, endo	32.91	NA	NA	12.55	12.55	4.80	090
33282		A	Implant pat-active ht record	4.70	NA	NA	4.23	4.12	0.23	090
33284		A	Remove pat-active ht record	3.04	NA	NA	3.37	3.45	0.14	090
33300		A	Repair of heart wound	44.89	NA	NA	15.05	12.14	2.66	090
33305		A	Repair of heart wound	76.85	NA	NA	25.11	17.85	3.13	090
33310		A	Exploratory heart surgery	20.22	NA	NA	8.35	8.96	2.59	090
33315		A	Exploratory heart surgery	26.05	NA	NA	10.34	10.61	3.28	090
33320		A	Repair major blood vessel(s)	18.46	NA	NA	8.00	8.11	2.08	090
33321		A	Repair major vessel	20.71	NA	NA	8.37	9.07	2.91	090
33322		A	Repair major blood vessel(s)	24.30	NA	NA	9.54	9.95	2.86	090
33330		A	Insert major vessel graft	25.17	NA	NA	9.49	9.87	2.82	090
33332		A	Insert major vessel graft	24.46	NA	NA	9.45	9.98	3.03	090
33335		A	Insert major vessel graft	33.79	NA	NA	12.48	12.90	4.28	090
33400		A	Repair of aortic valve	41.37	NA	NA	14.56	15.11	4.11	090
33401		A	Valvuloplasty, open	24.41	NA	NA	10.27	11.88	3.57	090
33403		A	Valvuloplasty, w/cp bypass	25.39	NA	NA	12.52	13.41	3.55	090
33404		A	Prepare heart-aorta conduit	31.25	NA	NA	12.00	13.27	4.33	090
33405		A	Replacement of aortic valve	41.19	NA	NA	15.10	16.69	5.33	090
33406		A	Replacement of aortic valve	52.55	NA	NA	18.36	18.74	5.45	090
33410		A	Replacement of aortic valve	46.28	NA	NA	16.51	16.54	4.69	090
33411		A	Replacement of aortic valve	61.94	NA	NA	21.08	19.90	5.48	090
33412		A	Replacement of aortic valve	43.77	NA	NA	16.20	18.30	6.39	090
33413		A	Replacement of aortic valve	59.74	NA	NA	23.52	22.16	6.53	090
33414		A	Repair of aortic valve	39.29	NA	NA	14.27	14.20	4.57	090
33415		A	Revision, subvalvular tissue	37.19	NA	NA	13.14	12.57	4.14	090
33416		A	Revise ventricle muscle	36.43	NA	NA	13.23	13.36	4.57	090
33417		A	Repair of aortic valve	29.17	NA	NA	11.69	12.65	4.10	090
33420		A	Revision of mitral valve	25.67	NA	NA	9.49	9.52	1.82	090
33422		A	Revision of mitral valve	29.61	NA	NA	11.35	12.50	3.94	090
33425		A	Repair of mitral valve	49.83	NA	NA	17.59	15.32	4.07	090
33426		A	Repair of mitral valve	43.15	NA	NA	15.74	16.43	5.03	090
33427		A	Repair of mitral valve	44.70	NA	NA	15.69	17.52	6.09	090
33430		A	Replacement of mitral valve	50.75	NA	NA	18.55	17.91	5.10	090
33460		A	Revision of tricuspid valve	44.62	NA	NA	14.70	13.00	3.45	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	NA	19.71	16.31	3.87	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	NA	19.71	16.31	3.87	090
33464		A	Valvuloplasty, tricuspid	44.49	NA	NA	15.83	14.67	4.15	090
33465		A	Replace tricuspid valve	50.59	NA	NA	17.63	15.29	4.39	090
33468		A	Revision of tricuspid valve	32.82	NA	NA	15.23	14.44	4.07	090
33470		A	Revision of pulmonary valve	21.32	NA	NA	7.92	9.30	1.03	090
33471		A	Valvotomy, pulmonary valve	22.83	NA	NA	11.58	10.67	3.39	090
33472		A	Revision of pulmonary valve	22.90	NA	NA	8.78	10.31	3.55	090
33474		A	Revision of pulmonary valve	39.27	NA	NA	12.93	11.90	3.22	090
33475		A	Replacement, pulmonary valve	42.27	NA	NA	15.05	15.21	4.93	090
33476		A	Revision of heart chamber	26.41	NA	NA	10.36	11.15	2.42	090
33478		A	Revision of heart chamber	27.38	NA	NA	11.01	12.03	3.89	090
33496		A	Repair, prosth valve clot	29.71	NA	NA	11.08	11.91	4.13	090
33500		A	Repair heart vessel fistula	27.82	NA	NA	11.02	11.24	3.87	090
33501		A	Repair heart vessel fistula	19.43	NA	NA	7.99	8.13	1.91	090
33502		A	Coronary artery correction	21.69	NA	NA	9.33	10.19	3.00	090
33503		A	Coronary artery graft	22.29	NA	NA	12.31	11.02	1.78	090
33504		A	Coronary artery graft	25.30	NA	NA	10.58	11.19	3.36	090
33505		A	Repair artery w/tunnel	38.35	NA	NA	15.12	14.01	2.19	090
33506		A	Repair artery, translocation	37.80	NA	NA	12.69	13.62	4.66	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
33507		A	Repair art, intramural	31.35	NA	NA	11.08	12.36	4.06	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.09	0.10	0.04	ZZZ
33510		A	CABG, vein, single	34.87	NA	NA	12.90	14.61	4.41	090
33511		A	CABG, vein, two	38.34	NA	NA	14.15	15.60	4.56	090
33512		A	CABG, vein, three	43.87	NA	NA	15.93	16.76	4.67	090
33513		A	CABG, vein, four	45.26	NA	NA	16.36	17.07	4.88	090
33514		A	CABG, vein, five	47.97	NA	NA	17.33	17.69	4.77	090
33516		A	Cabg, vein, six or more	49.65	NA	NA	17.95	18.37	5.13	090
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.08	0.96	0.39	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.36	1.97	0.73	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.14	2.73	1.04	ZZZ
33521		A	CABG, artery-vein, four	12.59	NA	NA	3.77	3.42	1.37	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	4.23	4.02	1.78	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	4.78	4.65	2.13	ZZZ
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	2.95	2.43	0.88	ZZZ
33533		A	CABG, arterial, single	33.64	NA	NA	12.55	14.50	4.56	090
33534		A	CABG, arterial, two	39.77	NA	NA	14.73	16.22	4.70	090
33535		A	CABG, arterial, three	44.64	NA	NA	16.29	17.20	5.03	090
33536		A	Cabg, arterial, four or more	48.32	NA	NA	17.31	17.80	5.44	090
33542		A	Removal of heart lesion	48.08	NA	NA	16.88	14.93	4.38	090
33545		A	Repair of heart damage	56.93	NA	NA	20.13	17.87	5.21	090
33548		A	Restore/remodel, ventricle	53.96	NA	NA	19.32	19.30	5.53	090
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.31	1.38	0.65	ZZZ
33600		A	Closure of valve	30.15	NA	NA	12.14	12.32	4.42	090
33602		A	Closure of valve	29.18	NA	NA	11.16	11.80	3.82	090
33606		A	Anastomosis/artery-aorta	31.37	NA	NA	11.90	12.78	4.41	090
33608		A	Repair anomaly w/conduit	31.72	NA	NA	12.85	13.47	4.74	090
33610		A	Repair by enlargement	31.24	NA	NA	13.54	13.57	4.56	090
33611		A	Repair double ventricle	35.49	NA	NA	12.36	13.24	4.37	090
33612		A	Repair double ventricle	36.49	NA	NA	14.30	14.72	5.30	090
33615		A	Repair, modified fontan	35.76	NA	NA	13.78	13.46	4.32	090
33617		A	Repair single ventricle	38.96	NA	NA	13.94	14.96	5.66	090
33619		A	Repair single ventricle	48.60	NA	NA	17.97	19.38	6.46	090
33641		A	Repair heart septum defect	29.50	NA	NA	10.88	10.22	3.23	090
33645		A	Revision of heart veins	27.98	NA	NA	10.66	11.21	3.79	090
33647		A	Repair heart septum defects	29.37	NA	NA	12.70	13.23	3.32	090
33660		A	Repair of heart defects	31.75	NA	NA	11.82	12.65	4.49	090
33665		A	Repair of heart defects	34.77	NA	NA	12.16	12.99	4.00	090
33670		A	Repair of heart chambers	36.58	NA	NA	15.62	14.39	4.65	090
33675		A	Close mult vsd	35.87	NA	NA	15.74	15.74	4.95	090
33676		A	Close mult vsd w/resection	36.87	NA	NA	16.04	16.04	5.44	090
33677		A	Cl mult vsd w/rem pul band	38.37	NA	NA	16.61	16.61	5.68	090
33681		A	Repair heart septum defect	32.16	NA	NA	12.87	13.77	4.45	090
33684		A	Repair heart septum defect	34.29	NA	NA	13.28	13.45	3.39	090
33688		A	Repair heart septum defect	34.67	NA	NA	11.61	11.04	4.73	090
33690		A	Reinforce pulmonary artery	20.20	NA	NA	8.63	9.39	1.97	090
33692		A	Repair of heart defects	31.38	NA	NA	19.57	16.74	4.58	090
33694		A	Repair of heart defects	35.49	NA	NA	10.04	12.12	5.28	090
33697		A	Repair of heart defects	37.49	NA	NA	16.93	15.90	4.09	090
33702		A	Repair of heart defects	27.11	NA	NA	10.52	11.54	3.68	090
33710		A	Repair of heart defects	30.28	NA	NA	11.25	12.60	4.43	090
33720		A	Repair of heart defect	27.13	NA	NA	10.68	11.48	3.84	090
33722		A	Repair of heart defect	29.05	NA	NA	10.60	12.22	1.30	090
33724		A	Repair venous anomaly	27.55	NA	NA	10.37	10.37	4.00	090
33726		A	Repair pul venous stenosis	37.04	NA	NA	13.21	13.21	5.03	090
33730		A	Repair heart-vein defect(s)	36.01	NA	NA	12.85	13.48	5.03	090
33732		A	Repair heart-vein defect	28.80	NA	NA	12.65	13.01	3.68	090
33735		A	Revision of heart chamber	22.04	NA	NA	11.03	9.99	1.92	090
33736		A	Revision of heart chamber	24.16	NA	NA	12.06	11.95	3.09	090
33737		A	Revision of heart chamber	22.34	NA	NA	9.12	10.02	3.25	090
33750		A	Major vessel shunt	22.06	NA	NA	9.42	9.81	1.16	090
33755		A	Major vessel shunt	22.44	NA	NA	7.79	8.29	3.26	090
33762		A	Major vessel shunt	22.44	NA	NA	8.68	9.41	3.14	090
33764		A	Major vessel shunt & graft	22.44	NA	NA	8.94	9.58	3.01	090
33766		A	Major vessel shunt	23.41	NA	NA	8.47	10.06	3.70	090
33767		A	Major vessel shunt	25.14	NA	NA	8.50	10.11	3.82	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	1.84	2.25	1.19	ZZZ
33770		A	Repair great vessels defect	39.02	NA	NA	11.91	13.29	5.74	090
33771		A	Repair great vessels defect	40.58	NA	NA	13.07	12.73	5.68	090
33774		A	Repair great vessels defect	31.54	NA	NA	12.19	13.42	4.81	090
33775		A	Repair great vessels defect	32.83	NA	NA	10.09	12.54	4.99	090
33776		A	Repair great vessels defect	34.53	NA	NA	10.24	13.02	5.09	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
33777	.....	A	Repair great vessels defect	33.95	NA	NA	9.91	12.76	5.49	090
33778	.....	A	Repair great vessels defect	42.62	NA	NA	14.91	15.90	6.20	090
33779	.....	A	Repair great vessels defect	43.15	NA	NA	12.44	13.90	2.92	090
33780	.....	A	Repair great vessels defect	43.85	NA	NA	13.13	16.10	3.68	090
33781	.....	A	Repair great vessels defect	43.16	NA	NA	11.11	12.22	5.97	090
33786	.....	A	Repair arterial trunk	41.74	NA	NA	14.09	15.40	5.71	090
33788	.....	A	Revision of pulmonary artery	27.26	NA	NA	8.24	10.09	4.03	090
33800	.....	A	Aortic suspension	17.23	NA	NA	6.82	7.46	2.46	090
33802	.....	A	Repair vessel defect	18.24	NA	NA	7.94	8.58	2.27	090
33803	.....	A	Repair vessel defect	20.18	NA	NA	6.38	8.07	3.20	090
33813	.....	A	Repair septal defect	21.23	NA	NA	8.80	9.85	3.13	090
33814	.....	A	Repair septal defect	26.41	NA	NA	10.39	11.52	3.85	090
33820	.....	A	Revise major vessel	16.61	NA	NA	6.95	7.65	2.35	090
33822	.....	A	Revise major vessel	17.63	NA	NA	5.93	7.44	2.68	090
33824	.....	A	Revise major vessel	20.10	NA	NA	8.45	9.21	2.89	090
33840	.....	A	Remove aorta constriction	21.21	NA	NA	9.33	9.81	2.16	090
33845	.....	A	Remove aorta constriction	22.77	NA	NA	9.37	10.36	3.22	090
33851	.....	A	Remove aorta constriction	21.85	NA	NA	8.87	9.77	3.18	090
33852	.....	A	Repair septal defect	24.28	NA	NA	14.75	13.05	2.16	090
33853	.....	A	Repair septal defect	32.35	NA	NA	12.24	13.53	4.48	090
33860	.....	A	Ascending aortic graft	59.33	NA	NA	20.20	18.32	5.76	090
33861	.....	A	Ascending aortic graft	43.94	NA	NA	15.69	16.69	6.37	090
33863	.....	A	Ascending aortic graft	58.71	NA	NA	19.58	19.13	6.59	090
33864	.....	A	Ascending aortic graft	60.00	NA	NA	20.09	20.09	6.73	090
33870	.....	A	Transverse aortic arch graft	45.93	NA	NA	16.27	17.32	6.62	090
33875	.....	A	Thoracic aortic graft	35.68	NA	NA	12.90	13.49	4.89	090
33877	.....	A	Thoracoabdominal graft	68.85	NA	NA	21.00	18.65	5.94	090
33880	.....	A	Endovasc taa repr incl subcl	34.48	NA	NA	10.91	12.19	2.75	090
33881	.....	A	Endovasc taa repr w/o subcl	29.48	NA	NA	9.66	10.80	2.33	090
33883	.....	A	Insert endovasc prosth, taa	20.99	NA	NA	7.23	8.20	2.11	090
33884	.....	A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.08	2.33	0.86	ZZZ
33886	.....	A	Endovasc prosth, delayed	17.99	NA	NA	6.33	7.28	1.80	090
33889	.....	A	Artery transpose/endovas taa	15.92	NA	NA	3.98	4.58	2.18	000
33891	.....	A	Car-car bp grft/endovas taa	20.00	NA	NA	5.81	6.38	2.73	000
33910	.....	A	Remove lung artery emboli	29.59	NA	NA	11.34	11.38	3.70	090
33915	.....	A	Remove lung artery emboli	24.83	NA	NA	9.11	9.37	1.44	090
33916	.....	A	Surgery of great vessel	28.30	NA	NA	10.82	11.07	3.67	090
33917	.....	A	Repair pulmonary artery	25.14	NA	NA	10.02	11.10	3.70	090
33920	.....	A	Repair pulmonary atresia	32.58	NA	NA	9.46	11.64	4.38	090
33922	.....	A	Transect pulmonary artery	24.09	NA	NA	10.24	10.57	3.10	090
33924	.....	A	Remove pulmonary shunt	5.49	NA	NA	1.59	1.72	0.82	ZZZ
33925	.....	A	Rpr pul art unifocal w/o cpb	31.25	NA	NA	16.42	15.54	4.61	090
33926	.....	A	Repr pul art, unifocal w/cpb	44.68	NA	NA	14.79	16.23	6.22	090
33930	.....	X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933	.....	C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935	.....	R	Transplantation, heart/lung	61.68	NA	NA	22.94	25.84	9.06	090
33940	.....	X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944	.....	C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945	.....	R	Transplantation of heart	89.08	NA	NA	30.37	25.87	6.26	090
33960	.....	A	External circulation assist	19.33	NA	NA	5.25	5.08	2.67	000
33961	.....	A	External circulation assist	10.91	NA	NA	2.98	3.30	0.88	ZZZ
33967	.....	A	Insert ia percut device	4.84	NA	NA	2.40	2.12	0.35	000
33968	.....	A	Remove aortic assist device	0.64	NA	NA	0.26	0.24	0.07	000
33970	.....	A	Aortic circulation assist	6.74	NA	NA	2.53	2.41	0.82	000
33971	.....	A	Aortic circulation assist	11.91	NA	NA	6.00	6.00	1.25	090
33973	.....	A	Insert balloon device	9.75	NA	NA	3.94	3.62	1.26	000
33974	.....	A	Remove intra-aortic balloon	14.93	NA	NA	7.73	7.80	1.74	090
33975	.....	A	Implant ventricular device	20.97	NA	NA	6.29	6.29	3.07	XXX
33976	.....	A	Implant ventricular device	22.97	NA	NA	7.66	7.60	3.26	XXX
33977	.....	A	Remove ventricular device	20.07	NA	NA	9.41	10.23	2.81	090
33978	.....	A	Remove ventricular device	22.51	NA	NA	10.42	11.08	3.31	090
33979	.....	A	Insert intracorporeal device	45.93	NA	NA	13.28	14.09	6.97	XXX
33980	.....	A	Remove intracorporeal device	64.86	NA	NA	23.06	24.14	8.59	090
33999	.....	C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001	.....	A	Removal of artery clot	17.78	NA	NA	6.36	6.53	1.85	090
34051	.....	A	Removal of artery clot	16.91	NA	NA	7.43	7.60	2.21	090
34101	.....	A	Removal of artery clot	10.85	NA	NA	4.30	4.82	1.41	090
34111	.....	A	Removal of arm artery clot	10.85	NA	NA	4.28	4.82	1.40	090
34151	.....	A	Removal of artery clot	26.41	NA	NA	8.65	9.52	3.56	090
34201	.....	A	Removal of artery clot	19.38	NA	NA	6.54	5.98	1.45	090
34203	.....	A	Removal of leg artery clot	17.73	NA	NA	6.38	7.21	2.36	090
34401	.....	A	Removal of vein clot	26.41	NA	NA	9.26	9.96	3.10	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
34421		A	Removal of vein clot	13.29	NA	NA	5.19	5.74	1.55	090
34451		A	Removal of vein clot	28.41	NA	NA	9.38	10.40	3.84	090
34471		A	Removal of vein clot	21.00	NA	NA	7.86	6.58	1.18	090
34490		A	Removal of vein clot	10.83	NA	NA	4.34	4.88	1.41	090
34501		A	Repair valve, femoral vein	16.74	NA	NA	6.42	7.45	2.35	090
34502		A	Reconstruct vena cava	27.86	NA	NA	10.47	11.38	3.63	090
34510		A	Transposition of vein valve	19.80	NA	NA	7.52	8.46	2.33	090
34520		A	Cross-over vein graft	19.05	NA	NA	7.01	7.73	2.29	090
34530		A	Leg vein fusion	17.77	NA	NA	6.76	7.68	1.74	090
34800		A	Endovas aaa repr w/sm tube	21.46	NA	NA	7.25	8.20	2.46	090
34802		A	Endovas aaa repr w/2-p part	23.71	NA	NA	8.17	8.97	2.33	090
34803		A	Endovas aaa repr w/3-p part	24.74	NA	NA	8.01	9.11	2.01	090
34804		A	Endovas aaa repr w/1-p part	23.71	NA	NA	8.06	8.93	2.30	090
34805		A	Endovas aaa repr w/long tube	22.59	NA	NA	7.26	8.45	2.01	090
34806		A	Aneurysm press sensor add-on	2.06	0.51	0.51	0.51	0.51	0.30	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.05	1.21	0.59	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	1.66	1.95	1.18	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.16	1.36	0.67	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	2.45	2.84	1.50	000
34825		A	Endovasc extend prosth, init	12.72	NA	NA	5.14	5.64	1.28	090
34826		A	Endovasc exten prosth, add'l	4.12	NA	NA	1.14	1.25	0.44	ZZZ
34830		A	Open aortic tube prosth repr	35.10	NA	NA	10.33	12.01	4.55	090
34831		A	Open aortoiliac prosth repr	37.85	NA	NA	11.27	11.49	4.89	090
34832		A	Open aortofemor prosth repr	37.85	NA	NA	11.80	13.21	4.85	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	3.29	3.86	1.70	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	1.57	1.88	0.76	000
34900		A	Endovasc iliac repr w/graft	16.77	NA	NA	6.05	6.81	2.00	090
35001		A	Repair defect of artery	20.70	NA	NA	7.70	8.62	2.81	090
35002		A	Repair artery rupture, neck	22.12	NA	NA	7.51	8.60	3.00	090
35005		A	Repair defect of artery	19.18	NA	NA	8.52	8.68	1.77	090
35011		A	Repair defect of artery	18.50	NA	NA	6.29	7.13	2.55	090
35013		A	Repair artery rupture, arm	23.10	NA	NA	7.76	8.71	3.10	090
35021		A	Repair defect of artery	22.09	NA	NA	8.46	8.93	2.87	090
35022		A	Repair artery rupture, chest	25.62	NA	NA	10.57	10.21	3.17	090
35045		A	Repair defect of arm artery	17.94	NA	NA	6.27	6.88	2.45	090
35081		A	Repair defect of artery	33.37	NA	NA	10.70	11.08	4.01	090
35082		A	Repair artery rupture, aorta	41.93	NA	NA	12.76	14.02	5.44	090
35091		A	Repair defect of artery	35.35	NA	NA	9.99	11.77	5.14	090
35092		A	Repair artery rupture, aorta	50.81	NA	NA	14.50	16.06	6.40	090
35102		A	Repair defect of artery	36.37	NA	NA	11.28	11.82	4.48	090
35103		A	Repair artery rupture, groin	43.49	NA	NA	12.63	14.23	5.76	090
35111		A	Repair defect of artery	26.17	NA	NA	8.50	9.48	3.47	090
35112		A	Repair artery rupture,spleen	32.44	NA	NA	10.07	11.01	4.08	090
35121		A	Repair defect of artery	31.41	NA	NA	9.96	11.16	4.30	090
35122		A	Repair artery rupture, belly	37.76	NA	NA	11.51	12.65	4.75	090
35131		A	Repair defect of artery	26.29	NA	NA	8.63	9.68	3.80	090
35132		A	Repair artery rupture, groin	32.44	NA	NA	10.28	11.32	4.30	090
35141		A	Repair defect of artery	20.83	NA	NA	6.93	7.92	2.90	090
35142		A	Repair artery rupture, thigh	25.03	NA	NA	8.24	9.30	3.36	090
35151		A	Repair defect of artery	23.61	NA	NA	7.64	8.81	3.24	090
35152		A	Repair artery rupture, knee	27.53	NA	NA	9.11	10.24	3.61	090
35180		A	Repair blood vessel lesion	15.01	NA	NA	6.25	6.60	1.00	090
35182		A	Repair blood vessel lesion	31.58	NA	NA	10.82	11.81	4.36	090
35184		A	Repair blood vessel lesion	18.72	NA	NA	6.50	7.39	2.53	090
35188		A	Repair blood vessel lesion	15.05	NA	NA	6.28	6.95	2.16	090
35189		A	Repair blood vessel lesion	29.85	NA	NA	10.67	11.30	4.01	090
35190		A	Repair blood vessel lesion	13.33	NA	NA	5.23	5.85	1.80	090
35201		A	Repair blood vessel lesion	16.84	NA	NA	6.31	7.15	2.34	090
35206		A	Repair blood vessel lesion	13.76	NA	NA	5.30	5.92	1.87	090
35207		A	Repair blood vessel lesion	10.85	NA	NA	6.63	6.99	1.48	090
35211		A	Repair blood vessel lesion	24.50	NA	NA	9.70	10.15	3.20	090
35216		A	Repair blood vessel lesion	36.47	NA	NA	13.56	11.26	2.65	090
35221		A	Repair blood vessel lesion	26.54	NA	NA	8.33	9.13	3.37	090
35226		A	Repair blood vessel lesion	15.22	NA	NA	5.79	6.61	2.02	090
35231		A	Repair blood vessel lesion	21.08	NA	NA	7.72	8.74	2.89	090
35236		A	Repair blood vessel lesion	17.94	NA	NA	6.29	7.08	2.43	090
35241		A	Repair blood vessel lesion	25.50	NA	NA	10.02	10.56	3.53	090
35246		A	Repair blood vessel lesion	28.15	NA	NA	10.10	10.76	3.86	090
35251		A	Repair blood vessel lesion	31.83	NA	NA	9.45	10.61	4.13	090
35256		A	Repair blood vessel lesion	18.98	NA	NA	6.37	7.35	2.63	090
35261		A	Repair blood vessel lesion	18.88	NA	NA	6.97	7.49	2.61	090
35266		A	Repair blood vessel lesion	15.75	NA	NA	5.47	6.23	2.10	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
35271	.....	A	Repair blood vessel lesion	24.50	NA	NA	9.68	10.09	3.16	090
35276	.....	A	Repair blood vessel lesion	25.72	NA	NA	9.78	10.48	3.49	090
35281	.....	A	Repair blood vessel lesion	29.93	NA	NA	9.28	10.48	3.97	090
35286	.....	A	Repair blood vessel lesion	17.06	NA	NA	6.31	7.17	2.35	090
35301	.....	A	Rechanneling of artery	19.53	NA	NA	6.68	7.55	2.68	090
35302	.....	A	Rechanneling of artery	21.27	NA	NA	6.90	6.90	2.98	090
35303	.....	A	Rechanneling of artery	23.52	NA	NA	7.45	7.45	3.26	090
35304	.....	A	Rechanneling of artery	24.52	NA	NA	7.70	7.70	3.41	090
35305	.....	A	Rechanneling of artery	23.52	NA	NA	7.45	7.45	3.26	090
35306	.....	A	Rechanneling of artery	9.25	NA	NA	2.28	2.28	1.34	ZZZ
35311	.....	A	Rechanneling of artery	28.52	NA	NA	9.63	10.68	3.42	090
35321	.....	A	Rechanneling of artery	16.51	NA	NA	5.77	6.57	2.25	090
35331	.....	A	Rechanneling of artery	27.61	NA	NA	8.81	10.01	3.83	090
35341	.....	A	Rechanneling of artery	26.10	NA	NA	8.24	9.55	3.78	090
35351	.....	A	Rechanneling of artery	24.53	NA	NA	7.64	8.61	3.35	090
35355	.....	A	Rechanneling of artery	19.78	NA	NA	6.35	7.21	2.67	090
35361	.....	A	Rechanneling of artery	30.11	NA	NA	9.59	10.64	4.15	090
35363	.....	A	Rechanneling of artery	32.22	NA	NA	10.43	11.50	4.33	090
35371	.....	A	Rechanneling of artery	15.23	NA	NA	5.33	6.14	2.14	090
35372	.....	A	Rechanneling of artery	18.50	NA	NA	6.12	7.08	2.63	090
35390	.....	A	Reoperation, carotid add-on	3.19	NA	NA	0.82	0.94	0.46	ZZZ
35400	.....	A	Angioscopy	3.00	NA	NA	0.72	0.91	0.43	ZZZ
35450	.....	A	Repair arterial blockage	10.05	NA	NA	2.97	3.26	1.25	000
35452	.....	A	Repair arterial blockage	6.90	NA	NA	2.06	2.33	0.94	000
35454	.....	A	Repair arterial blockage	6.03	NA	NA	1.76	2.04	0.87	000
35456	.....	A	Repair arterial blockage	7.34	NA	NA	2.12	2.44	1.04	000
35458	.....	A	Repair arterial blockage	9.48	NA	NA	2.80	3.13	1.26	000
35459	.....	A	Repair arterial blockage	8.62	NA	NA	2.65	2.91	1.21	000
35460	.....	A	Repair venous blockage	6.03	NA	NA	1.74	2.01	0.83	000
35470	.....	A	Repair arterial blockage	8.62	61.12	74.97	3.44	3.39	0.69	000
35471	.....	A	Repair arterial blockage	10.05	65.97	83.09	4.68	4.31	0.67	000
35472	.....	A	Repair arterial blockage	6.90	47.48	55.90	2.81	2.78	0.58	000
35473	.....	A	Repair arterial blockage	6.03	46.50	53.15	2.49	2.46	0.51	000
35474	.....	A	Repair arterial blockage	7.35	60.37	74.03	2.98	2.93	0.57	000
35475	.....	R	Repair arterial blockage	9.48	48.63	52.35	3.38	3.47	0.62	000
35476	.....	A	Repair venous blockage	6.03	37.11	40.91	2.23	2.29	0.34	000
35480	.....	A	Atherectomy, open	11.06	NA	NA	4.04	4.04	1.28	000
35481	.....	A	Atherectomy, open	7.60	NA	NA	2.57	2.72	1.13	000
35482	.....	A	Atherectomy, open	6.64	NA	NA	2.01	2.28	0.89	000
35483	.....	A	Atherectomy, open	8.09	NA	NA	2.56	2.79	1.15	000
35484	.....	A	Atherectomy, open	10.42	NA	NA	2.90	3.33	1.27	000
35485	.....	A	Atherectomy, open	9.48	NA	NA	2.87	3.20	1.35	000
35490	.....	A	Atherectomy, percutaneous	11.06	NA	NA	5.17	4.93	0.71	000
35491	.....	A	Atherectomy, percutaneous	7.60	NA	NA	3.85	3.57	0.74	000
35492	.....	A	Atherectomy, percutaneous	6.64	NA	NA	3.48	3.34	0.43	000
35493	.....	A	Atherectomy, percutaneous	8.09	NA	NA	3.96	3.88	0.56	000
35494	.....	A	Atherectomy, percutaneous	10.42	NA	NA	5.15	4.80	0.59	000
35495	.....	A	Atherectomy, percutaneous	9.48	NA	NA	4.45	4.42	0.69	000
35500	.....	A	Harvest vein for bypass	6.44	NA	NA	1.59	1.81	0.93	ZZZ
35501	.....	A	Artery bypass graft	28.99	NA	NA	11.06	9.75	4.10	090
35506	.....	A	Artery bypass graft	25.23	NA	NA	8.31	8.88	2.87	090
35508	.....	A	Artery bypass graft	25.99	NA	NA	8.76	9.10	2.78	090
35509	.....	A	Artery bypass graft	27.99	NA	NA	10.77	9.77	3.92	090
35510	.....	A	Artery bypass graft	24.29	NA	NA	7.69	8.93	2.12	090
35511	.....	A	Artery bypass graft	22.12	NA	NA	7.65	8.50	2.91	090
35512	.....	A	Artery bypass graft	23.79	NA	NA	7.47	8.73	2.12	090
35515	.....	A	Artery bypass graft	25.99	NA	NA	9.08	9.18	2.78	090
35516	.....	A	Artery bypass graft	24.11	NA	NA	7.45	7.12	2.34	090
35518	.....	A	Artery bypass graft	22.57	NA	NA	7.32	8.14	3.03	090
35521	.....	A	Artery bypass graft	24.00	NA	NA	7.94	8.88	3.13	090
35522	.....	A	Artery bypass graft	23.05	NA	NA	7.39	8.57	2.12	090
35523	.....	A	Artery bypass graft	24.00	NA	NA	9.20	9.20	2.14	090
35525	.....	A	Artery bypass graft	21.59	NA	NA	7.03	8.20	2.12	090
35526	.....	A	Artery bypass graft	31.47	NA	NA	14.03	13.26	3.63	090
35531	.....	A	Artery bypass graft	38.98	NA	NA	11.46	12.96	5.18	090
35533	.....	A	Artery bypass graft	29.79	NA	NA	9.49	10.60	3.85	090
35536	.....	A	Artery bypass graft	33.60	NA	NA	9.50	11.22	4.62	090
35537	.....	A	Artery bypass graft	41.75	NA	NA	13.08	13.08	5.72	090
35538	.....	A	Artery bypass graft	46.82	NA	NA	14.43	14.43	6.39	090
35539	.....	A	Artery bypass graft	43.98	NA	NA	13.46	13.46	6.02	090
35540	.....	A	Artery bypass graft	49.20	NA	NA	14.80	14.80	6.76	090
35548	.....	A	Artery bypass graft	22.57	NA	NA	7.73	8.57	2.98	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
35549		A	Artery bypass graft	24.34	NA	NA	8.73	9.55	3.30	090
35551		A	Artery bypass graft	27.72	NA	NA	9.37	10.42	3.75	090
35556		A	Artery bypass graft	26.62	NA	NA	8.63	9.17	3.10	090
35558		A	Artery bypass graft	23.00	NA	NA	7.86	8.70	3.00	090
35560		A	Artery bypass graft	33.90	NA	NA	10.61	11.96	4.75	090
35563		A	Artery bypass graft	25.99	NA	NA	8.87	9.69	3.52	090
35565		A	Artery bypass graft	25.00	NA	NA	8.16	9.14	3.30	090
35566		A	Artery bypass graft	32.22	NA	NA	9.84	10.61	3.83	090
35571		A	Artery bypass graft	25.39	NA	NA	8.08	9.46	3.43	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	1.92	2.08	0.99	ZZZ
35583		A	Vein bypass graft	27.62	NA	NA	8.63	9.39	3.17	090
35585		A	Vein bypass graft	32.22	NA	NA	10.10	11.15	4.02	090
35587		A	Vein bypass graft	26.08	NA	NA	8.50	9.97	3.52	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.52	1.57	0.73	ZZZ
35601		A	Artery bypass graft	26.99	NA	NA	10.42	9.52	3.72	090
35606		A	Artery bypass graft	22.36	NA	NA	7.30	8.15	2.70	090
35612		A	Artery bypass graft	16.71	NA	NA	6.31	7.09	2.09	090
35616		A	Artery bypass graft	21.74	NA	NA	7.12	7.61	2.20	090
35621		A	Artery bypass graft	20.95	NA	NA	6.77	7.72	2.92	090
35623		A	Bypass graft, not vein	25.79	NA	NA	8.43	9.46	3.46	090
35626		A	Artery bypass graft	29.06	NA	NA	10.27	11.12	4.08	090
35631		A	Artery bypass graft	35.90	NA	NA	10.55	12.18	4.96	090
35636		A	Artery bypass graft	31.62	NA	NA	9.71	11.00	4.10	090
35637		A	Artery bypass graft	32.92	NA	NA	10.64	10.64	4.44	090
35638		A	Artery bypass graft	33.47	NA	NA	10.78	10.78	4.52	090
35642		A	Artery bypass graft	18.85	NA	NA	6.21	7.45	2.28	090
35645		A	Artery bypass graft	18.34	NA	NA	7.97	8.12	2.50	090
35646		A	Artery bypass graft	32.84	NA	NA	10.44	11.77	4.44	090
35647		A	Artery bypass graft	29.62	NA	NA	9.65	10.70	3.99	090
35650		A	Artery bypass graft	20.08	NA	NA	6.92	7.64	2.72	090
35651		A	Artery bypass graft	25.97	NA	NA	8.70	9.71	3.36	090
35654		A	Artery bypass graft	26.17	NA	NA	8.35	9.50	3.53	090
35656		A	Artery bypass graft	20.39	NA	NA	6.83	7.71	2.80	090
35661		A	Artery bypass graft	20.22	NA	NA	7.04	7.98	2.72	090
35663		A	Artery bypass graft	23.80	NA	NA	7.89	8.93	3.11	090
35665		A	Artery bypass graft	22.22	NA	NA	7.35	8.40	3.01	090
35666		A	Artery bypass graft	23.53	NA	NA	8.50	9.56	3.16	090
35671		A	Artery bypass graft	20.64	NA	NA	7.62	8.49	2.78	090
35681		A	Composite bypass graft	1.60	NA	NA	0.40	0.47	0.23	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	1.69	2.04	1.03	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	1.96	2.39	1.20	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	0.96	1.15	0.58	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	0.85	0.99	0.47	ZZZ
35691		A	Arterial transposition	18.32	NA	NA	5.94	7.17	2.59	090
35693		A	Arterial transposition	15.64	NA	NA	6.11	6.91	2.22	090
35694		A	Arterial transposition	19.19	NA	NA	6.31	7.45	2.70	090
35695		A	Arterial transposition	19.97	NA	NA	6.70	7.62	2.74	090
35697		A	Reimplant artery each	3.00	NA	NA	0.74	0.88	0.41	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	0.76	0.89	0.44	ZZZ
35701		A	Exploration, carotid artery	9.11	NA	NA	4.31	4.73	1.12	090
35721		A	Exploration, femoral artery	7.66	NA	NA	3.83	4.13	1.03	090
35741		A	Exploration popliteal artery	8.61	NA	NA	3.86	4.26	1.12	090
35761		A	Exploration of artery/vein	5.84	NA	NA	3.43	3.72	0.75	090
35800		A	Explore neck vessels	7.99	NA	NA	3.95	4.30	0.95	090
35820		A	Explore chest vessels	36.81	NA	NA	12.90	10.05	1.95	090
35840		A	Explore abdominal vessels	10.87	NA	NA	4.81	5.04	1.34	090
35860		A	Explore limb vessels	6.72	NA	NA	3.38	3.70	0.78	090
35870		A	Repair vessel graft defect	24.39	NA	NA	7.91	8.84	3.01	090
35875		A	Removal of clot in graft	10.64	NA	NA	4.28	4.73	1.41	090
35876		A	Removal of clot in graft	17.74	NA	NA	5.94	6.72	2.40	090
35879		A	Revise graft w/vein	17.28	NA	NA	5.97	6.83	2.28	090
35881		A	Revise graft w/vein	19.22	NA	NA	6.46	7.56	2.56	090
35883		A	Revise graft w/nonauto graft	23.07	NA	NA	8.49	8.49	3.19	090
35884		A	Revise graft w/vein	24.57	NA	NA	8.93	8.93	3.41	090
35901		A	Excision, graft, neck	8.26	NA	NA	4.24	4.77	1.15	090
35903		A	Excision, graft, extremity	9.44	NA	NA	4.60	5.37	1.30	090
35905		A	Excision, graft, thorax	33.39	NA	NA	10.65	11.91	4.44	090
35907		A	Excision, graft, abdomen	37.14	NA	NA	10.87	12.51	4.92	090
36000		A	Place needle in vein	0.18	0.46	0.51	0.06	0.06	0.01	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.24	2.55	0.85	0.91	0.17	000
36005		A	Injection ext venography	0.95	8.46	8.05	0.39	0.35	0.05	000
36010		A	Place catheter in vein	2.43	11.09	15.19	0.78	0.79	0.20	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
36011		A	Place catheter in vein	3.14	19.61	23.71	1.01	1.03	0.27	XXX
36012		A	Place catheter in vein	3.51	20.23	19.58	1.28	1.23	0.23	XXX
36013		A	Place catheter in artery	2.52	18.76	20.06	0.93	0.81	0.25	XXX
36014		A	Place catheter in artery	3.02	18.94	19.52	1.11	1.07	0.19	XXX
36015		A	Place catheter in artery	3.51	18.54	21.09	1.05	1.12	0.21	XXX
36100		A	Establish access to artery	3.02	11.23	11.65	1.21	1.16	0.26	XXX
36120		A	Establish access to artery	2.01	9.20	9.95	0.59	0.62	0.14	XXX
36140		A	Establish access to artery	2.01	10.47	11.62	0.71	0.67	0.16	XXX
36145		A	Artery to vein shunt	2.01	10.28	11.41	0.66	0.66	0.11	XXX
36160		A	Establish access to aorta	2.52	11.54	12.51	1.05	0.94	0.26	XXX
36200		A	Place catheter in aorta	3.02	13.65	15.08	1.02	1.01	0.24	XXX
36215		A	Place catheter in artery	4.67	25.94	26.48	1.89	1.75	0.27	XXX
36216		A	Place catheter in artery	5.27	28.03	28.54	2.09	1.94	0.31	XXX
36217		A	Place catheter in artery	6.29	45.85	50.63	2.43	2.30	0.44	XXX
36218		A	Place catheter in artery	1.01	3.76	4.42	0.39	0.36	0.07	ZZZ
36245		A	Place catheter in artery	4.67	28.77	30.42	2.11	1.89	0.31	XXX
36246		A	Place catheter in artery	5.27	27.41	28.68	1.99	1.91	0.38	XXX
36247		A	Place catheter in artery	6.29	45.15	47.31	2.36	2.25	0.47	XXX
36248		A	Place catheter in artery	1.01	3.17	3.61	0.38	0.36	0.07	ZZZ
36260		A	Insertion of infusion pump	9.82	NA	NA	4.64	4.76	1.29	090
36261		A	Revision of infusion pump	5.55	NA	NA	3.06	3.36	0.70	090
36262		A	Removal of infusion pump	4.05	NA	NA	2.71	2.73	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	0.28	0.28	0.09	0.09	0.03	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.27	0.27	0.08	0.08	0.03	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.25	0.26	0.04	0.05	0.01	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.32	0.30	0.05	0.05	0.01	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.21	0.24	0.07	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.21	0.21	0.06	XXX
36430		A	Blood transfusion service	0.00	0.93	0.97	NA	NA	0.06	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.25	0.27	0.10	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	0.77	0.74	0.21	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.66	0.84	0.15	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	1.81	2.03	0.79	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.41	2.54	0.64	0.68	0.12	010
36471		A	Injection therapy of veins	1.60	2.56	2.82	0.79	0.87	0.19	010
36475		A	Endovenous rf, 1st vein	6.72	35.74	43.55	1.88	2.20	0.37	000
36476		A	Endovenous rf, vein add-on	3.38	6.14	7.00	0.83	0.98	0.18	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	26.95	36.85	2.04	2.29	0.37	000
36479		A	Endovenous laser vein addon	3.38	6.35	7.17	0.95	1.04	0.18	ZZZ
36481		A	Insertion of catheter, vein	6.98	NA	NA	2.35	2.47	0.55	000
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.25	1.31	0.20	000
36510		A	Insertion of catheter, vein	1.09	1.08	2.48	0.30	0.45	0.10	000
36511		A	Apheresis wbc	1.74	NA	NA	0.57	0.65	0.08	000
36512		A	Apheresis rbc	1.74	NA	NA	0.60	0.67	0.08	000
36513		A	Apheresis platelets	1.74	NA	NA	0.55	0.64	0.17	000
36514		A	Apheresis plasma	1.74	10.49	13.73	0.53	0.62	0.08	000
36515		A	Apheresis, adsorp/reinfuse	1.74	45.46	55.86	0.48	0.57	0.08	000
36516		A	Apheresis, selective	1.22	49.53	66.77	0.39	0.43	0.08	000
36522		A	Photopheresis	1.67	37.40	34.87	0.94	0.95	0.13	000
36555		A	Insert non-tunnel cv cath	2.68	3.81	4.78	0.59	0.69	0.11	000
36556		A	Insert non-tunnel cv cath	2.50	2.85	4.24	0.55	0.65	0.19	000
36557		A	Insert tunneled cv cath	5.11	15.09	18.11	2.29	2.47	0.57	010
36558		A	Insert tunneled cv cath	4.81	14.84	17.93	2.35	2.45	0.57	010
36560		A	Insert tunneled cv cath	6.26	21.31	25.48	2.72	2.87	0.57	010
36561		A	Insert tunneled cv cath	6.01	22.24	25.90	2.64	2.79	0.57	010
36563		A	Insert tunneled cv cath	6.21	23.09	24.91	2.60	2.79	0.84	010
36565		A	Insert tunneled cv cath	6.01	17.51	21.10	2.47	2.71	0.57	010
36566		A	Insert tunneled cv cath	6.51	111.82	68.65	2.60	2.85	0.57	010
36568		A	Insert picc cath	1.92	5.87	6.70	0.59	0.59	0.11	000
36569		A	Insert picc cath	1.82	4.47	5.90	0.67	0.62	0.19	000
36570		A	Insert picvad cath	5.33	21.23	27.19	2.10	2.41	0.57	010
36571		A	Insert picvad cath	5.31	24.50	28.86	2.44	2.58	0.57	010
36575		A	Repair tunneled cv cath	0.67	3.30	3.67	0.23	0.25	0.20	000
36576		A	Repair tunneled cv cath	3.21	5.90	6.42	1.56	1.70	0.19	010
36578		A	Replace tunneled cv cath	3.51	9.16	10.14	2.00	2.15	0.19	010
36580		A	Replace cvad cath	1.31	3.96	5.45	0.43	0.42	0.19	000
36581		A	Replace tunneled cv cath	3.45	15.49	17.49	1.73	1.83	0.19	010

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
36582		A	Replace tunneled cv cath	5.21	21.53	23.76	2.45	2.66	0.19	010
36583		A	Replace tunneled cv cath	5.26	21.57	23.80	2.48	2.68	0.19	010
36584		A	Replace picc cath	1.20	3.96	5.47	0.61	0.58	0.19	000
36585		A	Replace picvad cath	4.81	22.54	25.17	2.42	2.58	0.19	010
36589		A	Removal tunneled cv cath	2.27	1.86	2.05	1.23	1.31	0.24	010
36590		A	Removal tunneled cv cath	3.32	3.62	3.49	1.59	1.65	0.44	010
36591		T	Draw blood off venous device	0.00	0.54	0.54	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.67	0.67	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.82	0.60	NA	NA	0.37	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.83	14.04	1.38	1.41	0.21	000
36596		A	Mech remov tunneled cv cath	0.75	2.57	3.13	0.43	0.47	0.05	000
36597		A	Reposition venous catheter	1.21	2.04	2.22	0.46	0.45	0.07	000
36598		T	Inj w/fluor, eval cv device	0.74	2.22	2.43	0.27	1.45	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.50	0.49	0.07	0.08	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.15	0.19	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	NA	0.50	0.52	0.26	000
36640		A	Insertion catheter, artery	2.10	NA	NA	0.91	0.97	0.21	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.41	0.42	0.14	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.28	0.38	0.11	000
36800		A	Insertion of cannula	2.43	NA	NA	1.53	1.67	0.25	000
36810		A	Insertion of cannula	3.96	NA	NA	1.32	1.50	0.45	000
36815		A	Insertion of cannula	2.62	NA	NA	1.04	1.10	0.35	000
36818		A	Av fuse, uppr arm, cephalic	11.81	NA	NA	4.49	5.26	1.90	090
36819		A	Av fuse, uppr arm, basilic	14.39	NA	NA	5.11	5.74	1.96	090
36820		A	Av fusion/forearm vein	14.39	NA	NA	5.24	5.81	1.95	090
36821		A	Av fusion direct any site	9.15	NA	NA	3.94	4.29	1.23	090
36822		A	Insertion of cannula(s)	5.51	NA	NA	3.74	4.06	0.79	090
36823		A	Insertion of cannula(s)	22.82	NA	NA	8.63	9.00	2.89	090
36825		A	Artery-vein autograft	10.00	NA	NA	4.22	4.63	1.35	090
36830		A	Artery-vein nonautograft	12.00	NA	NA	4.13	4.68	1.66	090
36831		A	Open thrombect av fistula	8.01	NA	NA	3.18	3.56	1.09	090
36832		A	Av fistula revision, open	10.50	NA	NA	3.74	4.23	1.44	090
36833		A	Av fistula revision	11.95	NA	NA	4.12	4.66	1.65	090
36834		A	Repair A-V aneurysm	11.11	NA	NA	4.21	4.50	1.37	090
36835		A	Artery to vein shunt	7.43	NA	NA	3.74	4.03	0.98	090
36838		A	Dist revas ligation, hemo	21.59	NA	NA	7.04	8.21	3.02	090
36860		A	External cannula declotting	2.01	3.36	2.57	0.63	0.65	0.11	000
36861		A	Cannula declotting	2.52	NA	NA	1.22	1.35	0.27	000
36870		A	Percut thrombect av fistula	5.17	40.78	46.89	2.76	2.95	0.29	090
37140		A	Revision of circulation	25.12	NA	NA	8.92	9.70	2.02	090
37145		A	Revision of circulation	26.13	NA	NA	10.45	10.65	3.26	090
37160		A	Revision of circulation	23.13	NA	NA	7.92	8.59	2.82	090
37180		A	Revision of circulation	26.13	NA	NA	9.27	9.78	3.35	090
37181		A	Splice spleen/kidney veins	28.26	NA	NA	8.83	9.91	3.41	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	6.33	6.19	1.00	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	NA	3.09	3.05	0.47	000
37184		A	Prim art mech thrombectomy	8.66	49.91	60.78	3.23	3.29	0.55	000
37185		A	Prim art m-thrombect add-on	3.28	16.38	19.62	1.12	1.11	0.21	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	34.90	42.13	1.79	1.72	0.32	ZZZ
37187		A	Venous mech thrombectomy	8.03	48.21	59.18	2.99	3.06	0.51	000
37188		A	Venous m-thrombectomy add-on	5.71	42.22	52.08	2.18	2.27	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	1.65	1.57	0.27	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.33	2.44	0.33	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	3.34	3.18	0.43	000
37203		A	Transcatheter retrieval	5.02	30.10	31.48	2.07	2.05	0.29	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.23	6.07	1.48	000
37205		A	Transcath iv stent, percut	8.27	108.64	56.20	3.25	3.50	0.60	000
37206		A	Transcath iv stent/perc addl	4.12	66.45	33.94	1.58	1.50	0.31	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	2.37	2.77	1.17	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.01	1.19	0.59	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.77	0.75	0.15	000
37210		A	Embolization uterine fibroid	10.60	83.21	83.21	3.68	3.68	0.60	000
37215		R	Transcath stent, cca w/eps	19.58	NA	NA	9.93	9.51	1.09	090
37216		N	Transcath stent, cca w/o eps	18.85	NA	NA	5.75	7.28	1.04	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.77	0.76	0.21	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.50	0.52	0.19	ZZZ
37500		A	Endoscopy ligate perf veins	11.54	NA	NA	5.35	6.10	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	5.13	5.38	1.33	090
37600		A	Ligation of neck artery	12.34	NA	NA	4.91	5.77	1.41	090
37605		A	Ligation of neck artery	14.20	NA	NA	5.44	6.17	1.99	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
37606	.....	A	Ligation of neck artery	8.72	NA	NA	4.86	4.71	1.23	090
37607	.....	A	Ligation of a-v fistula	6.19	NA	NA	3.02	3.29	0.85	090
37609	.....	A	Temporal artery procedure	3.02	4.19	4.34	1.82	1.89	0.36	010
37615	.....	A	Ligation of neck artery	7.72	NA	NA	4.09	4.10	0.68	090
37616	.....	A	Ligation of chest artery	18.89	NA	NA	7.92	8.00	2.33	090
37617	.....	A	Ligation of abdomen artery	23.71	NA	NA	7.88	8.52	2.98	090
37618	.....	A	Ligation of extremity artery	5.95	NA	NA	3.36	3.48	0.67	090
37620	.....	A	Revision of major vein	11.49	NA	NA	5.45	5.58	0.91	090
37650	.....	A	Revision of major vein	8.41	NA	NA	4.23	4.45	1.01	090
37660	.....	A	Revision of major vein	22.20	NA	NA	7.58	8.32	2.49	090
37700	.....	A	Revise leg vein	3.76	NA	NA	2.38	2.59	0.53	090
37718	.....	A	Ligate/strip short leg vein	7.05	NA	NA	3.47	3.76	0.14	090
37722	.....	A	Ligate/strip long leg vein	8.08	NA	NA	3.68	4.04	0.86	090
37735	.....	A	Removal of leg veins/lesion	10.81	NA	NA	4.68	5.09	1.48	090
37760	.....	A	Ligation, leg veins, open	10.69	NA	NA	4.48	4.91	1.44	090
37765	.....	A	Phleb veins extrem 10–20	7.63	NA	NA	3.57	4.09	0.48	090
37766	.....	A	Phleb veins extrem 20+	9.58	NA	NA	4.13	4.72	0.48	090
37780	.....	A	Revision of leg vein	3.87	NA	NA	2.39	2.62	0.53	090
37785	.....	A	Ligate/divide/excise vein	3.87	4.91	5.05	2.57	2.65	0.54	090
37788	.....	A	Revascularization, penis	23.21	NA	NA	12.03	10.56	2.26	090
37790	.....	A	Penile venous occlusion	8.37	NA	NA	5.15	4.76	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	6.84	6.50	1.92	090
38101	.....	A	Removal of spleen, partial	19.47	NA	NA	6.91	6.71	2.05	090
38102	.....	A	Removal of spleen, total	4.79	NA	NA	1.23	1.43	0.63	ZZZ
38115	.....	A	Repair of ruptured spleen	21.80	NA	NA	7.43	7.04	2.09	090
38120	.....	A	Laparoscopy, splenectomy	16.97	NA	NA	6.92	7.15	2.25	090
38129	.....	C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200	.....	A	Injection for spleen x-ray	2.64	NA	NA	1.09	0.99	0.14	000
38204	.....	B	Bl donor search management	2.00	0.46	0.46	0.46	0.46	0.06	XXX
38205	.....	R	Harvest allogenic stem cells	1.50	NA	NA	0.53	0.60	0.07	000
38206	.....	R	Harvest auto stem cells	1.50	NA	NA	0.55	0.61	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	0.71	0.71	0.71	0.71	0.03	XXX
38211	.....	I	Tumor cell deplete of harvst	1.42	0.64	0.64	0.64	0.64	0.02	XXX
38212	.....	I	Rbc depletion of harvest	0.94	0.42	0.42	0.42	0.42	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	0.36	0.36	0.36	0.36	0.01	XXX
38215	.....	I	Harvest stem cell concentrte	0.94	0.42	0.42	0.42	0.42	0.02	XXX
38220	.....	A	Bone marrow aspiration	1.08	2.67	3.20	0.45	0.48	0.05	XXX
38221	.....	A	Bone marrow biopsy	1.37	2.78	3.36	0.57	0.61	0.07	XXX
38230	.....	R	Bone marrow collection	4.80	NA	NA	3.13	3.17	0.48	010
38240	.....	R	Bone marrow/stem transplant	2.24	NA	NA	0.93	0.98	0.11	XXX
38241	.....	R	Bone marrow/stem transplant	2.24	NA	NA	0.94	0.99	0.11	XXX
38242	.....	A	Lymphocyte infuse transplant	1.71	NA	NA	0.67	0.72	0.08	000
38300	.....	A	Drainage, lymph node lesion	2.28	4.22	4.26	2.03	2.04	0.25	010
38305	.....	A	Drainage, lymph node lesion	6.55	NA	NA	4.20	4.32	0.88	090
38308	.....	A	Incision of lymph channels	6.73	NA	NA	3.54	3.64	0.85	090
38380	.....	A	Thoracic duct procedure	8.34	NA	NA	5.05	5.37	0.74	090
38381	.....	A	Thoracic duct procedure	13.32	NA	NA	6.07	6.47	1.85	090
38382	.....	A	Thoracic duct procedure	10.51	NA	NA	5.43	5.59	1.37	090
38500	.....	A	Biopsy/removal, lymph nodes	3.76	3.75	3.72	2.02	2.05	0.49	010
38505	.....	A	Needle biopsy, lymph nodes	1.14	2.11	2.08	0.73	0.76	0.09	000
38510	.....	A	Biopsy/removal, lymph nodes	6.69	5.38	5.46	3.08	3.28	0.72	010
38520	.....	A	Biopsy/removal, lymph nodes	6.95	NA	NA	3.75	3.90	0.84	090
38525	.....	A	Biopsy/removal, lymph nodes	6.35	NA	NA	3.47	3.38	0.80	090
38530	.....	A	Biopsy/removal, lymph nodes	8.26	NA	NA	4.12	4.25	1.12	090
38542	.....	A	Explore deep node(s), neck	6.08	NA	NA	3.96	4.22	0.60	090
38550	.....	A	Removal, neck/armpit lesion	6.99	NA	NA	4.28	4.09	0.88	090
38555	.....	A	Removal, neck/armpit lesion	15.42	NA	NA	7.45	7.98	1.76	090
38562	.....	A	Removal, pelvic lymph nodes	10.92	NA	NA	5.76	5.76	1.20	090
38564	.....	A	Removal, abdomen lymph nodes	11.29	NA	NA	5.20	5.22	1.32	090
38570	.....	A	Laparoscopy, lymph node biop	9.28	NA	NA	4.03	4.00	1.13	010
38571	.....	A	Laparoscopy, lymphadenectomy	14.70	NA	NA	6.79	6.22	1.15	010
38572	.....	A	Laparoscopy, lymphadenectomy	16.86	NA	NA	5.93	6.50	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	6.51	6.37	0.72	090
38720	.....	A	Removal of lymph nodes, neck	21.72	NA	NA	10.16	9.76	1.20	090
38724	.....	A	Removal of lymph nodes, neck	23.72	NA	NA	10.92	10.37	1.28	090
38740	.....	A	Remove armpit lymph nodes	10.57	NA	NA	5.00	4.96	1.32	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
38745		A	Remove armpit lymph nodes	13.71	NA	NA	6.04	6.06	1.74	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.42	1.51	0.72	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	1.26	1.46	0.64	ZZZ
38760		A	Remove groin lymph nodes	13.49	NA	NA	5.91	6.02	1.72	090
38765		A	Remove groin lymph nodes	21.78	NA	NA	8.34	8.57	2.48	090
38770		A	Remove pelvis lymph nodes	13.98	NA	NA	6.71	6.22	1.40	090
38780		A	Remove abdomen lymph nodes	17.56	NA	NA	7.98	8.08	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	0.46	0.06	000
38794		A	Access thoracic lymph duct	4.51	NA	NA	3.17	3.31	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	4.27	4.46	0.89	090
39010		A	Exploration of chest	13.11	NA	NA	6.33	6.93	1.76	090
39200		A	Removal chest lesion	15.04	NA	NA	6.19	6.86	2.03	090
39220		A	Removal chest lesion	19.47	NA	NA	7.99	8.67	2.46	090
39400		A	Visualization of chest	8.00	NA	NA	4.15	4.50	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	5.81	6.13	1.78	090
39502		A	Repair paraesophageal hernia	17.09	NA	NA	6.58	6.86	2.17	090
39503		A	Repair of diaphragm hernia	108.67	NA	NA	27.38	30.37	10.98	090
39520		A	Repair of diaphragm hernia	16.63	NA	NA	6.79	7.41	2.24	090
39530		A	Repair of diaphragm hernia	16.22	NA	NA	6.23	6.68	2.11	090
39531		A	Repair of diaphragm hernia	17.23	NA	NA	6.58	6.98	2.22	090
39540		A	Repair of diaphragm hernia	14.51	NA	NA	5.70	5.96	1.80	090
39541		A	Repair of diaphragm hernia	15.67	NA	NA	6.06	6.32	1.93	090
39545		A	Revision of diaphragm	14.58	NA	NA	6.92	7.23	1.84	090
39560		A	Resect diaphragm, simple	12.97	NA	NA	5.52	5.90	1.59	090
39561		A	Resect diaphragm, complex	19.75	NA	NA	9.31	9.32	2.45	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40490		A	Biopsy of lip	1.22	2.08	1.85	0.57	0.59	0.05	000
40500		A	Partial excision of lip	4.35	7.90	7.40	4.36	4.34	0.38	090
40510		A	Partial excision of lip	4.74	6.73	6.67	3.62	3.81	0.49	090
40520		A	Partial excision of lip	4.71	6.99	7.26	3.81	3.96	0.52	090
40525		A	Reconstruct lip with flap	7.61	NA	NA	5.33	5.81	0.85	090
40527		A	Reconstruct lip with flap	9.20	NA	NA	6.13	6.74	0.97	090
40530		A	Partial removal of lip	5.45	7.58	7.69	4.26	4.42	0.55	090
40650		A	Repair lip	3.69	5.98	6.38	3.16	3.23	0.38	090
40652		A	Repair lip	4.32	7.25	7.49	4.11	4.18	0.52	090
40654		A	Repair lip	5.37	8.08	8.34	4.68	4.80	0.60	090
40700		A	Repair cleft lip/nasal	13.97	NA	NA	8.65	8.86	0.95	090
40701		A	Repair cleft lip/nasal	17.03	NA	NA	7.81	9.56	1.65	090
40702		A	Repair cleft lip/nasal	14.09	NA	NA	5.81	7.03	1.23	090
40720		A	Repair cleft lip/nasal	14.54	NA	NA	9.52	9.70	1.80	090
40761		A	Repair cleft lip/nasal	15.69	NA	NA	9.28	9.77	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	3.84	3.40	1.88	1.83	0.13	010
40801		A	Drainage of mouth lesion	2.57	4.88	4.45	2.58	2.66	0.31	010
40804		A	Removal, foreign body, mouth	1.26	3.78	3.59	1.83	1.84	0.11	010
40805		A	Removal, foreign body, mouth	2.73	5.13	4.80	2.65	2.73	0.32	010
40806		A	Incision of lip fold	0.31	2.43	2.13	0.51	0.50	0.04	000
40808		A	Biopsy of mouth lesion	0.98	3.60	3.13	1.62	1.55	0.10	010
40810		A	Excision of mouth lesion	1.33	3.68	3.28	1.72	1.69	0.13	010
40812		A	Excise/repair mouth lesion	2.33	4.54	4.13	2.28	2.34	0.28	010
40814		A	Excise/repair mouth lesion	3.45	5.69	5.31	3.69	3.79	0.41	090
40816		A	Excision of mouth lesion	3.70	5.90	5.53	3.77	3.88	0.40	090
40818		A	Excise oral mucosa for graft	2.72	5.82	5.49	3.74	3.85	0.21	090
40819		A	Excise lip or cheek fold	2.45	4.93	4.50	3.10	3.10	0.29	090
40820		A	Treatment of mouth lesion	1.30	5.30	4.61	2.94	2.69	0.11	010
40830		A	Repair mouth laceration	1.78	4.04	3.88	2.00	2.05	0.19	010
40831		A	Repair mouth laceration	2.50	5.24	4.94	2.70	2.87	0.30	010
40840		R	Reconstruction of mouth	9.03	10.01	9.90	5.58	6.27	1.08	090
40842		R	Reconstruction of mouth	9.03	10.20	10.13	5.72	6.25	1.08	090
40843		R	Reconstruction of mouth	12.62	11.33	11.63	5.74	6.77	1.39	090
40844		R	Reconstruction of mouth	16.57	15.21	15.48	9.11	10.33	2.00	090
40845		R	Reconstruction of mouth	19.13	16.02	16.54	10.21	11.71	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	2.55	2.43	1.33	1.37	0.12	010
41005		A	Drainage of mouth lesion	1.28	4.32	3.83	1.77	1.74	0.12	010
41006		A	Drainage of mouth lesion	3.28	5.43	5.11	2.82	2.99	0.35	090
41007		A	Drainage of mouth lesion	3.14	5.34	5.24	2.72	2.87	0.31	090
41008		A	Drainage of mouth lesion	3.40	5.51	5.09	2.84	3.02	0.42	090
41009		A	Drainage of mouth lesion	3.63	5.83	5.40	3.14	3.35	0.47	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
41010		A	Incision of tongue fold	1.08	3.90	3.66	1.56	1.58	0.07	010
41015		A	Drainage of mouth lesion	4.00	6.29	5.84	3.98	4.06	0.46	090
41016		A	Drainage of mouth lesion	4.11	6.22	5.92	4.07	4.14	0.53	090
41017		A	Drainage of mouth lesion	4.11	6.37	6.00	4.12	4.21	0.53	090
41018		A	Drainage of mouth lesion	5.14	6.75	6.44	4.48	4.52	0.68	090
41019		A	Place needles h&n for rt	8.84	NA	NA	3.28	3.28	0.59	000
41100		A	Biopsy of tongue	1.39	2.68	2.55	1.17	1.29	0.15	010
41105		A	Biopsy of tongue	1.44	2.67	2.49	1.20	1.26	0.13	010
41108		A	Biopsy of floor of mouth	1.07	2.52	2.30	1.08	1.10	0.10	010
41110		A	Excision of tongue lesion	1.53	3.65	3.32	1.64	1.64	0.13	010
41112		A	Excision of tongue lesion	2.77	5.26	4.86	3.24	3.23	0.28	090
41113		A	Excision of tongue lesion	3.23	5.51	5.12	3.39	3.43	0.34	090
41114		A	Excision of tongue lesion	8.71	NA	NA	6.30	6.74	0.83	090
41115		A	Excision of tongue fold	1.76	4.18	3.74	1.72	1.79	0.18	010
41116		A	Excision of mouth lesion	2.47	5.56	4.95	2.80	2.80	0.23	090
41120		A	Partial removal of tongue	10.91	NA	NA	14.32	14.81	0.79	090
41130		A	Partial removal of tongue	15.51	NA	NA	15.88	16.03	0.93	090
41135		A	Tongue and neck surgery	29.83	NA	NA	21.84	22.53	1.89	090
41140		A	Removal of tongue	28.81	NA	NA	23.56	25.11	2.27	090
41145		A	Tongue removal, neck surgery	37.59	NA	NA	28.79	29.66	2.55	090
41150		A	Tongue, mouth, jaw surgery	29.52	NA	NA	23.02	23.86	1.95	090
41153		A	Tongue, mouth, neck surgery	33.28	NA	NA	23.92	24.46	2.01	090
41155		A	Tongue, jaw, & neck surgery	43.96	NA	NA	27.59	27.19	2.34	090
41250		A	Repair tongue laceration	1.93	3.86	3.30	1.61	1.39	0.18	010
41251		A	Repair tongue laceration	2.29	3.48	3.38	1.78	1.66	0.22	010
41252		A	Repair tongue laceration	2.99	4.59	4.24	2.12	2.19	0.29	010
41500		A	Fixation of tongue	3.74	NA	NA	7.52	7.48	0.30	090
41510		A	Tongue to lip surgery	3.45	NA	NA	6.47	7.20	0.20	090
41520		A	Reconstruction, tongue fold	2.77	5.80	5.21	3.26	3.44	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	4.80	3.69	2.12	1.70	0.12	010
41805		A	Removal foreign body, gum	1.28	4.64	3.65	2.70	2.46	0.13	010
41806		A	Removal foreign body,jawbone	2.73	5.82	4.70	3.34	3.19	0.37	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.35	4.80	4.34	1.85	1.86	0.31	010
41823		R	Excision of gum lesion	3.63	6.45	6.01	3.73	3.87	0.47	090
41825		A	Excision of gum lesion	1.35	3.69	3.37	1.46	1.85	0.15	010
41826		A	Excision of gum lesion	2.35	5.09	3.76	2.57	2.34	0.30	010
41827		A	Excision of gum lesion	3.72	6.64	6.08	3.38	3.52	0.35	090
41828		R	Excision of gum lesion	3.11	4.09	3.94	1.64	2.30	0.44	010
41830		R	Removal of gum tissue	3.38	5.98	5.47	3.11	3.37	0.44	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.90	6.04	5.53	3.30	3.38	0.30	090
41874		R	Repair tooth socket	3.13	5.66	5.25	2.72	2.94	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	2.48	2.52	1.20	1.22	0.12	010
42100		A	Biopsy roof of mouth	1.33	2.27	2.18	1.26	1.31	0.13	010
42104		A	Excision lesion, mouth roof	1.66	3.57	3.06	1.67	1.60	0.16	010
42106		A	Excision lesion, mouth roof	2.12	4.45	3.83	2.07	2.25	0.25	010
42107		A	Excision lesion, mouth roof	4.48	6.53	6.12	3.69	3.82	0.44	090
42120		A	Remove palate/lesion	11.70	NA	NA	12.28	12.02	0.52	090
42140		A	Excision of uvula	1.65	4.58	4.15	2.11	2.10	0.13	090
42145		A	Repair palate, pharynx/uvula	9.63	NA	NA	7.48	7.48	0.65	090
42160		A	Treatment mouth roof lesion	1.82	3.77	4.01	1.69	1.99	0.17	010
42180		A	Repair palate	2.52	3.37	3.22	1.86	1.98	0.21	010
42182		A	Repair palate	3.84	3.99	3.93	2.39	2.71	0.40	010
42200		A	Reconstruct cleft palate	12.41	NA	NA	8.62	9.41	1.27	090
42205		A	Reconstruct cleft palate	13.57	NA	NA	7.36	8.71	1.58	090
42210		A	Reconstruct cleft palate	14.91	NA	NA	10.24	10.84	2.17	090
42215		A	Reconstruct cleft palate	8.88	NA	NA	7.41	8.24	1.31	090
42220		A	Reconstruct cleft palate	7.07	NA	NA	7.21	6.99	0.73	090
42225		A	Reconstruct cleft palate	9.66	NA	NA	12.23	14.64	0.86	090
42226		A	Lengthening of palate	10.24	NA	NA	11.89	13.29	1.01	090
42227		A	Lengthening of palate	9.81	NA	NA	11.20	13.37	0.98	090
42235		A	Repair palate	7.92	NA	NA	10.34	11.09	0.72	090
42260		A	Repair nose to lip fistula	10.10	9.73	9.96	6.02	6.54	1.26	090
42280		A	Preparation, palate mold	1.56	2.23	2.10	0.83	0.98	0.19	010
42281		A	Insertion, palate prosthesis	1.95	3.03	2.83	1.69	1.78	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	3.13	2.98	1.74	1.77	0.16	010

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
42305		A	Drainage of salivary gland	6.23	NA	NA	3.99	4.35	0.51	090
42310		A	Drainage of salivary gland	1.58	2.29	2.28	1.39	1.46	0.13	010
42320		A	Drainage of salivary gland	2.37	3.74	3.50	1.88	1.99	0.21	010
42330		A	Removal of salivary stone	2.23	3.41	3.27	1.73	1.79	0.19	010
42335		A	Removal of salivary stone	3.35	5.77	5.33	2.85	2.99	0.29	090
42340		A	Removal of salivary stone	4.64	6.70	6.37	3.48	3.70	0.42	090
42400		A	Biopsy of salivary gland	0.78	2.00	1.82	0.65	0.68	0.06	000
42405		A	Biopsy of salivary gland	3.31	3.96	3.98	2.15	2.30	0.28	010
42408		A	Excision of salivary cyst	4.58	6.41	6.16	3.27	3.44	0.45	090
42409		A	Drainage of salivary cyst	2.85	5.31	4.91	2.53	2.65	0.27	090
42410		A	Excise parotid gland/lesion	9.46	NA	NA	5.36	5.79	0.91	090
42415		A	Excise parotid gland/lesion	17.99	NA	NA	8.62	9.74	1.43	090
42420		A	Excise parotid gland/lesion	20.87	NA	NA	9.56	10.97	1.65	090
42425		A	Excise parotid gland/lesion	13.31	NA	NA	6.83	7.72	1.05	090
42426		A	Excise parotid gland/lesion	22.54	NA	NA	10.00	11.50	1.81	090
42440		A	Excise submaxillary gland	7.05	NA	NA	3.86	4.32	0.59	090
42450		A	Excise sublingual gland	4.66	6.38	6.14	4.02	4.14	0.42	090
42500		A	Repair salivary duct	4.34	6.11	5.90	3.86	4.02	0.41	090
42505		A	Repair salivary duct	6.23	7.27	7.19	4.71	5.04	0.55	090
42507		A	Parotid duct diversion	6.16	NA	NA	6.33	6.43	0.49	090
42508		A	Parotid duct diversion	9.22	NA	NA	8.07	8.20	1.04	090
42509		A	Parotid duct diversion	11.65	NA	NA	8.91	9.55	0.93	090
42510		A	Parotid duct diversion	8.26	NA	NA	6.89	7.34	0.66	090
42550		A	Injection for salivary x-ray	1.25	2.28	2.74	0.44	0.43	0.07	000
42600		A	Closure of salivary fistula	4.86	6.57	6.57	3.42	3.77	0.43	090
42650		A	Dilation of salivary duct	0.77	1.28	1.19	0.66	0.68	0.07	000
42660		A	Dilation of salivary duct	1.13	1.46	1.40	0.75	0.80	0.09	000
42665		A	Ligation of salivary duct	2.57	5.00	4.58	2.40	2.49	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	2.81	1.65	1.67	0.13	010
42720		A	Drainage of throat abscess	6.31	4.69	4.76	3.17	3.48	0.44	010
42725		A	Drainage of throat abscess	12.28	NA	NA	7.08	7.65	0.91	090
42800		A	Biopsy of throat	1.41	2.46	2.32	1.30	1.35	0.11	010
42802		A	Biopsy of throat	1.56	4.13	4.44	1.67	1.87	0.12	010
42804		A	Biopsy of upper nose/throat	1.26	3.58	3.66	1.50	1.62	0.10	010
42806		A	Biopsy of upper nose/throat	1.60	3.83	3.95	1.61	1.77	0.13	010
42808		A	Excise pharynx lesion	2.32	3.22	3.15	1.60	1.77	0.19	010
42809		A	Remove pharynx foreign body	1.83	2.23	2.28	1.32	1.32	0.16	010
42810		A	Excision of neck cyst	3.30	6.22	5.96	3.73	3.63	0.29	090
42815		A	Excision of neck cyst	7.23	NA	NA	6.25	6.33	0.61	090
42820		A	Remove tonsils and adenoids	4.17	NA	NA	2.85	3.07	0.31	090
42821		A	Remove tonsils and adenoids	4.31	NA	NA	2.99	3.24	0.35	090
42825		A	Removal of tonsils	3.45	NA	NA	2.90	3.03	0.25	090
42826		A	Removal of tonsils	3.40	NA	NA	2.68	2.86	0.27	090
42830		A	Removal of adenoids	2.60	NA	NA	2.43	2.49	0.20	090
42831		A	Removal of adenoids	2.75	NA	NA	2.66	2.75	0.22	090
42835		A	Removal of adenoids	2.33	NA	NA	1.78	2.12	0.21	090
42836		A	Removal of adenoids	3.21	NA	NA	2.64	2.80	0.26	090
42842		A	Extensive surgery of throat	12.02	NA	NA	12.03	11.51	0.71	090
42844		A	Extensive surgery of throat	17.57	NA	NA	15.46	15.84	1.16	090
42845		A	Extensive surgery of throat	32.35	NA	NA	21.14	22.16	1.99	090
42860		A	Excision of tonsil tags	2.25	NA	NA	2.30	2.35	0.18	090
42870		A	Excision of lingual tonsil	5.44	NA	NA	8.70	8.63	0.44	090
42890		A	Partial removal of pharynx	18.92	NA	NA	15.24	14.69	1.05	090
42892		A	Revision of pharyngeal walls	25.77	NA	NA	19.20	18.18	1.28	090
42894		A	Revision of pharyngeal walls	33.61	NA	NA	23.53	22.77	1.87	090
42900		A	Repair throat wound	5.26	NA	NA	2.95	3.30	0.50	010
42950		A	Reconstruction of throat	8.16	NA	NA	11.06	11.46	0.72	090
42953		A	Repair throat, esophagus	9.33	NA	NA	13.77	15.54	0.88	090
42955		A	Surgical opening of throat	7.92	NA	NA	10.10	10.38	0.80	090
42960		A	Control throat bleeding	2.35	NA	NA	1.71	1.84	0.19	010
42961		A	Control throat bleeding	5.69	NA	NA	4.48	4.72	0.45	090
42962		A	Control throat bleeding	7.31	NA	NA	5.18	5.54	0.58	090
42970		A	Control nose/throat bleeding	5.76	NA	NA	3.58	3.88	0.39	090
42971		A	Control nose/throat bleeding	6.54	NA	NA	4.50	4.81	0.51	090
42972		A	Control nose/throat bleeding	7.53	NA	NA	4.98	5.34	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	4.57	4.99	0.87	090
43030		A	Throat muscle surgery	7.91	NA	NA	4.51	5.00	0.70	090
43045		A	Incision of esophagus	21.70	NA	NA	9.30	9.99	2.59	090
43100		A	Excision of esophagus lesion	9.55	NA	NA	5.20	5.71	0.93	090
43101		A	Excision of esophagus lesion	16.99	NA	NA	7.16	7.52	2.32	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
43107	.....	A	Removal of esophagus	43.97	NA	NA	16.25	17.25	5.24	090
43108	.....	A	Removal of esophagus	82.66	NA	NA	24.46	19.33	4.08	090
43112	.....	A	Removal of esophagus	47.27	NA	NA	17.00	18.18	5.81	090
43113	.....	A	Removal of esophagus	79.85	NA	NA	25.34	20.22	4.43	090
43116	.....	A	Partial removal of esophagus	92.78	NA	NA	30.30	23.49	3.06	090
43117	.....	A	Partial removal of esophagus	43.52	NA	NA	15.14	16.20	5.19	090
43118	.....	A	Partial removal of esophagus	66.86	NA	NA	21.50	17.64	4.11	090
43121	.....	A	Partial removal of esophagus	51.22	NA	NA	18.26	15.96	3.91	090
43122	.....	A	Partial removal of esophagus	43.97	NA	NA	15.60	16.49	5.42	090
43123	.....	A	Partial removal of esophagus	82.91	NA	NA	25.75	19.92	4.16	090
43124	.....	A	Removal of esophagus	68.83	NA	NA	24.34	18.71	3.74	090
43130	.....	A	Removal of esophagus pouch	12.41	NA	NA	6.37	6.96	1.16	090
43135	.....	A	Removal of esophagus pouch	26.09	NA	NA	9.92	9.00	2.34	090
43200	.....	A	Esophagus endoscopy	1.59	3.72	3.92	0.98	1.02	0.13	000
43201	.....	A	Esoph scope w/submucous inj	2.09	5.62	5.12	1.19	1.14	0.15	000
43202	.....	A	Esophagus endoscopy, biopsy	1.89	5.16	5.35	0.98	0.96	0.15	000
43204	.....	A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.01	1.76	0.30	000
43205	.....	A	Esophagus endoscopy/ligation	3.78	NA	NA	2.06	1.79	0.28	000
43215	.....	A	Esophagus endoscopy	2.60	NA	NA	1.29	1.24	0.22	000
43216	.....	A	Esophagus endoscopy/lesion	2.40	3.08	2.07	1.26	1.16	0.20	000
43217	.....	A	Esophagus endoscopy	2.90	6.57	6.76	1.38	1.28	0.26	000
43219	.....	A	Esophagus endoscopy	2.80	NA	NA	1.55	1.45	0.24	000
43220	.....	A	Esoph endoscopy, dilation	2.10	NA	NA	1.13	1.05	0.17	000
43226	.....	A	Esoph endoscopy, dilation	2.34	NA	NA	1.29	1.16	0.19	000
43227	.....	A	Esoph endoscopy, repair	3.59	NA	NA	1.77	1.61	0.28	000
43228	.....	A	Esoph endoscopy, ablation	3.76	NA	NA	1.89	1.72	0.34	000
43231	.....	A	Esoph endoscopy w/us exam	3.19	NA	NA	1.76	1.53	0.23	000
43232	.....	A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.39	2.10	0.34	000
43234	.....	A	Upper GI endoscopy, exam	2.01	4.98	5.15	1.02	0.94	0.17	000
43235	.....	A	Uppr gi endoscopy, diagnosis	2.39	5.29	5.22	1.35	1.18	0.19	000
43236	.....	A	Uppr gi scope w/submuc inj	2.92	6.71	6.55	1.65	1.43	0.21	000
43237	.....	A	Endoscopic us exam, esoph	3.98	NA	NA	2.16	1.87	0.43	000
43238	.....	A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.56	2.26	0.43	000
43239	.....	A	Upper GI endoscopy, biopsy	2.87	6.05	5.88	1.56	1.37	0.22	000
43240	.....	A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.28	2.94	0.56	000
43241	.....	A	Upper GI endoscopy with tube	2.59	NA	NA	1.40	1.25	0.21	000
43242	.....	A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	3.67	3.20	0.53	000
43243	.....	A	Upper gi endoscopy & inject	4.56	NA	NA	2.35	2.07	0.33	000
43244	.....	A	Upper GI endoscopy/ligation	5.04	NA	NA	2.64	2.30	0.37	000
43245	.....	A	Uppr gi scope dilate strictr	3.18	NA	NA	1.63	1.46	0.26	000
43246	.....	A	Place gastrostomy tube	4.32	NA	NA	2.11	1.90	0.34	000
43247	.....	A	Operative upper GI endoscopy	3.38	NA	NA	1.78	1.57	0.27	000
43248	.....	A	Uppr gi endoscopy/guide wire	3.15	NA	NA	1.77	1.54	0.23	000
43249	.....	A	Esoph endoscopy, dilation	2.90	NA	NA	1.62	1.41	0.22	000
43250	.....	A	Upper GI endoscopy/tumor	3.20	NA	NA	1.61	1.46	0.26	000
43251	.....	A	Operative upper GI endoscopy	3.69	NA	NA	1.92	1.70	0.29	000
43255	.....	A	Operative upper GI endoscopy	4.81	NA	NA	2.52	2.20	0.35	000
43256	.....	A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.25	1.98	0.32	000
43257	.....	A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	2.14	2.17	0.36	000
43258	.....	A	Operative upper GI endoscopy	4.54	NA	NA	2.37	2.07	0.33	000
43259	.....	A	Endoscopic ultrasound exam	5.19	NA	NA	2.69	2.34	0.35	000
43260	.....	A	Endo cholangiopancreatograph	5.95	NA	NA	3.06	2.67	0.43	000
43261	.....	A	Endo cholangiopancreatograph	6.26	NA	NA	3.20	2.80	0.46	000
43262	.....	A	Endo cholangiopancreatograph	7.38	NA	NA	3.73	3.25	0.54	000
43263	.....	A	Endo cholangiopancreatograph	7.28	NA	NA	3.63	3.20	0.54	000
43264	.....	A	Endo cholangiopancreatograph	8.89	NA	NA	4.44	3.87	0.65	000
43265	.....	A	Endo cholangiopancreatograph	10.00	NA	NA	4.98	4.34	0.73	000
43267	.....	A	Endo cholangiopancreatograph	7.38	NA	NA	3.39	3.09	0.54	000
43268	.....	A	Endo cholangiopancreatograph	7.38	NA	NA	3.88	3.38	0.54	000
43269	.....	A	Endo cholangiopancreatograph	8.20	NA	NA	4.10	3.58	0.60	000
43271	.....	A	Endo cholangiopancreatograph	7.38	NA	NA	3.70	3.24	0.54	000
43272	.....	A	Endo cholangiopancreatograph	7.38	NA	NA	3.77	3.28	0.54	000
43280	.....	A	Laparoscopy, fundoplasty	18.00	NA	NA	6.65	6.96	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	5.41	5.89	1.12	090
43305	.....	A	Repair esophagus and fistula	17.98	NA	NA	8.33	9.51	1.54	090
43310	.....	A	Repair of esophagus	26.18	NA	NA	9.81	10.43	3.61	090
43312	.....	A	Repair esophagus and fistula	29.23	NA	NA	10.27	11.07	4.01	090
43313	.....	A	Esophagoplasty congenital	48.17	NA	NA	17.46	18.13	5.47	090
43314	.....	A	Tracheo-esophagoplasty cong	53.15	NA	NA	15.09	17.13	6.65	090
43320	.....	A	Fuse esophagus & stomach	23.18	NA	NA	8.60	8.90	2.74	090
43324	.....	A	Revise esophagus & stomach	22.86	NA	NA	8.34	8.55	2.76	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
43325		A	Revise esophagus & stomach	22.47	NA	NA	8.38	8.58	2.60	090
43326		A	Revise esophagus & stomach	22.15	NA	NA	9.20	9.24	2.85	090
43330		A	Repair of esophagus	22.06	NA	NA	8.09	8.31	2.63	090
43331		A	Repair of esophagus	22.93	NA	NA	9.82	9.80	2.94	090
43340		A	Fuse esophagus & intestine	22.86	NA	NA	9.27	9.12	2.46	090
43341		A	Fuse esophagus & intestine	24.10	NA	NA	9.65	9.83	2.92	090
43350		A	Surgical opening, esophagus	19.31	NA	NA	8.75	8.59	1.42	090
43351		A	Surgical opening, esophagus	21.87	NA	NA	10.86	10.32	2.47	090
43352		A	Surgical opening, esophagus	17.68	NA	NA	7.94	8.16	2.06	090
43360		A	Gastrointestinal repair	39.90	NA	NA	14.88	14.97	4.97	090
43361		A	Gastrointestinal repair	45.50	NA	NA	18.13	17.50	4.50	090
43400		A	Ligate esophagus veins	25.47	NA	NA	13.58	11.51	1.96	090
43401		A	Esophagus surgery for veins	26.36	NA	NA	9.54	9.51	3.05	090
43405		A	Ligate/staple esophagus	24.55	NA	NA	10.66	10.12	2.84	090
43410		A	Repair esophagus wound	16.28	NA	NA	7.66	7.64	1.72	090
43415		A	Repair esophagus wound	28.70	NA	NA	11.83	11.78	3.53	090
43420		A	Repair esophagus opening	16.65	NA	NA	7.47	7.43	1.43	090
43425		A	Repair esophagus opening	24.91	NA	NA	10.45	10.21	3.03	090
43450		A	Dilate esophagus	1.38	2.67	2.65	0.93	0.81	0.11	000
43453		A	Dilate esophagus	1.51	6.31	6.18	1.01	0.87	0.11	000
43456		A	Dilate esophagus	2.57	13.01	13.37	1.45	1.27	0.20	000
43458		A	Dilate esophagus	3.06	6.92	6.78	1.59	1.43	0.24	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	1.76	1.62	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	5.29	5.12	1.45	090
43501		A	Surgical repair of stomach	22.47	NA	NA	8.09	8.19	2.65	090
43502		A	Surgical repair of stomach	25.56	NA	NA	8.96	9.21	3.10	090
43510		A	Surgical opening of stomach	15.01	NA	NA	9.13	7.85	1.48	090
43520		A	Incision of pyloric muscle	11.21	NA	NA	4.81	5.03	1.36	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.77	0.71	0.14	000
43605		A	Biopsy of stomach	13.64	NA	NA	5.36	5.32	1.58	090
43610		A	Excision of stomach lesion	16.26	NA	NA	6.03	6.08	1.94	090
43611		A	Excision of stomach lesion	20.25	NA	NA	7.48	7.52	2.36	090
43620		A	Removal of stomach	33.91	NA	NA	11.09	11.44	3.96	090
43621		A	Removal of stomach	39.40	NA	NA	12.39	12.17	4.04	090
43622		A	Removal of stomach	39.90	NA	NA	12.49	12.53	4.30	090
43631		A	Removal of stomach, partial	24.38	NA	NA	8.58	8.87	2.99	090
43632		A	Removal of stomach, partial	35.01	NA	NA	11.26	10.21	2.99	090
43633		A	Removal of stomach, partial	33.01	NA	NA	10.75	10.03	3.06	090
43634		A	Removal of stomach, partial	36.51	NA	NA	11.78	10.93	3.33	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.52	0.61	0.27	ZZZ
43640		A	Vagotomy & pylorus repair	19.43	NA	NA	7.34	7.29	2.26	090
43641		A	Vagotomy & pylorus repair	19.68	NA	NA	7.62	7.49	2.25	090
43644		A	Lap gastric bypass/roux-en-y	29.24	NA	NA	10.10	10.65	3.16	090
43645		A	Lap gastr bypass incl smll i	31.37	NA	NA	10.48	11.24	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	4.61	4.68	1.33	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	5.22	5.49	1.55	090
43653		A	Laparoscopy, gastrostomy	8.38	NA	NA	4.46	4.32	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	0.26	0.26	0.02	000
43760		A	Change gastrostomy tube	0.90	5.98	4.03	0.33	0.39	0.09	000
43761		A	Reposition gastrostomy tube	2.01	1.04	1.10	0.70	0.68	0.13	000
43770		A	Lap place gastr adj device	17.85	NA	NA	7.40	7.55	2.19	090
43771		A	Lap revise gastr adj device	20.64	NA	NA	8.12	8.35	2.55	090
43772		A	Lap rmvl gastr adj device	15.62	NA	NA	5.99	6.21	1.93	090
43773		A	Lap replace gastr adj device	20.64	NA	NA	8.10	8.34	2.56	090
43774		A	Lap rmvl gastr adj all parts	15.66	NA	NA	6.18	6.37	1.85	090
43800		A	Reconstruction of pylorus	15.35	NA	NA	5.81	5.85	1.82	090
43810		A	Fusion of stomach and bowel	16.80	NA	NA	6.13	6.15	1.94	090
43820		A	Fusion of stomach and bowel	22.40	NA	NA	8.07	7.23	2.04	090
43825		A	Fusion of stomach and bowel	21.63	NA	NA	7.89	7.95	2.54	090
43830		A	Place gastrostomy tube	10.75	NA	NA	5.17	5.00	1.25	090
43831		A	Place gastrostomy tube	8.38	NA	NA	4.92	4.71	1.03	090
43832		A	Place gastrostomy tube	17.26	NA	NA	7.06	6.95	1.98	090
43840		A	Repair of stomach lesion	22.70	NA	NA	8.14	7.45	2.06	090
43842		N	V-band gastroplasty	20.90	NA	NA	6.75	7.26	2.45	090
43843		A	Gastroplasty w/o v-band	21.08	NA	NA	7.84	7.79	2.46	090
43845		A	Gastroplasty duodenal switch	33.12	NA	NA	12.88	11.82	4.06	090
43846		A	Gastric bypass for obesity	27.23	NA	NA	9.97	9.99	3.19	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
43847		A	Gastric bypass incl small i	30.10	NA	NA	10.51	10.70	3.56	090
43848		A	Revision gastroplasty	32.57	NA	NA	11.29	11.55	3.88	090
43850		A	Revise stomach-bowel fusion	27.45	NA	NA	9.49	9.65	3.28	090
43855		A	Revise stomach-bowel fusion	28.56	NA	NA	9.70	10.01	3.47	090
43860		A	Revise stomach-bowel fusion	27.76	NA	NA	9.47	9.71	3.31	090
43865		A	Revise stomach-bowel fusion	28.92	NA	NA	9.73	10.11	3.51	090
43870		A	Repair stomach opening	11.36	NA	NA	4.95	4.73	1.27	090
43880		A	Repair stomach-bowel fistula	27.05	NA	NA	9.27	9.58	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	3.44	3.29	0.25	090
43887		A	Remove gastric port, open	4.24	NA	NA	3.05	2.91	0.51	090
43888		A	Change gastric port, open	6.34	NA	NA	4.01	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	6.58	6.64	2.15	090
44010		A	Incision of small bowel	14.18	NA	NA	5.53	5.48	1.64	090
44015		A	Insert needle cath bowel	2.62	NA	NA	0.68	0.78	0.35	ZZZ
44020		A	Explore small intestine	16.14	NA	NA	6.00	5.96	1.86	090
44021		A	Decompress small bowel	16.23	NA	NA	6.15	6.05	1.87	090
44025		A	Incision of large bowel	16.43	NA	NA	6.05	6.03	1.90	090
44050		A	Reduce bowel obstruction	15.44	NA	NA	5.82	5.88	1.86	090
44055		A	Correct malrotation of bowel	25.53	NA	NA	8.48	8.60	2.91	090
44100		A	Biopsy of bowel	2.01	NA	NA	0.91	0.81	0.17	000
44110		A	Excise intestine lesion(s)	13.96	NA	NA	5.50	5.36	1.55	090
44111		A	Excision of bowel lesion(s)	16.44	NA	NA	6.09	6.10	1.87	090
44120		A	Removal of small intestine	20.74	NA	NA	7.14	7.11	2.25	090
44121		A	Removal of small intestine	4.44	NA	NA	1.12	1.32	0.58	ZZZ
44125		A	Removal of small intestine	19.93	NA	NA	7.03	7.14	2.27	090
44126		A	Enterectomy w/o taper, cong	42.02	NA	NA	13.59	13.85	4.69	090
44127		A	Enterectomy w/taper, cong	49.09	NA	NA	15.63	15.67	5.77	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.21	1.37	0.61	ZZZ
44130		A	Bowel to bowel fusion	21.98	NA	NA	7.97	7.09	1.88	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.56	0.66	0.28	ZZZ
44140		A	Partial removal of colon	22.46	NA	NA	8.06	8.35	2.71	090
44141		A	Partial removal of colon	29.75	NA	NA	11.83	10.93	2.53	090
44143		A	Partial removal of colon	27.63	NA	NA	10.28	10.48	3.05	090
44144		A	Partial removal of colon	29.75	NA	NA	10.62	10.11	2.86	090
44145		A	Partial removal of colon	28.45	NA	NA	9.48	10.13	3.29	090
44146		A	Partial removal of colon	35.14	NA	NA	13.36	13.10	3.41	090
44147		A	Partial removal of colon	33.56	NA	NA	10.77	9.73	2.56	090
44150		A	Removal of colon	29.99	NA	NA	12.60	12.30	3.04	090
44151		A	Removal of colon/ileostomy	34.73	NA	NA	13.91	13.65	3.49	090
44155		A	Removal of colon/ileostomy	34.23	NA	NA	13.44	13.37	3.28	090
44156		A	Removal of colon/ileostomy	37.23	NA	NA	14.48	14.75	3.95	090
44157		A	Colectomy w/ileoanal anast	35.49	NA	NA	17.08	17.08	3.93	090
44158		A	Colectomy w/neo-rectum pouch	36.49	NA	NA	17.42	17.42	4.06	090
44160		A	Removal of colon	20.78	NA	NA	7.51	7.62	2.37	090
44180		A	Lap, enterolysis	15.19	NA	NA	5.80	6.01	1.86	090
44186		A	Lap, jejunostomy	10.30	NA	NA	4.58	4.68	1.27	090
44187		A	Lap, ileo/jejuno-stomy	17.27	NA	NA	8.12	8.19	1.96	090
44188		A	Lap, colostomy	19.20	NA	NA	8.67	8.75	2.24	090
44202		A	Lap, enterectomy	23.26	NA	NA	8.31	8.61	2.85	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.12	1.31	0.57	ZZZ
44204		A	Laparo partial colectomy	26.29	NA	NA	8.88	9.41	3.11	090
44205		A	Lap colectomy part w/ileum	22.86	NA	NA	7.80	8.32	2.75	090
44206		A	Lap part colectomy w/stoma	29.63	NA	NA	10.46	10.85	3.46	090
44207		A	L colectomy/coloproctostomy	31.79	NA	NA	10.10	10.78	3.67	090
44208		A	L colectomy/coloproctostomy	33.86	NA	NA	12.01	12.57	3.88	090
44210		A	Laparo total proctocolectomy	29.88	NA	NA	11.17	11.52	3.42	090
44211		A	Lap colectomy w/proctectomy	36.87	NA	NA	13.58	14.12	4.17	090
44212		A	Laparo total proctocolectomy	34.37	NA	NA	13.03	13.35	3.78	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	0.86	1.04	0.44	ZZZ
44227		A	Lap, close enterostomy	28.49	NA	NA	9.48	10.05	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	5.55	5.52	1.60	090
44310		A	Ileostomy/jejunostomy	17.49	NA	NA	6.40	6.54	1.99	090
44312		A	Revision of ileostomy	9.33	NA	NA	4.65	4.32	0.92	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
44314		A	Revision of ileostomy	16.61	NA	NA	6.77	6.66	1.75	090
44316		A	Devise bowel pouch	23.46	NA	NA	8.87	8.70	2.38	090
44320		A	Colostomy	19.75	NA	NA	7.59	7.62	2.26	090
44322		A	Colostomy with biopsies	13.15	NA	NA	9.10	8.83	1.54	090
44340		A	Revision of colostomy	9.12	NA	NA	4.93	4.60	0.99	090
44345		A	Revision of colostomy	17.06	NA	NA	6.92	6.90	1.97	090
44346		A	Revision of colostomy	19.47	NA	NA	7.52	7.45	2.13	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.50	1.30	0.19	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.63	1.41	0.21	000
44363		A	Small bowel endoscopy	3.49	NA	NA	1.85	1.61	0.27	000
44364		A	Small bowel endoscopy	3.73	NA	NA	1.97	1.73	0.27	000
44365		A	Small bowel endoscopy	3.31	NA	NA	1.74	1.55	0.24	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.37	2.05	0.32	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.36	2.05	0.33	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	2.56	2.26	0.37	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.12	1.93	0.35	000
44373		A	Small bowel endoscopy	3.49	NA	NA	1.76	1.59	0.27	000
44376		A	Small bowel endoscopy	5.25	NA	NA	2.47	2.25	0.42	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	2.76	2.45	0.40	000
44378		A	Small bowel endoscopy	7.12	NA	NA	3.57	3.13	0.52	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	3.92	3.42	0.62	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.74	0.65	0.08	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.84	0.73	0.12	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.61	1.44	0.21	000
44385		A	Endoscopy of bowel pouch	1.82	4.90	4.12	0.89	0.82	0.15	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.65	6.64	1.02	0.95	0.20	000
44388		A	Colonoscopy	2.82	6.12	5.60	1.35	1.25	0.26	000
44389		A	Colonoscopy with biopsy	3.13	7.11	6.86	1.57	1.42	0.27	000
44390		A	Colonoscopy for foreign body	3.82	8.33	7.72	1.92	1.70	0.32	000
44391		A	Colonoscopy for bleeding	4.31	8.93	8.83	2.21	1.95	0.34	000
44392		A	Colonoscopy & polypectomy	3.81	7.36	6.97	1.72	1.60	0.34	000
44393		A	Colonoscopy, lesion removal	4.83	8.03	7.46	2.13	2.00	0.42	000
44394		A	Colonoscopy w/snare	4.42	8.50	8.15	2.07	1.89	0.38	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.16	1.97	0.39	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.17	0.17	0.03	000
44602		A	Suture, small intestine	24.64	NA	NA	7.61	7.00	2.12	090
44603		A	Suture, small intestine	28.03	NA	NA	8.96	8.11	2.42	090
44604		A	Suture, large intestine	18.06	NA	NA	6.06	6.25	2.12	090
44605		A	Repair of bowel lesion	22.00	NA	NA	7.82	8.10	2.52	090
44615		A	Intestinal stricturoplasty	18.08	NA	NA	6.53	6.60	2.07	090
44620		A	Repair bowel opening	14.35	NA	NA	5.50	5.41	1.51	090
44625		A	Repair bowel opening	17.20	NA	NA	6.14	6.22	1.86	090
44626		A	Repair bowel opening	27.82	NA	NA	8.88	9.34	3.27	090
44640		A	Repair bowel-skin fistula	24.12	NA	NA	8.01	8.29	2.78	090
44650		A	Repair bowel fistula	25.04	NA	NA	8.30	8.59	2.93	090
44660		A	Repair bowel-bladder fistula	23.83	NA	NA	9.75	9.04	2.14	090
44661		A	Repair bowel-bladder fistula	27.27	NA	NA	9.39	9.47	2.81	090
44680		A	Surgical revision, intestine	17.88	NA	NA	6.68	6.56	2.00	090
44700		A	Suspend bowel w/prosthesis	17.40	NA	NA	6.15	6.40	1.84	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	0.76	0.91	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	1.27	1.48	0.37	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	1.78	2.08	0.97	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.94	NA	NA	5.49	5.43	1.47	090
44820		A	Excision of mesentery lesion	13.63	NA	NA	5.56	5.52	1.59	090
44850		A	Repair of mesentery	12.03	NA	NA	5.01	5.00	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	5.02	4.85	1.33	090
44901		A	Drain app abscess, percut	3.37	19.79	23.83	1.20	1.15	0.22	000
44950		A	Appendectomy	10.52	NA	NA	4.04	4.17	1.31	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.40	0.47	0.20	ZZZ
44960		A	Appendectomy	14.39	NA	NA	5.40	5.37	1.63	090
44970		A	Laparoscopy, appendectomy	9.35	NA	NA	4.19	4.13	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	3.57	3.26	0.52	090
45005		A	Drainage of rectal abscess	2.00	3.98	4.01	1.59	1.58	0.25	010
45020		A	Drainage of rectal abscess	8.43	NA	NA	4.54	3.91	0.55	090
45100		A	Biopsy of rectum	3.96	NA	NA	2.81	2.59	0.44	090
45108		A	Removal of anorectal lesion	5.04	NA	NA	3.09	2.93	0.59	090
45110		A	Removal of rectum	30.57	NA	NA	11.84	12.12	3.36	090
45111		A	Partial removal of rectum	17.89	NA	NA	6.99	7.07	2.07	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
45112		A	Removal of rectum	33.05	NA	NA	10.30	11.02	3.43	090
45113		A	Partial proctectomy	33.09	NA	NA	11.57	12.08	3.49	090
45114		A	Partial removal of rectum	30.63	NA	NA	10.28	10.57	3.36	090
45116		A	Partial removal of rectum	27.56	NA	NA	9.64	9.83	2.88	090
45119		A	Remove rectum w/reservoir	33.35	NA	NA	11.53	11.99	3.36	090
45120		A	Removal of rectum	26.25	NA	NA	9.26	9.69	2.90	090
45121		A	Removal of rectum and colon	28.93	NA	NA	10.03	10.56	3.25	090
45123		A	Partial proctectomy	18.70	NA	NA	6.94	6.89	1.86	090
45126		A	Pelvic exenteration	48.89	NA	NA	17.87	18.53	4.33	090
45130		A	Excision of rectal prolapse	18.37	NA	NA	6.66	6.71	1.80	090
45135		A	Excision of rectal prolapse	22.15	NA	NA	8.60	8.50	2.36	090
45136		A	Excise ileoanal reservior	30.63	NA	NA	11.94	12.23	2.82	090
45150		A	Excision of rectal stricture	5.77	NA	NA	3.34	3.15	0.61	090
45160		A	Excision of rectal lesion	16.17	NA	NA	6.43	6.54	1.68	090
45170		A	Excision of rectal lesion	12.48	NA	NA	5.36	5.29	1.35	090
45190		A	Destruction, rectal tumor	10.29	NA	NA	5.52	5.07	1.13	090
45300		A	Proctosigmoidoscopy dx	0.80	1.96	1.74	0.45	0.37	0.04	000
45303		A	Proctosigmoidoscopy dilate	1.50	19.91	19.29	0.66	0.49	0.05	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.19	2.91	0.59	0.55	0.11	000
45307		A	Proctosigmoidoscopy fb	1.70	3.25	3.14	0.70	0.59	0.11	000
45308		A	Proctosigmoidoscopy removal	1.40	3.40	2.70	0.63	0.53	0.09	000
45309		A	Proctosigmoidoscopy removal	1.50	3.53	3.17	0.67	0.75	0.22	000
45315		A	Proctosigmoidoscopy removal	1.80	3.82	3.34	0.87	0.75	0.15	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.36	2.90	0.76	0.71	0.15	000
45320		A	Proctosigmoidoscopy ablate	1.78	3.40	3.15	0.80	0.75	0.16	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	0.86	0.71	0.13	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	0.91	0.80	0.16	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.52	2.40	0.62	0.56	0.08	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.28	3.17	0.79	0.69	0.09	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.53	5.26	0.99	0.90	0.16	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.66	5.26	0.99	0.89	0.15	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.53	1.34	0.20	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.34	4.27	0.90	0.79	0.11	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.25	1.12	0.21	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.90	5.56	1.28	1.14	0.19	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.73	4.59	1.66	1.47	0.26	000
45340		A	Sig w/balloon dilation	1.89	10.25	8.21	1.03	0.93	0.15	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.47	1.27	0.19	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.17	1.85	0.30	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.50	1.33	0.23	000
45355		A	Surgical colonoscopy	3.51	NA	NA	1.58	1.48	0.36	000
45378		A	Diagnostic colonoscopy	3.69	6.38	6.26	1.82	1.64	0.30	000
45378	53	A	Diagnostic colonoscopy	0.96	2.52	2.40	0.62	0.56	0.08	000
45379		A	Colonoscopy w/fb removal	4.68	8.07	7.86	2.17	1.99	0.39	000
45380		A	Colonoscopy and biopsy	4.43	7.75	7.47	2.23	1.98	0.35	000
45381		A	Colonoscopy, submucous inj	4.19	7.72	7.41	2.16	1.90	0.30	000
45382		A	Colonoscopy/control bleeding	5.68	10.35	10.14	2.88	2.53	0.41	000
45383		A	Lesion removal colonoscopy	5.86	8.55	8.23	2.63	2.43	0.48	000
45384		A	Lesion remove colonoscopy	4.69	7.19	6.99	2.18	2.00	0.38	000
45385		A	Lesion removal colonoscopy	5.30	8.37	8.08	2.59	2.31	0.42	000
45386		A	Colonoscopy dilate stricture	4.57	12.35	12.38	2.17	1.98	0.39	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	2.80	2.57	0.48	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	2.60	2.29	0.42	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.21	2.85	0.42	000
45395		A	Lap, removal of rectum	32.79	NA	NA	12.94	13.30	3.63	090
45397		A	Lap, remove rectum w/pouch	36.29	NA	NA	13.38	13.82	3.67	090
45400		A	Laparoscopic proc	19.31	NA	NA	7.07	7.45	2.03	090
45402		A	Lap proctopexy w/sig resect	26.38	NA	NA	8.73	9.35	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	4.46	3.99	0.75	090
45505		A	Repair of rectum	8.20	NA	NA	5.04	4.44	0.86	090
45520		A	Treatment of rectal prolapse	0.55	2.86	2.25	0.38	0.38	0.05	000
45540		A	Correct rectal prolapse	18.02	NA	NA	5.83	6.31	1.85	090
45541		A	Correct rectal prolapse	14.72	NA	NA	6.59	6.26	1.55	090
45550		A	Repair rectum/remove sigmoid	24.67	NA	NA	8.95	9.08	2.62	090
45560		A	Repair of rectocele	11.42	NA	NA	5.52	5.28	1.13	090
45562		A	Exploration/repair of rectum	17.82	NA	NA	8.10	7.54	1.84	090
45563		A	Exploration/repair of rectum	26.22	NA	NA	10.75	10.62	3.11	090
45800		A	Repair rect/bladder fistula	20.18	NA	NA	9.14	8.28	1.86	090
45805		A	Repair fistula w/colostomy	23.19	NA	NA	9.92	9.71	2.03	090
45820		A	Repair rectourethral fistula	20.24	NA	NA	9.09	8.35	1.58	090
45825		A	Repair fistula w/colostomy	24.01	NA	NA	9.46	9.63	2.32	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
45900		A	Reduction of rectal prolapse	2.96	NA	NA	1.65	1.57	0.30	010
45905		A	Dilation of anal sphincter	2.32	NA	NA	1.60	1.51	0.27	010
45910		A	Dilation of rectal narrowing	2.82	NA	NA	1.84	1.75	0.30	010
45915		A	Remove rectal obstruction	3.16	4.20	4.26	2.01	2.05	0.30	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	0.72	0.76	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	3.26	2.80	2.35	2.10	0.31	010
46030		A	Removal of rectal marker	1.24	1.88	1.61	0.81	0.76	0.14	010
46040		A	Incision of rectal abscess	5.26	6.53	6.01	3.98	3.78	0.62	090
46045		A	Incision of rectal abscess	5.79	NA	NA	3.94	3.41	0.54	090
46050		A	Incision of anal abscess	1.21	3.19	2.87	0.98	0.91	0.14	010
46060		A	Incision of rectal abscess	6.24	NA	NA	4.41	3.83	0.67	090
46070		A	Incision of anal septum	2.74	NA	NA	2.35	2.09	0.36	090
46080		A	Incision of anal sphincter	2.50	3.06	2.71	1.12	1.12	0.30	010
46083		A	Incise external hemorrhoid	1.42	2.36	2.44	0.96	0.94	0.15	010
46200		A	Removal of anal fissure	3.48	6.29	5.07	3.73	3.29	0.39	090
46210		A	Removal of anal crypt	2.73	5.82	5.46	3.30	2.96	0.31	090
46211		A	Removal of anal crypts	4.31	7.84	6.62	4.66	4.08	0.48	090
46220		A	Removal of anal tag	1.58	3.02	2.66	1.10	1.02	0.17	010
46221		A	Ligation of hemorrhoid(s)	2.31	3.73	3.19	2.00	1.87	0.23	010
46230		A	Removal of anal tags	2.59	3.50	3.29	1.33	1.31	0.30	010
46250		A	Hemorrhoidectomy	4.17	5.95	5.63	2.83	2.72	0.48	090
46255		A	Hemorrhoidectomy	4.88	6.34	6.08	3.06	2.95	0.58	090
46257		A	Remove hemorrhoids & fissure	5.68	NA	NA	3.84	3.36	0.64	090
46258		A	Remove hemorrhoids & fistula	6.28	NA	NA	3.95	3.61	0.68	090
46260		A	Hemorrhoidectomy	6.65	NA	NA	4.06	3.62	0.76	090
46261		A	Remove hemorrhoids & fissure	7.63	NA	NA	4.29	3.94	0.79	090
46262		A	Remove hemorrhoids & fistula	7.80	NA	NA	4.65	4.19	0.83	090
46270		A	Removal of anal fistula	4.81	6.38	5.68	3.91	3.37	0.46	090
46275		A	Removal of anal fistula	5.31	6.62	5.62	3.97	3.47	0.52	090
46280		A	Removal of anal fistula	6.28	NA	NA	4.27	3.76	0.66	090
46285		A	Removal of anal fistula	5.31	6.53	5.14	3.95	3.35	0.44	090
46288		A	Repair anal fistula	7.68	NA	NA	4.67	4.17	0.79	090
46320		A	Removal of hemorrhoid clot	1.62	2.41	2.26	0.88	0.86	0.18	010
46500		A	Injection into hemorrhoid(s)	1.64	3.60	2.86	1.25	1.20	0.16	010
46505		A	Chemodenervation anal musc	3.13	3.28	3.16	2.28	2.12	0.14	010
46600		A	Diagnostic anoscopy	0.55	1.37	1.46	0.38	0.36	0.05	000
46604		A	Anoscopy and dilation	1.03	12.51	10.81	0.51	0.56	0.12	000
46606		A	Anoscopy and biopsy	1.20	3.87	3.82	0.58	0.50	0.09	000
46608		A	Anoscopy, remove for body	1.30	3.76	4.08	0.58	0.61	0.16	000
46610		A	Anoscopy, remove lesion	1.28	3.79	3.91	0.59	0.60	0.15	000
46611		A	Anoscopy	1.30	2.53	2.93	0.57	0.67	0.19	000
46612		A	Anoscopy, remove lesions	1.50	4.70	4.94	0.72	0.85	0.28	000
46614		A	Anoscopy, control bleeding	1.00	1.93	2.13	0.52	0.68	0.20	000
46615		A	Anoscopy	1.50	1.74	2.11	0.64	0.85	0.33	000
46700		A	Repair of anal stricture	9.68	NA	NA	5.15	4.67	0.94	090
46705		A	Repair of anal stricture	7.32	NA	NA	4.06	3.87	0.91	090
46706		A	Repr of anal fistula w/glue	2.41	NA	NA	1.49	1.37	0.28	010
46710		A	Repr per/vag pouch sngl proc	17.01	NA	NA	7.54	7.64	1.38	090
46712		A	Repr per/vag pouch dbl proc	36.32	NA	NA	14.00	14.52	3.67	090
46715		A	Rep perf anoper fistu	7.54	NA	NA	3.75	3.66	0.92	090
46716		A	Rep perf anoper/vestib fistu	17.14	NA	NA	9.59	8.77	1.58	090
46730		A	Construction of absent anus	30.17	NA	NA	12.49	12.25	2.47	090
46735		A	Construction of absent anus	35.66	NA	NA	15.00	14.27	3.21	090
46740		A	Construction of absent anus	33.42	NA	NA	15.28	14.25	2.42	090
46742		A	Repair of imperforated anus	39.66	NA	NA	13.75	15.56	3.20	090
46744		A	Repair of cloacal anomaly	58.46	NA	NA	18.13	19.61	6.40	090
46746		A	Repair of cloacal anomaly	64.93	NA	NA	19.66	22.39	7.70	090
46748		A	Repair of cloacal anomaly	70.91	NA	NA	21.04	22.33	3.37	090
46750		A	Repair of anal sphincter	12.02	NA	NA	5.76	5.40	1.10	090
46751		A	Repair of anal sphincter	9.19	NA	NA	5.02	5.22	0.94	090
46753		A	Reconstruction of anus	8.81	NA	NA	4.59	4.21	0.94	090
46754		A	Removal of suture from anus	2.88	3.63	3.61	2.21	1.94	0.19	010
46760		A	Repair of anal sphincter	17.21	NA	NA	8.05	7.56	1.59	090
46761		A	Repair of anal sphincter	15.16	NA	NA	6.47	6.23	1.43	090
46762		A	Implant artificial sphincter	14.66	NA	NA	7.07	6.29	1.24	090
46900		A	Destruction, anal lesion(s)	1.91	3.65	3.12	1.31	1.29	0.17	010
46910		A	Destruction, anal lesion(s)	1.88	3.88	3.39	1.20	1.13	0.19	010
46916		A	Cryosurgery, anal lesion(s)	1.88	3.77	3.46	1.58	1.48	0.11	010
46917		A	Laser surgery, anal lesions	1.88	8.78	8.95	1.22	1.17	0.21	010
46922		A	Excision of anal lesion(s)	1.88	4.14	3.70	1.20	1.13	0.22	010
46924		A	Destruction, anal lesion(s)	2.78	9.57	9.13	1.51	1.43	0.26	010

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
46934		A	Destruction of hemorrhoids	3.79	5.56	5.31	2.87	2.91	0.32	090
46935		A	Destruction of hemorrhoids	2.44	3.86	3.66	1.11	1.16	0.23	010
46936		A	Destruction of hemorrhoids	3.70	6.23	5.55	2.65	2.57	0.34	090
46937		A	Cryotherapy of rectal lesion	2.70	3.40	3.09	1.43	1.32	0.14	010
46938		A	Cryotherapy of rectal lesion	4.70	5.62	4.80	3.55	3.30	0.58	090
46940		A	Treatment of anal fissure	2.33	2.84	2.42	1.04	1.06	0.23	010
46942		A	Treatment of anal fissure	2.05	2.80	2.32	0.96	0.99	0.19	010
46945		A	Ligation of hemorrhoids	2.13	4.79	4.03	2.98	2.72	0.19	090
46946		A	Ligation of hemorrhoids	2.60	4.63	4.17	2.64	2.52	0.27	090
46947		A	Hemorrhoidopexy by stapling	5.49	NA	NA	3.10	2.91	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	7.66	5.36	0.70	0.66	0.12	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.48	0.57	0.25	ZZZ
47010		A	Open drainage, liver lesion	19.27	NA	NA	8.31	8.35	1.81	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.32	1.26	0.22	000
47015		A	Inject/aspirate liver cyst	18.37	NA	NA	8.16	7.82	1.84	090
47100		A	Wedge biopsy of liver	12.78	NA	NA	6.31	6.17	1.53	090
47120		A	Partial removal of liver	38.82	NA	NA	14.07	14.60	4.66	090
47122		A	Extensive removal of liver	59.35	NA	NA	18.74	20.08	7.21	090
47125		A	Partial removal of liver	52.91	NA	NA	17.16	18.33	6.47	090
47130		A	Partial removal of liver	57.06	NA	NA	18.10	19.53	6.96	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.29	NA	NA	27.72	29.60	9.96	090
47136		R	Transplantation of liver	70.39	NA	NA	24.53	25.76	8.44	090
47140		A	Partial removal, donor liver	59.22	NA	NA	21.60	21.93	5.19	090
47141		A	Partial removal, donor liver	71.27	NA	NA	25.33	26.11	5.19	090
47142		A	Partial removal, donor liver	79.21	NA	NA	27.34	28.39	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	1.78	0.83	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	1.77	2.08	0.97	XXX
47300		A	Surgery for liver lesion	18.01	NA	NA	7.74	7.48	1.99	090
47350		A	Repair liver wound	22.36	NA	NA	8.77	8.81	2.59	090
47360		A	Repair liver wound	31.18	NA	NA	11.24	11.40	3.38	090
47361		A	Repair liver wound	52.47	NA	NA	17.38	17.94	5.87	090
47362		A	Repair liver wound	23.41	NA	NA	9.30	9.00	2.51	090
47370		A	Laparo ablate liver tumor rf	20.67	NA	NA	7.69	7.90	2.56	090
47371		A	Laparo ablate liver cryosurg	20.67	NA	NA	7.89	8.01	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	8.60	8.97	2.87	090
47381		A	Open ablate liver tumor cryo	24.72	NA	NA	9.31	9.44	2.85	090
47382		A	Percut ablate liver rf	15.19	NA	NA	6.20	6.14	0.96	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.23	NA	NA	13.01	13.21	3.08	090
47420		A	Incision of bile duct	21.92	NA	NA	8.54	8.65	2.63	090
47425		A	Incision of bile duct	22.20	NA	NA	8.64	8.72	2.62	090
47460		A	Incise bile duct sphincter	20.41	NA	NA	9.13	8.74	2.21	090
47480		A	Incision of gallbladder	13.12	NA	NA	6.64	6.27	1.42	090
47490		A	Incision of gallbladder	8.05	NA	NA	5.29	5.43	0.43	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.71	0.67	0.12	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.27	0.26	0.04	000
47510		A	Insert catheter, bile duct	7.94	NA	NA	4.63	4.82	0.46	090
47511		A	Insert bile duct drain	10.74	NA	NA	5.04	5.06	0.62	090
47525		A	Change bile duct catheter	5.55	14.85	14.96	2.69	2.74	0.33	010
47530		A	Revise/reinsert bile tube	5.96	30.56	32.16	3.44	3.58	0.37	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	0.78	0.90	0.40	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.48	2.43	0.42	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.25	2.16	0.37	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.29	3.32	0.96	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.74	2.60	0.45	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	3.09	2.93	0.50	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	1.24	1.45	0.65	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	1.58	1.75	0.66	000
47562		A	Laparoscopic cholecystectomy	11.63	NA	NA	5.26	5.12	1.46	090
47563		A	Laparo cholecystectomy/graph	12.03	NA	NA	5.06	5.18	1.58	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	NA	5.41	5.68	1.89	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	4.96	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	7.22	6.67	1.80	090
47605		A	Removal of gallbladder	15.90	NA	NA	6.38	6.43	1.95	090
47610		A	Removal of gallbladder	20.84	NA	NA	7.65	7.78	2.49	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
47612		A	Removal of gallbladder	21.13	NA	NA	7.67	7.77	2.48	090
47620		A	Removal of gallbladder	22.99	NA	NA	8.15	8.33	2.74	090
47630		A	Remove bile duct stone	9.57	NA	NA	4.73	4.80	0.65	090
47700		A	Exploration of bile ducts	16.39	NA	NA	7.30	7.35	2.07	090
47701		A	Bile duct revision	28.62	NA	NA	10.64	11.05	3.68	090
47711		A	Excision of bile duct tumor	25.77	NA	NA	9.64	9.77	3.05	090
47712		A	Excision of bile duct tumor	33.59	NA	NA	11.65	12.02	3.93	090
47715		A	Excision of bile duct cyst	21.42	NA	NA	8.60	8.51	2.49	090
47720		A	Fuse gallbladder & bowel	18.21	NA	NA	7.70	7.58	2.11	090
47721		A	Fuse upper gi structures	21.86	NA	NA	8.54	8.54	2.53	090
47740		A	Fuse gallbladder & bowel	21.10	NA	NA	8.33	8.34	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	13.03	11.93	3.42	090
47765		A	Fuse liver ducts & bowel	52.01	NA	NA	16.94	13.86	3.30	090
47780		A	Fuse bile ducts and bowel	42.14	NA	NA	14.11	12.65	3.50	090
47785		A	Fuse bile ducts and bowel	56.01	NA	NA	17.84	15.36	4.10	090
47800		A	Reconstruction of bile ducts	26.04	NA	NA	9.77	9.90	3.08	090
47801		A	Placement, bile duct support	17.47	NA	NA	8.43	8.28	1.16	090
47802		A	Fuse liver duct & intestine	24.80	NA	NA	9.68	9.66	2.86	090
47900		A	Suture bile duct injury	22.31	NA	NA	8.85	8.85	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	10.86	11.17	3.48	090
48001		A	Placement of drain, pancreas	39.56	NA	NA	12.76	13.30	4.69	090
48020		A	Removal of pancreatic stone	18.96	NA	NA	7.59	7.44	2.13	090
48100		A	Biopsy of pancreas, open	14.38	NA	NA	5.95	5.77	1.62	090
48102		A	Needle biopsy, pancreas	4.68	9.60	8.77	1.91	1.93	0.28	010
48105		A	Resect/debride pancreas	49.05	NA	NA	15.76	16.15	5.56	090
48120		A	Removal of pancreas lesion	18.33	NA	NA	6.85	6.84	2.10	090
48140		A	Partial removal of pancreas	26.19	NA	NA	9.37	9.45	3.03	090
48145		A	Partial removal of pancreas	27.26	NA	NA	9.55	9.68	3.18	090
48146		A	Pancreatectomy	30.42	NA	NA	11.93	11.94	3.50	090
48148		A	Removal of pancreatic duct	20.26	NA	NA	8.20	7.89	2.30	090
48150		A	Partial removal of pancreas	52.63	NA	NA	18.01	18.74	6.32	090
48152		A	Pancreatectomy	48.47	NA	NA	16.82	17.50	5.80	090
48153		A	Pancreatectomy	52.61	NA	NA	17.89	18.70	6.31	090
48154		A	Pancreatectomy	48.70	NA	NA	17.05	17.62	5.84	090
48155		A	Removal of pancreas	29.27	NA	NA	11.96	11.80	3.27	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection, intraop add-on	1.95	NA	NA	0.66	0.65	0.15	ZZZ
48500		A	Surgery of pancreatic cyst	18.03	NA	NA	7.66	7.49	2.03	090
48510		A	Drain pancreatic pseudocyst	17.06	NA	NA	7.60	7.51	1.83	090
48511		A	Drain pancreatic pseudocyst	3.99	20.17	20.53	1.43	1.37	0.24	000
48520		A	Fuse pancreas cyst and bowel	18.07	NA	NA	6.82	6.76	2.06	090
48540		A	Fuse pancreas cyst and bowel	21.86	NA	NA	7.80	7.94	2.61	090
48545		A	Pancreatorrhaphy	22.10	NA	NA	8.41	8.19	2.38	090
48547		A	Duodenal exclusion	30.25	NA	NA	10.28	10.37	3.42	090
48548		A	Fuse pancreas and bowel	27.96	NA	NA	9.88	10.01	3.28	090
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.14	1.30	0.31	XXX
48554		R	Transpl allograft pancreas	37.03	NA	NA	20.51	19.37	4.19	090
48556		A	Removal, allograft pancreas	19.24	NA	NA	9.22	8.64	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	5.20	5.29	1.52	090
49002		A	Reopening of abdomen	17.55	NA	NA	6.38	5.69	1.37	090
49010		A	Exploration behind abdomen	15.98	NA	NA	6.19	6.04	1.51	090
49020		A	Drain abdominal abscess	26.46	NA	NA	9.88	10.03	2.85	090
49021		A	Drain abdominal abscess	3.37	19.63	20.33	1.21	1.16	0.20	000
49040		A	Drain, open, abdom abscess	16.41	NA	NA	6.51	6.46	1.70	090
49041		A	Drain, percut, abdom abscess	3.99	19.91	19.71	1.43	1.37	0.24	000
49060		A	Drain, open, retrop abscess	18.42	NA	NA	7.24	7.33	1.75	090
49061		A	Drain, percut, retroper absc	3.69	19.74	19.68	1.33	1.27	0.22	000
49062		A	Drain to peritoneal cavity	12.12	NA	NA	5.11	5.27	1.39	090
49080		A	Puncture, peritoneal cavity	1.35	2.73	3.35	0.48	0.47	0.08	000
49081		A	Removal of abdominal fluid	1.26	2.93	2.76	0.47	0.45	0.09	000
49180		A	Biopsy, abdominal mass	1.73	2.47	2.79	0.62	0.59	0.10	000
49203		A	Exc abd tum 5 cm or less	20.00	NA	NA	7.65	7.65	2.27	090
49204		A	Exc abd tum over 5 cm	26.00	NA	NA	9.26	9.26	2.94	090
49205		A	Exc abd tum over 10 cm	30.00	NA	NA	10.34	10.34	3.40	090
49215		A	Excise sacral spine tumor	37.66	NA	NA	12.67	13.35	4.38	090
49220		A	Multiple surgery, abdomen	15.70	NA	NA	6.45	6.54	1.89	090
49250		A	Excision of umbilicus	8.93	NA	NA	4.34	4.30	1.08	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
49255		A	Removal of omentum	12.41	NA	NA	5.62	5.61	1.43	090
49320		A	Diag laparo separate proc	5.09	NA	NA	2.44	2.53	0.65	010
49321		A	Laparoscopy, biopsy	5.39	NA	NA	2.56	2.60	0.70	010
49322		A	Laparoscopy, aspiration	5.96	NA	NA	2.63	2.81	0.71	010
49323		A	Laparo drain lymphocele	10.13	NA	NA	4.68	4.58	1.20	090
49324		A	Lap insertion perm ip cath	6.27	NA	NA	2.78	2.78	0.73	010
49325		A	Lap revision perm ip cath	6.77	NA	NA	2.91	2.91	0.86	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	0.92	0.92	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	2.47	2.77	0.62	0.62	0.15	000
49402		A	Remove foreign body, adbomen	14.01	NA	NA	5.51	5.50	1.62	090
49419		A	Insrt abdom cath for chemotx	7.03	NA	NA	3.43	3.49	0.81	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.18	1.13	0.21	000
49421		A	Insert abdom drain, perm	5.87	NA	NA	3.12	3.13	0.74	090
49422		A	Remove perm cannula/catheter	6.26	NA	NA	2.61	2.75	0.83	010
49423		A	Exchange drainage catheter	1.46	13.08	13.57	0.56	0.54	0.09	000
49424		A	Assess cyst, contrast inject	0.76	3.08	3.39	0.30	0.30	0.04	000
49425		A	Insert abdomen-venous drain	12.13	NA	NA	5.29	5.44	1.54	090
49426		A	Revise abdomen-venous shunt	10.33	NA	NA	4.56	4.66	1.28	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.32	0.31	0.07	000
49428		A	Ligation of shunt	6.79	NA	NA	2.99	3.45	0.80	010
49429		A	Removal of shunt	7.41	NA	NA	2.99	3.20	1.02	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.61	0.61	0.28	ZZZ
49436		A	Embedded ip cath exit-site	2.69	NA	NA	1.66	1.66	0.28	010
49440		A	Place gastrostomy tube perc	4.18	25.03	25.03	1.81	1.81	0.49	010
49441		A	Place duod/jej tube perc	4.77	30.10	30.10	2.00	2.00	0.29	010
49442		A	Place cecostomy tube perc	4.00	24.43	24.43	1.63	1.63	0.24	010
49446		A	Change g-tube to g-j perc	3.31	25.74	25.74	1.15	1.15	0.18	000
49450		A	Replace g/c tube perc	1.36	18.94	18.94	0.44	0.44	0.08	000
49451		A	Replace duod/jej tube perc	1.84	19.69	19.69	0.64	0.64	0.11	000
49452		A	Replace g-j tube perc	2.86	23.48	23.48	1.00	1.00	0.18	000
49460		A	Fix g/colon tube w/device	0.96	20.56	20.56	0.31	0.31	0.05	000
49465		A	Fluoro exam of g/colon tube	0.62	3.88	3.88	0.22	0.22	0.03	000
49491		A	Rpr hern preemie reduc	12.42	NA	NA	4.61	4.83	1.40	090
49492		A	Rpr ing hern premie, blocked	15.32	NA	NA	6.22	6.16	1.81	090
49495		A	Rpr ing hernia baby, reduc	6.15	NA	NA	3.06	3.01	0.74	090
49496		A	Rpr ing hernia baby, blocked	9.32	NA	NA	4.44	4.35	1.07	090
49500		A	Rpr ing hernia, init, reduce	5.76	NA	NA	3.64	3.38	0.71	090
49501		A	Rpr ing hernia, init blocked	9.28	NA	NA	4.26	4.23	1.12	090
49505		A	Prp i/hern init reduc >5 yr	7.88	NA	NA	3.88	3.81	1.03	090
49507		A	Prp i/hern init block >5 yr	9.97	NA	NA	4.45	4.45	1.27	090
49520		A	Rerepair ing hernia, reduce	9.91	NA	NA	4.37	4.40	1.28	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	NA	4.98	5.11	1.59	090
49525		A	Repair ing hernia, sliding	8.85	NA	NA	4.12	4.09	1.13	090
49540		A	Repair lumbar hernia	10.66	NA	NA	4.57	4.65	1.37	090
49550		A	Rpr rem hernia, init, reduce	8.91	NA	NA	4.11	4.11	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	4.20	4.23	1.20	090
49557		A	Rerepair fem hernia, blocked	11.54	NA	NA	4.83	4.90	1.47	090
49560		A	Rpr ventral hern init, reduc	11.84	NA	NA	4.87	5.00	1.52	090
49561		A	Rpr ventral hern init, block	15.30	NA	NA	5.79	5.92	1.89	090
49565		A	Rerepair ventrl hern, reduce	12.29	NA	NA	5.08	5.15	1.52	090
49566		A	Rerepair ventrl hern, block	15.45	NA	NA	5.85	5.98	1.91	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	1.24	1.45	0.64	ZZZ
49570		A	Rpr epigastric hern, reduce	5.97	NA	NA	3.38	3.27	0.75	090
49572		A	Rpr epigastric hern, blocked	7.79	NA	NA	3.82	3.64	0.88	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.39	NA	NA	2.94	2.77	0.54	090
49582		A	Rpr umbil hern, block < 5 yr	7.05	NA	NA	3.69	3.57	0.88	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.51	NA	NA	3.51	3.40	0.82	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	NA	3.86	3.79	0.99	090
49590		A	Repair spigelian hernia	8.82	NA	NA	4.08	4.08	1.13	090
49600		A	Repair umbilical lesion	11.47	NA	NA	5.38	5.35	1.32	090
49605		A	Repair umbilical lesion	86.85	NA	NA	27.56	28.02	9.39	090
49606		A	Repair umbilical lesion	18.92	NA	NA	6.77	7.22	2.46	090
49610		A	Repair umbilical lesion	10.83	NA	NA	5.28	5.24	1.07	090
49611		A	Repair umbilical lesion	9.26	NA	NA	4.21	5.59	0.78	090
49650		A	Laparo hernia repair initial	6.30	NA	NA	3.34	3.27	0.93	090
49651		A	Laparo hernia repair recur	8.29	NA	NA	4.22	4.13	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	6.28	6.25	1.62	090
49904		A	Omental flap, extra-abdom	22.16	NA	NA	11.88	13.54	2.70	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	1.69	1.99	0.75	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	6.73	5.97	0.93	090
50020		A	Renal abscess, open drain	17.88	NA	NA	8.48	8.11	1.34	090
50021		A	Renal abscess, percut drain	3.37	21.09	21.36	1.22	1.16	0.20	000
50040		A	Drainage of kidney	16.48	NA	NA	8.82	7.81	1.03	090
50045		A	Exploration of kidney	16.67	NA	NA	8.14	7.36	1.24	090
50060		A	Removal of kidney stone	20.80	NA	NA	10.81	9.31	1.36	090
50065		A	Incision of kidney	22.17	NA	NA	11.51	8.79	1.59	090
50070		A	Incision of kidney	21.70	NA	NA	11.32	9.76	1.44	090
50075		A	Removal of kidney stone	26.91	NA	NA	13.49	11.69	1.81	090
50080		A	Removal of kidney stone	15.61	NA	NA	8.55	7.41	1.04	090
50081		A	Removal of kidney stone	23.32	NA	NA	12.17	10.46	1.54	090
50100		A	Revise kidney blood vessels	17.30	NA	NA	6.51	7.14	2.07	090
50120		A	Exploration of kidney	17.06	NA	NA	9.11	7.93	1.21	090
50125		A	Explore and drain kidney	17.67	NA	NA	9.71	8.33	1.43	090
50130		A	Removal of kidney stone	18.67	NA	NA	10.05	8.60	1.22	090
50135		A	Exploration of kidney	20.44	NA	NA	10.69	9.23	1.33	090
50200		A	Biopsy of kidney	2.63	NA	NA	1.19	1.24	0.16	000
50205		A	Biopsy of kidney	12.19	NA	NA	5.51	5.25	1.30	090
50220		A	Remove kidney, open	18.53	NA	NA	9.51	8.37	1.35	090
50225		A	Removal kidney open, complex	21.73	NA	NA	11.01	9.57	1.50	090
50230		A	Removal kidney open, radical	23.68	NA	NA	11.64	10.10	1.55	090
50234		A	Removal of kidney & ureter	23.90	NA	NA	12.03	10.42	1.59	090
50236		A	Removal of kidney & ureter	26.74	NA	NA	13.90	12.07	1.77	090
50240		A	Partial removal of kidney	24.01	NA	NA	12.60	10.80	1.55	090
50250		A	Cryoablate renal mass open	22.06	NA	NA	11.48	10.31	1.39	090
50280		A	Removal of kidney lesion	16.94	NA	NA	9.06	7.87	1.19	090
50290		A	Removal of kidney lesion	16.00	NA	NA	7.73	7.09	1.41	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.28	NA	NA	12.30	11.47	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	1.09	1.22	0.29	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	0.98	1.08	0.26	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.05	1.09	0.25	XXX
50340		A	Removal of kidney	13.86	NA	NA	7.80	7.14	1.65	090
50360		A	Transplantation of kidney	40.45	NA	NA	18.66	17.06	3.82	090
50365		A	Transplantation of kidney	45.68	NA	NA	19.40	18.79	4.43	090
50370		A	Remove transplanted kidney	18.68	NA	NA	9.18	8.16	1.68	090
50380		A	Reimplantation of kidney	29.66	NA	NA	16.19	14.10	2.51	090
50382		A	Change ureter stent, percut	5.50	26.34	31.22	2.05	1.96	0.34	000
50384		A	Remove ureter stent, percut	5.00	20.66	27.93	1.86	1.78	0.31	000
50385		A	Change stent via transureth	4.44	30.61	30.61	2.05	2.05	0.27	000
50386		A	Remove stent via transureth	3.30	19.36	19.36	1.60	1.60	0.20	000
50387		A	Change ext/int ureter stent	2.00	12.60	15.40	0.73	0.70	0.12	000
50389		A	Remove renal tube w/fluoro	1.10	6.67	9.71	0.40	0.38	0.07	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.71	0.67	0.12	000
50391		A	Instll rx agnt into rnal tub	1.96	1.38	1.48	0.72	0.67	0.14	000
50392		A	Insert kidney drain	3.37	NA	NA	1.52	1.52	0.20	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.80	1.79	0.25	000
50394		A	Injection for kidney x-ray	0.76	1.87	2.28	0.58	0.62	0.05	000
50395		A	Create passage to kidney	3.37	NA	NA	1.56	1.53	0.21	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.08	1.08	0.13	000
50398		A	Change kidney tube	1.46	11.83	14.07	0.56	0.54	0.09	000
50400		A	Revision of kidney/ureter	21.12	NA	NA	10.94	9.40	1.38	090
50405		A	Revision of kidney/ureter	25.68	NA	NA	12.90	10.96	1.79	090
50500		A	Repair of kidney wound	21.07	NA	NA	8.69	8.53	2.02	090
50520		A	Close kidney-skin fistula	18.73	NA	NA	9.24	8.33	1.49	090
50525		A	Repair renal-abdomen fistula	24.21	NA	NA	11.79	10.39	1.84	090
50526		A	Repair renal-abdomen fistula	26.13	NA	NA	8.15	9.00	1.97	090
50540		A	Revision of horseshoe kidney	20.95	NA	NA	10.61	9.46	1.36	090
50541		A	Laparo ablate renal cyst	16.76	NA	NA	8.69	7.58	1.13	090
50542		A	Laparo ablate renal mass	21.18	NA	NA	11.17	9.65	1.39	090
50543		A	Laparo partial nephrectomy	27.18	NA	NA	14.08	12.13	1.81	090
50544		A	Laparoscopy, pyeloplasty	23.27	NA	NA	11.43	9.97	1.58	090
50545		A	Laparo radical nephrectomy	24.93	NA	NA	12.14	10.66	1.71	090
50546		A	Laparoscopic nephrectomy	21.69	NA	NA	11.28	9.81	1.57	090
50547		A	Laparo removal donor kidney	26.24	NA	NA	12.47	11.78	2.77	090
50548		A	Laparo remove w/ureter	25.26	NA	NA	12.10	10.64	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	4.59	4.36	2.64	2.31	0.40	000

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
50553	.....	A	Kidney endoscopy	5.98	4.49	4.42	2.63	2.40	0.39	000
50555	.....	A	Kidney endoscopy & biopsy	6.52	5.09	4.95	3.02	2.68	0.45	000
50557	.....	A	Kidney endoscopy & treatment	6.61	5.26	4.92	3.07	2.68	0.47	000
50561	.....	A	Kidney endoscopy & treatment	7.58	5.80	5.44	3.40	3.02	0.54	000
50562	.....	A	Renal scope w/tumor resect	10.90	NA	NA	5.36	4.83	0.73	090
50570	.....	A	Kidney endoscopy	9.53	NA	NA	4.14	3.68	0.68	000
50572	.....	A	Kidney endoscopy	10.33	NA	NA	4.31	3.90	0.85	000
50574	.....	A	Kidney endoscopy & biopsy	11.00	NA	NA	4.79	4.26	0.77	000
50575	.....	A	Kidney endoscopy	13.96	NA	NA	5.95	5.29	0.99	000
50576	.....	A	Kidney endoscopy & treatment	10.97	NA	NA	4.77	4.22	0.78	000
50580	.....	A	Kidney endoscopy & treatment	11.84	NA	NA	5.09	4.52	0.83	000
50590	.....	A	Fragmenting of kidney stone	9.64	17.08	14.73	6.12	5.11	0.65	090
50592	.....	A	Perc rf ablate renal tumor	6.77	75.40	112.17	3.00	2.99	0.43	010
50593	.....	A	Perc cryo ablate renal tum	9.08	114.48	114.48	3.44	3.44	0.58	010
50600	.....	A	Exploration of ureter	17.04	NA	NA	8.50	7.58	1.13	090
50605	.....	A	Insert ureteral support	16.66	NA	NA	7.88	7.31	1.45	090
50610	.....	A	Removal of ureter stone	17.12	NA	NA	8.97	7.96	1.43	090
50620	.....	A	Removal of ureter stone	16.30	NA	NA	8.87	7.60	1.07	090
50630	.....	A	Removal of ureter stone	16.08	NA	NA	8.19	7.23	1.09	090
50650	.....	A	Removal of ureter	18.67	NA	NA	9.95	8.58	1.23	090
50660	.....	A	Removal of ureter	20.87	NA	NA	10.72	9.33	1.38	090
50684	.....	A	Injection for ureter x-ray	0.76	3.96	4.46	0.63	0.55	0.05	000
50686	.....	A	Measure ureter pressure	1.51	2.29	2.87	0.81	0.82	0.11	000
50688	.....	A	Change of ureter tube/stent	1.18	NA	NA	0.95	1.00	0.07	010
50690	.....	A	Injection for ureter x-ray	1.16	1.45	1.64	0.75	0.73	0.07	000
50700	.....	A	Revision of ureter	16.54	NA	NA	8.75	7.93	1.27	090
50715	.....	A	Release of ureter	20.49	NA	NA	8.53	8.63	2.14	090
50722	.....	A	Release of ureter	17.80	NA	NA	7.26	7.53	1.91	090
50725	.....	A	Release/revise ureter	20.05	NA	NA	8.81	8.42	1.52	090
50727	.....	A	Revise ureter	8.17	NA	NA	5.72	5.00	0.61	090
50728	.....	A	Revise ureter	12.00	NA	NA	6.74	6.15	1.00	090
50740	.....	A	Fusion of ureter & kidney	19.92	NA	NA	8.96	8.34	1.97	090
50750	.....	A	Fusion of ureter & kidney	21.07	NA	NA	11.07	9.52	1.38	090
50760	.....	A	Fusion of ureters	19.92	NA	NA	9.88	8.77	1.55	090
50770	.....	A	Splicing of ureters	21.07	NA	NA	10.87	9.41	1.45	090
50780	.....	A	Reimplant ureter in bladder	19.80	NA	NA	10.10	8.84	1.51	090
50782	.....	A	Reimplant ureter in bladder	19.51	NA	NA	9.88	9.32	1.61	090
50783	.....	A	Reimplant ureter in bladder	20.52	NA	NA	10.11	9.15	1.99	090
50785	.....	A	Reimplant ureter in bladder	22.08	NA	NA	11.18	9.73	1.45	090
50800	.....	A	Implant ureter in bowel	16.23	NA	NA	9.16	7.81	1.19	090
50810	.....	A	Fusion of ureter & bowel	22.38	NA	NA	10.56	9.82	2.32	090
50815	.....	A	Urine shunt to intestine	22.06	NA	NA	11.45	9.94	1.54	090
50820	.....	A	Construct bowel bladder	23.89	NA	NA	11.84	10.24	1.90	090
50825	.....	A	Construct bowel bladder	30.48	NA	NA	14.89	13.00	2.08	090
50830	.....	A	Revise urine flow	33.57	NA	NA	15.60	13.88	2.38	090
50840	.....	A	Replace ureter by bowel	22.19	NA	NA	11.92	10.16	1.47	090
50845	.....	A	Appendico-vesicostomy	22.21	NA	NA	12.05	10.47	1.57	090
50860	.....	A	Transplant ureter to skin	16.93	NA	NA	9.21	7.91	1.29	090
50900	.....	A	Repair of ureter	14.89	NA	NA	7.98	7.06	1.14	090
50920	.....	A	Closure ureter/skin fistula	15.66	NA	NA	8.51	7.54	1.01	090
50930	.....	A	Closure ureter/bowel fistula	20.04	NA	NA	9.48	8.72	1.28	090
50940	.....	A	Release of ureter	15.78	NA	NA	7.78	7.08	1.26	090
50945	.....	A	Laparoscopy ureterolithotomy	17.87	NA	NA	9.28	8.15	1.36	090
50947	.....	A	Laparo new ureter/bladder	25.63	NA	NA	12.28	10.98	2.17	090
50948	.....	A	Laparo new ureter/bladder	23.69	NA	NA	11.17	9.93	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	4.82	4.55	2.76	2.40	0.41	000
50953	.....	A	Endoscopy of ureter	6.23	4.92	4.66	3.21	2.79	0.43	000
50955	.....	A	Ureter endoscopy & biopsy	6.74	5.14	5.77	3.45	3.06	0.48	000
50957	.....	A	Ureter endoscopy & treatment	6.78	5.37	4.96	3.14	2.75	0.48	000
50961	.....	A	Ureter endoscopy & treatment	6.04	4.74	4.55	2.79	2.48	0.41	000
50970	.....	A	Ureter endoscopy	7.13	NA	NA	3.24	2.85	0.52	000
50972	.....	A	Ureter endoscopy & catheter	6.88	NA	NA	3.05	2.76	0.49	000
50974	.....	A	Ureter endoscopy & biopsy	9.16	NA	NA	3.76	3.43	0.64	000
50976	.....	A	Ureter endoscopy & treatment	9.03	NA	NA	3.85	3.45	0.66	000
50980	.....	A	Ureter endoscopy & treatment	6.84	NA	NA	3.12	2.75	0.48	000
51020	.....	A	Incise & treat bladder	7.56	NA	NA	5.38	4.62	0.47	090
51030	.....	A	Incise & treat bladder	7.68	NA	NA	4.89	4.43	0.58	090
51040	.....	A	Incise & drain bladder	4.43	NA	NA	3.68	3.22	0.31	090
51045	.....	A	Incise bladder/drain ureter	7.68	NA	NA	5.14	4.53	0.52	090
51050	.....	A	Removal of bladder stone	7.87	NA	NA	5.32	4.48	0.49	090
51060	.....	A	Removal of ureter stone	9.82	NA	NA	6.42	5.45	0.62	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
51065		A	Remove ureter calculus	9.82	NA	NA	6.24	5.29	0.63	090
51080		A	Drainage of bladder abscess	6.61	NA	NA	4.60	4.07	0.43	090
51100		A	Drain bladder by needle	0.78	0.92	0.92	0.27	0.27	0.05	000
51101		A	Drain bladder by trocar/cath	1.02	2.40	2.40	0.34	0.34	0.10	000
51102		A	Drain bl w/cath insertion	4.27	4.74	4.74	2.36	2.36	0.28	010
51500		A	Removal of bladder cyst	10.92	NA	NA	5.75	5.37	1.03	090
51520		A	Removal of bladder lesion	10.08	NA	NA	6.31	5.48	0.69	090
51525		A	Removal of bladder lesion	15.29	NA	NA	8.46	7.29	0.99	090
51530		A	Removal of bladder lesion	13.58	NA	NA	7.38	6.56	1.05	090
51535		A	Repair of ureter lesion	13.77	NA	NA	7.37	6.74	1.23	090
51550		A	Partial removal of bladder	17.10	NA	NA	8.70	7.71	1.31	090
51555		A	Partial removal of bladder	23.03	NA	NA	11.34	10.00	1.70	090
51565		A	Revise bladder & ureter(s)	23.50	NA	NA	12.11	10.53	1.63	090
51570		A	Removal of bladder	27.31	NA	NA	13.48	11.60	1.72	090
51575		A	Removal of bladder & nodes	34.00	NA	NA	16.43	14.22	2.17	090
51580		A	Remove bladder/revise tract	35.14	NA	NA	17.57	15.02	2.25	090
51585		A	Removal of bladder & nodes	39.41	NA	NA	19.24	16.46	2.49	090
51590		A	Remove bladder/revise tract	36.15	NA	NA	17.22	14.91	2.28	090
51595		A	Remove bladder/revise tract	41.12	NA	NA	19.56	16.83	2.60	090
51596		A	Remove bladder/create pouch	44.01	NA	NA	21.18	18.19	2.78	090
51597		A	Removal of pelvic structures	42.61	NA	NA	20.17	17.49	2.82	090
51600		A	Injection for bladder x-ray	0.88	4.23	4.64	0.32	0.31	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.43	0.39	0.04	000
51610		A	Injection for bladder x-ray	1.05	1.91	2.10	0.70	0.65	0.07	000
51700		A	Irrigation of bladder	0.88	1.50	1.55	0.34	0.31	0.06	000
51701		A	Insert bladder catheter	0.50	1.04	1.31	0.24	0.22	0.04	000
51702		A	Insert temp bladder cath	0.50	1.53	1.80	0.33	0.29	0.04	000
51703		A	Insert bladder cath, complex	1.47	2.26	2.49	0.80	0.68	0.10	000
51705		A	Change of bladder tube	1.03	2.02	2.15	0.84	0.73	0.07	010
51710		A	Change of bladder tube	1.50	2.72	3.03	1.17	0.97	0.11	010
51715		A	Endoscopic injection/implant	3.73	4.41	4.15	1.72	1.54	0.29	000
51720		A	Treatment of bladder lesion	1.50	1.61	1.68	0.74	0.71	0.14	000
51725		A	Simple cystometrogram	1.51	4.22	4.90	NA	NA	0.16	000
51725	TC	A	Simple cystometrogram	0.00	3.67	4.38	NA	NA	0.04	000
51725	26	A	Simple cystometrogram	1.51	0.55	0.52	0.55	0.52	0.12	000
51726		A	Complex cystometrogram	1.71	7.11	7.30	NA	NA	0.18	000
51726	TC	A	Complex cystometrogram	0.00	6.47	6.70	NA	NA	0.05	000
51726	26	A	Complex cystometrogram	1.71	0.64	0.60	0.64	0.60	0.13	000
51736		A	Urine flow measurement	0.61	0.94	0.76	NA	NA	0.06	000
51736	TC	A	Urine flow measurement	0.00	0.70	0.54	NA	NA	0.01	000
51736	26	A	Urine flow measurement	0.61	0.24	0.22	0.24	0.22	0.05	000
51741		A	Electro-uroflowmetry, first	1.14	1.27	1.02	NA	NA	0.11	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.83	0.62	NA	NA	0.02	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.44	0.40	0.44	0.40	0.09	000
51772		A	Urethra pressure profile	1.61	5.06	5.31	NA	NA	0.20	000
51772	TC	A	Urethra pressure profile	0.00	4.51	4.76	NA	NA	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	4.12	4.05	NA	NA	0.16	000
51784	TC	A	Anal/urinary muscle study	0.00	3.56	3.52	NA	NA	0.04	000
51784	26	A	Anal/urinary muscle study	1.53	0.56	0.53	0.56	0.53	0.12	000
51785		A	Anal/urinary muscle study	1.53	4.55	4.49	NA	NA	0.15	000
51785	TC	A	Anal/urinary muscle study	0.00	3.99	3.96	NA	NA	0.04	000
51785	26	A	Anal/urinary muscle study	1.53	0.56	0.53	0.56	0.53	0.11	000
51792		A	Urinary reflex study	1.10	5.05	5.52	NA	NA	0.20	000
51792	TC	A	Urinary reflex study	0.00	4.66	5.12	NA	NA	0.13	000
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	6.72	7.00	NA	NA	0.22	000
51795	TC	A	Urine voiding pressure study	0.00	6.15	6.47	NA	NA	0.10	000
51795	26	A	Urine voiding pressure study	1.53	0.57	0.53	0.57	0.53	0.12	000
51797		A	Intraabdominal pressure test	0.80	2.43	4.11	NA	NA	0.17	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	2.14	3.70	NA	NA	0.05	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.29	0.41	0.29	0.41	0.12	ZZZ
51798		A	Us urine capacity measure	0.00	0.59	0.47	NA	NA	0.08	XXX
51800		A	Revision of bladder/urethra	18.74	NA	NA	9.71	8.63	1.32	090
51820		A	Revision of urinary tract	19.41	NA	NA	9.74	9.01	1.75	090
51840		A	Attach bladder/urethra	11.28	NA	NA	5.75	5.66	1.06	090
51841		A	Attach bladder/urethra	13.60	NA	NA	6.85	6.61	1.24	090
51845		A	Repair bladder neck	10.07	NA	NA	5.88	5.31	0.79	090
51860		A	Repair of bladder wound	12.49	NA	NA	6.73	6.24	1.16	090
51865		A	Repair of bladder wound	15.69	NA	NA	8.32	7.49	1.23	090
51880		A	Repair of bladder opening	7.81	NA	NA	4.72	4.34	0.72	090
51900		A	Repair bladder/vagina lesion	14.48	NA	NA	7.97	7.01	1.21	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
51920	.....	A	Close bladder-uterus fistula	13.26	NA	NA	8.03	6.83	1.18	090
51925	.....	A	Hysterectomy/bladder repair	17.35	NA	NA	12.40	10.50	2.04	090
51940	.....	A	Correction of bladder defect	30.48	NA	NA	11.72	11.89	2.15	090
51960	.....	A	Revision of bladder & bowel	25.20	NA	NA	12.88	11.25	1.63	090
51980	.....	A	Construct bladder opening	12.44	NA	NA	7.06	6.21	0.86	090
51990	.....	A	Laparo urethral suspension	13.26	NA	NA	5.92	6.03	1.39	090
51992	.....	A	Laparo sling operation	14.77	NA	NA	6.51	6.35	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	3.66	3.48	1.31	1.03	0.14	000
52001	.....	A	Cystoscopy, removal of clots	5.44	5.04	5.05	2.56	2.21	0.39	000
52005	.....	A	Cystoscopy & ureter catheter	2.37	5.73	5.64	1.37	1.13	0.17	000
52007	.....	A	Cystoscopy and biopsy	3.02	10.70	13.57	1.61	1.38	0.22	000
52010	.....	A	Cystoscopy & duct catheter	3.02	8.07	9.41	1.62	1.38	0.21	000
52204	.....	A	Cystoscopy w/biopsy(s)	2.59	8.30	11.40	1.37	1.14	0.17	000
52214	.....	A	Cystoscopy and treatment	3.70	19.87	28.97	1.83	1.58	0.26	000
52224	.....	A	Cystoscopy and treatment	3.14	19.05	27.74	1.60	1.37	0.22	000
52234	.....	A	Cystoscopy and treatment	4.62	NA	NA	2.27	1.96	0.33	000
52235	.....	A	Cystoscopy and treatment	5.44	NA	NA	2.63	2.28	0.39	000
52240	.....	A	Cystoscopy and treatment	9.71	NA	NA	4.34	3.82	0.69	000
52250	.....	A	Cystoscopy and radiotracer	4.49	NA	NA	2.29	1.97	0.32	000
52260	.....	A	Cystoscopy and treatment	3.91	NA	NA	1.93	1.67	0.28	000
52265	.....	A	Cystoscopy and treatment	2.94	7.48	10.41	1.46	1.28	0.22	000
52270	.....	A	Cystoscopy & revise urethra	3.36	7.02	9.02	1.74	1.49	0.24	000
52275	.....	A	Cystoscopy & revise urethra	4.69	9.29	12.42	2.27	1.96	0.33	000
52276	.....	A	Cystoscopy and treatment	4.99	NA	NA	2.44	2.11	0.35	000
52277	.....	A	Cystoscopy and treatment	6.16	NA	NA	2.90	2.56	0.44	000
52281	.....	A	Cystoscopy and treatment	2.80	5.28	6.18	1.54	1.31	0.20	000
52282	.....	A	Cystoscopy, implant stent	6.39	NA	NA	2.95	2.59	0.45	000
52283	.....	A	Cystoscopy and treatment	3.73	4.06	4.00	1.86	1.62	0.26	000
52285	.....	A	Cystoscopy and treatment	3.60	4.32	4.16	1.83	1.58	0.26	000
52290	.....	A	Cystoscopy and treatment	4.58	NA	NA	2.26	1.95	0.32	000
52300	.....	A	Cystoscopy and treatment	5.30	NA	NA	2.55	2.23	0.38	000
52301	.....	A	Cystoscopy and treatment	5.50	NA	NA	2.68	2.33	0.46	000
52305	.....	A	Cystoscopy and treatment	5.30	NA	NA	2.48	2.17	0.38	000
52310	.....	A	Cystoscopy and treatment	2.81	4.00	4.34	1.42	1.23	0.20	000
52315	.....	A	Cystoscopy and treatment	5.20	6.62	7.64	2.47	2.15	0.37	000
52317	.....	A	Remove bladder stone	6.71	17.04	22.98	2.99	2.63	0.48	000
52318	.....	A	Remove bladder stone	9.18	NA	NA	4.03	3.56	0.65	000
52320	.....	A	Cystoscopy and treatment	4.69	NA	NA	2.20	1.91	0.33	000
52325	.....	A	Cystoscopy, stone removal	6.15	NA	NA	2.78	2.44	0.44	000
52327	.....	A	Cystoscopy, inject material	5.18	2.04	16.92	2.04	1.93	0.37	000
52330	.....	A	Cystoscopy and treatment	5.03	20.39	29.59	2.34	2.05	0.36	000
52332	.....	A	Cystoscopy and treatment	2.83	12.41	9.07	1.55	1.30	0.21	000
52334	.....	A	Create passage to kidney	4.82	NA	NA	2.33	2.03	0.35	000
52341	.....	A	Cysto w/ureter stricture tx	6.11	NA	NA	3.03	2.62	0.43	000
52342	.....	A	Cysto w/up stricture tx	6.61	NA	NA	3.25	2.80	0.46	000
52343	.....	A	Cysto w/renal stricture tx	7.31	NA	NA	3.48	3.03	0.51	000
52344	.....	A	Cysto/uretero, stricture tx	7.81	NA	NA	3.90	3.34	0.55	000
52345	.....	A	Cysto/uretero w/up stricture	8.31	NA	NA	4.10	3.53	0.58	000
52346	.....	A	Cystouretero w/renal strict	9.34	NA	NA	4.50	3.89	0.65	000
52351	.....	A	Cystouretero & or pyeloscope	5.85	NA	NA	2.95	2.55	0.41	000
52352	.....	A	Cystouretero w/stone remove	6.87	NA	NA	3.46	2.98	0.49	000
52353	.....	A	Cystouretero w/lithotripsy	7.96	NA	NA	3.90	3.37	0.57	000
52354	.....	A	Cystouretero w/biopsy	7.33	NA	NA	3.64	3.15	0.52	000
52355	.....	A	Cystouretero w/excise tumor	8.81	NA	NA	4.24	3.69	0.63	000
52400	.....	A	Cystouretero w/congen repr	10.06	NA	NA	5.39	4.56	0.68	090
52402	.....	A	Cystourethro cut ejacul duct	5.27	NA	NA	2.15	1.92	0.40	000
52450	.....	A	Incision of prostate	7.63	NA	NA	5.47	4.57	0.54	090
52500	.....	A	Revision of bladder neck	9.39	NA	NA	6.17	5.04	0.60	090
52601	.....	A	Prostatectomy (TURP)	15.13	NA	NA	8.42	6.75	0.87	090
52606	.....	A	Control postop bleeding	8.84	NA	NA	5.47	4.51	0.57	090
52612	.....	A	Prostatectomy, first stage	9.07	NA	NA	5.87	4.80	0.56	090
52614	.....	A	Prostatectomy, second stage	7.81	NA	NA	5.37	4.35	0.48	090
52620	.....	A	Remove residual prostate	7.19	NA	NA	4.61	3.79	0.47	090
52630	.....	A	Remove prostate regrowth	7.65	NA	NA	4.79	3.99	0.51	090
52640	.....	A	Relieve bladder contracture	6.89	NA	NA	4.41	3.68	0.47	090
52647	.....	A	Laser surgery of prostate	11.15	41.90	57.90	6.88	5.70	0.73	090
52648	.....	A	Laser surgery of prostate	12.00	42.44	58.17	7.21	6.00	0.79	090
52649	.....	A	2Prostate laser enucleation	17.16	NA	NA	9.31	9.31	1.11	090
52700	.....	A	Drainage of prostate abscess	7.39	NA	NA	4.89	4.04	0.48	090
53000	.....	A	Incision of urethra	2.30	NA	NA	1.78	1.66	0.16	010
53010	.....	A	Incision of urethra	4.35	NA	NA	3.83	3.37	0.24	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
53020		A	Incision of urethra	1.77	NA	NA	0.95	0.81	0.13	000
53025		A	Incision of urethra	1.13	NA	NA	0.82	0.66	0.08	000
53040		A	Drainage of urethra abscess	6.49	NA	NA	4.40	3.91	0.45	090
53060		A	Drainage of urethra abscess	2.65	2.09	2.09	1.54	1.45	0.28	010
53080		A	Drainage of urinary leakage	6.82	NA	NA	4.96	5.46	0.52	090
53085		A	Drainage of urinary leakage	11.05	NA	NA	4.41	5.90	0.92	090
53200		A	Biopsy of urethra	2.59	1.70	1.51	1.29	1.13	0.20	000
53210		A	Removal of urethra	13.59	NA	NA	7.75	6.79	0.89	090
53215		A	Removal of urethra	16.72	NA	NA	9.11	7.87	1.10	090
53220		A	Treatment of urethra lesion	7.53	NA	NA	4.97	4.34	0.49	090
53230		A	Removal of urethra lesion	10.31	NA	NA	6.36	5.53	0.73	090
53235		A	Removal of urethra lesion	10.86	NA	NA	6.92	5.90	0.72	090
53240		A	Surgery for urethra pouch	6.98	NA	NA	4.86	4.19	0.52	090
53250		A	Removal of urethra gland	6.42	NA	NA	4.38	3.83	0.49	090
53260		A	Treatment of urethra lesion	3.00	2.45	2.35	1.83	1.62	0.25	010
53265		A	Treatment of urethra lesion	3.14	2.93	2.82	1.98	1.70	0.24	010
53270		A	Removal of urethra gland	3.11	2.46	2.33	1.84	1.69	0.30	010
53275		A	Repair of urethra defect	4.54	NA	NA	2.76	2.51	0.32	010
53400		A	Revise urethra, stage 1	13.98	NA	NA	8.16	7.09	0.98	090
53405		A	Revise urethra, stage 2	15.51	NA	NA	8.68	7.49	1.10	090
53410		A	Reconstruction of urethra	17.53	NA	NA	9.66	8.35	1.16	090
53415		A	Reconstruction of urethra	20.55	NA	NA	10.68	9.00	1.37	090
53420		A	Reconstruct urethra, stage 1	15.04	NA	NA	7.11	6.69	0.96	090
53425		A	Reconstruct urethra, stage 2	16.94	NA	NA	8.99	7.93	1.13	090
53430		A	Reconstruction of urethra	17.30	NA	NA	8.80	7.89	1.15	090
53431		A	Reconstruct urethra/bladder	21.03	NA	NA	10.97	9.50	1.41	090
53440		A	Male sling procedure	15.34	NA	NA	9.18	7.57	0.96	090
53442		A	Remove/revise male sling	13.29	NA	NA	8.35	6.89	0.82	090
53444		A	Insert tandem cuff	14.06	NA	NA	8.01	6.94	0.94	090
53445		A	Insert uro/ves nck sphincter	15.21	NA	NA	8.74	7.91	0.99	090
53446		A	Remove uro sphincter	10.89	NA	NA	6.99	6.10	0.72	090
53447		A	Remove/replace ur sphincter	14.15	NA	NA	8.37	7.39	0.95	090
53448		A	Remov/replc ur sphinctr comp	23.26	NA	NA	12.31	10.67	1.50	090
53449		A	Repair uro sphincter	10.43	NA	NA	6.60	5.66	0.68	090
53450		A	Revision of urethra	6.67	NA	NA	4.75	4.02	0.43	090
53460		A	Revision of urethra	7.65	NA	NA	5.04	4.36	0.50	090
53500		A	Urethrlys, transvag w/ scope	12.87	NA	NA	7.40	6.80	0.90	090
53502		A	Repair of urethra injury	8.16	NA	NA	5.10	4.54	0.62	090
53505		A	Repair of urethra injury	8.16	NA	NA	5.37	4.62	0.54	090
53510		A	Repair of urethra injury	10.83	NA	NA	6.82	5.99	0.74	090
53515		A	Repair of urethra injury	14.09	NA	NA	7.95	6.94	1.05	090
53520		A	Repair of urethra defect	9.35	NA	NA	6.20	5.33	0.61	090
53600		A	Dilate urethra stricture	1.21	1.15	1.14	0.57	0.50	0.09	000
53601		A	Dilate urethra stricture	0.98	1.36	1.31	0.52	0.44	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.51	0.46	0.09	000
53620		A	Dilate urethra stricture	1.62	1.70	1.84	0.83	0.71	0.11	000
53621		A	Dilate urethra stricture	1.35	1.81	1.94	0.67	0.58	0.10	000
53660		A	Dilation of urethra	0.71	1.32	1.31	0.45	0.38	0.05	000
53661		A	Dilation of urethra	0.72	1.29	1.29	0.41	0.35	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	49.19	71.60	5.86	4.90	0.67	090
53852		A	Prostatic rf thermotx	10.68	46.31	67.52	6.65	5.51	0.70	090
53853		A	Prostatic water thermother	5.54	29.06	42.19	4.34	3.60	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	2.69	2.80	1.48	1.20	0.11	010
54001		A	Slitting of prepuce	2.21	3.05	3.12	1.67	1.39	0.15	010
54015		A	Drain penis lesion	5.33	NA	NA	3.21	2.88	0.38	010
54050		A	Destruction, penis lesion(s)	1.26	2.10	1.87	1.39	1.21	0.08	010
54055		A	Destruction, penis lesion(s)	1.23	1.97	1.77	1.23	1.01	0.08	010
54056		A	Cryosurgery, penis lesion(s)	1.26	2.37	2.03	1.53	1.33	0.06	010
54057		A	Laser surg, penis lesion(s)	1.26	2.63	2.42	1.36	1.10	0.09	010
54060		A	Excision of penis lesion(s)	1.95	3.08	3.09	1.63	1.34	0.13	010
54065		A	Destruction, penis lesion(s)	2.44	3.29	2.96	1.99	1.61	0.13	010
54100		A	Biopsy of penis	1.90	3.34	3.07	1.36	1.09	0.10	000
54105		A	Biopsy of penis	3.51	3.97	4.12	2.43	2.18	0.25	010
54110		A	Treatment of penis lesion	10.79	NA	NA	6.71	5.73	0.72	090
54111		A	Treat penis lesion, graft	14.29	NA	NA	8.02	6.89	0.96	090
54112		A	Treat penis lesion, graft	16.83	NA	NA	9.30	8.04	1.11	090
54115		A	Treatment of penis lesion	6.82	5.75	5.06	4.94	4.19	0.43	090
54120		A	Partial removal of penis	10.88	NA	NA	6.72	5.69	0.68	090
54125		A	Removal of penis	14.43	NA	NA	8.06	6.94	0.95	090
54130		A	Remove penis & nodes	21.66	NA	NA	11.56	9.86	1.52	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
54135		A	Remove penis & nodes	27.99	NA	NA	14.10	12.13	1.88	090
54150		A	Circumcision w/regionl block	1.90	2.39	3.13	0.73	0.72	0.16	000
54160		A	Circumcision, neonate	2.50	3.80	3.97	1.48	1.28	0.19	010
54161		A	Circum 28 days or older	3.29	NA	NA	2.20	1.88	0.23	010
54162		A	Lysis penil circumic lesion	3.27	4.00	4.32	2.26	1.85	0.21	010
54163		A	Repair of circumcision	3.27	NA	NA	2.85	2.43	0.21	010
54164		A	Frenulotomy of penis	2.77	NA	NA	2.65	2.24	0.18	010
54200		A	Treatment of penis lesion	1.08	2.01	1.90	1.30	1.13	0.08	010
54205		A	Treatment of penis lesion	8.84	NA	NA	6.05	5.36	0.56	090
54220		A	Treatment of penis lesion	2.42	3.31	3.58	1.35	1.15	0.17	000
54230		A	Prepare penis study	1.34	1.40	1.24	0.90	0.77	0.09	000
54231		A	Dynamic cavernosometry	2.04	1.97	1.67	1.24	1.06	0.16	000
54235		A	Penile injection	1.19	1.39	1.17	0.89	0.73	0.08	000
54240		A	Penis study	1.31	1.51	1.26	NA	NA	0.17	000
54240	TC	A	Penis study	0.00	1.03	0.81	NA	NA	0.06	000
54240	26	A	Penis study	1.31	0.48	0.45	0.48	0.45	0.11	000
54250		A	Penis study	2.22	1.22	1.06	NA	NA	0.18	000
54250	TC	A	Penis study	0.00	0.37	0.28	NA	NA	0.02	000
54250	26	A	Penis study	2.22	0.85	0.78	0.85	0.78	0.16	000
54300		A	Revision of penis	11.07	NA	NA	6.70	6.13	0.76	090
54304		A	Revision of penis	13.15	NA	NA	7.79	7.05	0.88	090
54308		A	Reconstruction of urethra	12.49	NA	NA	4.75	5.35	0.84	090
54312		A	Reconstruction of urethra	14.36	NA	NA	8.86	7.92	1.24	090
54316		A	Reconstruction of urethra	17.90	NA	NA	9.93	8.93	1.21	090
54318		A	Reconstruction of urethra	12.28	NA	NA	4.83	5.30	1.39	090
54322		A	Reconstruction of urethra	13.85	NA	NA	7.93	7.19	0.92	090
54324		A	Reconstruction of urethra	17.40	NA	NA	9.74	8.84	1.14	090
54326		A	Reconstruction of urethra	16.87	NA	NA	9.15	8.46	1.11	090
54328		A	Revise penis/urethra	16.74	NA	NA	9.47	8.35	0.98	090
54332		A	Revise penis/urethra	18.22	NA	NA	10.06	8.88	1.21	090
54336		A	Revise penis/urethra	21.44	NA	NA	7.31	8.79	2.21	090
54340		A	Secondary urethral surgery	9.58	NA	NA	6.35	5.69	0.63	090
54344		A	Secondary urethral surgery	16.91	NA	NA	9.53	8.63	1.54	090
54348		A	Secondary urethral surgery	18.17	NA	NA	10.12	9.22	1.23	090
54352		A	Reconstruct urethra/penis	25.95	NA	NA	13.98	12.57	2.25	090
54360		A	Penis plastic surgery	12.65	NA	NA	7.44	6.73	0.84	090
54380		A	Repair penis	14.03	NA	NA	8.03	7.32	0.93	090
54385		A	Repair penis	16.38	NA	NA	11.29	9.77	0.86	090
54390		A	Repair penis and bladder	22.59	NA	NA	7.41	8.41	1.54	090
54400		A	Insert semi-rigid prosthesis	9.09	NA	NA	5.74	5.04	0.64	090
54401		A	Insert self-contd prosthesis	10.26	NA	NA	8.14	6.93	0.73	090
54405		A	Insert multi-comp penis pros	14.39	NA	NA	8.11	7.01	0.95	090
54406		A	Remove muti-comp penis pros	12.76	NA	NA	7.59	6.50	0.86	090
54408		A	Repair multi-comp penis pros	13.73	NA	NA	8.24	6.98	0.90	090
54410		A	Remove/replace penis prosth	16.48	NA	NA	9.34	7.97	1.10	090
54411		A	Remov/replc penis pros, comp	18.14	NA	NA	10.39	8.71	1.13	090
54415		A	Remove self-contd penis pros	8.75	NA	NA	6.00	5.09	0.58	090
54416		A	Remv/repl penis contain pros	11.87	NA	NA	7.89	6.63	0.77	090
54417		A	Remv/replc penis pros, compl	15.94	NA	NA	9.09	7.63	1.00	090
54420		A	Revision of penis	12.26	NA	NA	7.38	6.47	0.81	090
54430		A	Revision of penis	10.93	NA	NA	6.96	6.03	0.72	090
54435		A	Revision of penis	6.71	NA	NA	4.99	4.30	0.43	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.85	0.90	0.48	0.46	0.08	000
54500		A	Biopsy of testis	1.31	NA	NA	0.76	0.66	0.10	000
54505		A	Biopsy of testis	3.47	NA	NA	2.44	2.18	0.27	010
54512		A	Excise lesion testis	9.23	NA	NA	5.66	4.89	0.67	090
54520		A	Removal of testis	5.25	NA	NA	3.71	3.25	0.50	090
54522		A	Orchiectomy, partial	10.15	NA	NA	5.58	5.22	0.89	090
54530		A	Removal of testis	9.31	NA	NA	6.05	5.14	0.66	090
54535		A	Extensive testis surgery	13.06	NA	NA	6.90	6.22	0.95	090
54550		A	Exploration for testis	8.31	NA	NA	5.20	4.50	0.59	090
54560		A	Exploration for testis	11.97	NA	NA	6.87	6.00	0.90	090
54600		A	Reduce testis torsion	7.54	NA	NA	5.11	4.32	0.51	090
54620		A	Suspension of testis	5.16	NA	NA	3.22	2.82	0.37	010
54640		A	Suspension of testis	7.57	NA	NA	5.34	4.53	0.62	090
54650		A	Orchiopexy (Fowler-Stephens)	12.24	NA	NA	5.65	5.52	1.16	090
54660		A	Revision of testis	5.64	NA	NA	4.34	3.67	0.44	090
54670		A	Repair testis injury	6.57	NA	NA	4.79	4.16	0.47	090
54680		A	Relocation of testis(es)	13.91	NA	NA	7.69	6.92	1.16	090
54690		A	Laparoscopy, orchiectomy	11.60	NA	NA	5.58	5.25	1.02	090
54692		A	Laparoscopy, orchiopexy	13.64	NA	NA	7.55	6.49	1.30	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	2.37	2.15	0.28	010
54800		A	Biopsy of epididymis	2.33	NA	NA	1.22	1.06	0.23	000
54830		A	Remove epididymis lesion	5.91	NA	NA	4.43	3.72	0.41	090
54840		A	Remove epididymis lesion	5.22	NA	NA	3.79	3.28	0.37	090
54860		A	Removal of epididymis	6.85	NA	NA	4.86	4.08	0.45	090
54861		A	Removal of epididymis	9.57	NA	NA	6.24	5.27	0.63	090
54865		A	Explore epididymis	5.67	NA	NA	4.26	3.59	0.40	090
54900		A	Fusion of spermatic ducts	14.05	NA	NA	5.24	5.51	0.93	090
54901		A	Fusion of spermatic ducts	18.92	NA	NA	10.50	9.00	1.83	090
55000		A	Drainage of hydrocele	1.43	1.85	1.96	0.91	0.78	0.11	000
55040		A	Removal of hydrocele	5.39	NA	NA	3.95	3.42	0.43	090
55041		A	Removal of hydroceles	8.41	NA	NA	5.68	4.82	0.60	090
55060		A	Repair of hydrocele	6.05	NA	NA	4.45	3.76	0.46	090
55100		A	Drainage of scrotum abscess	2.40	3.49	3.58	2.10	1.83	0.17	010
55110		A	Explore scrotum	6.23	NA	NA	4.48	3.80	0.43	090
55120		A	Removal of scrotum lesion	5.62	NA	NA	4.20	3.57	0.39	090
55150		A	Removal of scrotum	8.01	NA	NA	5.44	4.63	0.56	090
55175		A	Revision of scrotum	5.77	NA	NA	4.33	3.66	0.37	090
55180		A	Revision of scrotum	11.63	NA	NA	7.26	6.31	0.90	090
55200		A	Incision of sperm duct	4.50	8.00	10.15	3.30	2.84	0.33	090
55250		A	Removal of sperm duct(s)	3.32	7.82	9.64	3.06	2.64	0.25	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.75	1.53	0.25	000
55400		A	Repair of sperm duct	8.53	NA	NA	5.40	4.73	0.64	090
55450		A	Ligation of sperm duct	4.38	5.46	6.22	2.56	2.21	0.29	010
55500		A	Removal of hydrocele	6.12	NA	NA	4.19	3.64	0.55	090
55520		A	Removal of sperm cord lesion	6.56	NA	NA	3.81	3.53	0.75	090
55530		A	Revise spermatic cord veins	5.69	NA	NA	4.08	3.54	0.45	090
55535		A	Revise spermatic cord veins	7.09	NA	NA	4.83	4.11	0.47	090
55540		A	Revise hernia & sperm veins	8.20	NA	NA	4.24	4.02	0.94	090
55550		A	Laparo ligate spermatic vein	7.10	NA	NA	4.54	3.92	0.57	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.91	NA	NA	4.90	4.11	0.62	090
55605		A	Incise sperm duct pouch	8.63	NA	NA	4.62	4.45	0.64	090
55650		A	Remove sperm duct pouch	12.52	NA	NA	7.39	6.33	0.92	090
55680		A	Remove sperm pouch lesion	5.59	NA	NA	3.92	3.44	0.47	090
55700		A	Biopsy of prostate	2.58	3.71	3.95	1.32	0.98	0.11	000
55705		A	Biopsy of prostate	4.58	NA	NA	2.85	2.57	0.32	010
55720		A	Drainage of prostate abscess	7.67	NA	NA	4.88	4.34	0.95	090
55725		A	Drainage of prostate abscess	9.90	NA	NA	6.27	5.37	0.70	090
55801		A	Removal of prostate	19.62	NA	NA	10.33	8.96	1.34	090
55810		A	Extensive prostate surgery	24.14	NA	NA	12.33	10.62	1.60	090
55812		A	Extensive prostate surgery	29.69	NA	NA	14.19	12.57	2.05	090
55815		A	Extensive prostate surgery	32.75	NA	NA	16.18	14.02	2.17	090
55821		A	Removal of prostate	15.63	NA	NA	8.66	7.43	1.01	090
55831		A	Removal of prostate	17.06	NA	NA	9.23	7.93	1.10	090
55840		A	Extensive prostate surgery	24.45	NA	NA	12.67	10.97	1.61	090
55842		A	Extensive prostate surgery	26.31	NA	NA	13.46	11.64	1.73	090
55845		A	Extensive prostate surgery	30.52	NA	NA	14.85	12.87	2.03	090
55860		A	Surgical exposure, prostate	15.71	NA	NA	8.53	7.46	1.02	090
55862		A	Extensive prostate surgery	19.89	NA	NA	10.69	9.26	1.49	090
55865		A	Extensive prostate surgery	24.39	NA	NA	12.40	10.82	1.63	090
55866		A	Laparo radical prostatectomy	32.25	NA	NA	15.94	13.82	2.17	090
55870		A	Electroejaculation	2.58	2.49	2.01	1.45	1.26	0.16	000
55873		A	Cryoablate prostate	20.25	NA	NA	11.27	10.10	1.38	090
55875		A	Transperi needle place, pros	13.31	NA	NA	7.83	6.83	0.89	090
55876		A	Place rt device/marker, pros	1.73	2.07	2.07	1.05	1.05	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	3.13	3.13	0.58	000
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.46	1.18	1.25	1.16	1.15	0.17	010
56420		A	Drainage of gland abscess	1.41	1.52	1.90	0.78	0.91	0.16	010
56440		A	Surgery for vulva lesion	2.86	NA	NA	1.56	1.63	0.34	010
56441		A	Lysis of labial lesion(s)	1.99	1.71	1.76	1.56	1.48	0.20	010
56442		A	Hymenotomy	0.68	NA	NA	0.52	0.51	0.08	000
56501		A	Destroy, vulva lesions, sim	1.55	1.63	1.71	1.21	1.22	0.18	010
56515		A	Destroy vulva lesion/s compl	3.03	2.39	2.47	1.74	1.78	0.33	010
56605		A	Biopsy of vulva/perineum	1.10	0.92	1.00	0.34	0.40	0.13	000
56606		A	Biopsy of vulva/perineum	0.55	0.36	0.42	0.15	0.19	0.07	ZZZ
56620		A	Partial removal of vulva	8.44	NA	NA	4.39	4.59	0.90	090
56625		A	Complete removal of vulva	9.55	NA	NA	4.81	5.06	1.02	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
56630		A	Extensive vulva surgery	14.67	NA	NA	6.28	6.55	1.49	090
56631		A	Extensive vulva surgery	18.81	NA	NA	7.78	8.29	1.96	090
56632		A	Extensive vulva surgery	21.61	NA	NA	9.29	9.40	2.39	090
56633		A	Extensive vulva surgery	19.47	NA	NA	7.80	8.19	1.98	090
56634		A	Extensive vulva surgery	20.48	NA	NA	8.18	8.80	2.17	090
56637		A	Extensive vulva surgery	24.57	NA	NA	9.30	10.18	2.61	090
56640		A	Extensive vulva surgery	24.65	NA	NA	8.83	9.72	2.89	090
56700		A	Partial removal of hymen	2.79	NA	NA	1.77	1.80	0.30	010
56740		A	Remove vagina gland lesion	4.83	NA	NA	2.33	2.45	0.56	010
56800		A	Repair of vagina	3.90	NA	NA	1.96	2.08	0.44	010
56805		A	Repair clitoris	19.75	NA	NA	7.68	8.54	2.15	090
56810		A	Repair of perineum	4.26	NA	NA	2.04	2.16	0.49	010
56820		A	Exam of vulva w/scope	1.50	1.19	1.25	0.53	0.59	0.18	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.53	1.64	0.68	0.79	0.25	000
57000		A	Exploration of vagina	2.99	NA	NA	1.75	1.73	0.31	010
57010		A	Drainage of pelvic abscess	6.74	NA	NA	3.80	3.80	0.71	090
57020		A	Drainage of pelvic fluid	1.50	0.77	0.85	0.45	0.52	0.18	000
57022		A	I & d vaginal hematoma, pp	2.70	NA	NA	1.42	1.45	0.26	010
57023		A	I & d vag hematoma, non-ob	5.13	NA	NA	2.37	2.47	0.58	010
57061		A	Destroy vag lesions, simple	1.27	1.52	1.58	1.11	1.12	0.15	010
57065		A	Destroy vag lesions, complex	2.63	2.02	2.16	1.49	1.58	0.31	010
57100		A	Biopsy of vagina	1.20	0.95	1.01	0.37	0.42	0.14	000
57105		A	Biopsy of vagina	1.71	1.59	1.69	1.33	1.37	0.20	010
57106		A	Remove vagina wall, partial	7.35	NA	NA	4.27	4.22	0.73	090
57107		A	Remove vagina tissue, part	24.43	NA	NA	9.05	9.75	2.72	090
57109		A	Vaginectomy partial w/nodes	28.25	NA	NA	10.25	10.74	3.22	090
57110		A	Remove vagina wall, complete	15.38	NA	NA	6.19	6.73	1.74	090
57111		A	Remove vagina tissue, compl	28.25	NA	NA	10.42	11.51	3.18	090
57112		A	Vaginectomy w/nodes, compl	30.37	NA	NA	10.61	11.35	3.08	090
57120		A	Closure of vagina	8.18	NA	NA	4.19	4.39	0.89	090
57130		A	Remove vagina lesion	2.44	1.96	2.06	1.47	1.50	0.29	010
57135		A	Remove vagina lesion	2.68	2.03	2.15	1.53	1.59	0.31	010
57150		A	Treat vagina infection	0.55	0.58	0.84	0.15	0.18	0.07	000
57155		A	Insert uteri tandems/ovoids	6.79	NA	NA	3.49	4.02	0.43	090
57160		A	Insert pessary/other device	0.89	1.04	1.03	0.25	0.30	0.10	000
57170		A	Fitting of diaphragm/cap	0.91	0.57	1.02	0.25	0.29	0.11	000
57180		A	Treat vaginal bleeding	1.60	1.86	2.01	0.93	1.09	0.19	010
57200		A	Repair of vagina	4.34	NA	NA	2.99	2.94	0.46	090
57210		A	Repair vagina/perineum	5.63	NA	NA	3.27	3.35	0.62	090
57220		A	Revision of urethra	4.77	NA	NA	3.00	3.05	0.51	090
57230		A	Repair of urethral lesion	6.22	NA	NA	3.64	3.52	0.54	090
57240		A	Repair bladder & vagina	11.42	NA	NA	5.48	4.65	0.62	090
57250		A	Repair rectum & vagina	11.42	NA	NA	5.03	4.30	0.65	090
57260		A	Repair of vagina	14.36	NA	NA	5.85	5.34	0.97	090
57265		A	Extensive repair of vagina	15.86	NA	NA	6.32	6.17	1.32	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	1.49	1.73	0.64	ZZZ
57268		A	Repair of bowel bulge	7.47	NA	NA	4.33	4.26	0.79	090
57270		A	Repair of bowel pouch	13.57	NA	NA	5.83	6.04	1.42	090
57280		A	Suspension of vagina	16.62	NA	NA	6.96	7.16	1.68	090
57282		A	Colpopexy, extraperitoneal	7.84	NA	NA	4.49	4.49	1.02	090
57283		A	Colpopexy, intraperitoneal	11.58	NA	NA	5.11	5.51	1.02	090
57284		A	Repair paravag defect, open	14.25	NA	NA	5.98	6.56	1.41	090
57285		A	Repair paravag defect, vag	11.52	NA	NA	5.16	5.16	0.63	090
57287		A	Revise/remove sling repair	11.49	NA	NA	6.35	5.91	0.90	090
57288		A	Repair bladder defect	14.01	NA	NA	7.01	6.46	1.12	090
57289		A	Repair bladder & vagina	12.69	NA	NA	6.70	6.37	1.21	090
57291		A	Construction of vagina	8.54	NA	NA	4.89	4.90	0.93	090
57292		A	Construct vagina with graft	13.91	NA	NA	5.90	6.41	1.58	090
57295		A	Revise vag graft via vagina	7.74	NA	NA	4.08	4.25	0.91	090
57296		A	Revise vag graft, open abd	16.46	NA	NA	6.66	6.66	1.68	090
57300		A	Repair rectum-vagina fistula	8.58	NA	NA	4.43	4.35	0.87	090
57305		A	Repair rectum-vagina fistula	15.24	NA	NA	6.19	6.23	1.73	090
57307		A	Fistula repair & colostomy	17.02	NA	NA	6.90	6.95	2.02	090
57308		A	Fistula repair, transperine	10.48	NA	NA	4.96	5.02	1.14	090
57310		A	Repair urethrovaginal lesion	7.55	NA	NA	5.01	4.42	0.54	090
57311		A	Repair urethrovaginal lesion	8.81	NA	NA	5.51	4.81	0.65	090
57320		A	Repair bladder-vagina lesion	8.78	NA	NA	5.28	4.82	0.69	090
57330		A	Repair bladder-vagina lesion	13.11	NA	NA	7.20	6.45	1.06	090
57335		A	Repair vagina	19.87	NA	NA	7.82	8.42	1.92	090
57400		A	Dilation of vagina	2.27	NA	NA	1.00	1.05	0.26	000
57410		A	Pelvic examination	1.75	NA	NA	0.91	0.90	0.18	000
57415		A	Remove vaginal foreign body	2.44	NA	NA	1.49	1.45	0.24	010

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
57420		A	Exam of vagina w/scope	1.60	1.23	1.29	0.56	0.61	0.19	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.59	1.72	0.72	0.84	0.27	000
57423		A	Repair paravag defect, lap	16.00	NA	NA	6.51	6.51	1.65	090
57425		A	Laparoscopy, surg, colpopexy	16.93	NA	NA	6.90	6.77	1.76	090
57452		A	Exam of cervix w/scope	1.50	1.18	1.23	0.74	0.75	0.18	000
57454		A	Bx/curett of cervix w/scope	2.33	1.39	1.51	0.95	1.05	0.28	000
57455		A	Biopsy of cervix w/scope	1.99	1.50	1.61	0.66	0.76	0.24	000
57456		A	Endocerv curettage w/scope	1.85	1.45	1.55	0.62	0.72	0.22	000
57460		A	Bx of cervix w/scope, leep	2.83	4.28	5.06	1.09	1.23	0.34	000
57461		A	Conz of cervix w/scope, leep	3.43	4.56	5.33	1.05	1.26	0.41	000
57500		A	Biopsy of cervix	1.20	2.01	2.28	0.64	0.64	0.12	000
57505		A	Endocervical curettage	1.16	1.32	1.39	1.07	1.08	0.14	010
57510		A	Cauterization of cervix	1.90	1.30	1.43	0.89	0.97	0.23	010
57511		A	Cryocautery of cervix	1.92	1.60	1.71	1.26	1.31	0.23	010
57513		A	Laser surgery of cervix	1.92	1.57	1.64	1.28	1.34	0.23	010
57520		A	Conization of cervix	4.06	3.38	3.65	2.51	2.69	0.49	090
57522		A	Conization of cervix	3.62	2.77	2.96	2.25	2.35	0.41	090
57530		A	Removal of cervix	5.19	NA	NA	3.10	3.24	0.58	090
57531		A	Removal of cervix, radical	29.77	NA	NA	10.85	12.00	3.35	090
57540		A	Removal of residual cervix	13.19	NA	NA	5.44	5.83	1.49	090
57545		A	Remove cervix/repair pelvis	14.00	NA	NA	5.72	6.19	1.52	090
57550		A	Removal of residual cervix	6.24	NA	NA	3.61	3.71	0.67	090
57555		A	Remove cervix/repair vagina	9.84	NA	NA	4.75	4.91	1.09	090
57556		A	Remove cervix, repair bowel	9.26	NA	NA	4.60	4.72	0.92	090
57558		A	D&c of cervical stump	1.69	1.34	1.40	1.05	1.09	0.20	010
57700		A	Revision of cervix	4.22	NA	NA	3.28	3.19	0.41	090
57720		A	Revision of cervix	4.53	NA	NA	2.93	3.02	0.49	090
57800		A	Dilation of cervical canal	0.77	0.72	0.74	0.41	0.44	0.09	000
58100		A	Biopsy of uterus lining	1.53	1.14	1.23	0.58	0.65	0.18	000
58110		A	Bx done w/colposcopy add-on	0.77	0.39	0.47	0.21	0.26	0.09	ZZZ
58120		A	Dilation and curettage	3.54	2.70	2.50	1.65	1.76	0.39	010
58140		A	Myomectomy abdom method	15.69	NA	NA	6.17	6.64	1.82	090
58145		A	Myomectomy vag method	8.81	NA	NA	4.23	4.50	0.97	090
58146		A	Myomectomy abdom complex	20.24	NA	NA	7.34	8.17	2.33	090
58150		A	Total hysterectomy	17.21	NA	NA	6.55	7.01	1.85	090
58152		A	Total hysterectomy	21.73	NA	NA	8.02	8.93	2.48	090
58180		A	Partial hysterectomy	16.50	NA	NA	6.33	6.89	1.64	090
58200		A	Extensive hysterectomy	23.00	NA	NA	8.14	9.06	2.55	090
58210		A	Extensive hysterectomy	30.76	NA	NA	10.71	11.95	3.38	090
58240		A	Removal of pelvis contents	49.02	NA	NA	17.62	17.61	4.23	090
58260		A	Vaginal hysterectomy	14.02	NA	NA	5.78	6.23	1.57	090
58262		A	Vag hyst including t/o	15.81	NA	NA	6.23	6.80	1.80	090
58263		A	Vag hyst w/t/o & vag repair	17.10	NA	NA	6.63	7.25	1.95	090
58267		A	Vag hyst w/urinary repair	18.23	NA	NA	6.96	7.66	2.07	090
58270		A	Vag hyst w/enterocele repair	15.20	NA	NA	5.93	6.49	1.74	090
58275		A	Hysterectomy/revise vagina	16.90	NA	NA	6.60	7.18	1.92	090
58280		A	Hysterectomy/revise vagina	18.20	NA	NA	6.95	7.60	2.07	090
58285		A	Extensive hysterectomy	23.30	NA	NA	7.93	8.93	2.71	090
58290		A	Vag hyst complex	20.17	NA	NA	7.34	8.23	2.30	090
58291		A	Vag hyst incl t/o, complex	21.96	NA	NA	7.81	8.84	2.53	090
58292		A	Vag hyst t/o & repair, compl	23.25	NA	NA	8.20	9.28	2.68	090
58293		A	Vag hyst w/uro repair, compl	24.23	NA	NA	8.50	9.57	2.79	090
58294		A	Vag hyst w/enterocele, compl	21.45	NA	NA	7.50	8.52	2.40	090
58300		N	Insert intrauterine device	1.01	0.63	1.02	0.23	0.31	0.12	XXX
58301		A	Remove intrauterine device	1.27	1.04	1.18	0.34	0.41	0.15	000
58321		A	Artificial insemination	0.92	0.94	1.04	0.23	0.30	0.10	000
58322		A	Artificial insemination	1.10	1.03	1.11	0.31	0.36	0.13	000
58323		A	Sperm washing	0.23	0.16	0.34	0.07	0.08	0.03	000
58340		A	Catheter for hysterography	0.88	2.15	2.66	0.56	0.61	0.09	000
58345		A	Reopen fallopian tube	4.67	NA	NA	2.11	2.27	0.41	010
58346		A	Insert heyman uteri capsule	7.48	NA	NA	3.73	3.83	0.56	090
58350		A	Reopen fallopian tube	1.03	1.35	1.42	0.88	0.90	0.12	010
58353		A	Endometr ablate, thermal	3.57	22.81	29.23	1.71	1.88	0.43	010
58356		A	Endometrial cryoablation	6.36	43.33	52.36	1.85	2.27	0.82	010
58400		A	Suspension of uterus	7.06	NA	NA	3.86	3.89	0.75	090
58410		A	Suspension of uterus	13.70	NA	NA	5.55	5.99	1.45	090
58520		A	Repair of ruptured uterus	13.38	NA	NA	5.48	5.76	1.47	090
58540		A	Revision of uterus	15.61	NA	NA	6.14	6.54	1.79	090
58541		A	Lsh, uterus 250 g or less	14.57	NA	NA	6.12	6.12	1.68	090
58542		A	Lsh w/t/o ut 250 g or less	16.43	NA	NA	6.63	6.63	1.69	090
58543		A	Lsh uterus above 250 g	16.74	NA	NA	6.71	6.71	1.73	090
58544		A	Lsh w/t/o uterus above 250 g	18.24	NA	NA	7.11	7.11	1.89	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
58545		A	Laparoscopic myomectomy	15.45	NA	NA	5.86	6.52	1.78	090
58546		A	Laparo-myomectomy, complex	19.84	NA	NA	7.04	7.98	2.31	090
58548		A	Lap radical hyst	31.45	NA	NA	12.45	12.45	3.52	090
58550		A	Laparo-asst vag hysterectomy	14.97	NA	NA	6.12	6.70	1.73	090
58552		A	Laparo-vag hyst incl t/o	16.78	NA	NA	6.55	7.28	1.73	090
58553		A	Laparo-vag hyst, complex	19.96	NA	NA	7.08	8.00	2.31	090
58554		A	Laparo-vag hyst w/t/o, compl	22.98	NA	NA	8.23	9.31	2.28	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.75	2.47	1.23	1.39	0.40	000
58558		A	Hysteroscopy, biopsy	4.74	3.62	2.90	1.65	1.91	0.57	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	2.04	2.38	0.74	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	2.31	2.70	0.84	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	3.11	3.69	1.21	000
58562		A	Hysteroscopy, remove fb	5.20	3.52	2.94	1.75	2.05	0.63	000
58563		A	Hysteroscopy, ablation	6.16	37.22	46.69	2.04	2.40	0.74	000
58565		A	Hysteroscopy, sterilization	7.06	41.94	45.74	3.37	3.63	1.19	090
58570		A	Tlh, uterus 250 g or less	15.75	NA	NA	6.45	6.45	1.82	090
58571		A	Tlh w/t/o 250 g or less	17.56	NA	NA	6.94	6.94	1.81	090
58572		A	Tlh, uterus over 250 g	19.96	NA	NA	7.59	7.59	2.31	090
58573		A	Tlh w/t/o uterus over 250 g	22.98	NA	NA	8.41	8.41	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	2.92	3.12	0.66	090
58605		A	Division of fallopian tube	5.25	NA	NA	2.71	2.91	0.59	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.40	0.48	0.18	ZZZ
58615		A	Occlude fallopian tube(s)	3.91	NA	NA	2.03	2.37	0.47	010
58660		A	Laparoscopy, lysis	11.54	NA	NA	4.49	4.87	1.40	090
58661		A	Laparoscopy, remove adnexa	11.30	NA	NA	3.98	4.55	1.34	010
58662		A	Laparoscopy, excise lesions	12.08	NA	NA	4.75	5.27	1.43	090
58670		A	Laparoscopy, tubal cautery	5.86	NA	NA	2.94	3.11	0.67	090
58671		A	Laparoscopy, tubal block	5.86	NA	NA	2.93	3.10	0.68	090
58672		A	Laparoscopy, fimbrioplasty	12.88	NA	NA	4.77	5.47	1.60	090
58673		A	Laparoscopy, salpingostomy	13.99	NA	NA	5.12	5.84	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	5.48	5.73	1.51	090
58720		A	Removal of ovary/tube(s)	12.08	NA	NA	5.08	5.43	1.39	090
58740		A	Revise fallopian tube(s)	14.79	NA	NA	6.05	6.59	1.72	090
58750		A	Repair oviduct	15.56	NA	NA	6.04	6.70	1.85	090
58752		A	Revise ovarian tube(s)	15.56	NA	NA	5.98	6.46	1.81	090
58760		A	Remove tubal obstruction	13.85	NA	NA	5.58	6.14	1.80	090
58770		A	Create new tubal opening	14.69	NA	NA	5.74	6.32	1.74	090
58800		A	Drainage of ovarian cyst(s)	4.54	3.21	3.42	2.69	2.79	0.43	090
58805		A	Drainage of ovarian cyst(s)	6.34	NA	NA	3.50	3.50	0.69	090
58820		A	Drain ovary abscess, open	4.62	NA	NA	2.90	3.09	0.52	090
58822		A	Drain ovary abscess, percut	11.71	NA	NA	5.15	5.18	1.16	090
58823		A	Drain pelvic abscess, percut	3.37	19.98	20.64	1.16	1.14	0.24	000
58825		A	Transposition, ovary(s)	11.70	NA	NA	4.83	5.31	1.32	090
58900		A	Biopsy of ovary(s)	6.51	NA	NA	3.55	3.56	0.69	090
58920		A	Partial removal of ovary(s)	11.87	NA	NA	5.05	5.31	1.43	090
58925		A	Removal of ovarian cyst(s)	12.33	NA	NA	5.24	5.46	1.41	090
58940		A	Removal of ovary(s)	8.12	NA	NA	4.03	4.06	0.91	090
58943		A	Removal of ovary(s)	19.42	NA	NA	7.17	7.90	2.23	090
58950		A	Resect ovarian malignancy	18.24	NA	NA	7.24	7.82	2.05	090
58951		A	Resect ovarian malignancy	24.15	NA	NA	8.59	9.51	2.64	090
58952		A	Resect ovarian malignancy	27.15	NA	NA	9.81	10.77	3.03	090
58953		A	Tah, rad dissect for debulk	33.97	NA	NA	11.62	13.08	3.84	090
58954		A	Tah rad debulk/lymph remove	36.97	NA	NA	12.51	14.10	4.18	090
58956		A	Bso, omentectomy w/tah	22.65	NA	NA	8.58	9.44	4.01	090
58957		A	Resect recurrent gyn mal	26.06	NA	NA	9.55	9.55	2.95	090
58958		A	Resect recur gyn mal w/lym	29.06	NA	NA	10.35	10.35	3.29	090
58960		A	Exploration of abdomen	15.68	NA	NA	6.24	6.79	1.80	090
58970		A	Retrieval of oocyte	3.52	1.85	2.08	1.28	1.38	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	1.94	2.31	1.20	1.51	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	1.75	1.91	0.55	0.61	0.31	000
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.07	1.24	0.71	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.13	1.33	0.82	000
59015		A	Chorion biopsy	2.20	1.42	1.48	0.79	0.91	0.52	000
59020		A	Fetal contract stress test	0.66	1.07	0.92	NA	NA	0.26	000
59020	TC	A	Fetal contract stress test	0.00	0.89	0.70	NA	NA	0.10	000
59020	26	A	Fetal contract stress test	0.66	0.18	0.22	0.18	0.22	0.16	000
59025		A	Fetal non-stress test	0.53	0.63	0.54	NA	NA	0.15	000

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
59025	TC	A	Fetal non-stress test	0.00	0.48	0.36	NA	NA	0.02	000
59025	26	A	Fetal non-stress test	0.53	0.15	0.18	0.15	0.18	0.13	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.46	0.61	0.47	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.27	0.31	0.21	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.20	0.25	0.17	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.39	4.77	1.76	2.04	0.28	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	2.39	2.75	0.16	000
59074		A	Fetal fluid drainage w/us	5.24	3.60	4.08	1.53	1.92	0.28	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	2.39	2.75	0.16	000
59100		A	Remove uterus lesion	13.26	NA	NA	5.55	6.00	2.95	090
59120		A	Treat ectopic pregnancy	12.56	NA	NA	5.39	5.82	2.73	090
59121		A	Treat ectopic pregnancy	12.64	NA	NA	5.34	5.83	2.79	090
59130		A	Treat ectopic pregnancy	14.98	NA	NA	6.73	5.76	3.39	090
59135		A	Treat ectopic pregnancy	14.82	NA	NA	5.08	6.15	3.31	090
59136		A	Treat ectopic pregnancy	14.15	NA	NA	4.93	5.76	3.14	090
59140		A	Treat ectopic pregnancy	5.86	NA	NA	3.30	2.76	1.29	090
59150		A	Treat ectopic pregnancy	12.19	NA	NA	5.23	5.61	2.79	090
59151		A	Treat ectopic pregnancy	12.01	NA	NA	4.86	5.45	2.74	090
59160		A	D & c after delivery	2.73	1.98	2.64	1.17	1.65	0.64	010
59200		A	Insert cervical dilator	0.79	0.94	1.06	0.22	0.26	0.19	000
59300		A	Episiotomy or vaginal repair	2.41	2.19	2.18	1.00	0.98	0.57	000
59320		A	Revision of cervix	2.48	NA	NA	1.00	1.12	0.59	000
59325		A	Revision of cervix	4.06	NA	NA	1.44	1.66	0.88	000
59350		A	Repair of uterus	4.94	NA	NA	1.21	1.54	1.17	000
59400		A	Obstetrical care	26.80	NA	NA	14.08	14.69	5.50	MMM
59409		A	Obstetrical care	13.48	NA	NA	3.70	4.50	3.22	MMM
59410		A	Obstetrical care	15.29	NA	NA	4.91	5.60	3.52	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.64	0.72	0.40	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.44	0.54	0.38	MMM
59425		A	Antepartum care only	6.22	4.24	4.22	1.68	1.77	1.14	MMM
59426		A	Antepartum care only	11.04	7.78	7.66	2.99	3.10	1.98	MMM
59430		A	Care after delivery	2.13	1.08	1.15	0.71	0.82	0.50	MMM
59510		A	Cesarean delivery	30.34	NA	NA	15.96	16.61	6.25	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	4.42	5.32	3.80	MMM
59515		A	Cesarean delivery	18.26	NA	NA	6.13	6.98	4.13	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	2.25	2.77	1.95	ZZZ
59610		A	Vbac delivery	28.21	NA	NA	14.93	15.39	5.87	MMM
59612		A	Vbac delivery only	15.04	NA	NA	4.19	5.12	3.59	MMM
59614		A	Vbac care after delivery	16.59	NA	NA	5.11	6.02	3.89	MMM
59618		A	Attempted vbac delivery	31.78	NA	NA	16.35	17.28	6.61	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	4.66	5.71	4.17	MMM
59622		A	Attempted vbac after care	19.70	NA	NA	6.70	7.66	4.50	MMM
59812		A	Treatment of miscarriage	4.39	3.10	2.82	2.35	2.45	0.95	090
59820		A	Care of miscarriage	4.68	4.07	4.24	3.46	3.51	0.95	090
59821		A	Treatment of miscarriage	4.97	3.91	4.09	3.23	3.32	1.06	090
59830		A	Treat uterus infection	6.51	NA	NA	3.44	3.71	1.44	090
59840		R	Abortion	3.01	2.00	2.06	1.77	1.95	0.71	010
59841		R	Abortion	5.57	3.11	3.30	2.54	2.76	1.24	010
59850		R	Abortion	5.90	NA	NA	2.45	2.85	1.28	090
59851		R	Abortion	5.92	NA	NA	3.28	3.51	1.28	090
59852		R	Abortion	8.23	NA	NA	3.82	4.43	1.81	090
59855		R	Abortion	6.38	NA	NA	3.07	3.31	1.45	090
59856		R	Abortion	7.74	NA	NA	3.31	3.68	1.79	090
59857		R	Abortion	9.30	NA	NA	3.64	4.17	2.02	090
59866		R	Abortion (mpr)	3.99	NA	NA	1.36	1.63	0.87	000
59870		A	Evacuate mole of uterus	6.40	NA	NA	4.38	4.43	1.42	090
59871		A	Remove cerclage suture	2.13	NA	NA	0.90	1.02	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	2.08	2.00	1.70	1.70	0.15	010
60100		A	Biopsy of thyroid	1.56	1.31	1.35	0.52	0.52	0.10	000
60200		A	Remove thyroid lesion	9.91	NA	NA	5.50	5.74	1.01	090
60210		A	Partial thyroid excision	11.15	NA	NA	5.22	5.43	1.23	090
60212		A	Partial thyroid excision	16.32	NA	NA	6.94	7.30	1.95	090
60220		A	Partial removal of thyroid	12.29	NA	NA	5.66	5.90	1.32	090
60225		A	Partial removal of thyroid	14.67	NA	NA	6.91	7.15	1.64	090
60240		A	Removal of thyroid	16.18	NA	NA	6.40	6.99	1.86	090
60252		A	Removal of thyroid	21.88	NA	NA	8.82	9.45	2.30	090
60254		A	Extensive thyroid surgery	28.29	NA	NA	11.21	12.67	2.61	090
60260		A	Repeat thyroid surgery	18.18	NA	NA	7.40	8.02	1.94	090
60270		A	Removal of thyroid	23.07	NA	NA	9.31	9.88	2.33	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
60271		A	Removal of thyroid	17.54	NA	NA	7.14	7.86	1.75	090
60280		A	Remove thyroid duct lesion	6.05	NA	NA	4.47	4.56	0.54	090
60281		A	Remove thyroid duct lesion	8.71	NA	NA	5.31	5.57	0.73	090
60300		A	Aspir/inj thyroid cyst	0.97	1.94	1.67	0.30	0.31	0.07	000
60500		A	Explore parathyroid glands	16.69	NA	NA	6.85	7.12	2.01	090
60502		A	Re-explore parathyroids	21.01	NA	NA	8.60	8.97	2.54	090
60505		A	Explore parathyroid glands	22.91	NA	NA	9.38	10.15	2.65	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	1.21	1.41	0.53	ZZZ
60520		A	Removal of thymus gland	17.07	NA	NA	7.01	7.64	2.20	090
60521		A	Removal of thymus gland	19.11	NA	NA	8.12	8.83	2.82	090
60522		A	Removal of thymus gland	23.37	NA	NA	9.60	10.43	3.27	090
60540		A	Explore adrenal gland	17.91	NA	NA	8.24	7.91	1.75	090
60545		A	Explore adrenal gland	20.82	NA	NA	8.94	8.73	2.08	090
60600		A	Remove carotid body lesion	24.99	NA	NA	8.82	9.89	2.20	090
60605		A	Remove carotid body lesion	31.86	NA	NA	12.13	12.19	2.50	090
60650		A	Laparoscopy adrenalectomy	20.63	NA	NA	8.08	8.03	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	1.24	1.09	0.13	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.08	1.07	0.16	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	1.63	1.48	0.34	000
61026		A	Injection into brain canal	1.69	NA	NA	1.30	1.34	0.33	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.15	1.21	0.11	000
61055		A	Injection into brain canal	2.10	NA	NA	1.33	1.37	0.17	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.16	1.08	0.17	000
61105		A	Twist drill hole	5.40	NA	NA	4.90	4.41	1.32	090
61107		A	Drill skull for implantation	4.99	NA	NA	1.83	2.18	1.29	000
61108		A	Drill skull for drainage	11.51	NA	NA	8.34	7.74	2.64	090
61120		A	Burr hole for puncture	9.52	NA	NA	6.77	6.38	2.10	090
61140		A	Pierce skull for biopsy	17.10	NA	NA	10.40	10.14	4.12	090
61150		A	Pierce skull for drainage	18.80	NA	NA	10.67	10.52	4.32	090
61151		A	Pierce skull for drainage	13.41	NA	NA	8.43	8.12	3.01	090
61154		A	Pierce skull & remove clot	16.92	NA	NA	10.82	10.15	4.21	090
61156		A	Pierce skull for drainage	17.37	NA	NA	9.71	9.77	4.23	090
61210		A	Pierce skull, implant device	5.83	NA	NA	2.15	2.53	1.50	000
61215		A	Insert brain-fluid device	5.77	NA	NA	5.44	4.72	1.26	090
61250		A	Pierce skull & explore	11.41	NA	NA	7.37	7.11	2.77	090
61253		A	Pierce skull & explore	13.41	NA	NA	7.48	7.60	2.62	090
61304		A	Open skull for exploration	23.31	NA	NA	12.53	12.68	5.63	090
61305		A	Open skull for exploration	28.51	NA	NA	14.95	15.13	6.09	090
61312		A	Open skull for drainage	30.07	NA	NA	15.22	15.12	6.36	090
61313		A	Open skull for drainage	27.94	NA	NA	15.35	15.07	6.45	090
61314		A	Open skull for drainage	25.77	NA	NA	14.14	13.58	6.28	090
61315		A	Open skull for drainage	29.52	NA	NA	15.49	15.75	7.16	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.51	0.55	0.35	ZZZ
61320		A	Open skull for drainage	27.32	NA	NA	14.23	14.48	6.62	090
61321		A	Open skull for drainage	30.40	NA	NA	16.05	16.08	7.14	090
61322		A	Decompressive craniotomy	34.08	NA	NA	17.46	16.56	7.63	090
61323		A	Decompressive lobectomy	34.93	NA	NA	17.29	16.68	8.03	090
61330		A	Decompress eye socket	25.17	NA	NA	11.52	12.62	2.32	090
61332		A	Explore/biopsy eye socket	28.50	NA	NA	12.95	14.27	4.83	090
61333		A	Explore orbit/remove lesion	29.17	NA	NA	12.87	14.22	3.92	090
61334		A	Explore orbit/remove object	19.50	NA	NA	9.01	9.81	1.75	090
61340		A	Subtemporal decompression	20.01	NA	NA	11.67	11.39	4.84	090
61343		A	Incise skull (press relief)	31.73	NA	NA	15.92	16.36	7.64	090
61345		A	Relieve cranial pressure	29.10	NA	NA	14.84	15.11	7.04	090
61440		A	Incise skull for surgery	28.53	NA	NA	15.22	14.70	6.90	090
61450		A	Incise skull for surgery	27.59	NA	NA	14.05	14.16	5.79	090
61458		A	Incise skull for brain wound	28.71	NA	NA	14.87	15.18	7.03	090
61460		A	Incise skull for surgery	30.11	NA	NA	14.56	15.48	6.04	090
61470		A	Incise skull for surgery	27.52	NA	NA	14.04	13.94	5.90	090
61480		A	Incise skull for surgery	27.95	NA	NA	8.13	11.70	6.73	090
61490		A	Incise skull for surgery	27.12	NA	NA	14.21	14.26	6.92	090
61500		A	Removal of skull lesion	19.05	NA	NA	10.68	10.74	4.11	090
61501		A	Remove infected skull bone	16.22	NA	NA	9.44	9.32	3.22	090
61510		A	Removal of brain lesion	30.63	NA	NA	16.93	16.81	7.35	090
61512		A	Remove brain lining lesion	36.99	NA	NA	18.44	19.05	9.08	090
61514		A	Removal of brain abscess	27.10	NA	NA	14.40	14.41	6.54	090
61516		A	Removal of brain lesion	26.45	NA	NA	14.04	14.15	6.35	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.51	0.57	0.35	ZZZ
61518		A	Removal of brain lesion	39.69	NA	NA	20.29	20.68	9.65	090
61519		A	Remove brain lining lesion	43.28	NA	NA	20.63	21.63	10.63	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
61520		A	Removal of brain lesion	56.89	NA	NA	25.93	28.12	11.21	090
61521		A	Removal of brain lesion	46.84	NA	NA	22.14	23.17	11.39	090
61522		A	Removal of brain abscess	31.41	NA	NA	15.75	16.08	7.62	090
61524		A	Removal of brain lesion	29.76	NA	NA	15.68	15.67	7.16	090
61526		A	Removal of brain lesion	53.90	NA	NA	22.50	25.98	7.07	090
61530		A	Removal of brain lesion	45.43	NA	NA	19.47	22.25	6.15	090
61531		A	Implant brain electrodes	16.28	NA	NA	10.45	9.79	3.79	090
61533		A	Implant brain electrodes	21.36	NA	NA	11.78	11.65	5.12	090
61534		A	Removal of brain lesion	22.88	NA	NA	13.11	12.59	5.44	090
61535		A	Remove brain electrodes	13.05	NA	NA	8.83	8.12	3.02	090
61536		A	Removal of brain lesion	37.59	NA	NA	18.51	19.14	9.21	090
61537		A	Removal of brain tissue	36.35	NA	NA	17.02	15.87	6.94	090
61538		A	Removal of brain tissue	39.35	NA	NA	18.35	16.82	6.94	090
61539		A	Removal of brain tissue	34.15	NA	NA	16.81	17.28	8.32	090
61540		A	Removal of brain tissue	31.30	NA	NA	16.28	16.76	8.32	090
61541		A	Incision of brain tissue	30.81	NA	NA	16.07	16.13	6.60	090
61542		A	Removal of brain tissue	33.03	NA	NA	16.76	17.29	8.03	090
61543		A	Removal of brain tissue	31.18	NA	NA	13.84	15.11	7.56	090
61544		A	Remove & treat brain lesion	27.26	NA	NA	14.26	14.04	5.97	090
61545		A	Excision of brain tumor	46.23	NA	NA	22.80	23.50	10.63	090
61546		A	Removal of pituitary gland	33.31	NA	NA	16.72	17.10	7.67	090
61548		A	Removal of pituitary gland	23.27	NA	NA	11.60	12.19	3.43	090
61550		A	Release of skull seams	15.44	NA	NA	5.65	6.29	0.98	090
61552		A	Release of skull seams	20.27	NA	NA	12.14	10.62	1.06	090
61556		A	Incise skull/sutures	24.00	NA	NA	13.27	12.31	4.65	090
61557		A	Incise skull/sutures	23.16	NA	NA	13.62	13.62	5.80	090
61558		A	Excision of skull/sutures	26.35	NA	NA	14.68	14.43	1.36	090
61559		A	Excision of skull/sutures	33.82	NA	NA	18.36	18.83	8.51	090
61563		A	Excision of skull tumor	28.35	NA	NA	13.07	14.15	5.17	090
61564		A	Excision of skull tumor	34.59	NA	NA	17.89	18.08	8.78	090
61566		A	Removal of brain tissue	32.32	NA	NA	16.63	17.19	6.94	090
61567		A	Incision of brain tissue	36.84	NA	NA	19.05	19.85	6.54	090
61570		A	Remove foreign body, brain	26.38	NA	NA	14.00	13.95	5.88	090
61571		A	Incise skull for brain wound	28.29	NA	NA	14.62	14.88	6.79	090
61575		A	Skull base/brainstem surgery	36.43	NA	NA	16.08	17.85	5.34	090
61576		A	Skull base/brainstem surgery	55.11	NA	NA	28.06	31.39	5.58	090
61580		A	Craniofacial approach, skull	34.34	NA	NA	22.82	24.19	3.37	090
61581		A	Craniofacial approach, skull	38.88	NA	NA	27.80	25.62	3.92	090
61582		A	Craniofacial approach, skull	34.93	NA	NA	30.44	28.86	7.21	090
61583		A	Craniofacial approach, skull	38.41	NA	NA	25.86	25.48	9.21	090
61584		A	Orbitocranial approach/skull	37.61	NA	NA	26.01	25.26	8.18	090
61585		A	Orbitocranial approach/skull	42.46	NA	NA	25.10	25.79	7.03	090
61586		A	Resect nasopharynx, skull	27.28	NA	NA	22.61	22.59	4.37	090
61590		A	Infratemporal approach/skull	46.87	NA	NA	24.78	26.69	5.31	090
61591		A	Infratemporal approach/skull	46.87	NA	NA	24.57	27.04	5.66	090
61592		A	Orbitocranial approach/skull	42.98	NA	NA	26.77	26.63	10.07	090
61595		A	Transtemporal approach/skull	33.57	NA	NA	21.12	21.73	3.98	090
61596		A	Transcochlear approach/skull	39.31	NA	NA	20.92	22.67	3.40	090
61597		A	Transcondylar approach/skull	40.73	NA	NA	23.25	23.11	8.84	090
61598		A	Transpetrosal approach/skull	36.41	NA	NA	22.13	22.68	5.70	090
61600		A	Resect/excise cranial lesion	29.84	NA	NA	19.74	19.75	3.79	090
61601		A	Resect/excise cranial lesion	31.04	NA	NA	22.35	21.42	6.63	090
61605		A	Resect/excise cranial lesion	32.40	NA	NA	19.44	20.69	2.86	090
61606		A	Resect/excise cranial lesion	41.94	NA	NA	23.74	24.44	8.97	090
61607		A	Resect/excise cranial lesion	40.82	NA	NA	20.98	22.37	6.90	090
61608		A	Resect/excise cranial lesion	45.45	NA	NA	26.29	26.43	10.75	090
61609		A	Transect artery, sinus	9.88	NA	NA	3.25	4.05	2.56	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	11.05	12.09	7.68	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	1.70	2.76	1.89	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	6.40	9.85	4.31	ZZZ
61613		A	Remove aneurysm, sinus	44.94	NA	NA	27.32	26.78	8.45	090
61615		A	Resect/excise lesion, skull	35.63	NA	NA	21.27	21.99	4.73	090
61616		A	Resect/excise lesion, skull	46.60	NA	NA	27.21	27.92	8.26	090
61618		A	Repair dura	18.58	NA	NA	10.42	10.43	3.72	090
61619		A	Repair dura	22.01	NA	NA	11.66	11.95	3.95	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	3.72	3.90	1.05	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	7.29	7.09	1.96	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	5.97	5.74	1.24	000
61630		N	Intracranial angioplasty	22.07	NA	NA	6.43	9.46	2.02	090
61635		N	Intracran angioplsty w/stent	24.28	NA	NA	6.94	10.24	2.21	090
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	2.83	2.83	0.71	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	0.99	0.99	0.25	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	1.99	1.99	0.50	ZZZ
61680		A	Intracranial vessel surgery	32.40	NA	NA	16.73	17.07	7.95	090
61682		A	Intracranial vessel surgery	63.31	NA	NA	27.51	29.85	15.90	090
61684		A	Intracranial vessel surgery	41.49	NA	NA	20.35	21.17	10.31	090
61686		A	Intracranial vessel surgery	67.32	NA	NA	30.44	32.57	16.71	090
61690		A	Intracranial vessel surgery	31.18	NA	NA	16.50	16.61	6.94	090
61692		A	Intracranial vessel surgery	54.43	NA	NA	24.32	25.89	13.43	090
61697		A	Brain aneurysm repr, complx	63.22	NA	NA	28.60	28.30	12.85	090
61698		A	Brain aneurysm repr, complx	69.45	NA	NA	30.55	28.62	12.54	090
61700		A	Brain aneurysm repr, simple	50.44	NA	NA	24.00	25.89	13.02	090
61702		A	Inner skull vessel surgery	59.86	NA	NA	27.47	26.74	10.79	090
61703		A	Clamp neck artery	18.70	NA	NA	10.05	10.25	4.06	090
61705		A	Revise circulation to head	37.97	NA	NA	18.30	18.77	8.87	090
61708		A	Revise circulation to head	37.07	NA	NA	14.86	15.00	2.51	090
61710		A	Revise circulation to head	31.19	NA	NA	13.77	13.70	4.52	090
61711		A	Fusion of skull arteries	38.10	NA	NA	18.59	19.19	9.42	090
61720		A	Incise skull/brain surgery	17.52	NA	NA	7.88	8.92	2.79	090
61735		A	Incise skull/brain surgery	22.22	NA	NA	9.16	10.66	2.73	090
61750		A	Incise skull/brain biopsy	19.73	NA	NA	10.94	10.77	4.72	090
61751		A	Brain biopsy w/ct/mr guide	18.64	NA	NA	11.35	11.08	4.56	090
61760		A	Implant brain electrodes	22.24	NA	NA	12.05	10.38	5.42	090
61770		A	Incise skull for treatment	23.09	NA	NA	9.88	11.06	3.55	090
61790		A	Treat trigeminal nerve	11.50	NA	NA	7.69	6.80	2.82	090
61791		A	Treat trigeminal tract	15.31	NA	NA	8.20	8.56	3.40	090
61793		A	Focus radiation beam	17.75	NA	NA	9.54	9.83	4.46	090
61795		A	Brain surgery using computer	4.03	NA	NA	1.43	1.73	0.79	ZZZ
61850		A	Implant neuroelectrodes	13.26	NA	NA	7.88	7.77	3.22	090
61860		A	Implant neuroelectrodes	22.16	NA	NA	11.59	11.82	4.95	090
61863		A	Implant neuroelectrode	20.56	NA	NA	12.40	12.08	5.43	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	1.67	1.98	5.43	ZZZ
61867		A	Implant neuroelectrode	32.88	NA	NA	16.35	17.18	5.43	090
61868		A	Implant neuroelectrde, add'l	7.91	NA	NA	2.94	3.47	5.43	ZZZ
61870		A	Implant neuroelectrodes	16.24	NA	NA	9.68	9.69	3.87	090
61875		A	Implant neuroelectrodes	16.36	NA	NA	5.33	6.94	2.95	090
61880		A	Revise/remove neuroelectrode	6.87	NA	NA	5.17	4.87	1.66	090
61885		A	Insrt/redo neurostim 1 array	7.37	NA	NA	7.05	6.18	1.59	090
61886		A	Implant neurostim arrays	9.73	NA	NA	8.51	7.43	1.97	090
61888		A	Revise/remove neuroreceiver	5.20	NA	NA	3.46	3.57	1.33	010
62000		A	Treat skull fracture	13.83	NA	NA	7.61	6.56	1.06	090
62005		A	Treat skull fracture	17.53	NA	NA	9.58	9.19	3.87	090
62010		A	Treatment of head injury	21.30	NA	NA	11.80	11.75	5.14	090
62100		A	Repair brain fluid leakage	23.40	NA	NA	12.08	12.43	4.84	090
62115		A	Reduction of skull defect	22.71	NA	NA	13.87	12.75	5.51	090
62116		A	Reduction of skull defect	24.90	NA	NA	13.33	13.34	6.11	090
62117		A	Reduction of skull defect	28.26	NA	NA	12.73	14.04	4.53	090
62120		A	Repair skull cavity lesion	24.39	NA	NA	17.31	17.89	3.00	090
62121		A	Incise skull repair	22.93	NA	NA	14.23	14.83	4.17	090
62140		A	Repair of skull defect	14.45	NA	NA	8.63	8.47	3.47	090
62141		A	Repair of skull defect	15.97	NA	NA	9.33	9.18	3.76	090
62142		A	Remove skull plate/flap	11.73	NA	NA	7.78	7.38	2.73	090
62143		A	Replace skull plate/flap	14.05	NA	NA	8.72	8.38	3.37	090
62145		A	Repair of skull & brain	19.99	NA	NA	10.25	10.56	4.50	090
62146		A	Repair of skull with graft	17.18	NA	NA	9.51	9.57	3.62	090
62147		A	Repair of skull with graft	20.57	NA	NA	10.98	11.14	4.32	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	0.74	0.80	0.48	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.11	1.32	0.77	ZZZ
62161		A	Dissect brain w/scope	21.10	NA	NA	12.14	12.11	5.19	090
62162		A	Remove colloid cyst w/scope	26.67	NA	NA	14.63	14.73	5.91	090
62163		A	Neuroendoscopy w/fb removal	16.40	NA	NA	9.24	9.58	4.01	090
62164		A	Remove brain tumor w/scope	29.27	NA	NA	15.91	15.42	5.38	090
62165		A	Remove pituit tumor w/scope	23.10	NA	NA	11.76	12.57	3.01	090
62180		A	Establish brain cavity shunt	22.45	NA	NA	12.36	12.32	4.98	090
62190		A	Establish brain cavity shunt	12.07	NA	NA	7.36	7.22	2.80	090
62192		A	Establish brain cavity shunt	13.25	NA	NA	8.01	7.81	3.02	090
62194		A	Replace/irrigate catheter	5.68	NA	NA	3.14	2.79	0.92	010
62200		A	Establish brain cavity shunt	19.19	NA	NA	10.69	10.76	4.65	090
62201		A	Brain cavity shunt w/scope	15.89	NA	NA	10.34	9.89	3.68	090
62220		A	Establish brain cavity shunt	14.00	NA	NA	8.61	8.29	3.35	090
62223		A	Establish brain cavity shunt	13.90	NA	NA	9.35	8.79	3.14	090
62225		A	Replace/irrigate catheter	6.11	NA	NA	5.48	4.78	1.39	090
62230		A	Replace/revise brain shunt	11.35	NA	NA	7.20	6.84	2.71	090
62252		A	Csf shunt reprogram	0.74	1.77	1.62	NA	NA	0.21	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
62252	TC	A	Csf shunt reprogram	0.00	1.50	1.30	NA	NA	0.02	XXX
62252	26	A	Csf shunt reprogram	0.74	0.27	0.32	0.27	0.32	0.19	XXX
62256		A	Remove brain cavity shunt	7.30	NA	NA	5.90	5.29	1.72	090
62258		A	Replace brain cavity shunt	15.54	NA	NA	9.29	9.00	3.74	090
62263		A	Epidural lysis mult sessions	6.41	9.45	11.07	2.97	3.08	0.41	010
62264		A	Epidural lysis on single day	4.42	5.62	6.67	1.24	1.33	0.27	010
62268		A	Drain spinal cord cyst	4.73	6.69	9.11	1.80	1.97	0.43	000
62269		A	Needle biopsy, spinal cord	5.01	6.25	10.46	1.48	1.73	0.37	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.39	2.69	0.57	0.57	0.08	000
62272		A	Drain cerebro spinal fluid	1.35	3.13	3.37	0.62	0.66	0.18	000
62273		A	Inject epidural patch	2.15	1.67	2.19	0.57	0.64	0.13	000
62280		A	Treat spinal cord lesion	2.63	4.62	5.77	1.15	1.08	0.30	010
62281		A	Treat spinal cord lesion	2.66	4.07	4.86	1.02	0.96	0.19	010
62282		A	Treat spinal canal lesion	2.33	4.08	6.22	1.11	1.01	0.17	010
62284		A	Injection for myelogram	1.54	3.79	4.37	0.71	0.70	0.13	000
62287		A	Percutaneous diskectomy	8.88	NA	NA	4.30	4.92	0.58	090
62290		A	Inject for spine disk x-ray	3.00	4.50	5.81	1.15	1.26	0.23	000
62291		A	Inject for spine disk x-ray	2.91	4.23	5.08	1.08	1.15	0.26	000
62292		A	Injection into disk lesion	9.14	NA	NA	2.87	3.67	0.82	090
62294		A	Injection into spinal artery	12.77	NA	NA	6.49	6.03	1.24	090
62310		A	Inject spine c/t	1.91	3.00	3.90	0.56	0.60	0.12	000
62311		A	Inject spine l/s (cd)	1.54	2.66	3.79	0.52	0.56	0.09	000
62318		A	Inject spine w/cath, c/t	2.04	3.09	4.40	0.43	0.54	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	2.79	3.88	0.44	0.52	0.11	000
62350		A	Implant spinal canal cath	8.04	NA	NA	3.98	3.96	1.02	090
62351		A	Implant spinal canal cath	11.54	NA	NA	7.64	7.38	2.25	090
62355		A	Remove spinal canal catheter	6.60	NA	NA	3.52	3.34	0.71	090
62360		A	Insert spine infusion device	3.68	NA	NA	3.17	2.92	0.34	090
62361		A	Implant spine infusion pump	6.59	NA	NA	4.06	3.99	0.80	090
62362		A	Implant spine infusion pump	8.58	NA	NA	4.65	4.50	1.18	090
62365		A	Remove spine infusion device	6.57	NA	NA	3.71	3.64	0.86	090
62367		A	Analyze spine infusion pump	0.48	0.42	0.52	0.11	0.11	0.03	XXX
62368		A	Analyze spine infusion pump	0.75	0.58	0.63	0.17	0.17	0.06	XXX
63001		A	Removal of spinal lamina	17.51	NA	NA	9.76	9.63	3.77	090
63003		A	Removal of spinal lamina	17.64	NA	NA	9.72	9.79	3.73	090
63005		A	Removal of spinal lamina	16.28	NA	NA	9.73	9.85	3.35	090
63011		A	Removal of spinal lamina	15.78	NA	NA	9.00	8.63	3.38	090
63012		A	Removal of spinal lamina	16.72	NA	NA	9.75	9.93	3.49	090
63015		A	Removal of spinal lamina	20.70	NA	NA	11.83	11.85	4.76	090
63016		A	Removal of spinal lamina	21.90	NA	NA	11.64	11.71	4.59	090
63017		A	Removal of spinal lamina	17.18	NA	NA	10.34	10.36	3.64	090
63020		A	Neck spine disk surgery	16.05	NA	NA	9.87	9.77	3.72	090
63030		A	Low back disk surgery	13.03	NA	NA	8.59	8.50	3.01	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.19	1.39	0.79	ZZZ
63040		A	Laminotomy, single cervical	20.18	NA	NA	11.01	11.25	4.68	090
63042		A	Laminotomy, single lumbar	18.61	NA	NA	10.57	10.95	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	10.33	10.34	3.99	090
63046		A	Removal of spinal lamina	17.12	NA	NA	9.78	9.98	3.56	090
63047		A	Removal of spinal lamina	15.22	NA	NA	9.32	9.61	3.24	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.32	1.49	0.72	ZZZ
63050		A	Cervical laminoplasty	21.88	NA	NA	11.81	11.82	4.67	090
63051		A	C-laminoplasty w/graft/plate	25.38	NA	NA	13.07	13.26	4.67	090
63055		A	Decompress spinal cord	23.42	NA	NA	12.44	12.78	5.29	090
63056		A	Decompress spinal cord	21.73	NA	NA	11.37	11.96	4.76	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	1.98	2.30	1.22	ZZZ
63064		A	Decompress spinal cord	26.09	NA	NA	13.20	13.81	5.71	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.21	1.43	0.69	ZZZ
63075		A	Neck spine disk surgery	19.47	NA	NA	11.00	11.54	4.63	090
63076		A	Neck spine disk surgery	4.04	NA	NA	1.51	1.78	0.96	ZZZ
63077		A	Spine disk surgery, thorax	22.75	NA	NA	11.06	11.92	3.99	090
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.21	1.42	0.66	ZZZ
63081		A	Removal of vertebral body	25.97	NA	NA	13.48	13.89	5.56	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	1.64	1.93	1.02	ZZZ
63085		A	Removal of vertebral body	29.34	NA	NA	13.52	14.49	4.49	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.17	1.38	0.59	ZZZ
63087		A	Removal of vertebral body	37.38	NA	NA	16.63	18.03	6.22	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	1.59	1.88	0.82	ZZZ
63090		A	Removal of vertebral body	30.78	NA	NA	14.38	15.20	4.22	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.14	1.30	0.48	ZZZ
63101		A	Removal of vertebral body	33.92	NA	NA	17.02	18.14	5.71	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
63102		A	Removal of vertebral body	33.92	NA	NA	16.81	18.04	5.71	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	1.74	2.12	0.69	ZZZ
63170		A	Incise spinal cord tract(s)	22.08	NA	NA	10.43	11.14	4.87	090
63172		A	Drainage of spinal cyst	19.66	NA	NA	11.06	10.85	4.49	090
63173		A	Drainage of spinal cyst	24.18	NA	NA	13.55	13.17	5.70	090
63180		A	Revise spinal cord ligaments	20.40	NA	NA	10.93	10.95	3.96	090
63182		A	Revise spinal cord ligaments	22.69	NA	NA	7.17	9.06	5.32	090
63185		A	Incise spinal column/nerves	16.36	NA	NA	9.79	8.94	2.80	090
63190		A	Incise spinal column/nerves	18.76	NA	NA	9.59	9.86	3.25	090
63191		A	Incise spinal column/nerves	18.79	NA	NA	4.10	7.28	6.36	090
63194		A	Incise spinal column & cord	21.97	NA	NA	11.18	11.44	3.27	090
63195		A	Incise spinal column & cord	21.54	NA	NA	12.09	11.56	4.88	090
63196		A	Incise spinal column & cord	25.14	NA	NA	13.77	13.57	5.78	090
63197		A	Incise spinal column & cord	23.95	NA	NA	7.46	9.83	5.38	090
63198		A	Incise spinal column & cord	29.75	NA	NA	8.92	8.67	6.45	090
63199		A	Incise spinal column & cord	31.32	NA	NA	9.28	12.15	1.40	090
63200		A	Release of spinal cord	21.31	NA	NA	12.09	11.68	4.97	090
63250		A	Revise spinal cord vessels	43.73	NA	NA	20.89	20.40	9.04	090
63251		A	Revise spinal cord vessels	44.49	NA	NA	21.51	22.04	10.44	090
63252		A	Revise spinal cord vessels	44.48	NA	NA	20.85	21.53	10.67	090
63265		A	Excise intraspinal lesion	23.69	NA	NA	12.98	12.87	5.45	090
63266		A	Excise intraspinal lesion	24.55	NA	NA	13.16	13.16	5.56	090
63267		A	Excise intraspinal lesion	19.32	NA	NA	11.12	11.09	4.38	090
63268		A	Excise intraspinal lesion	19.89	NA	NA	11.24	10.80	3.70	090
63270		A	Excise intraspinal lesion	29.67	NA	NA	15.34	15.39	6.84	090
63271		A	Excise intraspinal lesion	29.79	NA	NA	15.30	15.43	6.92	090
63272		A	Excise intraspinal lesion	27.37	NA	NA	14.28	14.47	6.20	090
63273		A	Excise intraspinal lesion	26.34	NA	NA	14.06	14.19	5.76	090
63275		A	Biopsy/excise spinal tumor	25.73	NA	NA	13.73	13.74	5.82	090
63276		A	Biopsy/excise spinal tumor	25.56	NA	NA	13.50	13.58	5.85	090
63277		A	Biopsy/excise spinal tumor	22.26	NA	NA	12.11	12.31	5.03	090
63278		A	Biopsy/excise spinal tumor	21.99	NA	NA	11.91	12.14	4.56	090
63280		A	Biopsy/excise spinal tumor	30.14	NA	NA	15.86	16.08	7.29	090
63281		A	Biopsy/excise spinal tumor	29.84	NA	NA	15.85	16.00	7.19	090
63282		A	Biopsy/excise spinal tumor	28.00	NA	NA	14.99	15.15	6.78	090
63283		A	Biopsy/excise spinal tumor	26.61	NA	NA	14.67	14.65	6.28	090
63285		A	Biopsy/excise spinal tumor	37.90	NA	NA	18.07	19.00	9.21	090
63286		A	Biopsy/excise spinal tumor	37.47	NA	NA	18.69	19.28	9.24	090
63287		A	Biopsy/excise spinal tumor	39.93	NA	NA	19.59	20.00	9.42	090
63290		A	Biopsy/excise spinal tumor	40.67	NA	NA	19.26	19.92	9.05	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	1.95	2.05	1.03	ZZZ
63300		A	Removal of vertebral body	26.67	NA	NA	13.78	14.03	5.99	090
63301		A	Removal of vertebral body	31.42	NA	NA	14.19	14.87	5.41	090
63302		A	Removal of vertebral body	31.00	NA	NA	13.77	14.80	5.55	090
63303		A	Removal of vertebral body	33.42	NA	NA	14.98	15.94	4.69	090
63304		A	Removal of vertebral body	33.70	NA	NA	17.56	17.40	6.43	090
63305		A	Removal of vertebral body	36.09	NA	NA	16.97	17.50	5.73	090
63306		A	Removal of vertebral body	35.40	NA	NA	16.63	17.20	8.35	090
63307		A	Removal of vertebral body	34.81	NA	NA	14.81	15.80	4.47	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	1.95	2.27	1.29	ZZZ
63600		A	Remove spinal cord lesion	15.02	NA	NA	4.03	4.71	1.52	090
63610		A	Stimulation of spinal cord	8.72	13.93	36.79	1.49	1.87	0.86	000
63615		A	Remove lesion of spinal cord	17.22	NA	NA	8.51	8.89	2.85	090
63650		A	Implant neuroelectrodes	7.57	NA	NA	2.92	3.04	0.53	090
63655		A	Implant neuroelectrodes	11.43	NA	NA	7.62	7.25	2.44	090
63660		A	Revise/remove neuroelectrode	6.87	NA	NA	3.42	3.51	0.78	090
63685		A	Insrt/redo spine n generator	7.87	NA	NA	3.65	3.89	1.05	090
63688		A	Revise/remove neuroreceiver	6.10	NA	NA	3.53	3.54	0.89	090
63700		A	Repair of spinal herniation	17.32	NA	NA	9.94	10.12	3.53	090
63702		A	Repair of spinal herniation	19.26	NA	NA	9.97	10.49	4.13	090
63704		A	Repair of spinal herniation	22.23	NA	NA	11.65	12.28	4.58	090
63706		A	Repair of spinal herniation	25.15	NA	NA	14.29	13.93	6.25	090
63707		A	Repair spinal fluid leakage	12.52	NA	NA	7.82	7.76	2.52	090
63709		A	Repair spinal fluid leakage	15.52	NA	NA	8.96	9.17	3.10	090
63710		A	Graft repair of spine defect	15.27	NA	NA	9.18	9.10	3.41	090
63740		A	Install spinal shunt	12.50	NA	NA	8.27	7.80	2.94	090
63741		A	Install spinal shunt	9.02	NA	NA	4.93	4.84	1.66	090
63744		A	Revision of spinal shunt	8.86	NA	NA	5.75	5.50	1.90	090
63746		A	Removal of spinal shunt	7.25	NA	NA	5.68	4.72	1.53	090
64400		A	N block inj, trigeminal	1.11	1.41	1.65	0.44	0.44	0.07	000
64402		A	N block inj, facial	1.25	1.41	1.51	0.49	0.55	0.09	000
64405		A	N block inj, occipital	1.32	1.16	1.31	0.49	0.48	0.08	000

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
64408		A	N block inj, vagus	1.41	1.45	1.51	0.71	0.78	0.10	000
64410		A	N block inj, phrenic	1.43	1.92	2.21	0.56	0.51	0.09	000
64412		A	N block inj, spinal accessor	1.18	2.13	2.39	0.58	0.51	0.08	000
64413		A	N block inj, cervical plexus	1.40	1.31	1.57	0.48	0.49	0.08	000
64415		A	N block inj, brachial plexus	1.48	1.41	2.11	0.30	0.38	0.09	000
64416		A	N block cont infuse, b plex	3.85	NA	NA	0.46	0.63	0.31	010
64417		A	N block inj, axillary	1.44	1.43	2.23	0.32	0.40	0.11	000
64418		A	N block inj, suprascapular	1.32	1.89	2.26	0.52	0.48	0.07	000
64420		A	N block inj, intercost, sng	1.18	2.40	3.14	0.44	0.43	0.08	000
64421		A	N block inj, intercost, mlt	1.68	3.55	4.81	0.53	0.52	0.11	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.29	1.47	0.53	0.53	0.13	000
64430		A	N block inj, pudendal	1.46	2.39	2.45	0.77	0.66	0.10	000
64435		A	N block inj, paracervical	1.45	1.99	2.26	0.55	0.62	0.16	000
64445		A	N block inj, sciatic, sng	1.48	1.62	2.15	0.50	0.50	0.10	000
64446		A	N blk inj, sciatic, cont inf	3.61	NA	NA	0.48	0.74	0.20	010
64447		A	N block inj fem, single	1.50	NA	NA	0.17	0.30	0.09	000
64448		A	N block inj fem, cont inf	3.36	NA	NA	0.39	0.60	0.18	010
64449		A	N block inj, lumbar plexus	3.24	NA	NA	0.42	0.69	0.15	010
64450		A	N block, other peripheral	1.27	1.27	1.25	0.49	0.48	0.13	000
64470		A	Inj paravertebral c/t	1.85	3.82	5.52	0.70	0.70	0.11	000
64472		A	Inj paravertebral c/t add-on	1.29	1.22	1.78	0.33	0.33	0.08	ZZZ
64475		A	Inj paravertebral l/s	1.41	3.64	5.26	0.58	0.60	0.10	000
64476		A	Inj paravertebral l/s add-on	0.98	1.10	1.61	0.22	0.23	0.07	ZZZ
64479		A	Inj foramen epidural c/t	2.20	3.75	5.62	0.81	0.85	0.12	000
64480		A	Inj foramen epidural add-on	1.54	1.55	2.19	0.39	0.43	0.10	ZZZ
64483		A	Inj foramen epidural l/s	1.90	3.81	5.85	0.75	0.79	0.11	000
64484		A	Inj foramen epidural add-on	1.33	1.62	2.45	0.32	0.35	0.08	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.13	1.18	0.74	0.70	0.10	000
64508		A	N block, carotid sinus s/p	1.12	2.03	2.68	0.56	0.65	0.07	000
64510		A	N block, stellate ganglion	1.22	1.90	2.67	0.43	0.47	0.07	000
64517		A	N block inj, hypogas plxs	2.20	1.72	2.22	0.68	0.77	0.11	000
64520		A	N block, lumbar/thoracic	1.35	2.57	3.85	0.51	0.53	0.08	000
64530		A	N block inj, celiac pelus	1.58	2.79	3.62	0.65	0.65	0.10	000
64550		A	Apply neurostimulator	0.18	0.20	0.24	0.05	0.05	0.01	000
64553		A	Implant neuroelectrodes	2.33	2.64	2.74	1.44	1.65	0.18	010
64555		A	Implant neuroelectrodes	2.29	2.78	2.94	1.49	1.34	0.19	010
64560		A	Implant neuroelectrodes	2.38	2.41	2.52	1.26	1.27	0.22	010
64561		A	Implant neuroelectrodes	7.07	19.59	24.81	3.76	3.26	0.51	010
64565		A	Implant neuroelectrodes	1.78	2.47	2.87	1.29	1.27	0.13	010
64573		A	Implant neuroelectrodes	8.15	NA	NA	5.16	5.20	1.60	090
64575		A	Implant neuroelectrodes	4.37	NA	NA	2.05	2.36	0.61	090
64577		A	Implant neuroelectrodes	4.64	NA	NA	4.78	4.03	1.04	090
64580		A	Implant neuroelectrodes	4.14	NA	NA	2.70	3.13	0.36	090
64581		A	Implant neuroelectrodes	14.15	NA	NA	6.60	5.98	1.05	090
64585		A	Revise/remove neuroelectrode	2.08	5.91	8.59	2.28	2.21	0.20	010
64590		A	Insrt/redo pn/gastr stimul	2.42	6.40	6.77	2.45	2.37	0.19	010
64595		A	Revise/rmv pn/gastr stimul	1.75	6.44	8.41	2.17	2.05	0.19	010
64600		A	Injection treatment of nerve	3.46	5.42	7.38	1.63	1.64	0.34	010
64605		A	Injection treatment of nerve	5.62	7.21	8.38	2.26	2.22	0.79	010
64610		A	Injection treatment of nerve	7.17	9.17	9.01	3.43	3.57	1.58	010
64612		A	Destroy nerve, face muscle	1.98	1.58	2.03	1.33	1.32	0.11	010
64613		A	Destroy nerve, neck muscle	1.98	1.37	2.15	1.14	1.18	0.11	010
64614		A	Destroy nerve, extrem musc	2.20	1.61	2.42	1.30	1.31	0.10	010
64620		A	Injection treatment of nerve	2.86	3.30	4.18	1.11	1.22	0.20	010
64622		A	Destr paravertebrl nerve l/s	3.02	4.05	5.90	1.25	1.31	0.18	010
64623		A	Destr paravertebral n add-on	0.99	1.68	2.32	0.22	0.22	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.82	4.74	6.25	1.87	1.92	0.20	010
64627		A	Destr paravertebral n add-on	1.16	2.37	3.45	0.25	0.26	0.07	ZZZ
64630		A	Injection treatment of nerve	3.02	2.76	2.75	1.84	1.62	0.22	010
64640		A	Injection treatment of nerve	2.78	2.42	3.30	1.42	1.63	0.29	010
64650		A	Chemodenerv eccrine glands	0.70	0.72	0.79	0.16	0.23	0.06	000
64653		A	Chemodenerv eccrine glands	0.88	0.75	0.83	0.19	0.28	0.08	000
64680		A	Injection treatment of nerve	2.64	4.25	5.48	1.20	1.31	0.18	010
64681		A	Injection treatment of nerve	3.78	4.81	7.05	1.27	1.67	0.28	010
64702		A	Revise finger/toe nerve	6.10	NA	NA	5.19	4.52	0.61	090
64704		A	Revise hand/foot nerve	4.61	NA	NA	3.28	3.29	0.61	090
64708		A	Revise arm/leg nerve	6.22	NA	NA	4.20	4.53	0.96	090
64712		A	Revision of sciatic nerve	7.98	NA	NA	4.37	4.66	0.95	090
64713		A	Revision of arm nerve(s)	11.29	NA	NA	6.04	5.96	1.83	090
64714		A	Revise low back nerve(s)	10.44	NA	NA	4.36	4.28	1.19	090
64716		A	Revision of cranial nerve	6.86	NA	NA	5.45	5.71	0.63	090
64718		A	Revise ulnar nerve at elbow	7.06	NA	NA	6.20	6.09	1.05	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
64719		A	Revise ulnar nerve at wrist	4.89	NA	NA	4.14	4.33	0.77	090
64721		A	Carpal tunnel surgery	4.84	4.70	5.03	4.65	5.00	0.73	090
64722		A	Relieve pressure on nerve(s)	4.74	NA	NA	2.99	3.02	0.48	090
64726		A	Release foot/toe nerve	4.21	NA	NA	2.80	2.79	0.54	090
64727		A	Internal nerve revision	3.10	NA	NA	1.19	1.34	0.48	ZZZ
64732		A	Incision of brow nerve	4.81	NA	NA	3.66	3.58	0.98	090
64734		A	Incision of cheek nerve	5.45	NA	NA	4.43	4.24	0.89	090
64736		A	Incision of chin nerve	5.13	NA	NA	3.72	3.87	0.52	090
64738		A	Incision of jaw nerve	6.26	NA	NA	4.64	4.62	1.08	090
64740		A	Incision of tongue nerve	6.12	NA	NA	4.98	5.05	0.69	090
64742		A	Incision of facial nerve	6.75	NA	NA	4.28	4.49	0.73	090
64744		A	Incise nerve, back of head	5.64	NA	NA	4.04	3.90	1.16	090
64746		A	Incise diaphragm nerve	6.46	NA	NA	3.86	4.18	0.82	090
64752		A	Incision of vagus nerve	7.59	NA	NA	3.79	4.03	0.93	090
64755		A	Incision of stomach nerves	14.97	NA	NA	5.50	5.56	1.84	090
64760		A	Incision of vagus nerve	7.49	NA	NA	3.78	3.61	0.81	090
64761		A	Incision of pelvis nerve	6.94	NA	NA	4.32	3.92	0.53	090
64763		A	Incise hip/thigh nerve	7.46	NA	NA	3.91	4.55	0.94	090
64766		A	Incise hip/thigh nerve	9.34	NA	NA	4.73	4.99	1.06	090
64771		A	Sever cranial nerve	8.02	NA	NA	5.63	5.59	1.23	090
64772		A	Incision of spinal nerve	7.74	NA	NA	5.12	5.01	1.40	090
64774		A	Remove skin nerve lesion	5.70	NA	NA	4.03	3.93	0.74	090
64776		A	Remove digit nerve lesion	5.52	NA	NA	3.72	3.70	0.76	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	1.21	1.35	0.46	ZZZ
64782		A	Remove limb nerve lesion	6.76	NA	NA	4.22	3.99	0.86	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	1.36	1.60	0.51	ZZZ
64784		A	Remove nerve lesion	10.49	NA	NA	6.40	6.49	1.38	090
64786		A	Remove sciatic nerve lesion	16.12	NA	NA	8.43	9.13	2.61	090
64787		A	Implant nerve end	4.29	NA	NA	1.64	1.88	0.58	ZZZ
64788		A	Remove skin nerve lesion	5.14	NA	NA	4.05	3.76	0.73	090
64790		A	Removal of nerve lesion	11.97	NA	NA	6.97	7.08	2.11	090
64792		A	Removal of nerve lesion	15.71	NA	NA	8.29	8.56	2.49	090
64795		A	Biopsy of nerve	3.01	NA	NA	1.43	1.49	0.52	000
64802		A	Remove sympathetic nerves	10.24	NA	NA	3.50	4.31	1.29	090
64804		A	Remove sympathetic nerves	15.78	NA	NA	5.96	6.56	2.15	090
64809		A	Remove sympathetic nerves	14.61	NA	NA	7.03	6.39	1.50	090
64818		A	Remove sympathetic nerves	11.24	NA	NA	4.32	4.80	1.33	090
64820		A	Remove sympathetic nerves	10.64	NA	NA	6.93	7.02	1.49	090
64821		A	Remove sympathetic nerves	9.19	NA	NA	6.53	6.93	1.24	090
64822		A	Remove sympathetic nerves	9.19	NA	NA	6.42	6.82	1.30	090
64823		A	Remove sympathetic nerves	10.80	NA	NA	6.46	7.29	1.57	090
64831		A	Repair of digit nerve	10.23	NA	NA	6.61	6.84	1.41	090
64832		A	Repair nerve add-on	5.65	NA	NA	2.31	2.62	0.85	ZZZ
64834		A	Repair of hand or foot nerve	10.71	NA	NA	6.44	6.76	1.54	090
64835		A	Repair of hand or foot nerve	11.60	NA	NA	6.90	7.29	1.74	090
64836		A	Repair of hand or foot nerve	11.60	NA	NA	7.06	7.36	1.68	090
64837		A	Repair nerve add-on	6.25	NA	NA	2.57	2.90	0.97	ZZZ
64840		A	Repair of leg nerve	13.87	NA	NA	7.51	7.88	1.37	090
64856		A	Repair/transpose nerve	14.94	NA	NA	8.47	8.83	2.13	090
64857		A	Repair arm/leg nerve	15.69	NA	NA	8.75	9.19	2.22	090
64858		A	Repair sciatic nerve	17.69	NA	NA	9.55	10.16	3.34	090
64859		A	Nerve surgery	4.25	NA	NA	1.75	1.97	0.67	ZZZ
64861		A	Repair of arm nerves	20.74	NA	NA	10.00	10.88	4.09	090
64862		A	Repair of low back nerves	20.94	NA	NA	10.12	11.02	4.32	090
64864		A	Repair of facial nerve	13.31	NA	NA	7.46	8.11	1.26	090
64865		A	Repair of facial nerve	15.96	NA	NA	11.52	12.52	1.50	090
64866		A	Fusion of facial/other nerve	16.70	NA	NA	11.09	12.13	2.05	090
64868		A	Fusion of facial/other nerve	14.80	NA	NA	9.78	10.60	1.43	090
64870		A	Fusion of facial/other nerve	16.95	NA	NA	8.05	8.39	1.30	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	0.78	0.93	0.29	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	1.26	1.39	0.42	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.42	1.58	0.47	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	NA	8.94	10.26	1.63	090
64886		A	Nerve graft, head or neck	20.72	NA	NA	10.36	11.95	2.09	090
64890		A	Nerve graft, hand or foot	16.11	NA	NA	8.97	9.48	2.30	090
64891		A	Nerve graft, hand or foot	17.22	NA	NA	9.65	8.61	1.63	090
64892		A	Nerve graft, arm or leg	15.61	NA	NA	9.12	8.99	2.48	090
64893		A	Nerve graft, arm or leg	16.74	NA	NA	9.62	9.74	2.62	090
64895		A	Nerve graft, hand or foot	20.26	NA	NA	11.03	10.34	2.58	090
64896		A	Nerve graft, hand or foot	21.81	NA	NA	11.65	11.31	3.17	090
64897		A	Nerve graft, arm or leg	19.25	NA	NA	10.49	10.58	2.55	090
64898		A	Nerve graft, arm or leg	20.82	NA	NA	11.45	11.61	2.78	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
64901		A	Nerve graft add-on	10.20	NA	NA	3.62	4.44	1.37	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	4.65	5.31	1.55	ZZZ
64905		A	Nerve pedicle transfer	14.98	NA	NA	6.99	7.74	2.01	090
64907		A	Nerve pedicle transfer	19.90	NA	NA	6.35	9.43	3.17	090
64910		A	Nerve repair w/allograft	11.21	NA	NA	4.66	4.66	1.74	090
64911		A	Neurorraphy w/vein autograft	14.21	NA	NA	5.31	5.31	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	6.72	7.53	0.32	090
65093		A	Revise eye with implant	6.93	NA	NA	6.78	7.75	0.34	090
65101		A	Removal of eye	8.10	NA	NA	7.95	8.74	0.35	090
65103		A	Remove eye/insert implant	8.64	NA	NA	8.11	8.92	0.37	090
65105		A	Remove eye/attach implant	9.70	NA	NA	8.76	9.61	0.42	090
65110		A	Removal of eye	15.42	NA	NA	11.41	12.54	0.81	090
65112		A	Remove eye/revise socket	18.18	NA	NA	13.29	14.71	1.30	090
65114		A	Remove eye/revise socket	19.32	NA	NA	13.55	14.94	1.02	090
65125		A	Revise ocular implant	3.18	6.70	7.75	3.16	3.38	0.19	090
65130		A	Insert ocular implant	8.22	NA	NA	7.67	8.41	0.35	090
65135		A	Insert ocular implant	8.40	NA	NA	7.73	8.52	0.36	090
65140		A	Attach ocular implant	9.23	NA	NA	8.37	9.12	0.40	090
65150		A	Revise ocular implant	6.32	NA	NA	6.29	7.12	0.31	090
65155		A	Reinsert ocular implant	9.87	NA	NA	8.76	9.62	0.50	090
65175		A	Removal of ocular implant	7.22	NA	NA	7.04	7.75	0.31	090
65205		A	Remove foreign body from eye	0.71	0.57	0.60	0.32	0.30	0.03	000
65210		A	Remove foreign body from eye	0.84	0.71	0.76	0.39	0.38	0.04	000
65220		A	Remove foreign body from eye	0.71	0.59	0.62	0.28	0.28	0.05	000
65222		A	Remove foreign body from eye	0.93	0.78	0.83	0.41	0.39	0.04	000
65235		A	Remove foreign body from eye	8.78	NA	NA	6.77	6.76	0.37	090
65260		A	Remove foreign body from eye	12.29	NA	NA	8.73	9.19	0.57	090
65265		A	Remove foreign body from eye	14.06	NA	NA	9.58	10.10	0.62	090
65270		A	Repair of eye wound	1.92	3.82	4.52	1.20	1.29	0.09	010
65272		A	Repair of eye wound	4.49	6.29	7.00	3.15	3.22	0.19	090
65273		A	Repair of eye wound	5.03	NA	NA	3.36	3.47	0.22	090
65275		A	Repair of eye wound	6.14	6.29	6.30	3.89	3.92	0.26	090
65280		A	Repair of eye wound	8.87	NA	NA	5.83	6.03	0.38	090
65285		A	Repair of eye wound	14.43	NA	NA	8.38	8.79	0.64	090
65286		A	Repair of eye wound	6.45	8.69	9.91	4.38	4.49	0.27	090
65290		A	Repair of eye socket wound	6.35	NA	NA	4.43	4.58	0.31	090
65400		A	Removal of eye lesion	7.27	7.43	7.88	5.83	5.98	0.30	090
65410		A	Biopsy of cornea	1.47	1.66	1.89	0.86	0.91	0.07	000
65420		A	Removal of eye lesion	4.24	6.84	7.85	3.95	4.19	0.21	090
65426		A	Removal of eye lesion	5.93	8.08	9.12	4.49	4.70	0.25	090
65430		A	Corneal smear	1.47	1.08	1.18	0.86	0.92	0.07	000
65435		A	Curette/treat cornea	0.92	0.85	0.93	0.64	0.68	0.04	000
65436		A	Curette/treat cornea	4.72	3.75	3.92	3.43	3.55	0.21	090
65450		A	Treatment of corneal lesion	3.35	3.67	3.87	3.59	3.76	0.16	090
65600		A	Revision of cornea	4.07	4.42	4.71	3.38	3.36	0.17	090
65710		A	Corneal transplant	14.09	NA	NA	10.13	10.66	0.61	090
65730		A	Corneal transplant	15.99	NA	NA	10.94	11.48	0.70	090
65750		A	Corneal transplant	16.60	NA	NA	10.60	11.28	0.74	090
65755		A	Corneal transplant	16.49	NA	NA	10.56	11.22	0.73	090
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.41	NA	NA	11.64	12.42	0.87	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	4.96	4.84	5.18	3.91	4.02	0.21	090
65775		A	Correction of astigmatism	6.73	NA	NA	5.29	5.62	0.28	090
65780		A	Ocular reconst, transplant	10.43	NA	NA	8.91	9.60	0.44	090
65781		A	Ocular reconst, transplant	17.84	NA	NA	11.56	12.61	0.44	090
65782		A	Ocular reconst, transplant	15.16	NA	NA	10.17	11.08	0.44	090
65800		A	Drainage of eye	1.91	1.39	1.59	1.02	1.10	0.09	000
65805		A	Drainage of eye	1.91	1.69	1.93	1.02	1.10	0.09	000
65810		A	Drainage of eye	5.67	NA	NA	4.66	4.68	0.24	090
65815		A	Drainage of eye	5.85	7.90	8.95	4.57	4.69	0.25	090
65820		A	Relieve inner eye pressure	8.72	NA	NA	7.49	8.27	0.40	090
65850		A	Incision of eye	11.24	NA	NA	7.31	7.87	0.52	090
65855		A	Laser surgery of eye	3.90	3.48	3.89	2.62	2.86	0.19	010
65860		A	Incise inner eye adhesions	3.56	3.25	3.64	2.07	2.29	0.18	090
65865		A	Incise inner eye adhesions	5.66	NA	NA	4.68	5.15	0.28	090
65870		A	Incise inner eye adhesions	7.21	NA	NA	5.69	6.05	0.31	090
65875		A	Incise inner eye adhesions	7.61	NA	NA	6.12	6.45	0.32	090
65880		A	Incise inner eye adhesions	8.16	NA	NA	6.29	6.66	0.35	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
65900		A	Remove eye lesion	12.26	NA	NA	8.88	9.56	0.54	090
65920		A	Remove implant of eye	9.74	NA	NA	7.45	7.81	0.41	090
65930		A	Remove blood clot from eye	8.24	NA	NA	5.76	6.30	0.37	090
66020		A	Injection treatment of eye	1.61	2.42	2.77	1.27	1.35	0.08	010
66030		A	Injection treatment of eye	1.27	2.29	2.63	1.15	1.21	0.06	010
66130		A	Remove eye lesion	7.74	7.50	8.56	4.86	5.23	0.38	090
66150		A	Glaucoma surgery	10.18	NA	NA	8.80	9.10	0.46	090
66155		A	Glaucoma surgery	10.17	NA	NA	8.80	9.07	0.41	090
66160		A	Glaucoma surgery	12.04	NA	NA	9.46	9.82	0.50	090
66165		A	Glaucoma surgery	9.89	NA	NA	8.76	9.00	0.40	090
66170		A	Glaucoma surgery	14.57	NA	NA	11.52	11.87	0.60	090
66172		A	Incision of eye	18.26	NA	NA	14.61	14.90	0.74	090
66180		A	Implant eye shunt	16.02	NA	NA	9.68	10.21	0.71	090
66185		A	Revise eye shunt	9.35	NA	NA	7.03	7.20	0.40	090
66220		A	Repair eye lesion	8.98	NA	NA	7.16	7.13	0.40	090
66225		A	Repair/graft eye lesion	12.38	NA	NA	8.10	8.42	0.55	090
66250		A	Follow-up surgery of eye	6.92	9.22	10.45	5.24	5.36	0.30	090
66500		A	Incision of iris	3.75	NA	NA	3.94	4.29	0.18	090
66505		A	Incision of iris	4.13	NA	NA	4.30	4.64	0.20	090
66600		A	Remove iris and lesion	9.89	NA	NA	8.24	8.23	0.43	090
66605		A	Removal of iris	13.99	NA	NA	9.44	9.73	0.77	090
66625		A	Removal of iris	5.19	NA	NA	4.20	4.46	0.26	090
66630		A	Removal of iris	7.10	NA	NA	5.33	5.52	0.31	090
66635		A	Removal of iris	7.19	NA	NA	5.36	5.55	0.31	090
66680		A	Repair iris & ciliary body	6.24	NA	NA	5.05	5.16	0.27	090
66682		A	Repair iris & ciliary body	7.15	NA	NA	6.70	6.65	0.31	090
66700		A	Destruction, ciliary body	5.06	4.77	5.01	3.58	3.76	0.24	090
66710		A	Ciliary transscleral therapy	5.06	4.59	4.88	3.59	3.72	0.23	090
66711		A	Ciliary endoscopic ablation	7.70	NA	NA	6.28	6.37	0.30	090
66720		A	Destruction, ciliary body	4.86	5.36	5.58	4.31	4.51	0.26	090
66740		A	Destruction, ciliary body	5.06	4.52	4.80	3.60	3.78	0.23	090
66761		A	Revision of iris	4.87	5.01	5.30	4.18	4.24	0.20	090
66762		A	Revision of iris	5.25	5.09	5.37	4.06	4.17	0.23	090
66770		A	Removal of inner eye lesion	5.98	5.52	5.80	4.58	4.69	0.26	090
66820		A	Incision, secondary cataract	3.93	NA	NA	4.61	5.21	0.19	090
66821		A	After cataract laser surgery	3.32	3.82	3.95	3.41	3.51	0.11	090
66825		A	Reposition intraocular lens	8.82	NA	NA	7.76	8.41	0.40	090
66830		A	Removal of lens lesion	9.27	NA	NA	6.36	6.65	0.36	090
66840		A	Removal of lens material	8.98	NA	NA	6.28	6.57	0.39	090
66850		A	Removal of lens material	10.32	NA	NA	7.06	7.35	0.45	090
66852		A	Removal of lens material	11.18	NA	NA	7.38	7.73	0.49	090
66920		A	Extraction of lens	9.93	NA	NA	6.63	6.96	0.44	090
66930		A	Extraction of lens	11.38	NA	NA	7.44	7.79	0.49	090
66940		A	Extraction of lens	10.14	NA	NA	6.99	7.29	0.43	090
66982		A	Cataract surgery, complex	14.83	NA	NA	8.94	9.40	0.63	090
66983		A	Cataract surg w/iol, 1 stage	10.20	NA	NA	6.50	6.31	0.14	090
66984		A	Cataract surg w/iol, 1 stage	10.36	NA	NA	6.44	6.93	0.39	090
66985		A	Insert lens prosthesis	9.73	NA	NA	7.12	7.28	0.36	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	8.04	8.61	0.60	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	0.54	0.61	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	4.57	4.71	0.28	090
67010		A	Partial removal of eye fluid	6.94	NA	NA	4.99	5.20	0.34	090
67015		A	Release of eye fluid	7.00	NA	NA	5.69	6.07	0.34	090
67025		A	Replace eye fluid	7.91	7.85	8.53	5.91	6.06	0.34	090
67027		A	Implant eye drug system	11.43	NA	NA	7.36	7.67	0.54	090
67028		A	Injection eye drug	2.52	2.15	2.42	1.24	1.35	0.12	000
67030		A	Incise inner eye strands	5.91	NA	NA	5.59	5.72	0.24	090
67031		A	Laser surgery, eye strands	4.34	4.09	4.34	3.42	3.53	0.18	090
67036		A	Removal of inner eye fluid	13.09	NA	NA	8.05	8.58	0.58	090
67039		A	Laser treatment of retina	16.39	NA	NA	10.68	11.43	0.71	090
67040		A	Laser treatment of retina	19.23	NA	NA	11.98	12.83	0.85	090
67041		A	Vit for macular pucker	19.00	NA	NA	10.36	10.36	0.86	090
67042		A	Vit for macular hole	22.13	NA	NA	11.48	11.48	1.00	090
67043		A	Vit for membrane dissect	22.94	NA	NA	12.34	12.34	1.04	090
67101		A	Repair detached retina	8.60	8.48	8.80	6.16	6.34	0.37	090
67105		A	Repair detached retina	8.35	7.40	7.74	5.78	5.96	0.37	090
67107		A	Repair detached retina	16.35	NA	NA	10.33	10.81	0.73	090
67108		A	Repair detached retina	22.49	NA	NA	12.92	13.66	1.02	090
67110		A	Repair detached retina	10.02	8.91	9.57	6.95	7.17	0.44	090
67112		A	Rerepair detached retina	18.45	NA	NA	10.84	11.32	0.83	090
67113		A	Repair retinal detach, cplx	22.49	NA	NA	12.75	12.75	1.13	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
67115		A	Release encircling material	5.93	NA	NA	4.92	5.00	0.25	090
67120		A	Remove eye implant material	6.92	7.34	7.96	5.27	5.40	0.29	090
67121		A	Remove eye implant material	12.00	NA	NA	7.94	8.23	0.53	090
67141		A	Treatment of retina	6.00	5.40	5.63	4.65	4.75	0.26	090
67145		A	Treatment of retina	6.17	5.33	5.53	4.70	4.81	0.27	090
67208		A	Treatment of retinal lesion	7.50	5.64	5.88	5.19	5.35	0.33	090
67210		A	Treatment of retinal lesion	9.35	5.91	6.24	5.43	5.65	0.44	090
67218		A	Treatment of retinal lesion	20.22	NA	NA	10.60	11.37	0.92	090
67220		A	Treatment of choroid lesion	14.19	9.20	9.81	8.15	8.58	0.65	090
67221		R	Ocular photodynamic ther	3.45	2.91	3.62	1.38	1.59	0.20	000
67225		A	Eye photodynamic ther add-on	0.47	0.22	0.24	0.17	0.19	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.38	5.99	6.28	5.15	5.34	0.33	090
67228		A	Treatment of retinal lesion	13.67	13.58	12.52	10.18	9.36	0.63	090
67229		A	Tr retinal les preterm inf	16.00	NA	NA	9.51	9.51	0.71	090
67250		A	Reinforce eye wall	9.46	NA	NA	7.66	8.41	0.47	090
67255		A	Reinforce/graft eye wall	9.97	NA	NA	8.42	9.15	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	5.49	5.76	0.37	090
67312		A	Revise two eye muscles	9.48	NA	NA	6.19	6.47	0.43	090
67314		A	Revise eye muscle	8.59	NA	NA	6.15	6.35	0.39	090
67316		A	Revise two eye muscles	10.73	NA	NA	6.91	7.20	0.49	090
67318		A	Revise eye muscle(s)	8.92	NA	NA	6.50	6.71	0.41	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	1.92	1.94	0.22	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	1.81	1.82	0.21	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	1.97	2.00	0.23	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	1.80	1.80	0.20	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	0.88	1.00	0.13	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	2.13	2.17	0.25	ZZZ
67343		A	Release eye tissue	8.29	NA	NA	6.06	6.28	0.37	090
67345		A	Destroy nerve of eye muscle	2.98	2.17	2.38	1.69	1.85	0.17	010
67346		A	Biopsy, eye muscle	2.87	NA	NA	1.62	1.75	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	9.41	10.33	0.56	090
67405		A	Explore/drain eye socket	9.00	NA	NA	8.33	9.05	0.44	090
67412		A	Explore/treat eye socket	10.17	NA	NA	8.52	9.72	0.48	090
67413		A	Explore/treat eye socket	10.09	NA	NA	8.69	9.73	0.50	090
67414		A	Explr/decompress eye socket	17.78	NA	NA	11.62	11.83	0.65	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	0.62	0.69	0.09	000
67420		A	Explore/treat eye socket	21.62	NA	NA	14.22	15.80	1.15	090
67430		A	Explore/treat eye socket	14.99	NA	NA	11.86	13.37	0.86	090
67440		A	Explore/drain eye socket	14.56	NA	NA	11.86	13.06	0.70	090
67445		A	Explr/decompress eye socket	18.96	NA	NA	12.13	13.02	0.90	090
67450		A	Explore/biopsy eye socket	15.11	NA	NA	12.29	13.48	0.68	090
67500		A	Inject/treat eye socket	1.44	0.57	0.62	0.44	0.37	0.05	000
67505		A	Inject/treat eye socket	1.27	0.65	0.67	0.50	0.41	0.05	000
67515		A	Inject/treat eye socket	1.40	0.77	0.68	0.61	0.49	0.03	000
67550		A	Insert eye socket implant	11.52	NA	NA	9.81	10.55	0.72	090
67560		A	Revise eye socket implant	11.93	NA	NA	9.77	10.57	0.60	090
67570		A	Decompress optic nerve	14.21	NA	NA	11.00	12.28	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	4.30	5.16	1.17	1.22	0.07	010
67710		A	Incision of eyelid	1.04	3.70	4.53	1.07	1.14	0.05	010
67715		A	Incision of eyelid fold	1.24	3.83	4.60	1.15	1.22	0.06	010
67800		A	Remove eyelid lesion	1.39	1.39	1.50	0.90	0.97	0.07	010
67801		A	Remove eyelid lesions	1.89	1.67	1.82	1.07	1.17	0.09	010
67805		A	Remove eyelid lesions	2.24	2.18	2.35	1.40	1.52	0.11	010
67808		A	Remove eyelid lesion(s)	4.47	NA	NA	3.60	3.69	0.19	090
67810		A	Biopsy of eyelid	1.48	3.93	3.63	0.68	0.68	0.06	000
67820		A	Revise eyelashes	0.71	0.43	0.52	0.50	0.53	0.04	000
67825		A	Revise eyelashes	1.40	1.40	1.57	1.26	1.33	0.07	010
67830		A	Revise eyelashes	1.72	3.99	4.76	1.32	1.41	0.08	010
67835		A	Revise eyelashes	5.61	NA	NA	4.12	4.37	0.28	090
67840		A	Remove eyelid lesion	2.06	3.90	4.69	1.45	1.55	0.10	010
67850		A	Treat eyelid lesion	1.71	3.28	3.33	1.44	1.45	0.07	010
67875		A	Closure of eyelid by suture	1.35	2.38	2.84	0.83	0.88	0.07	000
67880		A	Revision of eyelid	4.47	5.43	6.02	3.56	3.68	0.19	090
67882		A	Revision of eyelid	5.87	6.35	6.99	4.45	4.63	0.25	090
67900		A	Repair brow defect	6.69	7.36	8.21	4.60	4.93	0.38	090
67901		A	Repair eyelid defect	7.47	8.98	7.19	5.28	5.34	0.54	090
67902		A	Repair eyelid defect	9.68	NA	NA	6.33	5.90	0.60	090
67903		A	Repair eyelid defect	6.42	6.62	8.09	4.33	4.92	0.47	090
67904		A	Repair eyelid defect	7.83	8.16	8.89	5.37	5.30	0.41	090

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
67906	.....	A	Repair eyelid defect	6.84	NA	NA	4.46	4.74	0.46	090
67908	.....	A	Repair eyelid defect	5.19	5.55	6.09	4.12	4.73	0.28	090
67909	.....	A	Revise eyelid defect	5.46	6.17	7.10	4.16	4.55	0.31	090
67911	.....	A	Revise eyelid defect	7.38	NA	NA	5.04	4.91	0.31	090
67912	.....	A	Correction eyelid w/implant	6.23	13.12	16.02	4.73	5.13	0.28	090
67914	.....	A	Repair eyelid defect	3.70	4.74	5.54	2.67	2.86	0.19	090
67915	.....	A	Repair eyelid defect	3.21	4.31	5.15	2.43	2.61	0.16	090
67916	.....	A	Repair eyelid defect	5.37	6.36	7.20	4.14	4.45	0.28	090
67917	.....	A	Repair eyelid defect	6.08	6.72	7.58	4.40	4.73	0.36	090
67921	.....	A	Repair eyelid defect	3.42	4.61	5.40	2.55	2.72	0.17	090
67922	.....	A	Repair eyelid defect	3.09	4.15	5.03	2.33	2.54	0.15	090
67923	.....	A	Repair eyelid defect	5.94	6.43	7.27	4.32	4.64	0.30	090
67924	.....	A	Repair eyelid defect	5.84	6.90	7.91	4.05	4.36	0.30	090
67930	.....	A	Repair eyelid wound	3.62	4.36	5.04	1.78	1.97	0.19	010
67935	.....	A	Repair eyelid wound	6.27	6.76	7.63	3.58	3.99	0.39	090
67938	.....	A	Remove eyelid foreign body	1.35	3.83	4.60	1.22	1.24	0.06	010
67950	.....	A	Revision of eyelid	5.88	6.65	7.64	4.37	4.79	0.36	090
67961	.....	A	Revision of eyelid	5.75	6.81	7.74	4.30	4.66	0.33	090
67966	.....	A	Revision of eyelid	8.83	8.04	8.58	5.74	5.65	0.37	090
67971	.....	A	Reconstruction of eyelid	9.87	NA	NA	6.17	6.72	0.53	090
67973	.....	A	Reconstruction of eyelid	12.96	NA	NA	7.70	8.51	0.75	090
67974	.....	A	Reconstruction of eyelid	12.93	NA	NA	7.68	8.45	0.75	090
67975	.....	A	Reconstruction of eyelid	9.21	NA	NA	5.94	6.44	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	1.23	1.32	1.05	1.13	0.06	010
68040	.....	A	Treatment of eyelid lesions	0.85	0.60	0.65	0.35	0.39	0.04	000
68100	.....	A	Biopsy of eyelid lining	1.35	2.36	2.80	0.86	0.90	0.07	000
68110	.....	A	Remove eyelid lining lesion	1.79	3.07	3.58	1.48	1.56	0.09	010
68115	.....	A	Remove eyelid lining lesion	2.38	4.32	5.14	1.69	1.80	0.12	010
68130	.....	A	Remove eyelid lining lesion	4.99	6.63	7.67	4.02	4.31	0.24	090
68135	.....	A	Remove eyelid lining lesion	1.86	1.58	1.70	1.47	1.56	0.09	010
68200	.....	A	Treat eyelid by injection	0.49	0.45	0.49	0.29	0.31	0.02	000
68320	.....	A	Revise/graft eyelid lining	6.44	9.15	10.21	5.30	5.41	0.27	090
68325	.....	A	Revise/graft eyelid lining	8.43	NA	NA	6.09	6.32	0.44	090
68326	.....	A	Revise/graft eyelid lining	8.22	NA	NA	5.91	6.16	0.35	090
68328	.....	A	Revise/graft eyelid lining	9.25	NA	NA	6.37	6.83	0.54	090
68330	.....	A	Revise eyelid lining	5.63	7.40	8.41	4.44	4.58	0.24	090
68335	.....	A	Revise/graft eyelid lining	8.26	NA	NA	5.91	6.14	0.36	090
68340	.....	A	Separate eyelid adhesions	4.84	6.87	7.87	3.86	3.98	0.21	090
68360	.....	A	Revise eyelid lining	5.04	6.43	7.23	3.95	4.06	0.22	090
68362	.....	A	Revise eyelid lining	8.41	NA	NA	5.97	6.18	0.36	090
68371	.....	A	Harvest eye tissue, alograft	4.97	NA	NA	4.05	4.39	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	4.42	5.16	1.21	1.52	0.08	010
68420	.....	A	Incise/drain tear sac	2.32	4.58	5.39	1.41	1.76	0.11	010
68440	.....	A	Incise tear duct opening	0.96	1.25	1.67	1.18	1.22	0.05	010
68500	.....	A	Removal of tear gland	12.49	NA	NA	9.51	9.62	0.55	090
68505	.....	A	Partial removal, tear gland	12.41	NA	NA	8.90	9.77	0.55	090
68510	.....	A	Biopsy of tear gland	4.60	5.21	6.27	2.02	2.06	0.23	000
68520	.....	A	Removal of tear sac	8.58	NA	NA	6.49	6.95	0.37	090
68525	.....	A	Biopsy of tear sac	4.42	NA	NA	1.56	1.79	0.22	000
68530	.....	A	Clearance of tear duct	3.67	5.59	6.88	2.07	2.36	0.18	010
68540	.....	A	Remove tear gland lesion	11.93	NA	NA	8.48	8.93	0.52	090
68550	.....	A	Remove tear gland lesion	14.86	NA	NA	9.66	10.50	0.80	090
68700	.....	A	Repair tear ducts	7.67	NA	NA	5.55	5.77	0.32	090
68705	.....	A	Revise tear duct opening	2.08	3.03	3.60	1.58	1.69	0.10	010
68720	.....	A	Create tear sac drain	9.78	NA	NA	6.87	7.36	0.44	090
68745	.....	A	Create tear duct drain	9.70	NA	NA	6.97	7.41	0.52	090
68750	.....	A	Create tear duct drain	9.87	NA	NA	7.42	7.84	0.43	090
68760	.....	A	Close tear duct opening	1.75	2.58	3.06	1.45	1.54	0.09	010
68761	.....	A	Close tear duct opening	1.38	1.83	2.05	1.25	1.28	0.06	010
68770	.....	A	Close tear system fistula	8.09	NA	NA	5.74	4.46	0.35	090
68801	.....	A	Dilate tear duct opening	0.96	1.77	1.86	1.41	1.44	0.05	010
68810	.....	A	Probe nasolacrimal duct	2.63	3.39	3.52	2.68	2.67	0.10	010
68811	.....	A	Probe nasolacrimal duct	2.39	NA	NA	2.12	2.27	0.13	010
68815	.....	A	Probe nasolacrimal duct	3.24	6.41	7.32	2.43	2.62	0.17	010
68816	.....	A	Probe nl duct w/balloon	3.00	12.73	12.73	2.51	2.51	0.16	010
68840	.....	A	Explore/irrigate tear ducts	1.27	1.51	1.55	1.28	1.20	0.06	010
68850	.....	A	Injection for tear sac x-ray	0.80	0.72	0.80	0.60	0.64	0.04	000
68899	.....	C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000	.....	A	Drain external ear lesion	1.47	2.88	2.88	1.34	1.35	0.12	010
69005	.....	A	Drain external ear lesion	2.13	2.99	2.96	1.61	1.72	0.17	010

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69020		A	Drain outer ear canal lesion	1.50	4.09	4.04	1.90	1.98	0.12	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.85	1.78	0.39	0.39	0.03	000
69105		A	Biopsy of external ear canal	0.85	2.64	2.49	0.71	0.74	0.07	000
69110		A	Remove external ear, partial	3.47	7.83	7.29	4.44	4.45	0.30	090
69120		A	Removal of external ear	4.08	NA	NA	5.36	5.77	0.38	090
69140		A	Remove ear canal lesion(s)	8.03	NA	NA	13.21	13.24	0.65	090
69145		A	Remove ear canal lesion(s)	2.65	7.03	6.40	3.37	3.33	0.21	090
69150		A	Extensive ear canal surgery	13.49	NA	NA	11.45	12.42	1.22	090
69155		A	Extensive ear/neck surgery	23.06	NA	NA	16.98	18.25	1.93	090
69200		A	Clear outer ear canal	0.77	2.15	2.27	0.61	0.58	0.06	000
69205		A	Clear outer ear canal	1.20	NA	NA	1.24	1.30	0.10	010
69210		A	Remove impacted ear wax	0.61	0.58	0.60	0.17	0.20	0.05	000
69220		A	Clean out mastoid cavity	0.83	2.56	2.46	0.68	0.70	0.07	000
69222		A	Clean out mastoid cavity	1.42	3.97	3.91	1.90	1.98	0.12	010
69300		R	Revise external ear	6.69	10.71	7.46	5.18	4.70	0.72	YYY
69310		A	Rebuild outer ear canal	10.85	NA	NA	15.48	15.88	0.85	090
69320		A	Rebuild outer ear canal	17.03	NA	NA	20.05	20.94	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	2.49	0.68	0.67	0.07	000
69401		A	Inflate middle ear canal	0.63	1.53	1.38	0.59	0.62	0.05	000
69405		A	Catheterize middle ear canal	2.65	3.65	3.58	1.96	2.14	0.21	010
69420		A	Incision of eardrum	1.35	3.32	3.23	1.56	1.57	0.11	010
69421		A	Incision of eardrum	1.75	NA	NA	1.85	2.01	0.15	010
69424		A	Remove ventilating tube	0.85	2.34	2.26	0.68	0.68	0.07	000
69433		A	Create eardrum opening	1.54	3.32	3.20	1.59	1.61	0.13	010
69436		A	Create eardrum opening	1.98	NA	NA	1.90	2.09	0.19	010
69440		A	Exploration of middle ear	7.62	NA	NA	9.11	8.94	0.61	090
69450		A	Eardrum revision	5.61	NA	NA	7.61	7.32	0.45	090
69501		A	Mastoidectomy	9.12	NA	NA	8.65	8.82	0.73	090
69502		A	Mastoidectomy	12.44	NA	NA	11.04	11.31	1.00	090
69505		A	Remove mastoid structures	13.05	NA	NA	16.14	16.66	1.05	090
69511		A	Extensive mastoid surgery	13.58	NA	NA	16.32	16.89	1.09	090
69530		A	Extensive mastoid surgery	20.24	NA	NA	19.65	20.63	1.54	090
69535		A	Remove part of temporal bone	37.27	NA	NA	26.75	29.34	2.93	090
69540		A	Remove ear lesion	1.22	3.90	3.82	1.85	1.91	0.10	010
69550		A	Remove ear lesion	11.04	NA	NA	14.27	14.56	0.89	090
69552		A	Remove ear lesion	19.69	NA	NA	18.18	19.42	1.59	090
69554		A	Remove ear lesion	35.71	NA	NA	23.98	27.15	2.92	090
69601		A	Mastoid surgery revision	13.31	NA	NA	11.91	12.29	1.07	090
69602		A	Mastoid surgery revision	13.64	NA	NA	12.80	13.01	1.10	090
69603		A	Mastoid surgery revision	14.08	NA	NA	16.43	17.39	1.14	090
69604		A	Mastoid surgery revision	14.08	NA	NA	12.77	13.23	1.14	090
69605		A	Mastoid surgery revision	18.55	NA	NA	19.28	20.11	1.50	090
69610		A	Repair of eardrum	4.44	4.91	5.23	2.58	2.93	0.36	010
69620		A	Repair of eardrum	5.94	10.90	11.01	5.83	6.06	0.48	090
69631		A	Repair eardrum structures	9.93	NA	NA	11.52	11.36	0.80	090
69632		A	Rebuild eardrum structures	12.82	NA	NA	13.30	13.38	1.03	090
69633		A	Rebuild eardrum structures	12.17	NA	NA	13.08	13.06	0.98	090
69635		A	Repair eardrum structures	13.39	NA	NA	16.28	16.51	1.08	090
69636		A	Rebuild eardrum structures	15.29	NA	NA	18.19	18.74	1.23	090
69637		A	Rebuild eardrum structures	15.18	NA	NA	18.10	18.66	1.22	090
69641		A	Revise middle ear & mastoid	12.77	NA	NA	12.47	12.62	1.03	090
69642		A	Revise middle ear & mastoid	16.91	NA	NA	15.52	15.90	1.36	090
69643		A	Revise middle ear & mastoid	15.45	NA	NA	14.15	14.48	1.24	090
69644		A	Revise middle ear & mastoid	17.09	NA	NA	18.72	19.56	1.37	090
69645		A	Revise middle ear & mastoid	16.57	NA	NA	18.58	19.30	1.33	090
69646		A	Revise middle ear & mastoid	18.23	NA	NA	19.10	19.92	1.46	090
69650		A	Release middle ear bone	9.71	NA	NA	9.53	9.72	0.78	090
69660		A	Revise middle ear bone	11.94	NA	NA	10.49	10.83	0.96	090
69661		A	Revise middle ear bone	15.80	NA	NA	13.46	14.07	1.27	090
69662		A	Revise middle ear bone	15.49	NA	NA	12.50	13.12	1.25	090
69666		A	Repair middle ear structures	9.80	NA	NA	9.80	9.88	0.79	090
69667		A	Repair middle ear structures	9.81	NA	NA	9.83	9.90	0.79	090
69670		A	Remove mastoid air cells	11.62	NA	NA	11.24	11.47	0.93	090
69676		A	Remove middle ear nerve	9.58	NA	NA	10.60	10.67	0.81	090
69700		A	Close mastoid fistula	8.28	NA	NA	8.67	8.96	0.67	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.50	NA	NA	10.40	10.59	0.83	090
69714		A	Implant temple bone w/stimul	14.31	NA	NA	11.78	12.22	1.13	090
69715		A	Temple bne implnt w/stimulat	18.80	NA	NA	13.32	14.17	1.48	090
69717		A	Temple bone implant revision	15.29	NA	NA	11.95	13.21	0.90	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
69718		A	Revise temple bone implant	19.05	NA	NA	13.40	14.35	3.22	090
69720		A	Release facial nerve	14.57	NA	NA	14.01	14.26	1.16	090
69725		A	Release facial nerve	27.44	NA	NA	18.01	19.07	2.45	090
69740		A	Repair facial nerve	16.18	NA	NA	11.58	12.49	1.27	090
69745		A	Repair facial nerve	16.91	NA	NA	9.93	12.44	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	9.54	0.69	090
69802		A	Incise inner ear	13.39	NA	NA	11.86	12.09	1.06	090
69805		A	Explore inner ear	14.55	NA	NA	10.89	11.38	1.12	090
69806		A	Explore inner ear	12.52	NA	NA	10.39	10.71	1.00	090
69820		A	Establish inner ear window	10.40	NA	NA	10.24	10.73	0.90	090
69840		A	Revise inner ear window	10.32	NA	NA	11.37	12.27	0.79	090
69905		A	Remove inner ear	11.15	NA	NA	11.03	11.19	0.90	090
69910		A	Remove inner ear & mastoid	13.80	NA	NA	10.88	11.39	1.07	090
69915		A	Incise inner ear nerve	22.65	NA	NA	14.81	15.63	1.70	090
69930		A	Implant cochlear device	17.60	NA	NA	13.10	13.92	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	16.84	17.86	2.29	090
69955		A	Release facial nerve	29.22	NA	NA	19.38	20.37	2.49	090
69960		A	Release inner ear canal	29.22	NA	NA	17.90	18.97	2.18	090
69970		A	Remove inner ear lesion	32.21	NA	NA	19.51	21.39	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	1.53	0.89	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.82	3.76	NA	NA	0.27	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.40	3.36	NA	NA	0.22	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.42	0.40	0.42	0.40	0.05	XXX
70015		A	Contrast x-ray of brain	1.19	2.92	2.33	NA	NA	0.16	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.49	1.92	NA	NA	0.08	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.43	0.41	0.43	0.41	0.08	XXX
70030		A	X-ray eye for foreign body	0.17	0.61	0.54	NA	NA	0.03	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.55	0.48	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	0.63	0.61	NA	NA	0.03	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.58	0.55	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	0.81	0.75	NA	NA	0.05	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.72	0.67	NA	NA	0.04	XXX
70110	26	A	X-ray exam of jaw	0.25	0.09	0.08	0.09	0.08	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.69	0.69	NA	NA	0.05	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.64	0.63	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	1.15	1.02	NA	NA	0.07	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.04	0.91	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	0.92	0.87	NA	NA	0.07	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.80	0.76	NA	NA	0.05	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.12	0.11	0.12	0.11	0.02	XXX
70140		A	X-ray exam of facial bones	0.19	0.54	0.62	NA	NA	0.05	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.49	0.56	NA	NA	0.04	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.05	0.06	0.05	0.06	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.85	0.85	NA	NA	0.06	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.77	0.77	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	0.64	NA	NA	0.03	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.65	0.58	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	0.10	0.10	0.10	0.10	0.01	XXX
70190		A	X-ray exam of eye sockets	0.21	0.72	0.70	NA	NA	0.05	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.65	0.63	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	0.87	0.87	NA	NA	0.06	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.78	0.78	NA	NA	0.05	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.09	0.09	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.58	0.62	NA	NA	0.05	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.53	0.57	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	0.73	0.80	NA	NA	0.06	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.65	0.72	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	0.54	NA	NA	0.03	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.55	0.48	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	0.69	NA	NA	0.05	XXX
70250	TC	A	X-ray exam of skull	0.00	0.63	0.62	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	0.94	NA	NA	0.08	XXX
70260	TC	A	X-ray exam of skull	0.00	0.78	0.83	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	0.27	NA	NA	0.03	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.21	0.23	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	0.65	NA	NA	0.03	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.77	0.59	NA	NA	0.02	XXX
70310	26	A	X-ray exam of teeth	0.16	0.05	0.06	0.05	0.06	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.06	0.96	NA	NA	0.06	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.99	0.89	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	0.59	NA	NA	0.03	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.57	0.53	NA	NA	0.02	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	1.01	0.96	NA	NA	0.06	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.93	0.88	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	1.45	1.88	NA	NA	0.14	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.29	1.70	NA	NA	0.12	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.16	0.18	0.16	0.18	0.02	XXX
70336		A	Magnetic image, jaw joint	1.48	12.15	11.91	NA	NA	0.66	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.65	11.42	NA	NA	0.59	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.50	0.49	0.50	0.49	0.07	XXX
70350		A	X-ray head for orthodontia	0.17	0.32	0.39	NA	NA	0.03	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.27	0.33	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	0.47	NA	NA	0.05	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.23	0.40	NA	NA	0.04	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.07	0.07	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.56	0.52	NA	NA	0.03	XXX
70360	TC	A	X-ray exam of neck	0.00	0.51	0.46	NA	NA	0.02	XXX
70360	26	A	X-ray exam of neck	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.65	1.53	NA	NA	0.08	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.55	1.43	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	1.47	1.93	NA	NA	0.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.21	1.66	NA	NA	0.12	XXX
70371	26	A	Speech evaluation, complex	0.84	0.26	0.27	0.26	0.27	0.04	XXX
70373		A	Contrast x-ray of larynx	0.44	1.58	1.75	NA	NA	0.13	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.47	1.62	NA	NA	0.11	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.11	0.13	0.11	0.13	0.02	XXX
70380		A	X-ray exam of salivary gland	0.17	0.82	0.78	NA	NA	0.05	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.76	0.72	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	2.33	2.12	NA	NA	0.13	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.20	1.99	NA	NA	0.11	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.13	0.13	0.13	0.13	0.02	XXX
70450		A	Ct head/brain w/o dye	0.85	4.91	4.95	NA	NA	0.29	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.61	4.66	NA	NA	0.25	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.30	0.29	0.30	0.29	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	6.51	6.27	NA	NA	0.35	XXX
70460	TC	A	Ct head/brain w/dye	0.00	6.11	5.88	NA	NA	0.30	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.40	0.39	0.40	0.39	0.05	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	7.93	7.70	NA	NA	0.43	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.48	7.27	NA	NA	0.37	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.45	0.43	0.45	0.43	0.06	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	8.48	6.80	NA	NA	0.31	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	8.03	6.37	NA	NA	0.25	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.45	0.43	0.45	0.43	0.06	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	9.97	8.04	NA	NA	0.36	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	9.48	7.57	NA	NA	0.30	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.49	0.47	0.49	0.47	0.06	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	11.40	9.47	NA	NA	0.43	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	10.89	8.98	NA	NA	0.37	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.51	0.49	0.51	0.49	0.06	XXX
70486		A	Ct maxillofacial w/o dye	1.14	6.78	5.93	NA	NA	0.30	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
70486	TC	A	Ct maxillofacial w/o dye	0.00	6.39	5.55	NA	NA	0.25	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.39	0.38	0.39	0.38	0.05	XXX
70487		A	Ct maxillofacial w/dye	1.30	8.34	7.21	NA	NA	0.36	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	7.88	6.77	NA	NA	0.30	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.46	0.44	0.46	0.44	0.06	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	10.39	8.96	NA	NA	0.43	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	9.90	8.48	NA	NA	0.37	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.49	0.48	0.49	0.48	0.06	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	6.48	5.81	NA	NA	0.31	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	6.03	5.37	NA	NA	0.25	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.45	0.44	0.45	0.44	0.06	XXX
70491		A	Ct soft tissue neck w/dye	1.38	8.03	7.07	NA	NA	0.36	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	7.54	6.60	NA	NA	0.30	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.49	0.47	0.49	0.47	0.06	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	10.03	8.78	NA	NA	0.43	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	9.52	8.29	NA	NA	0.37	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.51	0.49	0.51	0.49	0.06	XXX
70496		A	Ct angiography, head	1.75	17.08	14.12	NA	NA	0.66	XXX
70496	TC	A	Ct angiography, head	0.00	16.45	13.52	NA	NA	0.58	XXX
70496	26	A	Ct angiography, head	1.75	0.63	0.60	0.63	0.60	0.08	XXX
70498		A	Ct angiography, neck	1.75	17.22	14.19	NA	NA	0.66	XXX
70498	TC	A	Ct angiography, neck	0.00	16.57	13.58	NA	NA	0.58	XXX
70498	26	A	Ct angiography, neck	1.75	0.65	0.61	0.65	0.61	0.08	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	14.16	12.90	NA	NA	0.45	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	13.70	12.45	NA	NA	0.39	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.46	0.45	0.46	0.45	0.06	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	15.28	14.61	NA	NA	0.54	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	14.72	14.07	NA	NA	0.47	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.56	0.54	0.56	0.54	0.07	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	18.75	22.16	NA	NA	0.94	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	18.01	21.44	NA	NA	0.84	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.74	0.72	0.74	0.72	0.10	XXX
70544		A	Mr angiography head w/o dye	1.20	15.84	13.72	NA	NA	0.64	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	15.42	13.31	NA	NA	0.59	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.42	0.41	0.42	0.41	0.05	XXX
70545		A	Mr angiography head w/dye	1.20	15.73	13.65	NA	NA	0.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	15.31	13.25	NA	NA	0.59	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.42	0.40	0.42	0.40	0.05	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	24.00	23.50	NA	NA	0.67	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	23.38	22.89	NA	NA	0.59	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.62	0.61	0.62	0.61	0.08	XXX
70547		A	Mr angiography neck w/o dye	1.20	15.77	13.68	NA	NA	0.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	15.36	13.28	NA	NA	0.59	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.41	0.40	0.41	0.40	0.05	XXX
70548		A	Mr angiography neck w/dye	1.20	16.63	14.11	NA	NA	0.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	16.21	13.70	NA	NA	0.59	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.42	0.41	0.42	0.41	0.05	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	24.02	23.50	NA	NA	0.67	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	23.39	22.89	NA	NA	0.59	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.63	0.61	0.63	0.61	0.08	XXX
70551		A	Mri brain w/o dye	1.48	14.42	13.05	NA	NA	0.66	XXX
70551	TC	A	Mri brain w/o dye	0.00	13.91	12.55	NA	NA	0.59	XXX
70551	26	A	Mri brain w/o dye	1.48	0.51	0.50	0.51	0.50	0.07	XXX
70552		A	Mri brain w/dye	1.78	15.58	14.79	NA	NA	0.78	XXX
70552	TC	A	Mri brain w/dye	0.00	14.96	14.19	NA	NA	0.70	XXX
70552	26	A	Mri brain w/dye	1.78	0.62	0.60	0.62	0.60	0.08	XXX
70553		A	Mri brain w/o & w/dye	2.36	18.06	21.86	NA	NA	1.41	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	17.24	21.06	NA	NA	1.31	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.82	0.80	0.82	0.80	0.10	XXX
70554		A	Fmri brain by tech	2.11	15.40	15.40	NA	NA	0.92	XXX
70554	TC	A	Fmri brain by tech	0.00	14.71	14.71	NA	NA	0.82	XXX
70554	26	A	Fmri brain by tech	2.11	0.69	0.69	0.69	0.69	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	0.90	0.90	0.90	0.90	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	1.03	1.08	1.03	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	1.09	1.16	1.09	1.16	0.10	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	1.14	1.19	1.14	1.19	0.12	XXX
71010		A	Chest x-ray	0.18	0.43	0.48	NA	NA	0.03	XXX
71010	TC	A	Chest x-ray	0.00	0.37	0.42	NA	NA	0.02	XXX
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	0.58	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	0.57	0.63	NA	NA	0.05	XXX
71020	TC	A	Chest x-ray	0.00	0.50	0.56	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	0.76	NA	NA	0.06	XXX
71021	TC	A	Chest x-ray	0.00	0.62	0.67	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	0.90	0.86	NA	NA	0.06	XXX
71022	TC	A	Chest x-ray	0.00	0.80	0.76	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	1.54	1.23	NA	NA	0.06	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.40	1.09	NA	NA	0.05	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.14	0.14	0.14	0.14	0.01	XXX
71030		A	Chest x-ray	0.31	0.92	0.90	NA	NA	0.06	XXX
71030	TC	A	Chest x-ray	0.00	0.82	0.80	NA	NA	0.05	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.10	0.10	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	2.11	1.85	NA	NA	0.10	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.90	1.67	NA	NA	0.08	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.21	0.18	0.21	0.18	0.02	XXX
71035		A	Chest x-ray	0.18	0.78	0.68	NA	NA	0.03	XXX
71035	TC	A	Chest x-ray	0.00	0.72	0.62	NA	NA	0.02	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.06	0.06	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.06	1.85	NA	NA	0.11	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.88	1.67	NA	NA	0.08	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.18	0.18	0.18	0.18	0.03	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.11	2.77	NA	NA	0.16	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.85	2.52	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	0.24	0.28	0.24	0.02	XXX
71100		A	X-ray exam of ribs	0.22	0.62	0.63	NA	NA	0.05	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.55	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	0.77	0.76	NA	NA	0.05	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.68	0.67	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	0.77	0.82	NA	NA	0.06	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.69	0.73	NA	NA	0.05	XXX
71110	26	A	X-ray exam of ribs	0.27	0.08	0.09	0.08	0.09	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	1.06	1.02	NA	NA	0.07	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.96	0.92	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	0.63	0.67	NA	NA	0.05	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.56	0.60	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	0.76	0.76	NA	NA	0.05	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.68	0.69	NA	NA	0.04	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.08	0.07	0.08	0.07	0.01	XXX
71250		A	Ct thorax w/o dye	1.16	6.45	6.36	NA	NA	0.36	XXX
71250	TC	A	Ct thorax w/o dye	0.00	6.04	5.97	NA	NA	0.31	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.41	0.39	0.41	0.39	0.05	XXX
71260		A	Ct thorax w/dye	1.24	7.99	7.73	NA	NA	0.42	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.55	7.31	NA	NA	0.37	XXX
71260	26	A	Ct thorax w/dye	1.24	0.44	0.42	0.44	0.42	0.05	XXX
71270		A	Ct thorax w/o & w/dye	1.38	10.03	9.67	NA	NA	0.52	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	9.55	9.20	NA	NA	0.46	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.48	0.47	0.48	0.47	0.06	XXX
71275		A	Ct angiography, chest	1.92	11.75	12.38	NA	NA	0.48	XXX
71275	TC	A	Ct angiography, chest	0.00	11.06	11.72	NA	NA	0.39	XXX
71275	26	A	Ct angiography, chest	1.92	0.69	0.66	0.69	0.66	0.09	XXX
71550		A	Mri chest w/o dye	1.46	16.35	14.01	NA	NA	0.51	XXX
71550	TC	A	Mri chest w/o dye	0.00	15.85	13.52	NA	NA	0.45	XXX
71550	26	A	Mri chest w/o dye	1.46	0.50	0.49	0.50	0.49	0.06	XXX
71551		A	Mri chest w/dye	1.73	17.92	15.96	NA	NA	0.60	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
71551	TC	A	Mri chest w/dye	0.00	17.32	15.38	NA	NA	0.52	XXX
71551	26	A	Mri chest w/dye	1.73	0.60	0.58	0.60	0.58	0.08	XXX
71552		A	Mri chest w/o & w/dye	2.26	22.55	24.08	NA	NA	0.78	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	21.75	23.31	NA	NA	0.68	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.80	0.77	0.80	0.77	0.10	XXX
71555		R	Mri angio chest w or w/o dye	1.81	15.30	13.54	NA	NA	0.67	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	14.64	12.91	NA	NA	0.59	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.66	0.63	0.66	0.63	0.08	XXX
72010		A	X-ray exam of spine	0.45	1.43	1.30	NA	NA	0.08	XXX
72010	TC	A	X-ray exam of spine	0.00	1.30	1.16	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	0.76	0.72	NA	NA	0.05	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.69	0.65	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	1.08	1.03	NA	NA	0.07	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.97	0.93	NA	NA	0.06	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.11	0.10	0.11	0.10	0.01	XXX
72052		A	X-ray exam of neck spine	0.36	1.39	1.32	NA	NA	0.08	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.27	1.20	NA	NA	0.06	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.12	0.12	0.02	XXX
72069		A	X-ray exam of trunk spine	0.22	0.76	0.66	NA	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.68	0.58	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	0.64	0.68	NA	NA	0.05	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.57	0.61	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	0.77	0.78	NA	NA	0.06	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.70	0.71	NA	NA	0.05	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.07	0.07	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.94	0.96	NA	NA	0.07	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.87	0.89	NA	NA	0.06	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.07	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	0.07	0.08	0.07	0.01	XXX
72090		A	X-ray exam of trunk spine	0.28	1.00	0.88	NA	NA	0.05	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.90	0.78	NA	NA	0.04	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.10	0.10	0.10	0.01	XXX
72100		A	X-ray exam of lower spine	0.22	0.81	0.77	NA	NA	0.05	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.74	0.70	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	1.15	1.07	NA	NA	0.07	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.04	0.97	NA	NA	0.06	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.11	0.10	0.11	0.10	0.01	XXX
72114		A	X-ray exam of lower spine	0.36	1.57	1.43	NA	NA	0.08	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.44	1.31	NA	NA	0.06	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.12	0.13	0.12	0.02	XXX
72120		A	X-ray exam of lower spine	0.22	1.08	1.01	NA	NA	0.07	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.00	0.94	NA	NA	0.06	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.08	0.07	0.08	0.07	0.01	XXX
72125		A	Ct neck spine w/o dye	1.16	6.46	6.37	NA	NA	0.36	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	6.05	5.98	NA	NA	0.31	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.41	0.39	0.41	0.39	0.05	XXX
72126		A	Ct neck spine w/dye	1.22	7.99	7.72	NA	NA	0.42	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.56	7.31	NA	NA	0.37	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.43	0.41	0.43	0.41	0.05	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	10.03	9.65	NA	NA	0.52	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	9.59	9.22	NA	NA	0.46	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.44	0.43	0.44	0.43	0.06	XXX
72128		A	Ct chest spine w/o dye	1.16	6.45	6.36	NA	NA	0.36	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	6.04	5.97	NA	NA	0.31	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.41	0.39	0.41	0.39	0.05	XXX
72129		A	Ct chest spine w/dye	1.22	7.99	7.72	NA	NA	0.42	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.56	7.31	NA	NA	0.37	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.43	0.41	0.43	0.41	0.05	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	9.97	9.62	NA	NA	0.52	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	9.53	9.19	NA	NA	0.46	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.44	0.43	0.44	0.43	0.06	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.42	6.36	NA	NA	0.36	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
72131	TC	A	Ct lumbar spine w/o dye	0.00	6.02	5.97	NA	NA	0.31	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.40	0.39	0.40	0.39	0.05	XXX
72132		A	Ct lumbar spine w/dye	1.22	7.97	7.71	NA	NA	0.42	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.54	7.30	NA	NA	0.37	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.43	0.41	0.43	0.41	0.05	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	10.01	9.64	NA	NA	0.52	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	9.57	9.21	NA	NA	0.46	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.44	0.43	0.44	0.43	0.06	XXX
72141		A	Mri neck spine w/o dye	1.60	12.45	12.09	NA	NA	0.66	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.90	11.55	NA	NA	0.59	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.55	0.54	0.55	0.54	0.07	XXX
72142		A	Mri neck spine w/dye	1.92	15.60	14.84	NA	NA	0.79	XXX
72142	TC	A	Mri neck spine w/dye	0.00	14.94	14.19	NA	NA	0.70	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.66	0.65	0.66	0.65	0.09	XXX
72146		A	Mri chest spine w/o dye	1.60	12.47	12.72	NA	NA	0.71	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	11.92	12.18	NA	NA	0.64	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.55	0.54	0.55	0.54	0.07	XXX
72147		A	Mri chest spine w/dye	1.92	13.56	13.81	NA	NA	0.79	XXX
72147	TC	A	Mri chest spine w/dye	0.00	12.89	13.16	NA	NA	0.70	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.67	0.65	0.67	0.65	0.09	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.41	12.67	NA	NA	0.71	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	11.90	12.17	NA	NA	0.64	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.51	0.50	0.51	0.50	0.07	XXX
72149		A	Mri lumbar spine w/dye	1.78	15.51	14.77	NA	NA	0.78	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	14.89	14.16	NA	NA	0.70	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.62	0.61	0.62	0.61	0.08	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	17.76	21.74	NA	NA	1.42	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	16.88	20.87	NA	NA	1.31	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.88	0.87	0.88	0.87	0.11	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	16.20	20.95	NA	NA	1.42	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	15.30	20.08	NA	NA	1.31	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.90	0.87	0.90	0.87	0.11	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	17.68	21.66	NA	NA	1.41	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	16.86	20.86	NA	NA	1.31	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.82	0.80	0.82	0.80	0.10	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	14.65	13.78	NA	NA	0.74	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	14.24	13.23	NA	NA	0.64	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.41	0.55	0.41	0.55	0.10	XXX
72170		A	X-ray exam of pelvis	0.17	0.50	0.54	NA	NA	0.03	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.44	0.48	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	0.84	0.79	NA	NA	0.05	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.77	0.72	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	11.32	11.97	NA	NA	0.47	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	10.67	11.35	NA	NA	0.39	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.65	0.62	0.65	0.62	0.08	XXX
72192		A	Ct pelvis w/o dye	1.09	6.03	6.15	NA	NA	0.36	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.64	5.78	NA	NA	0.31	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.39	0.37	0.39	0.37	0.05	XXX
72193		A	Ct pelvis w/dye	1.16	7.54	7.37	NA	NA	0.41	XXX
72193	TC	A	Ct pelvis w/dye	0.00	7.13	6.98	NA	NA	0.36	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.41	0.39	0.41	0.39	0.05	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	10.12	9.49	NA	NA	0.48	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	9.69	9.08	NA	NA	0.43	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.43	0.41	0.43	0.41	0.05	XXX
72195		A	Mri pelvis w/o dye	1.46	14.43	13.04	NA	NA	0.51	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	13.92	12.55	NA	NA	0.45	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.51	0.49	0.51	0.49	0.06	XXX
72196		A	Mri pelvis w/dye	1.73	15.52	14.76	NA	NA	0.60	XXX
72196	TC	A	Mri pelvis w/dye	0.00	14.91	14.17	NA	NA	0.52	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.61	0.59	0.61	0.59	0.08	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	18.95	22.27	NA	NA	1.02	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	18.16	21.51	NA	NA	0.92	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.79	0.76	0.79	0.76	0.10	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	15.08	13.42	NA	NA	0.67	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	14.44	12.81	NA	NA	0.59	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.64	0.61	0.64	0.61	0.08	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.59	0.59	NA	NA	0.03	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.54	0.53	NA	NA	0.02	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.05	0.06	0.05	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.74	0.71	NA	NA	0.05	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.67	0.65	NA	NA	0.04	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.06	0.07	0.06	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.57	0.61	NA	NA	0.05	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.52	0.55	NA	NA	0.04	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.05	0.06	0.05	0.06	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.58	3.80	NA	NA	0.29	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.26	3.50	NA	NA	0.25	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.32	0.30	0.32	0.30	0.04	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.24	3.42	NA	NA	0.26	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.96	3.14	NA	NA	0.22	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.28	0.28	0.28	0.28	0.04	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.53	3.43	NA	NA	0.26	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.24	3.16	NA	NA	0.22	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.29	0.27	0.29	0.27	0.04	XXX
72270		A	Contrast x-ray, spine	1.33	3.99	5.26	NA	NA	0.39	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.52	4.81	NA	NA	0.33	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.47	0.45	0.47	0.45	0.06	XXX
72275		A	Epidurography	0.76	1.73	2.02	NA	NA	0.26	XXX
72275	TC	A	Epidurography	0.00	1.53	1.82	NA	NA	0.22	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.20	0.20	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	1.44	5.08	NA	NA	0.50	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.14	4.75	NA	NA	0.43	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.30	0.33	0.30	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	0.47	0.47	0.47	0.47	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	0.50	0.49	0.50	0.49	0.07	XXX
72295		A	X-ray of lower spine disk	0.83	1.45	4.79	NA	NA	0.46	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.21	4.53	NA	NA	0.40	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.24	0.26	0.24	0.26	0.06	XXX
73000		A	X-ray exam of collar bone	0.16	0.55	0.56	NA	NA	0.03	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.50	0.51	NA	NA	0.02	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.58	0.58	NA	NA	0.03	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	0.52	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	0.44	0.48	NA	NA	0.03	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.39	0.43	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	0.57	0.60	NA	NA	0.05	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.51	0.54	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	2.24	2.26	NA	NA	0.14	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.05	2.08	NA	NA	0.12	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.19	0.18	0.19	0.18	0.02	XXX
73050		A	X-ray exam of shoulders	0.20	0.74	0.73	NA	NA	0.05	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.66	0.66	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	0.60	NA	NA	0.05	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.52	0.54	NA	NA	0.04	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73070		A	X-ray exam of elbow	0.15	0.55	0.56	NA	NA	0.03	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.50	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	0.76	0.69	NA	NA	0.05	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.70	0.63	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	1.83	2.07	NA	NA	0.14	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.65	1.88	NA	NA	0.12	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.18	0.19	0.18	0.19	0.02	XXX
73090		A	X-ray exam of forearm	0.16	0.55	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	0.58	0.56	NA	NA	0.03	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.53	0.51	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	0.57	NA	NA	0.03	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.55	0.52	NA	NA	0.02	XXX
73100	26	A	X-ray exam of wrist	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73110		A	X-ray exam of wrist	0.17	0.78	0.68	NA	NA	0.03	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
73110	TC	A	X-ray exam of wrist	0.00	0.72	0.62	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	2.33	2.04	NA	NA	0.12	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.14	1.86	NA	NA	0.10	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.19	0.18	0.19	0.18	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	0.66	0.62	NA	NA	0.03	XXX
73130	TC	A	X-ray exam of hand	0.00	0.60	0.56	NA	NA	0.02	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73140		A	X-ray exam of finger(s)	0.13	0.67	0.57	NA	NA	0.03	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.63	0.53	NA	NA	0.02	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.04	0.04	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	6.39	5.85	NA	NA	0.30	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	6.01	5.48	NA	NA	0.25	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.38	0.37	0.38	0.37	0.05	XXX
73201		A	Ct upper extremity w/dye	1.16	7.91	7.09	NA	NA	0.36	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	7.50	6.70	NA	NA	0.31	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.41	0.39	0.41	0.39	0.05	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	10.54	9.18	NA	NA	0.44	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	10.12	8.77	NA	NA	0.39	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.42	0.41	0.42	0.41	0.05	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	10.91	11.23	NA	NA	0.47	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.24	10.60	NA	NA	0.39	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.67	0.63	0.67	0.63	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	14.63	13.13	NA	NA	0.45	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	14.17	12.68	NA	NA	0.39	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.46	0.45	0.46	0.45	0.06	XXX
73219		A	Mri upper extremity w/dye	1.62	15.39	14.68	NA	NA	0.54	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	14.83	14.13	NA	NA	0.47	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.56	0.55	0.56	0.55	0.07	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	19.03	22.31	NA	NA	0.94	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	18.29	21.58	NA	NA	0.84	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.74	0.73	0.74	0.73	0.10	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	13.55	12.59	NA	NA	0.45	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	13.08	12.14	NA	NA	0.39	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.47	0.45	0.47	0.45	0.06	XXX
73222		A	Mri joint upr extrem w/dye	1.62	14.29	14.12	NA	NA	0.54	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.73	13.58	NA	NA	0.47	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.56	0.54	0.56	0.54	0.07	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	17.56	21.56	NA	NA	0.94	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	16.82	20.84	NA	NA	0.84	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.74	0.72	0.74	0.72	0.10	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	14.64	13.15	NA	NA	0.69	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	14.24	12.62	NA	NA	0.59	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.40	0.53	0.40	0.53	0.10	XXX
73500		A	X-ray exam of hip	0.17	0.49	0.51	NA	NA	0.03	XXX
73500	TC	A	X-ray exam of hip	0.00	0.43	0.45	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	0.77	0.71	NA	NA	0.05	XXX
73510	TC	A	X-ray exam of hip	0.00	0.70	0.64	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	0.77	NA	NA	0.05	XXX
73520	TC	A	X-ray exam of hips	0.00	0.70	0.68	NA	NA	0.04	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.09	0.09	0.01	XXX
73525		A	Contrast x-ray of hip	0.54	1.82	2.05	NA	NA	0.15	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.64	1.87	NA	NA	0.12	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.18	0.18	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	0.10	0.11	0.10	0.01	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.81	0.72	NA	NA	0.05	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.74	0.65	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	1.12	1.69	NA	NA	0.15	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	0.98	1.54	NA	NA	0.12	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.14	0.15	0.14	0.15	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.55	0.59	NA	NA	0.05	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.49	0.53	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	0.58	0.58	NA	NA	0.03	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	0.52	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	0.68	NA	NA	0.05	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.66	0.62	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	0.86	0.77	NA	NA	0.05	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.78	0.70	NA	NA	0.04	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.08	0.07	0.08	0.07	0.01	XXX
73565		A	X-ray exam of knees	0.17	0.65	0.60	NA	NA	0.03	XXX
73565	TC	A	X-ray exam of knees	0.00	0.59	0.54	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	2.55	2.67	NA	NA	0.17	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.36	2.49	NA	NA	0.14	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.19	0.18	0.19	0.18	0.03	XXX
73590		A	X-ray exam of lower leg	0.17	0.54	0.56	NA	NA	0.03	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.48	0.50	NA	NA	0.02	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73592		A	X-ray exam of leg, infant	0.16	0.58	0.56	NA	NA	0.03	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.53	0.51	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	0.55	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	0.63	NA	NA	0.03	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.62	0.57	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	2.00	2.14	NA	NA	0.15	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.82	1.96	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	0.52	0.54	NA	NA	0.03	XXX
73620	TC	A	X-ray exam of foot	0.00	0.48	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	0.65	0.62	NA	NA	0.03	XXX
73630	TC	A	X-ray exam of foot	0.00	0.60	0.56	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	0.53	NA	NA	0.03	XXX
73650	TC	A	X-ray exam of heel	0.00	0.50	0.48	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	0.55	NA	NA	0.03	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.60	0.51	NA	NA	0.02	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.04	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	6.40	5.86	NA	NA	0.30	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	6.02	5.49	NA	NA	0.25	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.38	0.37	0.38	0.37	0.05	XXX
73701		A	Ct lower extremity w/dye	1.16	7.97	7.13	NA	NA	0.36	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	7.56	6.73	NA	NA	0.31	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.41	0.40	0.41	0.40	0.05	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	10.72	9.27	NA	NA	0.44	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	10.28	8.85	NA	NA	0.39	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.44	0.42	0.44	0.42	0.05	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	12.34	11.96	NA	NA	0.47	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	11.62	11.29	NA	NA	0.39	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.72	0.67	0.72	0.67	0.08	XXX
73718		A	Mri lower extremity w/o dye	1.35	14.25	12.94	NA	NA	0.45	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	13.79	12.49	NA	NA	0.39	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.46	0.45	0.46	0.45	0.06	XXX
73719		A	Mri lower extremity w/dye	1.62	15.39	14.68	NA	NA	0.54	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	14.82	14.13	NA	NA	0.47	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.57	0.55	0.57	0.55	0.07	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	18.98	22.27	NA	NA	0.94	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	18.23	21.55	NA	NA	0.84	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.75	0.72	0.75	0.72	0.10	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	13.86	12.74	NA	NA	0.45	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	13.39	12.29	NA	NA	0.39	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.47	0.45	0.47	0.45	0.06	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	14.48	14.22	NA	NA	0.54	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.91	13.67	NA	NA	0.47	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.57	0.55	0.57	0.55	0.07	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	17.54	21.55	NA	NA	0.94	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	16.80	20.83	NA	NA	0.84	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.74	0.72	0.74	0.72	0.10	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	15.11	13.45	NA	NA	0.67	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	14.47	12.83	NA	NA	0.59	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.64	0.62	0.64	0.62	0.08	XXX
74000		A	X-ray exam of abdomen	0.18	0.46	0.52	NA	NA	0.03	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.40	0.46	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	0.79	0.72	NA	NA	0.05	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.71	0.64	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	0.81	0.76	NA	NA	0.05	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.72	0.67	NA	NA	0.04	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.09	0.09	0.01	XXX
74022		A	X-ray exam series, abdomen	0.32	0.98	0.91	NA	NA	0.06	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.87	0.80	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	6.06	6.06	NA	NA	0.35	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.64	5.65	NA	NA	0.30	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.42	0.41	0.42	0.41	0.05	XXX
74160		A	Ct abdomen w/dye	1.27	8.81	8.03	NA	NA	0.42	XXX
74160	TC	A	Ct abdomen w/dye	0.00	8.36	7.60	NA	NA	0.36	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.45	0.43	0.45	0.43	0.06	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	12.17	10.56	NA	NA	0.49	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	11.68	10.08	NA	NA	0.43	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.49	0.48	0.49	0.48	0.06	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.27	12.45	NA	NA	0.47	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	11.58	11.80	NA	NA	0.39	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.69	0.65	0.69	0.65	0.08	XXX
74181		A	Mri abdomen w/o dye	1.46	12.44	12.06	NA	NA	0.51	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.93	11.56	NA	NA	0.45	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.51	0.50	0.51	0.50	0.06	XXX
74182		A	Mri abdomen w/dye	1.73	17.42	15.72	NA	NA	0.60	XXX
74182	TC	A	Mri abdomen w/dye	0.00	16.82	15.13	NA	NA	0.52	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.60	0.59	0.60	0.59	0.08	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	18.98	22.29	NA	NA	1.02	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	18.19	21.53	NA	NA	0.92	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.79	0.76	0.79	0.76	0.10	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	15.07	13.42	NA	NA	0.67	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	14.43	12.81	NA	NA	0.59	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.64	0.61	0.64	0.61	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	0.17	0.16	0.17	0.16	0.02	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.77	1.53	NA	NA	0.08	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.64	1.41	NA	NA	0.06	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.13	0.12	0.13	0.12	0.02	XXX
74220		A	Contrast x-ray, esophagus	0.46	2.01	1.68	NA	NA	0.08	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.85	1.52	NA	NA	0.06	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.16	0.16	0.16	0.16	0.02	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.95	1.71	NA	NA	0.09	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.76	1.53	NA	NA	0.07	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.19	0.18	0.19	0.18	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	0.47	0.43	0.47	0.43	0.05	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.30	2.00	NA	NA	0.11	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	2.06	1.76	NA	NA	0.08	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.24	0.24	0.24	0.24	0.03	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.56	2.13	NA	NA	0.11	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.32	1.90	NA	NA	0.08	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.24	0.23	0.24	0.23	0.03	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.96	3.32	NA	NA	0.17	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.64	3.01	NA	NA	0.13	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.32	0.31	0.32	0.31	0.04	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	2.80	2.33	NA	NA	0.13	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.55	2.09	NA	NA	0.10	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.25	0.24	0.25	0.24	0.03	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.21	2.56	NA	NA	0.14	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	2.97	2.32	NA	NA	0.11	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.24	0.24	0.24	0.24	0.03	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.35	3.61	NA	NA	0.18	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	4.03	3.30	NA	NA	0.14	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.32	0.31	0.32	0.31	0.04	XXX
74250		A	X-ray exam of small bowel	0.47	2.48	1.97	NA	NA	0.09	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
74250	TC	A	X-ray exam of small bowel	0.00	2.32	1.81	NA	NA	0.07	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.16	0.16	0.16	0.16	0.02	XXX
74251		A	X-ray exam of small bowel	0.69	10.01	5.77	NA	NA	0.10	XXX
74251	TC	A	X-ray exam of small bowel	0.00	9.76	5.53	NA	NA	0.07	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.25	0.24	0.25	0.24	0.03	XXX
74260		A	X-ray exam of small bowel	0.50	8.30	4.97	NA	NA	0.10	XXX
74260	TC	A	X-ray exam of small bowel	0.00	8.12	4.80	NA	NA	0.08	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.18	0.17	0.18	0.17	0.02	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.59	2.76	NA	NA	0.14	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	3.34	2.52	NA	NA	0.11	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.25	0.24	0.25	0.24	0.03	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.94	3.74	NA	NA	0.17	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.59	3.41	NA	NA	0.13	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.35	0.33	0.35	0.33	0.04	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.49	3.35	NA	NA	0.23	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.80	2.68	NA	NA	0.14	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.69	0.67	0.69	0.67	0.09	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.58	1.21	NA	NA	0.06	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.47	1.10	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	1.55	1.02	NA	NA	0.03	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.48	0.95	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
74300	26	A	X-ray bile ducts/pancreas	0.36	0.13	0.12	0.13	0.12	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	0.15	0.15	0.15	0.15	0.02	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.13	2.73	NA	NA	0.19	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.93	2.54	NA	NA	0.17	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.20	0.19	0.20	0.19	0.02	XXX
74327		A	X-ray bile stone removal	0.70	2.97	2.48	NA	NA	0.14	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.72	2.24	NA	NA	0.11	XXX
74327	26	A	X-ray bile stone removal	0.70	0.25	0.24	0.25	0.24	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	0.26	0.25	0.26	0.25	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	0.25	0.27	0.25	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	0.33	0.31	0.33	0.31	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	0.19	0.19	0.19	0.19	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	0.28	0.26	0.28	0.26	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	0.21	0.24	0.21	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	0.32	0.30	0.32	0.30	0.04	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.60	2.22	NA	NA	0.13	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.43	2.05	NA	NA	0.11	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.17	0.17	0.17	0.17	0.02	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.69	2.40	NA	NA	0.13	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.51	2.23	NA	NA	0.11	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.18	0.17	0.18	0.17	0.02	XXX
74415		A	Contrst x-ray, urinary tract	0.49	3.27	2.78	NA	NA	0.14	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	3.10	2.61	NA	NA	0.12	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.17	0.17	0.17	0.17	0.02	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.14	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

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	0.13	0.13	0.13	0.13	0.02	XXX
74430		A	Contrast x-ray, bladder	0.32	1.96	1.55	NA	NA	0.08	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.84	1.44	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	2.11	1.68	NA	NA	0.08	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.97	1.55	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	0.45	0.41	0.45	0.41	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	2.18	1.94	NA	NA	0.12	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	2.06	1.82	NA	NA	0.10	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.12	0.12	0.12	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	0.17	0.18	0.17	0.18	0.02	XXX
74475		A	X-ray control, cath insert	0.54	2.12	3.18	NA	NA	0.24	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.92	2.99	NA	NA	0.22	XXX
74475	26	A	X-ray control, cath insert	0.54	0.20	0.19	0.20	0.19	0.02	XXX
74480		A	X-ray control, cath insert	0.54	2.13	3.19	NA	NA	0.24	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.93	3.00	NA	NA	0.22	XXX
74480	26	A	X-ray control, cath insert	0.54	0.20	0.19	0.20	0.19	0.02	XXX
74485		A	X-ray guide, GU dilation	0.54	2.27	2.80	NA	NA	0.20	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	2.07	2.61	NA	NA	0.17	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.20	0.19	0.20	0.19	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.64	0.90	NA	NA	0.08	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.53	0.79	NA	NA	0.06	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.11	0.11	0.02	XXX
74740		A	X-ray, female genital tract	0.38	1.76	1.60	NA	NA	0.09	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.63	1.47	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	0.19	0.20	0.19	0.20	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	0.22	0.21	0.22	0.21	0.03	XXX
75557		A	Cardiac mri for morph	2.35	11.25	11.25	NA	NA	0.97	XXX
75557	TC	A	Cardiac mri for morph	0.00	10.31	10.31	NA	NA	0.87	XXX
75557	26	A	Cardiac mri for morph	2.35	0.94	0.94	0.94	0.94	0.10	XXX
75558		N	Cardiac mri flow/velocity	2.60	12.38	12.38	NA	NA	1.07	XXX
75558	TC	N	Cardiac mri flow/velocity	0.00	11.78	11.78	NA	NA	0.96	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.60	0.60	0.60	0.60	0.11	XXX
75559		A	Cardiac mri w/stress img	2.95	17.24	17.24	NA	NA	0.97	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	15.97	15.97	NA	NA	0.87	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.27	1.27	1.27	1.27	0.10	XXX
75560		N	Cardiac mri flow/vel/stress	3.00	16.82	16.82	NA	NA	1.00	XXX
75560	TC	N	Cardiac mri flow/vel/stress	0.00	16.13	16.13	NA	NA	0.89	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	0.69	0.69	0.69	0.69	0.11	XXX
75561		A	Cardiac mri for morph w/dye	2.60	15.95	15.95	NA	NA	1.07	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	14.92	14.92	NA	NA	0.96	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	1.03	1.03	1.03	1.03	0.11	XXX
75562		N	Card mri flow/vel w/dye	2.86	16.75	16.75	NA	NA	1.03	XXX
75562	TC	N	Card mri flow/vel w/dye	0.00	16.09	16.09	NA	NA	0.92	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	0.66	0.66	0.66	0.66	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	20.20	20.20	NA	NA	1.08	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	18.82	18.82	NA	NA	0.97	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.38	1.38	1.38	1.38	0.11	XXX
75564		N	Ht mri w/flo/vel/strs & dye	3.35	19.71	19.71	NA	NA	1.21	XXX
75564	TC	N	Ht mri w/flo/vel/strs & dye	0.00	18.94	18.94	NA	NA	1.08	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	0.77	0.77	0.77	0.77	0.13	XXX
75600		A	Contrast x-ray exam of aorta	0.49	6.42	9.61	NA	NA	0.67	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	6.18	9.39	NA	NA	0.65	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.24	0.22	0.24	0.22	0.02	XXX
75605		A	Contrast x-ray exam of aorta	1.14	3.55	8.27	NA	NA	0.70	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	3.06	7.83	NA	NA	0.65	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.49	0.44	0.49	0.44	0.05	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.35	8.16	NA	NA	0.71	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.93	7.76	NA	NA	0.65	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.42	0.40	0.42	0.40	0.06	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.76	8.75	NA	NA	0.80	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	3.05	8.09	NA	NA	0.69	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.71	0.66	0.71	0.66	0.11	XXX
75635		A	Ct angio abdominal arteries	2.40	12.92	14.80	NA	NA	0.50	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	12.00	13.95	NA	NA	0.39	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.92	0.85	0.92	0.85	0.11	XXX
75650		A	Artery x-rays, head & neck	1.49	3.52	8.30	NA	NA	0.72	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	2.95	7.77	NA	NA	0.65	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.57	0.53	0.57	0.53	0.07	XXX
75658		A	Artery x-rays, arm	1.31	3.72	8.40	NA	NA	0.72	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.28	7.94	NA	NA	0.65	XXX
75658	26	A	Artery x-rays, arm	1.31	0.44	0.46	0.44	0.46	0.07	XXX
75660		A	Artery x-rays, head & neck	1.31	3.88	8.46	NA	NA	0.71	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.39	7.99	NA	NA	0.65	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.49	0.47	0.49	0.47	0.06	XXX
75662		A	Artery x-rays, head & neck	1.66	5.01	9.09	NA	NA	0.71	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	4.31	8.45	NA	NA	0.65	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.70	0.64	0.70	0.64	0.06	XXX
75665		A	Artery x-rays, head & neck	1.31	4.09	8.57	NA	NA	0.74	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.61	8.11	NA	NA	0.65	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.48	0.46	0.48	0.46	0.09	XXX
75671		A	Artery x-rays, head & neck	1.66	5.10	9.12	NA	NA	0.72	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	4.46	8.53	NA	NA	0.65	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.64	0.59	0.64	0.59	0.07	XXX
75676		A	Artery x-rays, neck	1.31	3.86	8.45	NA	NA	0.72	XXX
75676	TC	A	Artery x-rays, neck	0.00	3.38	7.99	NA	NA	0.65	XXX
75676	26	A	Artery x-rays, neck	1.31	0.48	0.46	0.48	0.46	0.07	XXX
75680		A	Artery x-rays, neck	1.66	4.61	8.87	NA	NA	0.72	XXX
75680	TC	A	Artery x-rays, neck	0.00	3.95	8.27	NA	NA	0.65	XXX
75680	26	A	Artery x-rays, neck	1.66	0.66	0.60	0.66	0.60	0.07	XXX
75685		A	Artery x-rays, spine	1.31	3.88	8.46	NA	NA	0.71	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.38	7.99	NA	NA	0.65	XXX
75685	26	A	Artery x-rays, spine	1.31	0.50	0.47	0.50	0.47	0.06	XXX
75705		A	Artery x-rays, spine	2.18	4.17	8.74	NA	NA	0.78	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.37	7.98	NA	NA	0.65	XXX
75705	26	A	Artery x-rays, spine	2.18	0.80	0.76	0.80	0.76	0.13	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.94	8.47	NA	NA	0.72	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.52	8.06	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	4.92	8.97	NA	NA	0.72	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	4.42	8.51	NA	NA	0.65	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.50	0.46	0.50	0.46	0.07	XXX
75722		A	Artery x-rays, kidney	1.14	3.84	8.42	NA	NA	0.70	XXX
75722	TC	A	Artery x-rays, kidney	0.00	3.37	7.98	NA	NA	0.65	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.47	0.44	0.47	0.44	0.05	XXX
75724		A	Artery x-rays, kidneys	1.49	5.12	9.14	NA	NA	0.70	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	4.38	8.49	NA	NA	0.65	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.74	0.65	0.74	0.65	0.05	XXX
75726		A	Artery x-rays, abdomen	1.14	3.76	8.36	NA	NA	0.70	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	3.34	7.97	NA	NA	0.65	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.42	0.39	0.42	0.39	0.05	XXX
75731		A	Artery x-rays, adrenal gland	1.14	4.09	8.54	NA	NA	0.71	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	3.59	8.10	NA	NA	0.65	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.50	0.44	0.50	0.44	0.06	XXX
75733		A	Artery x-rays, adrenals	1.31	5.45	9.25	NA	NA	0.71	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	4.80	8.70	NA	NA	0.65	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.65	0.55	0.65	0.55	0.06	XXX
75736		A	Artery x-rays, pelvis	1.14	3.87	8.42	NA	NA	0.71	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	3.44	8.02	NA	NA	0.65	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.43	0.40	0.43	0.40	0.06	XXX
75741		A	Artery x-rays, lung	1.31	3.18	8.10	NA	NA	0.71	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.69	7.64	NA	NA	0.65	XXX
75741	26	A	Artery x-rays, lung	1.31	0.49	0.46	0.49	0.46	0.06	XXX
75743		A	Artery x-rays, lungs	1.66	3.56	8.35	NA	NA	0.72	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.94	7.77	NA	NA	0.65	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.62	0.58	0.62	0.58	0.07	XXX
75746		A	Artery x-rays, lung	1.14	3.52	8.25	NA	NA	0.70	XXX
75746	TC	A	Artery x-rays, lung	0.00	3.12	7.86	NA	NA	0.65	XXX
75746	26	A	Artery x-rays, lung	1.14	0.40	0.39	0.40	0.39	0.05	XXX
75756		A	Artery x-rays, chest	1.14	4.34	8.69	NA	NA	0.69	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
75756	TC	A	Artery x-rays, chest	0.00	3.76	8.18	NA	NA	0.65	XXX
75756	26	A	Artery x-rays, chest	1.14	0.58	0.51	0.58	0.51	0.04	XXX
75774		A	Artery x-ray, each vessel	0.36	2.50	7.61	NA	NA	0.67	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.36	7.48	NA	NA	0.65	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.14	0.13	0.14	0.13	0.02	ZZZ
75790		A	Visualize A-V shunt	1.84	3.12	2.53	NA	NA	0.17	XXX
75790	TC	A	Visualize A-V shunt	0.00	2.52	1.93	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	0.22	0.25	0.22	0.25	0.08	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.40	0.39	0.40	0.39	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	0.27	0.27	0.27	0.27	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	0.39	0.39	0.39	0.39	0.05	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.17	1.54	NA	NA	0.07	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	2.01	1.39	NA	NA	0.05	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.16	0.15	0.16	0.15	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	0.39	0.38	0.39	0.38	0.05	XXX
75820		A	Vein x-ray, arm/leg	0.70	3.01	2.09	NA	NA	0.09	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.72	1.83	NA	NA	0.06	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.29	0.26	0.29	0.26	0.03	XXX
75822		A	Vein x-ray, arms/legs	1.06	3.17	2.50	NA	NA	0.13	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	2.80	2.14	NA	NA	0.08	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.37	0.36	0.37	0.36	0.05	XXX
75825		A	Vein x-ray, trunk	1.14	2.92	7.95	NA	NA	0.72	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.54	7.57	NA	NA	0.65	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.38	0.38	0.38	0.38	0.07	XXX
75827		A	Vein x-ray, chest	1.14	2.95	7.96	NA	NA	0.70	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.58	7.59	NA	NA	0.65	XXX
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.37	0.37	0.05	XXX
75831		A	Vein x-ray, kidney	1.14	3.05	8.00	NA	NA	0.71	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.67	7.63	NA	NA	0.65	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.38	0.37	0.38	0.37	0.06	XXX
75833		A	Vein x-ray, kidneys	1.49	3.67	8.38	NA	NA	0.74	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	3.17	7.88	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	2.96	7.97	NA	NA	0.72	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.60	7.60	NA	NA	0.65	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.36	0.37	0.36	0.37	0.07	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.75	8.41	NA	NA	0.72	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	3.20	7.90	NA	NA	0.65	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.55	0.51	0.55	0.51	0.07	XXX
75860		A	Vein x-ray, neck	1.14	3.39	8.19	NA	NA	0.69	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.90	7.75	NA	NA	0.65	XXX
75860	26	A	Vein x-ray, neck	1.14	0.49	0.44	0.49	0.44	0.04	XXX
75870		A	Vein x-ray, skull	1.14	3.29	8.14	NA	NA	0.70	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.89	7.74	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	4.04	8.51	NA	NA	0.79	XXX
75872	TC	A	Vein x-ray, skull	0.00	3.60	8.10	NA	NA	0.65	XXX
75872	26	A	Vein x-ray, skull	1.14	0.44	0.41	0.44	0.41	0.14	XXX
75880		A	Vein x-ray, eye socket	0.70	3.21	2.19	NA	NA	0.09	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	2.94	1.94	NA	NA	0.06	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.27	0.25	0.27	0.25	0.03	XXX
75885		A	Vein x-ray, liver	1.44	3.18	8.12	NA	NA	0.71	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.66	7.63	NA	NA	0.65	XXX
75885	26	A	Vein x-ray, liver	1.44	0.52	0.49	0.52	0.49	0.06	XXX
75887		A	Vein x-ray, liver	1.44	3.42	8.24	NA	NA	0.71	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.85	7.72	NA	NA	0.65	XXX
75887	26	A	Vein x-ray, liver	1.44	0.57	0.52	0.57	0.52	0.06	XXX
75889		A	Vein x-ray, liver	1.14	3.07	8.02	NA	NA	0.70	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.66	7.63	NA	NA	0.65	XXX
75889	26	A	Vein x-ray, liver	1.14	0.41	0.39	0.41	0.39	0.05	XXX
75891		A	Vein x-ray, liver	1.14	3.06	8.01	NA	NA	0.70	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
75891	TC	A	Vein x-ray, liver	0.00	2.65	7.62	NA	NA	0.65	XXX
75891	26	A	Vein x-ray, liver	1.14	0.41	0.39	0.41	0.39	0.05	XXX
75893		A	Venous sampling by catheter	0.54	2.86	7.82	NA	NA	0.67	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.66	7.63	NA	NA	0.65	XXX
75893	26	A	Venous sampling by catheter	0.54	0.20	0.19	0.20	0.19	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	0.46	0.44	0.46	0.44	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	0.48	0.52	0.48	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	0.63	0.59	0.63	0.59	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	0.16	0.17	0.16	0.03	XXX
75901		A	Remove cva device obstruct	0.49	4.15	2.80	NA	NA	0.85	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.98	2.64	NA	NA	0.83	XXX
75901	26	A	Remove cva device obstruct	0.49	0.17	0.16	0.17	0.16	0.02	XXX
75902		A	Remove cva lumen obstruct	0.39	1.63	1.53	NA	NA	0.85	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.50	1.40	NA	NA	0.83	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.13	0.13	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	0.18	0.18	0.18	0.18	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	0.13	0.12	0.13	0.05	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.30	1.39	1.30	1.39	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	0.42	0.40	0.42	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	0.63	0.70	0.63	0.70	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	1.88	2.29	1.88	2.29	0.69	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.63	1.97	1.63	1.97	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	1.04	1.29	1.04	1.29	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	0.92	1.14	0.92	1.14	0.34	XXX
75960		A	Transcath iv stent rs&i	0.82	2.71	8.94	NA	NA	0.82	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.39	8.64	NA	NA	0.77	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.32	0.30	0.32	0.30	0.05	XXX
75961		A	Retrieval, broken catheter	4.24	4.66	8.28	NA	NA	0.73	XXX
75961	TC	A	Retrieval, broken catheter	0.00	3.18	6.84	NA	NA	0.55	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.48	1.44	1.48	1.44	0.18	XXX
75962		A	Repair arterial blockage	0.54	3.50	9.71	NA	NA	0.86	XXX
75962	TC	A	Repair arterial blockage	0.00	3.30	9.52	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	2.35	5.42	NA	NA	0.46	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	2.22	5.30	NA	NA	0.43	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.13	0.12	0.13	0.12	0.03	ZZZ
75966		A	Repair arterial blockage	1.31	4.16	10.17	NA	NA	0.89	XXX
75966	TC	A	Repair arterial blockage	0.00	3.59	9.66	NA	NA	0.83	XXX
75966	26	A	Repair arterial blockage	1.31	0.57	0.51	0.57	0.51	0.06	XXX
75968		A	Repair artery blockage, each	0.36	2.41	5.46	NA	NA	0.45	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	2.25	5.32	NA	NA	0.43	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.16	0.14	0.16	0.14	0.02	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.31	0.29	0.31	0.29	0.04	XXX
75978		A	Repair venous blockage	0.54	3.26	9.59	NA	NA	0.85	XXX
75978	TC	A	Repair venous blockage	0.00	3.08	9.41	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	0.52	0.49	0.52	0.49	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	0.52	0.50	0.52	0.50	0.06	XXX
75984		A	Xray control catheter change	0.72	2.31	2.24	NA	NA	0.14	XXX
75984	TC	A	Xray control catheter change	0.00	2.05	2.00	NA	NA	0.11	XXX
75984	26	A	Xray control catheter change	0.72	0.26	0.24	0.26	0.24	0.03	XXX
75989		A	Abscess drainage under x-ray	1.19	2.24	2.89	NA	NA	0.22	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.82	2.48	NA	NA	0.17	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.42	0.41	0.42	0.41	0.05	XXX
75992		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.22	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	0.13	0.14	0.13	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	0.54	0.50	0.54	0.50	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	0.47	0.48	0.47	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	2.77	2.06	NA	NA	0.08	XXX
76000	TC	A	Fluoroscope examination	0.00	2.71	2.01	NA	NA	0.07	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.05	0.06	0.05	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	0.24	0.23	0.24	0.23	0.05	XXX
76010		A	X-ray, nose to rectum	0.18	0.54	0.56	NA	NA	0.03	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.48	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	1.10	1.16	NA	NA	0.08	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.90	0.97	NA	NA	0.06	XXX
76080	26	A	X-ray exam of fistula	0.54	0.20	0.19	0.20	0.19	0.02	XXX
76098		A	X-ray exam, breast specimen	0.16	0.32	0.39	NA	NA	0.03	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.27	0.34	NA	NA	0.02	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.05	0.05	0.01	XXX
76100		A	X-ray exam of body section	0.58	3.55	2.50	NA	NA	0.10	XXX
76100	TC	A	X-ray exam of body section	0.00	3.35	2.30	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	5.45	3.53	NA	NA	0.11	XXX
76101	TC	A	Complex body section x-ray	0.00	5.27	3.34	NA	NA	0.08	XXX
76101	26	A	Complex body section x-ray	0.58	0.18	0.19	0.18	0.19	0.03	XXX
76102		A	Complex body section x-rays	0.58	7.64	4.78	NA	NA	0.14	XXX
76102	TC	A	Complex body section x-rays	0.00	7.46	4.60	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	1.87	1.52	NA	NA	0.08	XXX
76120	TC	A	Cine/video x-rays	0.00	1.74	1.39	NA	NA	0.06	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.13	0.13	0.02	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.12	0.11	0.12	0.11	0.01	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.68	0.55	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	1.40	2.45	NA	NA	0.10	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.33	2.38	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	1.40	2.54	NA	NA	0.39	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.12	2.27	NA	NA	0.31	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.28	0.27	0.28	0.27	0.08	XXX
76380		A	CAT scan follow-up study	0.98	4.71	4.26	NA	NA	0.22	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
76380	TC	A	CAT scan follow-up study	0.00	4.37	3.93	NA	NA	0.18	XXX
76380	26	A	CAT scan follow-up study	0.98	0.34	0.33	0.34	0.33	0.04	XXX
76390		N	Mr spectroscopy	1.40	9.42	10.44	NA	NA	0.66	XXX
76390	TC	N	Mr spectroscopy	0.00	9.10	10.05	NA	NA	0.59	XXX
76390	26	N	Mr spectroscopy	1.40	0.32	0.39	0.32	0.39	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	2.76	2.21	NA	NA	0.14	XXX
76506	TC	A	Echo exam of head	0.00	2.56	1.99	NA	NA	0.08	XXX
76506	26	A	Echo exam of head	0.63	0.20	0.22	0.20	0.22	0.06	XXX
76510		A	Ophth us, b & quant a	1.55	2.25	2.55	NA	NA	0.10	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.70	1.94	NA	NA	0.07	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.55	0.61	0.55	0.61	0.03	XXX
76511		A	Ophth us, quant a only	0.94	1.35	1.88	NA	NA	0.10	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.02	1.52	NA	NA	0.07	XXX
76511	26	A	Ophth us, quant a only	0.94	0.33	0.36	0.33	0.36	0.03	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.16	1.69	NA	NA	0.12	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.83	1.32	NA	NA	0.10	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.33	0.37	0.33	0.37	0.02	XXX
76513		A	Echo exam of eye, water bath	0.66	1.52	1.66	NA	NA	0.12	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.29	1.40	NA	NA	0.10	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.23	0.26	0.23	0.26	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	0.10	0.08	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.06	0.07	0.06	0.07	0.01	XXX
76516		A	Echo exam of eye	0.54	1.15	1.30	NA	NA	0.08	XXX
76516	TC	A	Echo exam of eye	0.00	0.97	1.09	NA	NA	0.07	XXX
76516	26	A	Echo exam of eye	0.54	0.18	0.21	0.18	0.21	0.01	XXX
76519		A	Echo exam of eye	0.54	1.28	1.42	NA	NA	0.08	XXX
76519	TC	A	Echo exam of eye	0.00	1.09	1.20	NA	NA	0.07	XXX
76519	26	A	Echo exam of eye	0.54	0.19	0.22	0.19	0.22	0.01	XXX
76529		A	Echo exam of eye	0.57	1.15	1.26	NA	NA	0.10	XXX
76529	TC	A	Echo exam of eye	0.00	0.95	1.04	NA	NA	0.08	XXX
76529	26	A	Echo exam of eye	0.57	0.20	0.22	0.20	0.22	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.67	2.13	NA	NA	0.10	XXX
76536	TC	A	Us exam of head and neck	0.00	2.49	1.95	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	1.83	1.66	NA	NA	0.09	XXX
76604	TC	A	Us exam, chest	0.00	1.64	1.47	NA	NA	0.07	XXX
76604	26	A	Us exam, chest	0.55	0.19	0.19	0.19	0.19	0.02	XXX
76645		A	Us exam, breast(s)	0.54	2.12	1.67	NA	NA	0.08	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.93	1.49	NA	NA	0.06	XXX
76645	26	A	Us exam, breast(s)	0.54	0.19	0.18	0.19	0.18	0.02	XXX
76700		A	Us exam, abdom, complete	0.81	3.02	2.63	NA	NA	0.15	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.75	2.36	NA	NA	0.11	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.27	0.27	0.27	0.27	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.35	1.98	NA	NA	0.11	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.14	1.78	NA	NA	0.08	XXX
76705	26	A	Echo exam of abdomen	0.59	0.21	0.20	0.21	0.20	0.03	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.93	2.57	NA	NA	0.14	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.67	2.32	NA	NA	0.11	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.26	0.25	0.26	0.25	0.03	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.42	2.01	NA	NA	0.11	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	2.21	1.81	NA	NA	0.08	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.21	0.20	0.21	0.20	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.43	2.82	NA	NA	0.14	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.16	2.57	NA	NA	0.11	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.27	0.25	0.27	0.25	0.03	XXX
76800		A	Us exam, spinal canal	1.13	2.31	2.03	NA	NA	0.13	XXX
76800	TC	A	Us exam, spinal canal	0.00	2.03	1.72	NA	NA	0.08	XXX
76800	26	A	Us exam, spinal canal	1.13	0.28	0.31	0.28	0.31	0.05	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.46	2.45	NA	NA	0.16	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.16	2.13	NA	NA	0.12	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.30	0.32	0.30	0.32	0.04	XXX
76802		A	Ob us < 14 wks, add'l fetus	0.83	0.97	1.16	NA	NA	0.16	ZZZ
76802	TC	A	Ob us < 14 wks, add'l fetus	0.00	0.71	0.88	NA	NA	0.12	ZZZ
76802	26	A	Ob us < 14 wks, add'l fetus	0.83	0.26	0.28	0.26	0.28	0.04	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	3.04	2.74	NA	NA	0.16	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.73	2.42	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	1.65	1.52	NA	NA	0.26	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.35	1.20	NA	NA	0.22	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.30	0.32	0.30	0.32	0.04	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	3.05	3.64	NA	NA	0.52	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.51	3.02	NA	NA	0.43	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.54	0.62	0.54	0.62	0.09	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.98	2.84	NA	NA	0.49	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.48	2.26	NA	NA	0.41	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.50	0.58	0.50	0.58	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	1.81	1.81	NA	NA	0.14	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.40	0.40	0.40	0.40	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	0.29	0.29	0.29	0.29	0.05	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.80	1.72	NA	NA	0.11	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.60	1.51	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	2.38	1.90	NA	NA	0.10	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	2.13	1.62	NA	NA	0.06	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.25	0.28	0.25	0.28	0.04	XXX
76817		A	Transvaginal us, obstetric	0.75	2.02	1.89	NA	NA	0.09	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.79	1.65	NA	NA	0.06	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.23	0.24	0.23	0.24	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.21	2.11	NA	NA	0.15	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.91	1.76	NA	NA	0.10	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.30	0.35	0.30	0.35	0.05	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.63	1.75	NA	NA	0.13	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.40	1.50	NA	NA	0.10	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.23	0.25	0.23	0.25	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.56	1.18	NA	NA	0.15	XXX
76820	TC	A	Umbilical artery echo	0.00	0.42	1.01	NA	NA	0.12	XXX
76820	26	A	Umbilical artery echo	0.50	0.14	0.17	0.14	0.17	0.03	XXX
76821		A	Middle cerebral artery echo	0.70	1.86	1.87	NA	NA	0.15	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.66	1.63	NA	NA	0.12	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.20	0.24	0.20	0.24	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.37	3.47	NA	NA	0.18	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.87	2.92	NA	NA	0.11	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.50	0.55	0.50	0.55	0.07	XXX
76826		A	Echo exam of fetal heart	0.83	2.76	1.88	NA	NA	0.08	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.52	1.61	NA	NA	0.05	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.24	0.27	0.24	0.27	0.03	XXX
76827		A	Echo exam of fetal heart	0.58	1.07	1.50	NA	NA	0.14	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.90	1.31	NA	NA	0.12	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.17	0.19	0.17	0.19	0.02	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	0.98	NA	NA	0.11	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.48	0.79	NA	NA	0.08	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.15	0.19	0.15	0.19	0.03	XXX
76830		A	Transvaginal us, non-ob	0.69	2.76	2.26	NA	NA	0.13	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.54	2.03	NA	NA	0.10	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.22	0.23	0.22	0.23	0.03	XXX
76831		A	Echo exam, uterus	0.72	2.73	2.25	NA	NA	0.13	XXX
76831	TC	A	Echo exam, uterus	0.00	2.52	2.02	NA	NA	0.10	XXX
76831	26	A	Echo exam, uterus	0.72	0.21	0.23	0.21	0.23	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.79	2.26	NA	NA	0.13	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.55	2.03	NA	NA	0.10	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.24	0.23	0.24	0.23	0.03	XXX
76857		A	Us exam, pelvic, limited	0.38	2.48	2.15	NA	NA	0.08	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	2.34	2.02	NA	NA	0.06	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.14	0.13	0.14	0.13	0.02	XXX
76870		A	Us exam, scrotum	0.64	2.83	2.28	NA	NA	0.13	XXX
76870	TC	A	Us exam, scrotum	0.00	2.60	2.06	NA	NA	0.10	XXX
76870	26	A	Us exam, scrotum	0.64	0.23	0.22	0.23	0.22	0.03	XXX
76872		A	Us, transrectal	0.69	3.40	2.82	NA	NA	0.14	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
76872	TC	A	Us, transrectal	0.00	3.13	2.58	NA	NA	0.10	XXX
76872	26	A	Us, transrectal	0.69	0.27	0.24	0.27	0.24	0.04	XXX
76873		A	Echograp trans r, pros study	1.55	3.40	2.99	NA	NA	0.25	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.85	2.47	NA	NA	0.16	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.55	0.52	0.55	0.52	0.09	XXX
76880		A	Us exam, extremity	0.59	3.18	2.40	NA	NA	0.11	XXX
76880	TC	A	Us exam, extremity	0.00	3.00	2.21	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	3.26	2.50	NA	NA	0.13	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	3.01	2.26	NA	NA	0.10	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.25	0.24	0.25	0.24	0.03	XXX
76886		A	Us exam infant hips, static	0.62	2.27	1.94	NA	NA	0.11	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.05	1.73	NA	NA	0.08	XXX
76886	26	A	Us exam infant hips, static	0.62	0.22	0.21	0.22	0.21	0.03	XXX
76930		A	Echo guide, cardiocentesis	0.67	2.08	1.92	NA	NA	0.12	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.74	1.63	NA	NA	0.10	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.34	0.29	0.34	0.29	0.02	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.35	0.30	0.35	0.30	0.02	XXX
76936		A	Echo guide for artery repair	1.99	6.12	6.54	NA	NA	0.47	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.41	5.85	NA	NA	0.34	XXX
76936	26	A	Echo guide for artery repair	1.99	0.71	0.69	0.71	0.69	0.13	XXX
76937		A	Us guide, vascular access	0.30	0.62	0.55	NA	NA	0.13	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.52	0.45	NA	NA	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	0.38	0.42	0.38	0.42	0.07	XXX
76942		A	Echo guide for biopsy	0.67	4.79	3.91	NA	NA	0.13	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.55	3.68	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	1.05	NA	NA	0.12	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.34	0.93	NA	NA	0.10	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.11	0.12	0.11	0.12	0.02	XXX
76948		A	Echo guide, ova aspiration	0.38	0.45	1.04	NA	NA	0.12	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.35	0.93	NA	NA	0.10	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.10	0.11	0.10	0.11	0.02	XXX
76950		A	Echo guidance radiotherapy	0.58	1.21	1.35	NA	NA	0.10	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.02	1.16	NA	NA	0.07	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.19	0.19	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.20	3.60	NA	NA	0.37	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.70	3.14	NA	NA	0.29	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.50	0.46	0.50	0.46	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	1.98	1.58	NA	NA	0.08	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.87	1.46	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	0.29	0.30	0.29	0.04	XXX
76977		A	Us bone density measure	0.05	0.10	0.48	NA	NA	0.06	XXX
76977	TC	A	Us bone density measure	0.00	0.09	0.46	NA	NA	0.05	XXX
76977	26	A	Us bone density measure	0.05	0.01	0.02	0.01	0.02	0.01	XXX
76998		C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.35	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	2.72	2.08	NA	NA	0.11	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.59	1.95	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	1.23	1.35	NA	NA	0.09	XXX
77002	TC	A	Needle localization by xray	0.00	1.07	1.19	NA	NA	0.07	XXX
77002	26	A	Needle localization by xray	0.54	0.16	0.16	0.16	0.16	0.02	XXX
77003		A	Fluoroguide for spine inject	0.60	0.76	1.11	NA	NA	0.10	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
77003	TC	A	Fluoroguide for spine inject	0.00	0.62	0.96	NA	NA	0.07	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.14	0.15	0.14	0.15	0.03	XXX
77011		A	Ct scan for localization	1.21	20.26	14.45	NA	NA	0.47	XXX
77011	TC	A	Ct scan for localization	0.00	19.86	14.05	NA	NA	0.42	XXX
77011	26	A	Ct scan for localization	1.21	0.40	0.40	0.40	0.40	0.05	XXX
77012		A	Ct scan for needle biopsy	1.16	2.33	5.47	NA	NA	0.47	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.92	5.08	NA	NA	0.42	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.41	0.39	0.41	0.39	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	1.43	1.36	1.43	1.36	0.18	XXX
77014		A	Ct scan for therapy guide	0.85	4.47	3.85	NA	NA	0.20	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.19	3.57	NA	NA	0.16	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.28	0.28	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.70	10.70	NA	NA	0.64	XXX
77021	TC	A	Mr guidance for needle place	0.00	9.18	10.19	NA	NA	0.55	XXX
77021	26	A	Mr guidance for needle place	1.50	0.52	0.51	0.52	0.51	0.09	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.52	1.45	1.52	1.45	0.24	XXX
77031		A	Stereotact guide for brst bx	1.59	1.87	4.77	NA	NA	0.46	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.34	4.25	NA	NA	0.37	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.53	0.52	0.53	0.52	0.09	XXX
77032		A	Guidance for needle, breast	0.56	0.84	1.16	NA	NA	0.09	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.64	0.97	NA	NA	0.07	XXX
77032	26	A	Guidance for needle, breast	0.56	0.20	0.19	0.20	0.19	0.02	XXX
77051		A	Computer dx mammogram add-on	0.06	0.20	0.32	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.18	0.30	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.20	0.32	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.18	0.30	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.24	1.98	NA	NA	0.16	XXX
77053	TC	A	X-ray of mammary duct	0.00	1.11	1.86	NA	NA	0.14	XXX
77053	26	A	X-ray of mammary duct	0.36	0.13	0.12	0.13	0.12	0.02	XXX
77054		A	X-ray of mammary ducts	0.45	1.68	2.74	NA	NA	0.21	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.52	2.59	NA	NA	0.19	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.16	0.15	0.16	0.15	0.02	XXX
77055		A	Mammogram, one breast	0.70	1.65	1.46	NA	NA	0.09	XXX
77055	TC	A	Mammogram, one breast	0.00	1.40	1.22	NA	NA	0.06	XXX
77055	26	A	Mammogram, one breast	0.70	0.25	0.24	0.25	0.24	0.03	XXX
77056		A	Mammogram, both breasts	0.87	2.15	1.86	NA	NA	0.11	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.84	1.57	NA	NA	0.07	XXX
77056	26	A	Mammogram, both breasts	0.87	0.31	0.29	0.31	0.29	0.04	XXX
77057		A	Mammogram, screening	0.70	1.44	1.45	NA	NA	0.10	XXX
77057	TC	A	Mammogram, screening	0.00	1.20	1.21	NA	NA	0.07	XXX
77057	26	A	Mammogram, screening	0.70	0.24	0.24	0.24	0.24	0.03	XXX
77058		A	Mri, one breast	1.63	21.62	19.89	NA	NA	0.99	XXX
77058	TC	A	Mri, one breast	0.00	21.06	19.34	NA	NA	0.92	XXX
77058	26	A	Mri, one breast	1.63	0.56	0.55	0.56	0.55	0.07	XXX
77059		A	Mri, both breasts	1.63	21.56	22.99	NA	NA	1.31	XXX
77059	TC	A	Mri, both breasts	0.00	20.99	22.44	NA	NA	1.24	XXX
77059	26	A	Mri, both breasts	1.63	0.57	0.55	0.57	0.55	0.07	XXX
77071		A	X-ray stress view	0.41	0.77	0.47	0.77	0.47	0.06	XXX
77072		A	X-rays for bone age	0.19	0.42	0.42	NA	NA	0.03	XXX
77072	TC	A	X-rays for bone age	0.00	0.36	0.36	NA	NA	0.02	XXX
77072	26	A	X-rays for bone age	0.19	0.06	0.06	0.06	0.06	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.67	0.77	NA	NA	0.06	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.57	0.67	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	1.44	1.30	NA	NA	0.08	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.28	1.14	NA	NA	0.06	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.16	0.16	0.16	0.16	0.02	XXX
77075		A	X-rays, bone survey complete	0.54	2.29	1.96	NA	NA	0.10	XXX
77075	TC	A	X-rays, bone survey complete	0.00	2.10	1.77	NA	NA	0.08	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.19	0.19	0.19	0.19	0.02	XXX
77076		A	X-rays, bone survey, infant	0.70	2.13	1.54	NA	NA	0.08	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.90	1.31	NA	NA	0.05	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.23	0.23	0.23	0.23	0.03	XXX
77077		A	Joint survey, single view	0.31	0.66	0.93	NA	NA	0.08	XXX
77077	TC	A	Joint survey, single view	0.00	0.55	0.83	NA	NA	0.06	XXX
77077	26	A	Joint survey, single view	0.31	0.11	0.10	0.11	0.10	0.02	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
77078		A	Ct bone density, axial	0.25	4.74	3.88	NA	NA	0.17	XXX
77078	TC	A	Ct bone density, axial	0.00	4.65	3.80	NA	NA	0.16	XXX
77078	26	A	Ct bone density, axial	0.25	0.09	0.08	0.09	0.08	0.01	XXX
77079		A	Ct bone density, peripheral	0.22	0.83	1.92	NA	NA	0.06	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.75	1.85	NA	NA	0.05	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.08	0.07	0.08	0.07	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.10	2.15	NA	NA	0.18	XXX
77080	TC	A	Dxa bone density, axial	0.00	1.04	2.07	NA	NA	0.17	XXX
77080	26	A	Dxa bone density, axial	0.20	0.06	0.08	0.06	0.08	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	0.65	NA	NA	0.06	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.41	0.58	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	0.53	0.66	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.48	0.61	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	0.59	NA	NA	0.06	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.32	0.53	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	13.55	12.63	NA	NA	0.66	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	13.03	12.11	NA	NA	0.59	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.52	0.52	0.52	0.52	0.07	XXX
77261		A	Radiation therapy planning	1.39	0.48	0.49	0.48	0.49	0.07	XXX
77262		A	Radiation therapy planning	2.11	0.69	0.72	0.69	0.72	0.11	XXX
77263		A	Radiation therapy planning	3.14	1.03	1.07	1.03	1.07	0.16	XXX
77280		A	Set radiation therapy field	0.70	4.43	4.05	NA	NA	0.22	XXX
77280	TC	A	Set radiation therapy field	0.00	4.20	3.83	NA	NA	0.18	XXX
77280	26	A	Set radiation therapy field	0.70	0.23	0.22	0.23	0.22	0.04	XXX
77285		A	Set radiation therapy field	1.05	8.01	6.96	NA	NA	0.35	XXX
77285	TC	A	Set radiation therapy field	0.00	7.67	6.62	NA	NA	0.30	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.34	0.34	0.05	XXX
77290		A	Set radiation therapy field	1.56	13.41	10.21	NA	NA	0.43	XXX
77290	TC	A	Set radiation therapy field	0.00	12.90	9.71	NA	NA	0.35	XXX
77290	26	A	Set radiation therapy field	1.56	0.51	0.50	0.51	0.50	0.08	XXX
77295		A	Set radiation therapy field	4.56	7.45	18.41	NA	NA	1.71	XXX
77295	TC	A	Set radiation therapy field	0.00	5.95	16.93	NA	NA	1.48	XXX
77295	26	A	Set radiation therapy field	4.56	1.50	1.48	1.50	1.48	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	1.18	1.36	NA	NA	0.10	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.98	1.16	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	57.41	43.94	NA	NA	1.88	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	54.79	41.35	NA	NA	1.48	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.62	2.59	2.62	2.59	0.40	XXX
77305		A	Teletx isodose plan simple	0.70	0.90	1.50	NA	NA	0.15	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.67	1.27	NA	NA	0.11	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.23	0.23	0.04	XXX
77310		A	Teletx isodose plan intermed	1.05	1.24	1.96	NA	NA	0.18	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.90	1.62	NA	NA	0.13	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.34	0.34	0.34	0.34	0.05	XXX
77315		A	Teletx isodose plan complex	1.56	2.08	2.62	NA	NA	0.22	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.57	2.12	NA	NA	0.14	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.51	0.50	0.51	0.50	0.08	XXX
77321		A	Special teletx port plan	0.95	1.51	2.93	NA	NA	0.26	XXX
77321	TC	A	Special teletx port plan	0.00	1.20	2.62	NA	NA	0.21	XXX
77321	26	A	Special teletx port plan	0.95	0.31	0.31	0.31	0.31	0.05	XXX
77326		A	Brachytx isodose calc simp	0.93	2.98	2.82	NA	NA	0.18	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.68	2.52	NA	NA	0.13	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.30	0.30	0.30	0.30	0.05	XXX
77327		A	Brachytx isodose calc interm	1.39	4.09	4.00	NA	NA	0.25	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.64	3.55	NA	NA	0.18	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.45	0.45	0.45	0.45	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.25	5.44	NA	NA	0.36	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.56	4.76	NA	NA	0.25	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.69	0.68	0.69	0.68	0.11	XXX
77331		A	Special radiation dosimetry	0.87	0.81	0.79	NA	NA	0.06	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.52	0.51	NA	NA	0.02	XXX
77331	26	A	Special radiation dosimetry	0.87	0.29	0.28	0.29	0.28	0.04	XXX
77332		A	Radiation treatment aid(s)	0.54	1.55	1.52	NA	NA	0.10	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.37	1.35	NA	NA	0.07	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.18	0.17	0.18	0.17	0.03	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
77333		A	Radiation treatment aid(s)	0.84	0.52	1.34	NA	NA	0.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.24	1.07	NA	NA	0.11	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.28	0.27	0.28	0.27	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	2.71	3.18	NA	NA	0.23	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.31	2.78	NA	NA	0.17	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.40	0.40	0.06	XXX
77336		A	Radiation physics consult	0.00	1.14	2.06	NA	NA	0.16	XXX
77370		A	Radiation physics consult	0.00	3.04	3.27	NA	NA	0.18	XXX
77371		A	Srs, multisource	0.00	30.07	30.07	NA	NA	0.13	XXX
77372		A	Srs, linear based	0.00	22.80	22.80	NA	NA	0.13	XXX
77373		A	Sbrt delivery	0.00	42.62	42.62	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	0.47	1.12	NA	NA	0.11	XXX
77402		A	Radiation treatment delivery	0.00	4.34	3.06	NA	NA	0.11	XXX
77403		A	Radiation treatment delivery	0.00	3.75	2.76	NA	NA	0.11	XXX
77404		A	Radiation treatment delivery	0.00	4.20	2.99	NA	NA	0.11	XXX
77406		A	Radiation treatment delivery	0.00	4.23	3.00	NA	NA	0.11	XXX
77407		A	Radiation treatment delivery	0.00	5.78	3.93	NA	NA	0.12	XXX
77408		A	Radiation treatment delivery	0.00	5.19	3.64	NA	NA	0.12	XXX
77409		A	Radiation treatment delivery	0.00	5.76	3.93	NA	NA	0.12	XXX
77411		A	Radiation treatment delivery	0.00	5.73	3.91	NA	NA	0.12	XXX
77412		A	Radiation treatment delivery	0.00	6.78	4.56	NA	NA	0.13	XXX
77413		A	Radiation treatment delivery	0.00	6.85	4.59	NA	NA	0.13	XXX
77414		A	Radiation treatment delivery	0.00	7.71	5.02	NA	NA	0.13	XXX
77416		A	Radiation treatment delivery	0.00	7.72	5.02	NA	NA	0.13	XXX
77417		A	Radiology port film(s)	0.00	0.36	0.48	NA	NA	0.04	XXX
77418		A	Radiation tx delivery, imrt	0.00	13.15	15.58	NA	NA	0.13	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.38	2.93	NA	NA	0.12	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.25	2.80	NA	NA	0.10	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.13	0.13	0.13	0.13	0.02	XXX
77422		A	Neutron beam tx, simple	0.00	5.35	3.53	NA	NA	0.13	XXX
77423		A	Neutron beam tx, complex	0.00	7.46	4.86	NA	NA	0.13	XXX
77427		A	Radiation tx management, x5	3.70	1.39	1.22	1.39	1.22	0.17	XXX
77431		A	Radiation therapy management	1.81	0.77	0.73	0.77	0.73	0.09	XXX
77432		A	Stereotactic radiation trmt	7.92	2.59	2.75	2.59	2.75	0.41	XXX
77435		A	Sbrt management	13.00	4.75	4.75	NA	NA	0.67	XXX
77470		A	Special radiation treatment	2.09	1.92	6.87	NA	NA	0.70	XXX
77470	TC	A	Special radiation treatment	0.00	1.24	6.19	NA	NA	0.59	XXX
77470	26	A	Special radiation treatment	2.09	0.68	0.68	0.68	0.68	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	10.23	6.89	NA	NA	0.24	XXX
77600	TC	R	Hyperthermia treatment	0.00	9.73	6.39	NA	NA	0.16	XXX
77600	26	R	Hyperthermia treatment	1.56	0.50	0.50	0.50	0.50	0.08	XXX
77605		R	Hyperthermia treatment	2.09	18.46	11.58	NA	NA	0.38	XXX
77605	TC	R	Hyperthermia treatment	0.00	17.91	10.98	NA	NA	0.22	XXX
77605	26	R	Hyperthermia treatment	2.09	0.55	0.60	0.55	0.60	0.16	XXX
77610		R	Hyperthermia treatment	1.56	17.92	10.74	NA	NA	0.24	XXX
77610	TC	R	Hyperthermia treatment	0.00	17.56	10.31	NA	NA	0.16	XXX
77610	26	R	Hyperthermia treatment	1.56	0.36	0.43	0.36	0.43	0.08	XXX
77615		R	Hyperthermia treatment	2.09	25.90	15.31	NA	NA	0.33	XXX
77615	TC	R	Hyperthermia treatment	0.00	25.26	14.66	NA	NA	0.22	XXX
77615	26	R	Hyperthermia treatment	2.09	0.64	0.65	0.64	0.65	0.11	XXX
77620		R	Hyperthermia treatment	1.56	10.49	7.03	NA	NA	0.36	XXX
77620	TC	R	Hyperthermia treatment	0.00	10.09	6.57	NA	NA	0.16	XXX
77620	26	R	Hyperthermia treatment	1.56	0.40	0.46	0.40	0.46	0.20	XXX
77750		A	Infuse radioactive materials	4.94	4.55	3.73	NA	NA	0.32	090
77750	TC	A	Infuse radioactive materials	0.00	2.93	2.13	NA	NA	0.07	090
77750	26	A	Infuse radioactive materials	4.94	1.62	1.60	1.62	1.60	0.25	090
77761		A	Apply intrcav radiat simple	3.82	6.34	4.96	NA	NA	0.33	090
77761	TC	A	Apply intrcav radiat simple	0.00	5.10	3.80	NA	NA	0.14	090
77761	26	A	Apply intrcav radiat simple	3.82	1.24	1.16	1.24	1.16	0.19	090
77762		A	Apply intrcav radiat interm	5.73	7.62	6.53	NA	NA	0.48	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.75	4.68	NA	NA	0.19	090
77762	26	A	Apply intrcav radiat interm	5.73	1.87	1.85	1.87	1.85	0.29	090

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
77763		A	Apply intrcav radiat compl	8.60	10.33	8.78	NA	NA	0.66	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.52	6.00	NA	NA	0.23	090
77763	26	A	Apply intrcav radiat compl	8.60	2.81	2.78	2.81	2.78	0.43	090
77776		A	Apply interstit radiat simpl	4.67	7.46	5.29	NA	NA	0.57	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.79	3.98	NA	NA	0.13	090
77776	26	A	Apply interstit radiat simpl	4.67	1.67	1.31	1.67	1.31	0.44	090
77777		A	Apply interstit radiat inter	7.49	7.92	7.26	NA	NA	0.61	090
77777	TC	A	Apply interstit radiat inter	0.00	5.47	4.85	NA	NA	0.22	090
77777	26	A	Apply interstit radiat inter	7.49	2.45	2.41	2.45	2.41	0.39	090
77778		A	Apply interstit radiat compl	11.23	11.31	10.00	NA	NA	0.84	090
77778	TC	A	Apply interstit radiat compl	0.00	7.62	6.37	NA	NA	0.27	090
77778	26	A	Apply interstit radiat compl	11.23	3.69	3.63	3.69	3.63	0.57	090
77781		A	High intensity brachytherapy	1.21	4.41	12.61	NA	NA	1.14	XXX
77781	TC	A	High intensity brachytherapy	0.00	4.01	12.15	NA	NA	1.06	XXX
77781	26	A	High intensity brachytherapy	1.21	0.40	0.46	0.40	0.46	0.08	XXX
77782		A	High intensity brachytherapy	2.04	12.41	16.74	NA	NA	1.19	XXX
77782	TC	A	High intensity brachytherapy	0.00	11.74	16.01	NA	NA	1.06	XXX
77782	26	A	High intensity brachytherapy	2.04	0.67	0.73	0.67	0.73	0.13	XXX
77783		A	High intensity brachytherapy	3.27	24.19	22.83	NA	NA	1.25	XXX
77783	TC	A	High intensity brachytherapy	0.00	23.12	21.70	NA	NA	1.06	XXX
77783	26	A	High intensity brachytherapy	3.27	1.07	1.13	1.07	1.13	0.19	XXX
77784		A	High intensity brachytherapy	5.15	45.65	33.87	NA	NA	1.35	XXX
77784	TC	A	High intensity brachytherapy	0.00	43.97	32.13	NA	NA	1.06	XXX
77784	26	A	High intensity brachytherapy	5.15	1.68	1.74	1.68	1.74	0.29	XXX
77789		A	Apply surface radiation	1.14	2.02	1.42	NA	NA	0.08	000
77789	TC	A	Apply surface radiation	0.00	1.64	1.04	NA	NA	0.02	000
77789	26	A	Apply surface radiation	1.14	0.38	0.38	0.38	0.38	0.06	000
77790		A	Radiation handling	1.05	1.46	1.15	NA	NA	0.07	XXX
77790	TC	A	Radiation handling	0.00	1.12	0.81	NA	NA	0.02	XXX
77790	26	A	Radiation handling	1.05	0.34	0.34	0.34	0.34	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	1.85	1.44	NA	NA	0.07	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.79	1.38	NA	NA	0.06	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.06	0.06	0.06	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	2.30	1.85	NA	NA	0.08	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	2.21	1.76	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	1.94	1.50	NA	NA	0.07	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.82	1.39	NA	NA	0.06	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.12	0.11	0.12	0.11	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.22	4.38	NA	NA	0.15	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	6.05	4.22	NA	NA	0.13	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.17	0.16	0.17	0.16	0.02	XXX
78007		A	Thyroid image, mult uptakes	0.50	3.05	2.90	NA	NA	0.16	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.88	2.73	NA	NA	0.14	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.17	0.17	0.02	XXX
78010		A	Thyroid imaging	0.39	4.18	3.07	NA	NA	0.13	XXX
78010	TC	A	Thyroid imaging	0.00	4.05	2.94	NA	NA	0.11	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.13	0.13	0.02	XXX
78011		A	Thyroid imaging with flow	0.45	4.54	3.55	NA	NA	0.15	XXX
78011	TC	A	Thyroid imaging with flow	0.00	4.38	3.40	NA	NA	0.13	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.16	0.15	0.16	0.15	0.02	XXX
78015		A	Thyroid met imaging	0.67	5.34	4.07	NA	NA	0.17	XXX
78015	TC	A	Thyroid met imaging	0.00	5.12	3.84	NA	NA	0.14	XXX
78015	26	A	Thyroid met imaging	0.67	0.22	0.23	0.22	0.23	0.03	XXX
78016		A	Thyroid met imaging/studies	0.82	8.52	6.14	NA	NA	0.21	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	8.25	5.86	NA	NA	0.18	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.27	0.28	0.27	0.28	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	7.93	6.82	NA	NA	0.33	XXX
78018	TC	A	Thyroid met imaging, body	0.00	7.63	6.52	NA	NA	0.29	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.30	0.30	0.30	0.30	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.80	1.66	NA	NA	0.16	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.60	1.45	NA	NA	0.14	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.20	0.21	0.20	0.21	0.02	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.48	4.01	NA	NA	0.15	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	3.20	3.73	NA	NA	0.11	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.28	0.28	0.04	XXX
78075		A	Adrenal nuclear imaging	0.74	11.61	8.64	NA	NA	0.32	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	11.36	8.39	NA	NA	0.29	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.25	0.25	0.25	0.25	0.03	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	4.18	3.20	NA	NA	0.14	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.99	3.01	NA	NA	0.12	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.19	0.19	0.02	XXX
78103		A	Bone marrow imaging, mult	0.75	5.43	4.43	NA	NA	0.20	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	5.17	4.17	NA	NA	0.17	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.26	0.26	0.03	XXX
78104		A	Bone marrow imaging, body	0.80	6.23	5.28	NA	NA	0.25	XXX
78104	TC	A	Bone marrow imaging, body	0.00	5.94	5.00	NA	NA	0.22	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.29	0.28	0.29	0.28	0.03	XXX
78110		A	Plasma volume, single	0.19	2.13	1.57	NA	NA	0.07	XXX
78110	TC	A	Plasma volume, single	0.00	2.06	1.50	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	2.14	2.40	NA	NA	0.15	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.07	2.32	NA	NA	0.14	XXX
78111	26	A	Plasma volume, multiple	0.22	0.07	0.08	0.07	0.08	0.01	XXX
78120		A	Red cell mass, single	0.23	2.10	1.96	NA	NA	0.12	XXX
78120	TC	A	Red cell mass, single	0.00	2.02	1.88	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	2.20	2.61	NA	NA	0.15	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.10	2.50	NA	NA	0.14	XXX
78121	26	A	Red cell mass, multiple	0.32	0.10	0.11	0.10	0.11	0.01	XXX
78122		A	Blood volume	0.45	2.25	3.51	NA	NA	0.26	XXX
78122	TC	A	Blood volume	0.00	2.10	3.35	NA	NA	0.24	XXX
78122	26	A	Blood volume	0.45	0.15	0.16	0.15	0.16	0.02	XXX
78130		A	Red cell survival study	0.61	3.50	3.28	NA	NA	0.17	XXX
78130	TC	A	Red cell survival study	0.00	3.29	3.07	NA	NA	0.14	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.21	0.21	0.03	XXX
78135		A	Red cell survival kinetics	0.64	8.67	6.88	NA	NA	0.28	XXX
78135	TC	A	Red cell survival kinetics	0.00	8.45	6.66	NA	NA	0.25	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.22	0.22	0.03	XXX
78140		A	Red cell sequestration	0.61	2.94	3.53	NA	NA	0.24	XXX
78140	TC	A	Red cell sequestration	0.00	2.72	3.32	NA	NA	0.21	XXX
78140	26	A	Red cell sequestration	0.61	0.22	0.21	0.22	0.21	0.03	XXX
78185		A	Spleen imaging	0.40	5.19	3.85	NA	NA	0.15	XXX
78185	TC	A	Spleen imaging	0.00	5.05	3.71	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	8.37	7.24	NA	NA	0.38	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.12	6.92	NA	NA	0.30	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.25	0.32	0.25	0.32	0.08	XXX
78191		A	Platelet survival	0.61	3.51	5.53	NA	NA	0.40	XXX
78191	TC	A	Platelet survival	0.00	3.30	5.32	NA	NA	0.37	XXX
78191	26	A	Platelet survival	0.61	0.21	0.21	0.21	0.21	0.03	XXX
78195		A	Lymph system imaging	1.20	8.68	6.58	NA	NA	0.28	XXX
78195	TC	A	Lymph system imaging	0.00	8.27	6.17	NA	NA	0.22	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.41	0.41	0.41	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	4.59	3.55	NA	NA	0.15	XXX
78201	TC	A	Liver imaging	0.00	4.46	3.41	NA	NA	0.13	XXX
78201	26	A	Liver imaging	0.44	0.13	0.14	0.13	0.14	0.02	XXX
78202		A	Liver imaging with flow	0.51	5.34	4.20	NA	NA	0.16	XXX
78202	TC	A	Liver imaging with flow	0.00	5.17	4.03	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	5.27	5.70	NA	NA	0.34	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.02	5.46	NA	NA	0.31	XXX
78205	26	A	Liver imaging (3D)	0.71	0.25	0.24	0.25	0.24	0.03	XXX
78206		A	Liver image (3d) with flow	0.96	8.60	7.41	NA	NA	0.15	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.26	7.08	NA	NA	0.11	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.34	0.33	0.34	0.33	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.82	3.96	NA	NA	0.16	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.65	3.79	NA	NA	0.14	XXX
78215	26	A	Liver and spleen imaging	0.49	0.17	0.17	0.17	0.17	0.02	XXX
78216		A	Liver & spleen image/flow	0.57	2.84	3.26	NA	NA	0.20	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.65	3.07	NA	NA	0.18	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.19	0.19	0.19	0.02	XXX
78220		A	Liver function study	0.49	3.08	3.47	NA	NA	0.21	XXX
78220	TC	A	Liver function study	0.00	2.91	3.31	NA	NA	0.19	XXX
78220	26	A	Liver function study	0.49	0.17	0.16	0.17	0.16	0.02	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
78223		A	Hepatobiliary imaging	0.84	8.50	6.22	NA	NA	0.23	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.21	5.93	NA	NA	0.19	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.29	0.29	0.29	0.29	0.04	XXX
78230		A	Salivary gland imaging	0.45	4.17	3.25	NA	NA	0.15	XXX
78230	TC	A	Salivary gland imaging	0.00	4.01	3.10	NA	NA	0.13	XXX
78230	26	A	Salivary gland imaging	0.45	0.16	0.15	0.16	0.15	0.02	XXX
78231		A	Serial salivary imaging	0.52	2.80	3.07	NA	NA	0.19	XXX
78231	TC	A	Serial salivary imaging	0.00	2.63	2.90	NA	NA	0.17	XXX
78231	26	A	Serial salivary imaging	0.52	0.17	0.17	0.17	0.17	0.02	XXX
78232		A	Salivary gland function exam	0.47	2.77	3.24	NA	NA	0.20	XXX
78232	TC	A	Salivary gland function exam	0.00	2.62	3.08	NA	NA	0.18	XXX
78232	26	A	Salivary gland function exam	0.47	0.15	0.16	0.15	0.16	0.02	XXX
78258		A	Esophageal motility study	0.74	5.52	4.32	NA	NA	0.17	XXX
78258	TC	A	Esophageal motility study	0.00	5.25	4.06	NA	NA	0.14	XXX
78258	26	A	Esophageal motility study	0.74	0.27	0.26	0.27	0.26	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	6.00	5.17	NA	NA	0.25	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.76	4.93	NA	NA	0.22	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.24	0.24	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.95	5.21	NA	NA	0.25	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.73	4.99	NA	NA	0.22	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.22	0.22	0.22	0.22	0.03	XXX
78264		A	Gastric emptying study	0.78	7.16	5.78	NA	NA	0.25	XXX
78264	TC	A	Gastric emptying study	0.00	6.89	5.51	NA	NA	0.22	XXX
78264	26	A	Gastric emptying study	0.78	0.27	0.27	0.27	0.27	0.03	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.95	1.78	NA	NA	0.11	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.88	1.71	NA	NA	0.10	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.07	0.07	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.88	1.79	NA	NA	0.11	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.83	1.73	NA	NA	0.10	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.05	0.06	0.05	0.06	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	2.06	2.23	NA	NA	0.14	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.99	2.15	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	8.60	6.90	NA	NA	0.29	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	8.25	6.56	NA	NA	0.25	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.35	0.34	0.35	0.34	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	0.13	0.13	0.13	0.13	0.02	XXX
78290		A	Meckel's divert exam	0.68	8.51	5.89	NA	NA	0.19	XXX
78290	TC	A	Meckel's divert exam	0.00	8.27	5.66	NA	NA	0.16	XXX
78290	26	A	Meckel's divert exam	0.68	0.24	0.23	0.24	0.23	0.03	XXX
78291		A	Leveen/shunt patency exam	0.88	6.14	4.75	NA	NA	0.20	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.84	4.45	NA	NA	0.16	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.30	0.30	0.30	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	4.23	3.46	NA	NA	0.17	XXX
78300	TC	A	Bone imaging, limited area	0.00	4.01	3.25	NA	NA	0.14	XXX
78300	26	A	Bone imaging, limited area	0.62	0.22	0.21	0.22	0.21	0.03	XXX
78305		A	Bone imaging, multiple areas	0.83	5.47	4.70	NA	NA	0.23	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	5.19	4.42	NA	NA	0.19	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.28	0.28	0.04	XXX
78306		A	Bone imaging, whole body	0.86	6.06	5.31	NA	NA	0.26	XXX
78306	TC	A	Bone imaging, whole body	0.00	5.76	5.01	NA	NA	0.22	XXX
78306	26	A	Bone imaging, whole body	0.86	0.30	0.30	0.30	0.30	0.04	XXX
78315		A	Bone imaging, 3 phase	1.02	8.59	6.85	NA	NA	0.29	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	8.23	6.50	NA	NA	0.25	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.36	0.35	0.36	0.35	0.04	XXX
78320		A	Bone imaging (3D)	1.04	5.35	5.81	NA	NA	0.35	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.99	5.45	NA	NA	0.31	XXX
78320	26	A	Bone imaging (3D)	1.04	0.36	0.36	0.36	0.36	0.04	XXX
78350		N	Bone mineral, single photon	0.22	0.51	0.67	NA	NA	0.06	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.46	0.61	NA	NA	0.05	XXX
78350	26	N	Bone mineral, single photon	0.22	0.05	0.06	0.05	0.06	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	NA	NA	0.07	0.09	0.01	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	0.17	0.17	0.17	0.17	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	5.26	3.90	NA	NA	0.16	XXX
78428	TC	A	Cardiac shunt imaging	0.00	4.90	3.58	NA	NA	0.13	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.36	0.32	0.36	0.32	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.48	3.26	NA	NA	0.13	XXX
78445	TC	A	Vascular flow imaging	0.00	4.31	3.09	NA	NA	0.11	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.17	0.17	0.02	XXX
78456		A	Acute venous thrombus image	1.00	8.80	6.56	NA	NA	0.33	XXX
78456	TC	A	Acute venous thrombus image	0.00	8.43	6.20	NA	NA	0.29	XXX
78456	26	A	Acute venous thrombus image	1.00	0.37	0.36	0.37	0.36	0.04	XXX
78457		A	Venous thrombosis imaging	0.77	4.65	3.78	NA	NA	0.17	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.41	3.53	NA	NA	0.14	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.24	0.25	0.24	0.25	0.03	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.51	4.43	NA	NA	0.25	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.22	4.12	NA	NA	0.21	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.29	0.31	0.29	0.31	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	0.60	0.59	0.60	0.59	0.05	XXX
78460		A	Heart muscle blood, single	0.86	4.66	3.65	NA	NA	0.17	XXX
78460	TC	A	Heart muscle blood, single	0.00	4.34	3.35	NA	NA	0.13	XXX
78460	26	A	Heart muscle blood, single	0.86	0.32	0.30	0.32	0.30	0.04	XXX
78461		A	Heart muscle blood, multiple	1.23	4.07	4.60	NA	NA	0.30	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	3.61	4.16	NA	NA	0.25	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.46	0.44	0.46	0.44	0.05	XXX
78464		A	Heart image (3d), single	1.09	5.86	6.65	NA	NA	0.41	XXX
78464	TC	A	Heart image (3d), single	0.00	5.36	6.21	NA	NA	0.37	XXX
78464	26	A	Heart image (3d), single	1.09	0.50	0.44	0.50	0.44	0.04	XXX
78465		A	Heart image (3d), multiple	1.46	11.44	11.87	NA	NA	0.67	XXX
78465	TC	A	Heart image (3d), multiple	0.00	10.73	11.26	NA	NA	0.62	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.71	0.61	0.71	0.61	0.05	XXX
78466		A	Heart infarct image	0.69	4.57	3.71	NA	NA	0.17	XXX
78466	TC	A	Heart infarct image	0.00	4.28	3.45	NA	NA	0.14	XXX
78466	26	A	Heart infarct image	0.69	0.29	0.26	0.29	0.26	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	5.86	4.89	NA	NA	0.22	XXX
78468	TC	A	Heart infarct image (ef)	0.00	5.47	4.56	NA	NA	0.19	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.39	0.33	0.39	0.33	0.03	XXX
78469		A	Heart infarct image (3D)	0.92	6.28	5.90	NA	NA	0.31	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.84	5.53	NA	NA	0.28	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.44	0.37	0.44	0.37	0.03	XXX
78472		A	Gated heart, planar, single	0.98	6.03	5.93	NA	NA	0.34	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.62	5.56	NA	NA	0.30	XXX
78472	26	A	Gated heart, planar, single	0.98	0.41	0.37	0.41	0.37	0.04	XXX
78473		A	Gated heart, multiple	1.47	7.76	8.25	NA	NA	0.48	XXX
78473	TC	A	Gated heart, multiple	0.00	7.12	7.68	NA	NA	0.42	XXX
78473	26	A	Gated heart, multiple	1.47	0.64	0.57	0.64	0.57	0.06	XXX
78478		A	Heart wall motion add-on	0.50	0.80	1.30	NA	NA	0.12	XXX
78478	TC	A	Heart wall motion add-on	0.00	0.56	1.06	NA	NA	0.10	XXX
78478	26	A	Heart wall motion add-on	0.50	0.24	0.24	0.24	0.24	0.02	XXX
78480		A	Heart function add-on	0.30	0.70	1.24	NA	NA	0.12	XXX
78480	TC	A	Heart function add-on	0.00	0.56	1.06	NA	NA	0.10	XXX
78480	26	A	Heart function add-on	0.30	0.14	0.18	0.14	0.18	0.02	XXX
78481		A	Heart first pass, single	0.98	5.07	5.33	NA	NA	0.31	XXX
78481	TC	A	Heart first pass, single	0.00	4.58	4.90	NA	NA	0.28	XXX
78481	26	A	Heart first pass, single	0.98	0.49	0.43	0.49	0.43	0.03	XXX
78483		A	Heart first pass, multiple	1.47	6.87	7.63	NA	NA	0.46	XXX
78483	TC	A	Heart first pass, multiple	0.00	6.09	6.97	NA	NA	0.41	XXX
78483	26	A	Heart first pass, multiple	1.47	0.78	0.66	0.78	0.66	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	0.63	0.61	0.63	0.61	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	0.91	0.82	0.91	0.82	0.07	XXX
78494		A	Heart image, spect	1.19	6.22	6.85	NA	NA	0.35	XXX
78494	TC	A	Heart image, spect	0.00	5.68	6.37	NA	NA	0.30	XXX
78494	26	A	Heart image, spect	1.19	0.54	0.48	0.54	0.48	0.05	XXX
78496		A	Heart first pass add-on	0.50	0.88	4.06	NA	NA	0.32	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.65	3.86	NA	NA	0.30	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.23	0.20	0.23	0.20	0.02	ZZZ

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	5.13	4.41	NA	NA	0.21	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.87	4.15	NA	NA	0.18	XXX
78580	26	A	Lung perfusion imaging	0.74	0.26	0.26	0.26	0.26	0.03	XXX
78584		A	Lung V/Q image single breath	0.99	3.02	3.27	NA	NA	0.21	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.67	2.93	NA	NA	0.17	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.35	0.34	0.35	0.34	0.04	XXX
78585		A	Lung V/Q imaging	1.09	8.62	7.31	NA	NA	0.35	XXX
78585	TC	A	Lung V/Q imaging	0.00	8.24	6.94	NA	NA	0.30	XXX
78585	26	A	Lung V/Q imaging	1.09	0.38	0.37	0.38	0.37	0.05	XXX
78586		A	Aerosol lung image, single	0.40	4.17	3.44	NA	NA	0.16	XXX
78586	TC	A	Aerosol lung image, single	0.00	4.03	3.31	NA	NA	0.14	XXX
78586	26	A	Aerosol lung image, single	0.40	0.14	0.13	0.14	0.13	0.02	XXX
78587		A	Aerosol lung image, multiple	0.49	5.43	4.20	NA	NA	0.16	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	5.26	4.03	NA	NA	0.14	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.17	0.17	0.17	0.17	0.02	XXX
78588		A	Perfusion lung image	1.09	8.65	6.11	NA	NA	0.23	XXX
78588	TC	A	Perfusion lung image	0.00	8.27	5.74	NA	NA	0.18	XXX
78588	26	A	Perfusion lung image	1.09	0.38	0.37	0.38	0.37	0.05	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	4.17	3.57	NA	NA	0.16	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	4.03	3.44	NA	NA	0.14	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.14	0.13	0.14	0.13	0.02	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.82	4.21	NA	NA	0.20	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	4.65	4.05	NA	NA	0.18	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.17	0.16	0.17	0.16	0.02	XXX
78594		A	Vent image, mult proj, gas	0.53	5.29	5.22	NA	NA	0.27	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	5.11	5.04	NA	NA	0.25	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.18	0.18	0.02	XXX
78596		A	Lung differential function	1.27	8.67	8.08	NA	NA	0.42	XXX
78596	TC	A	Lung differential function	0.00	8.28	7.67	NA	NA	0.37	XXX
78596	26	A	Lung differential function	1.27	0.39	0.41	0.39	0.41	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	4.39	3.71	NA	NA	0.16	XXX
78600	TC	A	Brain image < 4 views	0.00	4.24	3.56	NA	NA	0.14	XXX
78600	26	A	Brain image < 4 views	0.44	0.15	0.15	0.15	0.15	0.02	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.38	4.47	NA	NA	0.20	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.20	4.30	NA	NA	0.18	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.18	0.17	0.18	0.17	0.02	XXX
78605		A	Brain image 4+ views	0.53	4.84	4.22	NA	NA	0.20	XXX
78605	TC	A	Brain image 4+ views	0.00	4.65	4.03	NA	NA	0.18	XXX
78605	26	A	Brain image 4+ views	0.53	0.19	0.19	0.19	0.19	0.02	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.53	6.30	NA	NA	0.24	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.31	6.09	NA	NA	0.21	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.22	0.21	0.22	0.21	0.03	XXX
78607		A	Brain imaging (3D)	1.23	8.63	7.80	NA	NA	0.40	XXX
78607	TC	A	Brain imaging (3D)	0.00	8.22	7.38	NA	NA	0.35	XXX
78607	26	A	Brain imaging (3D)	1.23	0.41	0.42	0.41	0.42	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	0.49	0.50	0.49	0.50	0.06	XXX
78609		N	Brain imaging (PET)	1.50	0.00	0.49	NA	NA	0.06	XXX
78609	TC	N	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (PET)	1.50	0.00	0.49	0.00	0.49	0.06	XXX
78610		A	Brain flow imaging only	0.30	4.45	4.23	NA	NA	0.11	XXX
78610	TC	A	Brain flow imaging only	0.00	4.35	4.10	NA	NA	0.10	XXX
78610	26	A	Brain flow imaging only	0.30	0.10	0.13	0.10	0.13	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	8.65	6.95	NA	NA	0.30	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.41	6.72	NA	NA	0.27	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.24	0.23	0.24	0.23	0.03	XXX
78635		A	CSF ventriculography	0.61	8.79	5.78	NA	NA	0.16	XXX
78635	TC	A	CSF ventriculography	0.00	8.58	5.56	NA	NA	0.14	XXX
78635	26	A	CSF ventriculography	0.61	0.21	0.22	0.21	0.22	0.02	XXX
78645		A	CSF shunt evaluation	0.57	8.48	6.04	NA	NA	0.20	XXX
78645	TC	A	CSF shunt evaluation	0.00	8.28	5.85	NA	NA	0.18	XXX
78645	26	A	CSF shunt evaluation	0.57	0.20	0.19	0.20	0.19	0.02	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.52	7.37	NA	NA	0.35	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.23	7.07	NA	NA	0.31	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.29	0.30	0.29	0.30	0.04	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
78650		A	CSF leakage imaging	0.61	8.56	6.70	NA	NA	0.27	XXX
78650	TC	A	CSF leakage imaging	0.00	8.35	6.49	NA	NA	0.24	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.21	0.21	0.03	XXX
78660		A	Nuclear exam of tear flow	0.53	4.26	3.28	NA	NA	0.14	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.07	3.10	NA	NA	0.12	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.19	0.18	0.19	0.18	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	4.38	3.80	NA	NA	0.18	XXX
78700	TC	A	Kidney imaging, morphol	0.00	4.22	3.64	NA	NA	0.16	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.16	0.16	0.16	0.16	0.02	XXX
78701		A	Kidney imaging with flow	0.49	5.38	4.55	NA	NA	0.20	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.21	4.38	NA	NA	0.18	XXX
78701	26	A	Kidney imaging with flow	0.49	0.17	0.17	0.17	0.17	0.02	XXX
78707		A	K flow/funct image w/o drug	0.96	5.49	5.14	NA	NA	0.27	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	5.15	4.81	NA	NA	0.23	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.34	0.33	0.34	0.33	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.48	4.18	NA	NA	0.28	XXX
78708	TC	A	K flow/funct image w/drug	0.00	3.05	3.76	NA	NA	0.23	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.43	0.42	0.43	0.42	0.05	XXX
78709		A	K flow/funct image, multiple	1.41	8.88	6.91	NA	NA	0.29	XXX
78709	TC	A	K flow/funct image, multiple	0.00	8.39	6.43	NA	NA	0.23	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.49	0.48	0.49	0.48	0.06	XXX
78710		A	Kidney imaging (3D)	0.66	5.28	5.70	NA	NA	0.34	XXX
78710	TC	A	Kidney imaging (3D)	0.00	5.06	5.48	NA	NA	0.31	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.22	0.22	0.03	XXX
78725		A	Kidney function study	0.38	2.35	2.14	NA	NA	0.13	XXX
78725	TC	A	Kidney function study	0.00	2.23	2.01	NA	NA	0.11	XXX
78725	26	A	Kidney function study	0.38	0.12	0.13	0.12	0.13	0.02	XXX
78730		A	Urinary bladder retention	0.15	1.98	1.78	NA	NA	0.10	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.92	1.69	NA	NA	0.08	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.06	0.09	0.06	0.09	0.02	ZZZ
78740		A	Ureteral reflux study	0.57	5.65	3.98	NA	NA	0.15	XXX
78740	TC	A	Ureteral reflux study	0.00	5.46	3.79	NA	NA	0.12	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.19	0.19	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.05	4.24	NA	NA	0.20	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.80	4.00	NA	NA	0.17	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.25	0.24	0.25	0.24	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	4.33	3.98	NA	NA	0.22	XXX
78800	TC	A	Tumor imaging, limited area	0.00	4.12	3.76	NA	NA	0.18	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.21	0.22	0.21	0.22	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	6.04	5.27	NA	NA	0.27	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.78	5.00	NA	NA	0.22	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.26	0.27	0.26	0.27	0.05	XXX
78802		A	Tumor imaging, whole body	0.86	8.14	6.98	NA	NA	0.34	XXX
78802	TC	A	Tumor imaging, whole body	0.00	7.84	6.69	NA	NA	0.30	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.30	0.29	0.30	0.29	0.04	XXX
78803		A	Tumor imaging (3D)	1.09	8.53	7.74	NA	NA	0.40	XXX
78803	TC	A	Tumor imaging (3D)	0.00	8.16	7.36	NA	NA	0.35	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.37	0.38	0.37	0.38	0.05	XXX
78804		A	Tumor imaging, whole body	1.07	14.83	13.13	NA	NA	0.34	XXX
78804	TC	A	Tumor imaging, whole body	0.00	14.46	12.76	NA	NA	0.30	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.37	0.37	0.37	0.37	0.04	XXX
78805		A	Abscess imaging, ltd area	0.73	4.22	3.94	NA	NA	0.21	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.97	3.69	NA	NA	0.18	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.25	0.25	0.03	XXX
78806		A	Abscess imaging, whole body	0.86	8.35	7.53	NA	NA	0.39	XXX
78806	TC	A	Abscess imaging, whole body	0.00	8.05	7.24	NA	NA	0.35	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.30	0.29	0.30	0.29	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.51	7.73	NA	NA	0.39	XXX
78807	TC	A	Nuclear localization/abscess	0.00	8.14	7.35	NA	NA	0.35	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.37	0.38	0.37	0.38	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	0.54	0.53	0.54	0.53	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	0.67	0.66	0.67	0.66	0.11	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	0.68	0.68	0.68	0.68	0.11	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.74	0.75	0.74	0.75	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	0.84	0.84	0.84	0.84	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	0.85	0.85	0.85	0.85	0.11	XXX
78890		B	Nuclear medicine data proc	0.05	0.39	0.86	NA	NA	0.07	XXX
78890	TC	B	Nuclear medicine data proc	0.00	0.38	0.84	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	0.88	1.77	NA	NA	0.14	XXX
78891	TC	B	Nuclear med data proc	0.00	0.86	1.74	NA	NA	0.13	XXX
78891	26	B	Nuclear med data proc	0.10	0.02	0.03	0.02	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	1.85	2.53	NA	NA	0.22	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.27	1.94	NA	NA	0.14	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.58	0.59	0.58	0.59	0.08	XXX
79101		A	Nuclear rx, iv admin	1.96	2.17	2.72	NA	NA	0.22	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.43	2.02	NA	NA	0.14	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.74	0.70	0.74	0.70	0.08	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.22	2.77	NA	NA	0.23	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.57	2.10	NA	NA	0.14	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.65	0.67	0.65	0.67	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	0.55	0.54	0.55	0.13	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.92	4.04	NA	NA	0.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.17	3.22	NA	NA	0.14	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.75	0.82	0.75	0.82	0.10	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.84	2.59	NA	NA	0.22	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.16	1.89	NA	NA	0.14	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.68	0.70	0.68	0.70	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	0.85	0.83	0.85	0.83	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	0.20	0.20	0.11	0.14	0.01	XXX
80502		A	Lab pathology consultation	1.33	0.31	0.43	0.25	0.40	0.04	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.12	0.13	0.12	0.13	0.01	XXX
83912	26	A	Genetic examination	0.37	0.11	0.12	0.11	0.12	0.01	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.12	0.13	0.12	0.13	0.01	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.12	0.13	0.12	0.13	0.01	XXX
84181	26	A	Western blot test	0.37	0.12	0.13	0.12	0.13	0.01	XXX
84182	26	A	Protein, western blot test	0.37	0.12	0.14	0.12	0.14	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.14	0.16	0.14	0.16	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.25	1.58	0.27	0.34	0.04	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.13	0.13	0.01	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.10	0.13	0.04	XXX
85576	26	A	Blood platelet aggregation	0.37	0.12	0.14	0.12	0.14	0.01	XXX
86077		A	Physician blood bank service	0.94	0.38	0.39	0.30	0.34	0.03	XXX
86078		A	Physician blood bank service	0.94	0.38	0.42	0.30	0.35	0.03	XXX
86079		A	Physician blood bank service	0.94	0.39	0.42	0.30	0.36	0.03	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.12	0.14	0.12	0.14	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.12	0.15	0.12	0.15	0.02	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.12	0.13	0.12	0.13	0.01	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.13	0.13	NA	NA	0.02	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.13	0.21	NA	NA	0.02	XXX
86510		A	Histoplasmosis skin test	0.00	0.13	0.22	NA	NA	0.02	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
86580		A	TB intradermal test	0.00	0.16	0.20	NA	NA	0.02	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.12	0.12	0.01	XXX
87207	26	A	Smear, special stain	0.37	0.12	0.14	0.12	0.14	0.01	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.19	1.02	NA	NA	0.04	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	1.03	0.82	NA	NA	0.02	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.16	0.20	0.16	0.20	0.02	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.52	1.44	NA	NA	0.04	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.37	1.24	NA	NA	0.02	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.15	0.20	0.15	0.20	0.02	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	2.00	1.77	NA	NA	0.05	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.77	1.49	NA	NA	0.02	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.23	0.28	0.23	0.28	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.47	1.34	NA	NA	0.04	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.32	1.14	NA	NA	0.02	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.15	0.20	0.15	0.20	0.02	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.47	1.72	NA	NA	0.04	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.18	1.32	NA	NA	0.02	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.29	0.40	0.29	0.40	0.02	XXX
88125		A	Forensic cytopathology	0.26	0.21	0.24	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.16	0.16	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.05	0.08	0.05	0.08	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.38	0.26	0.38	0.26	0.02	XXX
88160		A	Cytopath smear, other source	0.50	0.91	0.87	NA	NA	0.04	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.78	0.70	NA	NA	0.02	XXX
88160	26	A	Cytopath smear, other source	0.50	0.13	0.17	0.13	0.17	0.02	XXX
88161		A	Cytopath smear, other source	0.50	1.06	1.00	NA	NA	0.04	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.92	0.82	NA	NA	0.02	XXX
88161	26	A	Cytopath smear, other source	0.50	0.14	0.18	0.14	0.18	0.02	XXX
88162		A	Cytopath smear, other source	0.76	1.58	1.30	NA	NA	0.05	XXX
88162	TC	A	Cytopath smear, other source	0.00	1.35	1.02	NA	NA	0.02	XXX
88162	26	A	Cytopath smear, other source	0.76	0.23	0.28	0.23	0.28	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.81	0.77	NA	NA	0.04	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.64	0.55	NA	NA	0.02	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.17	0.22	0.17	0.22	0.02	XXX
88173		A	Cytopath eval, fna, report	1.39	2.20	2.16	NA	NA	0.07	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.82	1.68	NA	NA	0.02	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.38	0.48	0.38	0.48	0.05	XXX
88182		A	Cell marker study	0.77	2.02	1.99	NA	NA	0.07	XXX
88182	TC	A	Cell marker study	0.00	1.88	1.76	NA	NA	0.04	XXX
88182	26	A	Cell marker study	0.77	0.14	0.23	0.14	0.23	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.46	1.89	NA	NA	0.02	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.50	1.07	NA	NA	0.02	ZZZ
88187		A	Flowcytometry/read, 2–8	1.36	0.39	0.42	0.39	0.42	0.01	XXX
88188		A	Flowcytometry/read, 9–15	1.69	0.44	0.50	0.44	0.50	0.01	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.47	0.61	0.47	0.61	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	0.22	0.27	0.22	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.56	0.51	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.54	0.48	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.02	0.03	0.02	0.03	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.29	1.16	NA	NA	0.03	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.25	1.11	NA	NA	0.02	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.04	0.05	0.04	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.47	1.39	NA	NA	0.03	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.41	1.32	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	2.04	1.97	NA	NA	0.07	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.84	1.71	NA	NA	0.04	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.20	0.26	0.20	0.26	0.03	XXX
88307		A	Tissue exam by pathologist	1.59	4.41	3.78	NA	NA	0.12	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.94	3.20	NA	NA	0.06	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.47	0.58	0.47	0.58	0.06	XXX
88309		A	Tissue exam by pathologist	2.80	6.16	5.28	NA	NA	0.14	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.34	4.38	NA	NA	0.06	XXX
88309	26	A	Tissue exam by pathologist	2.80	0.82	0.90	0.82	0.90	0.08	XXX
88311		A	Decalcify tissue	0.24	0.24	0.23	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.17	0.15	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.07	0.08	0.07	0.08	0.01	XXX
88312		A	Special stains	0.54	2.29	1.90	NA	NA	0.03	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
88312	TC	A	Special stains	0.00	2.15	1.72	NA	NA	0.01	XXX
88312	26	A	Special stains	0.54	0.14	0.18	0.14	0.18	0.02	XXX
88313		A	Special stains	0.24	1.94	1.59	NA	NA	0.02	XXX
88313	TC	A	Special stains	0.00	1.88	1.51	NA	NA	0.01	XXX
88313	26	A	Special stains	0.24	0.06	0.08	0.06	0.08	0.01	XXX
88314		A	Histochemical stain	0.45	1.96	2.00	NA	NA	0.04	XXX
88314	TC	A	Histochemical stain	0.00	1.82	1.84	NA	NA	0.02	XXX
88314	26	A	Histochemical stain	0.45	0.14	0.16	0.14	0.16	0.02	XXX
88318		A	Chemical histochemistry	0.42	2.94	2.29	NA	NA	0.03	XXX
88318	TC	A	Chemical histochemistry	0.00	2.82	2.14	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.12	0.15	0.12	0.15	0.02	XXX
88319		A	Enzyme histochemistry	0.53	3.22	3.32	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.07	3.13	NA	NA	0.02	XXX
88319	26	A	Enzyme histochemistry	0.53	0.15	0.19	0.15	0.19	0.02	XXX
88321		A	Microslide consultation	1.63	0.71	0.75	0.46	0.51	0.05	XXX
88323		A	Microslide consultation	1.83	2.21	1.99	NA	NA	0.07	XXX
88323	TC	A	Microslide consultation	0.00	1.75	1.48	NA	NA	0.02	XXX
88323	26	A	Microslide consultation	1.83	0.46	0.51	0.46	0.51	0.05	XXX
88325		A	Comprehensive review of data	2.50	2.40	2.66	0.69	0.82	0.07	XXX
88329		A	Path consult introp	0.67	0.66	0.66	0.20	0.24	0.02	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.21	1.15	NA	NA	0.08	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.84	0.71	NA	NA	0.04	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.37	0.44	0.37	0.44	0.04	XXX
88332		A	Path consult intraop, add'l	0.59	0.48	0.46	NA	NA	0.04	XXX
88332	TC	A	Path consult intraop, add'l	0.00	0.30	0.25	NA	NA	0.02	XXX
88332	26	A	Path consult intraop, add'l	0.59	0.18	0.21	0.18	0.21	0.02	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.32	1.20	NA	NA	0.08	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.95	0.75	NA	NA	0.04	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.37	0.45	0.37	0.45	0.04	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.78	0.69	NA	NA	0.04	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.56	0.45	NA	NA	0.02	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.22	0.24	0.22	0.24	0.02	XXX
88342		A	Immunohistochemistry	0.85	1.99	1.72	NA	NA	0.05	XXX
88342	TC	A	Immunohistochemistry	0.00	1.77	1.43	NA	NA	0.02	XXX
88342	26	A	Immunohistochemistry	0.85	0.22	0.29	0.22	0.29	0.03	XXX
88346		A	Immunofluorescent study	0.86	1.91	1.73	NA	NA	0.05	XXX
88346	TC	A	Immunofluorescent study	0.00	1.68	1.44	NA	NA	0.02	XXX
88346	26	A	Immunofluorescent study	0.86	0.23	0.29	0.23	0.29	0.03	XXX
88347		A	Immunofluorescent study	0.86	1.31	1.29	NA	NA	0.05	XXX
88347	TC	A	Immunofluorescent study	0.00	1.13	1.02	NA	NA	0.02	XXX
88347	26	A	Immunofluorescent study	0.86	0.18	0.27	0.18	0.27	0.03	XXX
88348		A	Electron microscopy	1.51	18.24	13.79	NA	NA	0.13	XXX
88348	TC	A	Electron microscopy	0.00	17.82	13.26	NA	NA	0.07	XXX
88348	26	A	Electron microscopy	1.51	0.42	0.53	0.42	0.53	0.06	XXX
88349		A	Scanning electron microscopy	0.76	9.39	6.47	NA	NA	0.09	XXX
88349	TC	A	Scanning electron microscopy	0.00	9.16	6.19	NA	NA	0.06	XXX
88349	26	A	Scanning electron microscopy	0.76	0.23	0.28	0.23	0.28	0.03	XXX
88355		A	Analysis, skeletal muscle	1.85	3.22	5.99	NA	NA	0.13	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.85	5.41	NA	NA	0.06	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.37	0.58	0.37	0.58	0.07	XXX
88356		A	Analysis, nerve	3.02	5.35	4.77	NA	NA	0.19	XXX
88356	TC	A	Analysis, nerve	0.00	4.77	3.85	NA	NA	0.07	XXX
88356	26	A	Analysis, nerve	3.02	0.58	0.92	0.58	0.92	0.12	XXX
88358		A	Analysis, tumor	0.95	1.10	0.97	NA	NA	0.17	XXX
88358	TC	A	Analysis, tumor	0.00	0.94	0.69	NA	NA	0.07	XXX
88358	26	A	Analysis, tumor	0.95	0.16	0.28	0.16	0.28	0.10	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.22	1.97	NA	NA	0.08	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.95	1.60	NA	NA	0.02	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.27	0.37	0.27	0.37	0.06	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.79	2.91	NA	NA	0.17	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.52	2.53	NA	NA	0.07	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.27	0.38	0.27	0.38	0.10	XXX
88362		A	Nerve teasing preparations	2.17	4.99	4.84	NA	NA	0.15	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.42	4.09	NA	NA	0.06	XXX
88362	26	A	Nerve teasing preparations	2.17	0.57	0.75	0.57	0.75	0.09	XXX
88365		A	Insitu hybridization (fish)	1.20	3.34	2.73	NA	NA	0.05	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.04	2.33	NA	NA	0.02	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.30	0.40	0.30	0.40	0.03	XXX
88367		A	Insitu hybridization, auto	1.30	5.15	4.59	NA	NA	0.12	XXX
88367	TC	A	Insitu hybridization, auto	0.00	4.93	4.21	NA	NA	0.06	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.22	0.38	0.22	0.38	0.06	XXX
88368		A	Insitu hybridization, manual	1.40	4.97	3.69	NA	NA	0.12	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
88368	TC	A	Insitu hybridization, manual	0.00	4.72	3.26	NA	NA	0.06	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.25	0.43	0.25	0.43	0.06	XXX
88371	26	A	Protein, western blot tissue	0.37	0.10	0.12	0.10	0.12	0.01	XXX
88372	26	A	Protein analysis w/probe	0.37	0.12	0.14	0.12	0.14	0.01	XXX
88380		A	Microdissection, laser	1.56	2.65	2.65	NA	NA	0.14	XXX
88380	TC	A	Microdissection, laser	0.00	2.22	2.22	NA	NA	0.07	XXX
88380	26	A	Microdissection, laser	1.56	0.43	0.43	0.43	0.43	0.07	XXX
88381		A	Microdissection, manual	1.18	4.47	4.47	NA	NA	0.08	XXX
88381	TC	A	Microdissection, manual	0.00	4.15	4.15	NA	NA	0.02	XXX
88381	26	A	Microdissection, manual	1.18	0.32	0.32	0.32	0.32	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	15.53	11.31	NA	NA	0.12	XXX
88385	TC	A	Eval molecul probes, 51–250	0.00	15.26	10.85	NA	NA	0.06	XXX
88385	26	A	Eval molecul probes, 51–250	1.50	0.27	0.46	0.27	0.46	0.06	XXX
88386		A	Eval molecul probes, 251–500	1.88	15.44	11.24	NA	NA	0.16	XXX
88386	TC	A	Eval molecul probes, 251–500	0.00	15.10	10.66	NA	NA	0.08	XXX
88386	26	A	Eval molecul probes, 251–500	1.88	0.34	0.58	0.34	0.58	0.08	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	3.56	3.55	0.19	0.23	0.06	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.12	0.14	0.12	0.14	0.01	XXX
89100		A	Sample intestinal contents	0.60	7.89	4.86	0.54	0.37	0.03	XXX
89105		A	Sample intestinal contents	0.50	7.84	5.03	0.46	0.31	0.02	XXX
89130		A	Sample stomach contents	0.45	6.54	4.14	0.38	0.25	0.02	XXX
89132		A	Sample stomach contents	0.19	8.38	4.96	0.39	0.22	0.01	XXX
89135		A	Sample stomach contents	0.79	8.82	5.36	0.67	0.46	0.04	XXX
89136		A	Sample stomach contents	0.21	5.94	3.84	0.26	0.18	0.01	XXX
89140		A	Sample stomach contents	0.94	6.22	4.15	0.43	0.35	0.04	XXX
89141		A	Sample stomach contents	0.85	6.36	4.57	0.49	0.41	0.03	XXX
89220		A	Sputum specimen collection	0.00	0.37	0.40	NA	NA	0.02	XXX
89230		A	Collect sweat for test	0.00	0.07	0.09	NA	NA	0.02	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.44	0.38	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.12	0.12	0.04	0.08	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.17	0.17	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	0.38	NA	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.12	0.13	0.04	0.08	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.17	0.18	0.04	0.06	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.08	0.09	0.04	0.05	0.01	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
90646	.....	E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647	.....	E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648	.....	E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649	.....	E	H papilloma vacc 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655	.....	X	Flu vaccine no preserv 6–35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656	.....	X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657	.....	X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658	.....	X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660	.....	X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661	.....	X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662	.....	X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663	.....	X	Flu vacc pandemic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665	.....	E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669	.....	X	Pneumococcal vacc, ped <5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675	.....	E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676	.....	E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680	.....	E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690	.....	E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691	.....	E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692	.....	E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693	.....	E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698	.....	E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700	.....	E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701	.....	E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702	.....	E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703	.....	E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704	.....	E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705	.....	E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706	.....	E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707	.....	E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708	.....	E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710	.....	E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712	.....	E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713	.....	E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714	.....	E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715	.....	E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716	.....	E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717	.....	E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718	.....	E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719	.....	E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720	.....	E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721	.....	E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723	.....	I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725	.....	E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727	.....	E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732	.....	X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733	.....	E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734	.....	E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735	.....	E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736	.....	E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740	.....	X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743	.....	X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744	.....	X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746	.....	X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747	.....	X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748	.....	I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749	.....	E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90760	.....	A	Hydration iv infusion, init	0.17	1.32	1.37	NA	NA	0.07	XXX
90761	.....	A	Hydrate iv infusion, add-on	0.09	0.32	0.36	NA	NA	0.04	ZZZ
90765	.....	A	Ther/proph/diag iv inf, init	0.21	1.62	1.69	NA	NA	0.07	XXX
90766	.....	A	Ther/proph/dg iv inf, add-on	0.18	0.37	0.42	NA	NA	0.04	ZZZ
90767	.....	A	Tx/proph/dg addl seq iv inf	0.19	0.69	0.79	NA	NA	0.04	ZZZ
90768	.....	A	Ther/diag concurrent inf	0.17	0.33	0.39	NA	NA	0.04	ZZZ
90769	.....	A	Sc ther infusion, up to 1 hr	0.21	3.92	3.92	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	1.86	1.86	NA	NA	0.01	ZZZ
90772	.....	A	Ther/proph/diag inj, sc/im	0.17	0.44	0.38	NA	NA	0.01	XXX
90773	.....	A	Ther/proph/diag inj, ia	0.17	0.30	0.31	NA	NA	0.02	XXX
90774	.....	A	Ther/proph/diag inj, iv push	0.18	1.33	1.31	NA	NA	0.04	XXX
90775	.....	A	Tx/pro/dx inj new drug addon	0.10	0.51	0.54	NA	NA	0.04	ZZZ
90776	.....	X	Tx/pro/dx inj same drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
90779	.....	C	Ther/prop/diag inj/inf proc	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 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
90801		A	Psy dx interview	2.80	1.49	1.33	0.60	0.76	0.06	XXX
90802		A	Intac psy dx interview	3.01	1.54	1.37	0.68	0.83	0.07	XXX
90804		A	Psytx, office, 20–30 min	1.21	0.56	0.52	0.21	0.30	0.03	XXX
90805		A	Psytx, off, 20–30 min w/e&m	1.37	0.60	0.55	0.24	0.33	0.03	XXX
90806		A	Psytx, off, 45–50 min	1.86	0.53	0.61	0.33	0.46	0.04	XXX
90807		A	Psytx, off, 45–50 min w/e&m	2.02	0.70	0.70	0.35	0.49	0.05	XXX
90808		A	Psytx, office, 75–80 min	2.79	0.69	0.86	0.49	0.69	0.06	XXX
90809		A	Psytx, off, 75–80, w/e&m	2.95	0.86	0.93	0.52	0.72	0.07	XXX
90810		A	Intac psytx, off, 20–30 min	1.32	0.54	0.52	0.23	0.33	0.04	XXX
90811		A	Intac psytx, 20–30, w/e&m	1.48	0.72	0.64	0.26	0.36	0.04	XXX
90812		A	Intac psytx, off, 45–50 min	1.97	0.65	0.72	0.34	0.49	0.04	XXX
90813		A	Intac psytx, 45–50 min w/e&m	2.13	0.83	0.80	0.37	0.52	0.05	XXX
90814		A	Intac psytx, off, 75–80 min	2.90	0.81	0.95	0.53	0.75	0.06	XXX
90815		A	Intac psytx, 75–80 w/e&m	3.06	0.99	1.02	0.53	0.74	0.07	XXX
90816		A	Psytx, hosp, 20–30 min	1.25	NA	NA	0.32	0.39	0.03	XXX
90817		A	Psytx, hosp, 20–30 min w/e&m	1.41	NA	NA	0.35	0.40	0.03	XXX
90818		A	Psytx, hosp, 45–50 min	1.89	NA	NA	0.44	0.56	0.04	XXX
90819		A	Psytx, hosp, 45–50 min w/e&m	2.05	NA	NA	0.46	0.55	0.05	XXX
90821		A	Psytx, hosp, 75–80 min	2.83	NA	NA	0.60	0.80	0.06	XXX
90822		A	Psytx, hosp, 75–80 min w/e&m	2.99	NA	NA	0.62	0.79	0.08	XXX
90823		A	Intac psytx, hosp, 20–30 min	1.36	NA	NA	0.35	0.41	0.03	XXX
90824		A	Intac psytx, hsp 20–30 w/e&m	1.52	NA	NA	0.37	0.43	0.04	XXX
90826		A	Intac psytx, hosp, 45–50 min	2.01	NA	NA	0.46	0.59	0.05	XXX
90827		A	Intac psytx, hsp 45–50 w/e&m	2.16	NA	NA	0.48	0.58	0.05	XXX
90828		A	Intac psytx, hosp, 75–80 min	2.94	NA	NA	0.62	0.84	0.06	XXX
90829		A	Intac psytx, hsp 75–80 w/e&m	3.10	NA	NA	0.64	0.81	0.07	XXX
90845		A	Psychoanalysis	1.79	0.39	0.48	0.32	0.43	0.04	XXX
90846		R	Family psytx w/o patient	1.83	0.51	0.58	0.42	0.54	0.04	XXX
90847		R	Family psytx w/patient	2.21	0.74	0.78	0.49	0.63	0.05	XXX
90849		R	Multiple family group psytx	0.59	0.33	0.30	0.21	0.22	0.02	XXX
90853		A	Group psychotherapy	0.59	0.26	0.26	0.20	0.21	0.01	XXX
90857		A	Intac group psytx	0.63	0.38	0.33	0.21	0.23	0.01	XXX
90862		A	Medication management	0.95	0.62	0.51	0.27	0.29	0.02	XXX
90865		A	Narcosynthesis	2.84	1.16	1.26	0.63	0.77	0.12	XXX
90870		A	Electroconvulsive therapy	1.88	1.92	1.93	0.38	0.48	0.04	000
90875		N	Psychophysiological therapy	1.20	0.53	0.71	0.28	0.37	0.04	XXX
90876		N	Psychophysiological therapy	1.90	0.67	0.91	0.44	0.58	0.05	XXX
90880		A	Hypnotherapy	2.19	0.57	0.81	0.39	0.54	0.05	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.22	0.30	0.22	0.30	0.02	XXX
90887		B	Consultation with family	1.48	0.61	0.71	0.34	0.45	0.04	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.46	0.56	0.10	0.12	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.37	1.46	0.30	0.30	0.06	000
90918		I	ESRD related services, month	11.16	4.70	5.40	3.74	4.92	0.36	XXX
90919		I	ESRD related services, month	8.53	3.03	3.51	2.55	3.27	0.29	XXX
90920		I	ESRD related services, month	7.26	2.73	3.24	2.26	3.01	0.23	XXX
90921		I	ESRD related services, month	4.46	1.71	2.07	1.61	2.03	0.14	XXX
90922		I	ESRD related services, day	0.37	0.16	0.18	0.13	0.17	0.01	XXX
90923		I	Esrd related services, day	0.28	0.10	0.11	0.08	0.11	0.01	XXX
90924		I	Esrd related services, day	0.24	0.09	0.10	0.07	0.10	0.01	XXX
90925		I	Esrd related services, day	0.15	0.05	0.07	0.05	0.07	0.01	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.53	0.60	0.04	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	0.77	0.87	0.07	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.55	0.62	0.04	000
90947		A	Dialysis, repeated eval	2.16	NA	NA	0.79	0.89	0.07	000
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.50	0.58	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	2.13	1.23	NA	NA	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.91	0.99	NA	NA	0.01	000
91000	26	A	Esophageal intubation	0.73	0.22	0.24	0.22	0.24	0.03	000
91010		A	Esophagus motility study	1.25	3.67	4.03	NA	NA	0.12	000
91010	TC	A	Esophagus motility study	0.00	3.12	3.54	NA	NA	0.06	000
91010	26	A	Esophagus motility study	1.25	0.55	0.49	0.55	0.49	0.06	000
91011		A	Esophagus motility study	1.50	5.37	5.29	NA	NA	0.13	000
91011	TC	A	Esophagus motility study	0.00	4.65	4.67	NA	NA	0.06	000
91011	26	A	Esophagus motility study	1.50	0.72	0.62	0.72	0.62	0.07	000
91012		A	Esophagus motility study	1.46	5.44	5.60	NA	NA	0.13	000

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91012	TC	A	Esophagus motility study	0.00	4.76	5.00	NA	NA	0.07	000
91012	26	A	Esophagus motility study	1.46	0.68	0.60	0.68	0.60	0.06	000
91020		A	Gastric motility studies	1.44	4.81	4.66	NA	NA	0.13	000
91020	TC	A	Gastric motility studies	0.00	4.20	4.11	NA	NA	0.06	000
91020	26	A	Gastric motility studies	1.44	0.61	0.55	0.61	0.55	0.07	000
91022		A	Duodenal motility study	1.44	3.13	3.76	NA	NA	0.13	000
91022	TC	A	Duodenal motility study	0.00	2.51	3.20	NA	NA	0.06	000
91022	26	A	Duodenal motility study	1.44	0.62	0.56	0.62	0.56	0.07	000
91030		A	Acid perfusion of esophagus	0.91	2.90	2.66	NA	NA	0.06	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.48	2.29	NA	NA	0.02	000
91030	26	A	Acid perfusion of esophagus	0.91	0.42	0.37	0.42	0.37	0.04	000
91034		A	Gastroesophageal reflux test	0.97	4.15	4.69	NA	NA	0.12	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.73	4.31	NA	NA	0.06	000
91034	26	A	Gastroesophageal reflux test	0.97	0.42	0.38	0.42	0.38	0.06	000
91035		A	G-esoph reflx tst w/electrod	1.59	11.37	11.08	NA	NA	0.12	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.67	10.45	NA	NA	0.06	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.70	0.63	0.70	0.63	0.06	000
91037		A	Esoph imped function test	0.97	3.47	3.20	NA	NA	0.12	000
91037	TC	A	Esoph imped function test	0.00	3.03	2.81	NA	NA	0.06	000
91037	26	A	Esoph imped function test	0.97	0.44	0.39	0.44	0.39	0.06	000
91038		A	Esoph imped funct test > 1h	1.10	2.80	2.52	NA	NA	0.12	000
91038	TC	A	Esoph imped funct test > 1h	0.00	2.30	2.07	NA	NA	0.06	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.50	0.45	0.50	0.45	0.06	000
91040		A	Esoph balloon distension tst	0.97	7.72	9.42	NA	NA	0.12	000
91040	TC	A	Esoph balloon distension tst	0.00	7.44	9.11	NA	NA	0.06	000
91040	26	A	Esoph balloon distension tst	0.97	0.28	0.31	0.28	0.31	0.06	000
91052		A	Gastric analysis test	0.79	2.92	2.68	NA	NA	0.05	000
91052	TC	A	Gastric analysis test	0.00	2.55	2.36	NA	NA	0.02	000
91052	26	A	Gastric analysis test	0.79	0.37	0.32	0.37	0.32	0.03	000
91055		A	Gastric intubation for smear	0.94	2.57	2.76	NA	NA	0.07	000
91055	TC	A	Gastric intubation for smear	0.00	2.28	2.48	NA	NA	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	1.33	1.40	NA	NA	0.03	000
91065	TC	A	Breath hydrogen test	0.00	1.27	1.33	NA	NA	0.02	000
91065	26	A	Breath hydrogen test	0.20	0.06	0.07	0.06	0.07	0.01	000
91100		A	Pass intestine bleeding tube	1.08	2.14	2.46	0.32	0.30	0.07	000
91105		A	Gastric intubation treatment	0.37	1.67	1.89	0.07	0.08	0.03	000
91110		A	Gi tract capsule endoscopy	3.64	20.63	21.40	NA	NA	0.16	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	18.97	19.93	NA	NA	0.07	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.66	1.47	1.66	1.47	0.09	XXX
91111		A	Esophageal capsule endoscopy	1.00	18.82	18.82	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	18.37	18.37	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	8.88	9.92	NA	NA	0.11	XXX
91120	TC	A	Rectal sensation test	0.00	8.61	9.62	NA	NA	0.04	XXX
91120	26	A	Rectal sensation test	0.97	0.27	0.30	0.27	0.30	0.07	XXX
91122		A	Anal pressure record	1.77	4.30	4.70	NA	NA	0.21	000
91122	TC	A	Anal pressure record	0.00	3.68	4.09	NA	NA	0.08	000
91122	26	A	Anal pressure record	1.77	0.62	0.61	0.62	0.61	0.13	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.25	0.22	0.25	0.22	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.32	0.28	0.32	0.28	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	0.93	0.95	0.25	0.30	0.02	XXX
92004		A	Eye exam, new patient	1.82	1.57	1.63	0.55	0.62	0.04	XXX
92012		A	Eye exam established pat	0.92	0.99	1.01	0.31	0.30	0.02	XXX
92014		A	Eye exam & treatment	1.42	1.37	1.39	0.46	0.46	0.03	XXX
92015		N	Refraction	0.38	0.10	0.79	0.09	0.12	0.01	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	0.86	0.96	0.07	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.35	0.46	0.03	XXX
92020		A	Special eye evaluation	0.37	0.25	0.29	0.13	0.14	0.01	XXX
92025		A	Corneal topography	0.35	0.49	0.49	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.37	0.37	NA	NA	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	0.76	0.75	NA	NA	0.03	XXX
92060	TC	A	Special eye evaluation	0.00	0.54	0.49	NA	NA	0.01	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
92060	26	A	Special eye evaluation	0.69	0.22	0.26	0.22	0.26	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.86	0.69	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.77	0.57	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.09	0.12	0.09	0.12	0.01	XXX
92070		A	Fitting of contact lens	0.70	0.90	0.98	0.22	0.27	0.02	XXX
92081		A	Visual field examination(s)	0.36	0.95	0.94	NA	NA	0.02	XXX
92081	TC	A	Visual field examination(s)	0.00	0.84	0.81	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.11	0.13	0.11	0.13	0.01	XXX
92082		A	Visual field examination(s)	0.44	1.32	1.27	NA	NA	0.02	XXX
92082	TC	A	Visual field examination(s)	0.00	1.18	1.11	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.14	0.16	0.14	0.16	0.01	XXX
92083		A	Visual field examination(s)	0.50	1.51	1.47	NA	NA	0.02	XXX
92083	TC	A	Visual field examination(s)	0.00	1.35	1.28	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.16	0.19	0.16	0.19	0.01	XXX
92100		A	Serial tonometry exam(s)	0.92	1.24	1.29	0.27	0.32	0.02	XXX
92120		A	Tonography & eye evaluation	0.81	0.97	1.02	0.25	0.28	0.02	XXX
92130		A	Water provocation tonography	0.81	1.18	1.23	0.27	0.32	0.02	XXX
92135		A	Ophth dx imaging post seg	0.35	0.79	0.78	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.67	0.65	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	1.42	1.54	NA	NA	0.08	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.23	1.32	NA	NA	0.07	XXX
92136	26	A	Ophthalmic biometry	0.54	0.19	0.22	0.19	0.22	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	0.89	0.94	0.14	0.18	0.01	XXX
92225		A	Special eye exam, initial	0.38	0.24	0.23	0.12	0.14	0.01	XXX
92226		A	Special eye exam, subsequent	0.33	0.23	0.22	0.11	0.13	0.01	XXX
92230		A	Eye exam with photos	0.60	0.68	1.10	0.19	0.19	0.02	XXX
92235		A	Eye exam with photos	0.81	2.26	2.44	NA	NA	0.08	XXX
92235	TC	A	Eye exam with photos	0.00	1.97	2.11	NA	NA	0.06	XXX
92235	26	A	Eye exam with photos	0.81	0.29	0.33	0.29	0.33	0.02	XXX
92240		A	Icg angiography	1.10	4.38	5.23	NA	NA	0.09	XXX
92240	TC	A	Icg angiography	0.00	3.99	4.79	NA	NA	0.06	XXX
92240	26	A	Icg angiography	1.10	0.39	0.44	0.39	0.44	0.03	XXX
92250		A	Eye exam with photos	0.44	1.30	1.41	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.16	1.25	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.14	0.16	0.14	0.16	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.23	0.24	0.07	0.08	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.00	1.24	NA	NA	0.06	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.76	0.98	NA	NA	0.02	XXX
92265	26	A	Eye muscle evaluation	0.81	0.24	0.26	0.24	0.26	0.04	XXX
92270		A	Electro-oculography	0.81	1.32	1.42	NA	NA	0.05	XXX
92270	TC	A	Electro-oculography	0.00	1.09	1.14	NA	NA	0.02	XXX
92270	26	A	Electro-oculography	0.81	0.23	0.28	0.23	0.28	0.03	XXX
92275		A	Electroretinography	1.01	2.42	2.18	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.07	1.79	NA	NA	0.02	XXX
92275	26	A	Electroretinography	1.01	0.35	0.39	0.35	0.39	0.03	XXX
92283		A	Color vision examination	0.17	0.99	0.91	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	0.94	0.85	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	1.13	1.50	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.06	1.43	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.07	0.07	0.07	0.07	0.01	XXX
92285		A	Eye photography	0.20	0.80	0.89	NA	NA	0.02	XXX
92285	TC	A	Eye photography	0.00	0.73	0.81	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.07	0.08	0.07	0.08	0.01	XXX
92286		A	Internal eye photography	0.66	2.08	2.56	NA	NA	0.04	XXX
92286	TC	A	Internal eye photography	0.00	1.86	2.31	NA	NA	0.02	XXX
92286	26	A	Internal eye photography	0.66	0.22	0.25	0.22	0.25	0.02	XXX
92287		A	Internal eye photography	0.81	1.90	2.14	0.27	0.29	0.02	XXX
92310		N	Contact lens fitting	1.17	1.06	1.09	0.27	0.36	0.04	XXX
92311		A	Contact lens fitting	1.08	1.27	1.18	0.30	0.33	0.03	XXX
92312		A	Contact lens fitting	1.26	1.45	1.26	0.33	0.41	0.03	XXX
92313		A	Contact lens fitting	0.92	1.42	1.24	0.31	0.30	0.02	XXX
92314		N	Prescription of contact lens	0.69	1.14	1.04	0.16	0.21	0.01	XXX
92315		A	Prescription of contact lens	0.45	1.31	1.08	0.13	0.14	0.01	XXX
92316		A	Prescription of contact lens	0.68	1.63	1.27	0.22	0.26	0.02	XXX
92317		A	Prescription of contact lens	0.45	1.31	1.12	0.11	0.13	0.01	XXX
92325		A	Modification of contact lens	0.00	0.83	0.62	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.73	1.18	NA	NA	0.06	XXX
92340		N	Fitting of spectacles	0.37	0.44	0.57	0.09	0.11	0.01	XXX
92341		N	Fitting of spectacles	0.47	0.46	0.60	0.11	0.14	0.01	XXX
92342		N	Fitting of spectacles	0.53	0.48	0.62	0.12	0.17	0.01	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
92352		B	Special spectacles fitting	0.37	0.56	0.62	0.09	0.11	0.01	XXX
92353		B	Special spectacles fitting	0.50	0.59	0.66	0.11	0.15	0.02	XXX
92354		B	Special spectacles fitting	0.00	0.28	4.57	NA	NA	0.10	XXX
92355		B	Special spectacles fitting	0.00	0.44	2.38	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.24	0.60	NA	NA	0.05	XXX
92370		N	Repair & adjust spectacles	0.32	0.39	0.47	0.07	0.10	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.24	0.43	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	1.00	0.05	000
92504		A	Ear microscopy examination	0.18	0.60	0.55	0.06	0.07	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.49	3.04	0.28	0.34	0.03	XXX
92507		A	Speech/hearing therapy	0.52	1.23	1.17	0.16	0.19	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.55	0.53	0.09	0.11	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.12	3.21	0.67	0.72	0.03	000
92512		A	Nasal function studies	0.55	1.00	1.07	0.17	0.18	0.02	XXX
92516		A	Facial nerve function test	0.43	1.23	1.21	0.14	0.18	0.01	XXX
92520		A	Laryngeal function studies	0.75	0.93	0.72	0.24	0.31	0.03	XXX
92526		A	Oral function therapy	0.55	1.70	1.67	0.16	0.18	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.14	1.09	NA	NA	0.04	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	1.03	0.94	NA	NA	0.02	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.11	0.15	0.11	0.15	0.02	XXX
92542		A	Positional nystagmus test	0.33	1.29	1.22	NA	NA	0.03	XXX
92542	TC	A	Positional nystagmus test	0.00	1.20	1.09	NA	NA	0.02	XXX
92542	26	A	Positional nystagmus test	0.33	0.09	0.13	0.09	0.13	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.65	0.61	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.62	0.57	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	1.03	0.97	NA	NA	0.03	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.96	0.87	NA	NA	0.02	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.07	0.10	0.07	0.10	0.01	XXX
92545		A	Oscillating tracking test	0.23	1.00	0.90	NA	NA	0.03	XXX
92545	TC	A	Oscillating tracking test	0.00	0.94	0.81	NA	NA	0.02	XXX
92545	26	A	Oscillating tracking test	0.23	0.06	0.09	0.06	0.09	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	1.81	1.89	NA	NA	0.03	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.73	1.79	NA	NA	0.02	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.08	0.10	0.08	0.10	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.11	0.09	0.11	0.09	0.06	ZZZ
92548		A	Posturography	0.50	1.70	1.98	NA	NA	0.15	XXX
92548	TC	A	Posturography	0.00	1.56	1.78	NA	NA	0.13	XXX
92548	26	A	Posturography	0.50	0.14	0.20	0.14	0.20	0.02	XXX
92551		N	Pure tone hearing test, air	0.00	0.25	0.25	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.61	0.52	NA	NA	0.04	XXX
92553		A	Audiometry, air & bone	0.00	0.77	0.71	NA	NA	0.06	XXX
92555		A	Speech threshold audiometry	0.00	0.41	0.40	NA	NA	0.04	XXX
92556		A	Speech audiometry, complete	0.00	0.51	0.54	NA	NA	0.06	XXX
92557		A	Comprehensive hearing test	0.60	0.29	0.74	0.20	0.69	0.12	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.70	0.71	NA	NA	0.06	XXX
92562		A	Loudness balance test	0.00	0.62	0.51	NA	NA	0.04	XXX
92563		A	Tone decay hearing test	0.00	0.55	0.46	NA	NA	0.04	XXX
92564		A	Sisi hearing test	0.00	0.48	0.47	NA	NA	0.05	XXX
92565		A	Stenger test, pure tone	0.00	0.25	0.33	NA	NA	0.04	XXX
92567		A	Tympanometry	0.20	0.13	0.33	0.07	0.29	0.06	XXX
92568		A	Acoustic refl threshold tst	0.29	0.10	0.24	0.09	0.24	0.04	XXX
92569		A	Acoustic reflex decay test	0.20	0.07	0.24	0.07	0.24	0.04	XXX
92571		A	Filtered speech hearing test	0.00	0.44	0.41	NA	NA	0.04	XXX
92572		A	Staggered spondaic word test	0.00	0.59	0.34	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.15	0.72	NA	NA	0.02	XXX
92576		A	Synthetic sentence test	0.00	0.58	0.51	NA	NA	0.05	XXX
92577		A	Stenger test, speech	0.00	0.26	0.49	NA	NA	0.07	XXX
92579		A	Visual audiometry (vra)	0.70	0.35	0.54	0.23	0.48	0.06	XXX
92582		A	Conditioning play audiometry	0.00	1.17	0.95	NA	NA	0.06	XXX
92583		A	Select picture audiometry	0.00	0.73	0.81	NA	NA	0.08	XXX
92584		A	Electrocochleography	0.00	1.36	1.91	NA	NA	0.21	XXX
92585		A	Auditor evoke potent, compre	0.50	2.10	2.08	NA	NA	0.17	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
92585	TC	A	Auditor evoke potent, compre	0.00	1.95	1.90	NA	NA	0.14	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.15	0.18	0.15	0.18	0.03	XXX
92586		A	Auditor evoke potent, limit	0.00	1.41	1.63	NA	NA	0.14	XXX
92587		A	Evoked auditory test	0.13	0.65	1.01	NA	NA	0.12	XXX
92587	TC	A	Evoked auditory test	0.00	0.61	0.96	NA	NA	0.11	XXX
92587	26	A	Evoked auditory test	0.13	0.04	0.05	0.04	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.11	1.37	NA	NA	0.14	XXX
92588	TC	A	Evoked auditory test	0.00	1.00	1.23	NA	NA	0.13	XXX
92588	26	A	Evoked auditory test	0.36	0.11	0.14	0.11	0.14	0.01	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.02	0.80	NA	NA	0.06	XXX
92597		A	Oral speech device eval	0.86	1.99	1.84	0.28	0.37	0.03	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.08	2.29	0.64	2.07	0.07	XXX
92602		A	Reprogram cochlear implt < 7	1.30	0.84	1.61	0.40	1.39	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.19	1.66	0.73	1.44	0.07	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.78	1.06	0.41	0.88	0.07	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.63	3.85	NA	NA	0.05	XXX
92608		A	Ex for speech device rx addl	0.00	0.88	0.72	NA	NA	0.05	XXX
92609		A	Use of speech device service	0.00	2.45	2.02	NA	NA	0.04	XXX
92610		A	Evaluate swallowing function	0.00	1.70	2.56	NA	NA	0.08	XXX
92611		A	Motion fluoroscopy/swallow	0.00	1.95	2.69	NA	NA	0.08	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.97	2.85	0.42	0.54	0.04	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.24	0.32	0.23	0.31	0.05	XXX
92614		A	Laryngoscopic sensory test	1.27	2.42	2.46	0.42	0.54	0.04	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.21	0.28	0.20	0.28	0.05	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.16	3.27	0.60	0.80	0.06	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.26	0.35	0.26	0.35	0.05	XXX
92620		A	Auditory function, 60 min	0.00	1.93	1.53	NA	NA	0.06	XXX
92621		A	Auditory function, + 15 min	0.00	0.44	0.34	NA	NA	0.06	ZZZ
92625		A	Tinnitus assessment	0.00	1.94	1.53	1.94	1.53	0.06	XXX
92626		A	Eval aud rehab status	0.00	2.00	2.10	NA	NA	0.06	XXX
92627		A	Eval aud status rehab add-on	0.00	0.46	0.50	0.46	0.50	0.02	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	0.00	1.34	1.34	1.34	1.34	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	3.24	3.72	0.77	0.87	0.28	000
92953		A	Temporary external pacing	0.23	NA	NA	0.07	0.07	0.02	000
92960		A	Cardioversion electric, ext	2.25	4.37	5.34	1.45	1.31	0.07	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	2.43	2.26	0.29	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.46	1.26	0.16	000
92971		A	Cardioassist, external	1.77	NA	NA	1.09	0.97	0.06	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.76	1.52	0.23	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.62	1.40	0.21	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	3.83	3.32	0.50	000
92977		A	Dissolve clot, heart vessel	0.00	1.73	4.88	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	0.83	0.96	0.83	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	0.77	0.67	0.77	0.67	0.06	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	8.12	7.08	1.03	000
92981		A	Insert intracoronary stent	4.16	NA	NA	2.22	1.92	0.29	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	6.05	5.29	0.76	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.58	1.37	0.21	ZZZ
92986		A	Revision of aortic valve	22.70	NA	NA	15.32	13.57	1.51	090
92987		A	Revision of mitral valve	23.48	NA	NA	15.94	14.07	1.59	090
92990		A	Revision of pulmonary valve	18.12	NA	NA	11.33	10.56	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	6.64	5.80	0.84	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.76	1.51	0.10	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	5.61	5.21	0.40	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	3.00	2.60	0.28	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
93000		A	Electrocardiogram, complete	0.17	0.35	0.42	NA	NA	0.03	XXX
93005		A	Electrocardiogram, tracing	0.00	0.28	0.36	NA	NA	0.02	XXX
93010		A	Electrocardiogram report	0.17	0.07	0.06	0.07	0.06	0.01	XXX
93012		A	Transmission of ecg	0.00	4.16	5.09	NA	NA	0.18	XXX
93014		A	Report on transmitted ecg	0.52	0.22	0.21	0.22	0.21	0.02	XXX
93015		A	Cardiovascular stress test	0.75	1.90	1.93	NA	NA	0.14	XXX
93016		A	Cardiovascular stress test	0.45	0.22	0.20	0.22	0.20	0.02	XXX
93017		A	Cardiovascular stress test	0.00	1.53	1.60	NA	NA	0.11	XXX
93018		A	Cardiovascular stress test	0.30	0.15	0.13	0.15	0.13	0.01	XXX
93024		A	Cardiac drug stress test	1.17	2.40	1.98	NA	NA	0.12	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.82	1.47	NA	NA	0.08	XXX
93024	26	A	Cardiac drug stress test	1.17	0.58	0.51	0.58	0.51	0.04	XXX
93025		A	Microvolt t-wave assess	0.75	3.93	5.76	NA	NA	0.14	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.55	5.42	NA	NA	0.11	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.38	0.34	0.38	0.34	0.03	XXX
93040		A	Rhythm ECG with report	0.16	0.19	0.20	NA	NA	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	2.31	2.96	NA	NA	0.24	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.85	1.04	NA	NA	0.08	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	1.19	1.69	NA	NA	0.14	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.27	0.23	0.27	0.23	0.02	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	2.30	3.09	NA	NA	0.26	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.72	1.12	NA	NA	0.11	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.35	1.76	NA	NA	0.13	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.23	0.21	0.23	0.21	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	0.22	0.19	0.22	0.19	0.02	XXX
93268		A	ECG record/review	0.52	5.78	6.60	NA	NA	0.28	XXX
93270		A	ECG recording	0.00	0.29	0.76	NA	NA	0.08	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.27	5.64	NA	NA	0.18	XXX
93272		A	Ecg/review, interpret only	0.52	0.22	0.20	0.22	0.20	0.02	XXX
93278		A	ECG/signal-averaged	0.25	0.62	0.93	NA	NA	0.12	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.52	0.83	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	4.49	4.41	NA	NA	0.27	XXX
93303	TC	A	Echo transthoracic	0.00	3.96	3.91	NA	NA	0.23	XXX
93303	26	A	Echo transthoracic	1.30	0.53	0.50	0.53	0.50	0.04	XXX
93304		A	Echo transthoracic	0.75	3.10	2.66	NA	NA	0.15	XXX
93304	TC	A	Echo transthoracic	0.00	2.80	2.37	NA	NA	0.13	XXX
93304	26	A	Echo transthoracic	0.75	0.30	0.29	0.30	0.29	0.02	XXX
93307		A	Echo exam of heart	0.92	3.73	3.97	NA	NA	0.26	XXX
93307	TC	A	Echo exam of heart	0.00	3.28	3.57	NA	NA	0.23	XXX
93307	26	A	Echo exam of heart	0.92	0.45	0.40	0.45	0.40	0.03	XXX
93308		A	Echo exam of heart	0.53	2.62	2.38	NA	NA	0.15	XXX
93308	TC	A	Echo exam of heart	0.00	2.35	2.15	NA	NA	0.13	XXX
93308	26	A	Echo exam of heart	0.53	0.27	0.23	0.27	0.23	0.02	XXX
93312		A	Echo transesophageal	2.20	7.39	5.98	NA	NA	0.37	XXX
93312	TC	A	Echo transesophageal	0.00	6.42	5.10	NA	NA	0.29	XXX
93312	26	A	Echo transesophageal	2.20	0.97	0.88	0.97	0.88	0.08	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.12	0.17	0.06	XXX
93314		A	Echo transesophageal	1.25	7.21	5.73	NA	NA	0.33	XXX
93314	TC	A	Echo transesophageal	0.00	6.65	5.22	NA	NA	0.29	XXX
93314	26	A	Echo transesophageal	1.25	0.56	0.51	0.56	0.51	0.04	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.30	1.16	1.30	1.16	0.09	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.26	0.25	0.05	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.55	0.61	0.55	0.61	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	0.85	0.67	0.85	0.67	0.14	XXX
93320		A	Doppler echo exam, heart	0.38	1.67	1.77	NA	NA	0.13	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.49	1.60	NA	NA	0.12	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.18	0.17	0.18	0.17	0.01	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.61	0.89	NA	NA	0.09	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.54	0.82	NA	NA	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	0.66	1.80	NA	NA	0.22	ZZZ

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
93325	TC	A	Doppler color flow add-on	0.00	0.63	1.77	NA	NA	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	5.09	3.71	NA	NA	0.18	XXX
93350	TC	A	Echo transthoracic	0.00	4.33	3.05	NA	NA	0.13	XXX
93350	26	A	Echo transthoracic	1.48	0.76	0.66	0.76	0.66	0.05	XXX
93501		A	Right heart catheterization	3.02	18.69	18.37	NA	NA	1.27	000
93501	TC	A	Right heart catheterization	0.00	17.12	17.01	NA	NA	1.06	000
93501	26	A	Right heart catheterization	3.02	1.57	1.36	1.57	1.36	0.21	000
93503		C	Insert/place heart catheter	0.00	NA	NA	NA	NA	0.00	000
93505		A	Biopsy of heart lining	4.37	20.90	12.28	NA	NA	0.46	000
93505	TC	A	Biopsy of heart lining	0.00	18.62	10.30	NA	NA	0.16	000
93505	26	A	Biopsy of heart lining	4.37	2.28	1.98	2.28	1.98	0.30	000
93508		A	Cath placement, angiography	4.09	28.82	21.75	NA	NA	0.93	000
93508	TC	A	Cath placement, angiography	0.00	26.65	19.62	NA	NA	0.65	000
93508	26	A	Cath placement, angiography	4.09	2.17	2.13	2.17	2.13	0.28	000
93510		A	Left heart catheterization	4.32	28.12	33.61	NA	NA	2.61	000
93510	TC	A	Left heart catheterization	0.00	25.84	31.39	NA	NA	2.31	000
93510	26	A	Left heart catheterization	4.32	2.28	2.22	2.28	2.22	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	2.65	2.54	2.65	2.54	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	2.95	3.03	2.95	3.03	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	3.77	3.47	3.77	3.47	0.48	000
93526		A	Rt & Lt heart catheters	5.98	35.09	42.99	NA	NA	3.46	000
93526	TC	A	Rt & Lt heart catheters	0.00	31.93	40.00	NA	NA	3.04	000
93526	26	A	Rt & Lt heart catheters	5.98	3.16	2.99	3.16	2.99	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	3.85	3.58	3.85	3.58	0.51	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	4.43	4.23	4.43	4.23	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	2.58	2.43	2.58	2.43	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	1.84	1.89	1.84	1.89	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	3.57	3.57	3.57	3.57	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	3.65	3.95	3.65	3.95	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	3.15	2.97	3.15	2.97	0.47	000
93539		A	Injection, cardiac cath	0.40	2.46	11.72	0.21	0.19	0.01	000
93540		A	Injection, cardiac cath	0.43	8.61	15.53	0.23	0.20	0.01	000
93541		A	Injection for lung angiogram	0.29	0.15	7.60	0.15	0.13	0.01	000
93542		A	Injection for heart x-rays	0.29	5.18	10.07	0.15	0.13	0.01	000
93543		A	Injection for heart x-rays	0.29	2.62	8.86	0.16	0.13	0.01	000
93544		A	Injection for aortography	0.25	1.84	7.41	0.13	0.12	0.01	000
93545		A	Inject for coronary x-rays	0.40	5.86	13.42	0.21	0.19	0.01	000
93555		A	Imaging, cardiac cath	0.81	0.59	3.59	NA	NA	0.37	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.17	3.22	NA	NA	0.34	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.42	0.37	0.42	0.37	0.03	XXX
93556		A	Imaging, cardiac cath	0.83	0.88	5.54	NA	NA	0.54	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.44	5.16	NA	NA	0.51	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.44	0.38	0.44	0.38	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	0.14	0.15	0.14	0.15	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

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
93571	26	A	Heart flow reserve measure	1.80	0.95	0.82	0.95	0.82	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	0.74	0.62	0.74	0.62	0.04	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	9.40	8.39	1.25	000
93581		A	Transcath closure of vsd	24.39	NA	NA	11.55	10.47	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	0.96	1.09	0.96	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	1.04	0.93	1.04	0.93	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	1.04	0.92	1.04	0.92	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	2.61	2.28	2.61	2.28	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	1.47	1.31	1.47	1.31	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	1.42	1.29	1.42	1.29	0.25	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	3.69	3.22	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	0.54	0.40	0.54	0.40	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	0.26	0.35	0.26	0.35	0.09	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	2.28	1.97	2.28	1.97	0.30	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	3.87	3.52	3.87	3.52	0.51	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	6.08	5.46	6.08	5.46	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	0.96	1.10	0.96	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	1.56	1.39	1.56	1.39	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	1.30	1.49	1.30	0.20	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	2.60	2.39	2.60	2.39	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	2.75	2.76	2.75	2.76	0.97	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.81	1.58	1.81	1.58	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	2.71	3.10	2.71	0.41	000
93642		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93642	TC	A	Electrophysiology evaluation	0.00	4.76	5.97	NA	NA	0.42	000
93642	26	A	Electrophysiology evaluation	4.88	2.60	2.40	2.60	2.40	0.15	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	5.80	5.11	0.73	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	8.52	7.42	1.13	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	9.34	8.11	1.23	000
93660		A	Tilt table evaluation	1.89	3.01	2.71	NA	NA	0.08	000
93660	TC	A	Tilt table evaluation	0.00	2.04	1.86	NA	NA	0.02	000
93660	26	A	Tilt table evaluation	1.89	0.97	0.85	0.97	0.85	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

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
93662	26	A	Intracardiac ecg (ice)	2.80	1.47	1.29	1.47	1.29	0.09	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.41	0.41	NA	NA	0.01	XXX
93701		A	Bioimpedance, thoracic	0.17	0.70	0.84	NA	NA	0.02	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.64	0.77	NA	NA	0.01	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.06	0.07	0.06	0.07	0.01	XXX
93720		A	Total body plethysmography	0.17	1.17	0.97	NA	NA	0.07	XXX
93721		A	Plethysmography tracing	0.00	1.13	0.92	NA	NA	0.06	XXX
93722		A	Plethysmography report	0.17	0.04	0.05	0.04	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	3.22	4.55	NA	NA	0.39	000
93724	TC	A	Analyze pacemaker system	0.00	0.87	2.42	NA	NA	0.24	000
93724	26	A	Analyze pacemaker system	4.88	2.35	2.13	2.35	2.13	0.15	000
93727		A	Analyze ilr system	0.52	0.63	0.42	0.63	0.42	0.02	XXX
93731		A	Analyze pacemaker system	0.45	0.79	0.72	NA	NA	0.05	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.55	0.52	NA	NA	0.04	XXX
93731	26	A	Analyze pacemaker system	0.45	0.24	0.20	0.24	0.20	0.01	XXX
93732		A	Analyze pacemaker system	0.92	1.15	1.00	NA	NA	0.07	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.67	0.59	NA	NA	0.04	XXX
93732	26	A	Analyze pacemaker system	0.92	0.48	0.41	0.48	0.41	0.03	XXX
93733		A	Telephone analy, pacemaker	0.17	0.93	0.86	NA	NA	0.07	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.85	0.79	NA	NA	0.06	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.08	0.07	0.08	0.07	0.01	XXX
93734		A	Analyze pacemaker system	0.38	0.69	0.59	NA	NA	0.03	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.50	0.42	NA	NA	0.02	XXX
93734	26	A	Analyze pacemaker system	0.38	0.19	0.17	0.19	0.17	0.01	XXX
93735		A	Analyze pacemaker system	0.74	0.96	0.84	NA	NA	0.06	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.57	0.51	NA	NA	0.04	XXX
93735	26	A	Analyze pacemaker system	0.74	0.39	0.33	0.39	0.33	0.02	XXX
93736		A	Telephonic analy, pacemaker	0.15	0.91	0.79	NA	NA	0.07	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.84	0.73	NA	NA	0.06	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.07	0.06	0.07	0.06	0.01	XXX
93740		B	Temperature gradient studies	0.16	0.04	0.11	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	0.00	0.07	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.04	0.04	0.04	0.04	0.01	XXX
93741		A	Analyze ht pace device sngl	0.80	1.01	0.99	NA	NA	0.07	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.59	0.63	NA	NA	0.04	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.42	0.36	0.42	0.36	0.03	XXX
93742		A	Analyze ht pace device sngl	0.91	1.15	1.09	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	0.42	0.48	0.42	0.03	XXX
93743		A	Analyze ht pace device dual	1.03	1.19	1.16	NA	NA	0.07	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.64	0.69	NA	NA	0.04	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.55	0.47	0.55	0.47	0.03	XXX
93744		A	Analyze ht pace device dual	1.18	1.35	1.23	NA	NA	0.08	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.72	0.69	NA	NA	0.04	XXX
93744	26	A	Analyze ht pace device dual	1.18	0.63	0.54	0.63	0.54	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
93760		N	Cephalic thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93762		N	Peripheral thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	0.16	0.04	0.05	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	0.00	0.01	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.04	0.04	0.04	0.04	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	1.39	1.47	NA	NA	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.81	0.86	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.45	0.48	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.13	0.13	0.13	0.13	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	0.12	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	2.54	2.43	NA	NA	0.12	XXX
93875	TC	A	Extracranial study	0.00	2.47	2.36	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	6.15	5.85	NA	NA	0.39	XXX
93880	TC	A	Extracranial study	0.00	5.94	5.65	NA	NA	0.35	XXX
93880	26	A	Extracranial study	0.60	0.21	0.20	0.21	0.20	0.04	XXX
93882		A	Extracranial study	0.40	4.11	3.81	NA	NA	0.26	XXX
93882	TC	A	Extracranial study	0.00	4.00	3.68	NA	NA	0.22	XXX
93882	26	A	Extracranial study	0.40	0.11	0.13	0.11	0.13	0.04	XXX
93886		A	Intracranial study	0.94	7.02	6.87	NA	NA	0.45	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
93886	TC	A	Intracranial study	0.00	6.74	6.55	NA	NA	0.39	XXX
93886	26	A	Intracranial study	0.94	0.28	0.32	0.28	0.32	0.06	XXX
93888		A	Intracranial study	0.62	4.91	4.57	NA	NA	0.32	XXX
93888	TC	A	Intracranial study	0.00	4.71	4.36	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	6.44	5.67	NA	NA	0.45	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	6.13	5.31	NA	NA	0.39	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.31	0.36	0.31	0.36	0.06	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	6.84	6.00	NA	NA	0.45	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	6.52	5.61	NA	NA	0.39	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.32	0.39	0.32	0.39	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	6.99	6.00	NA	NA	0.45	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	6.66	5.61	NA	NA	0.39	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.33	0.39	0.33	0.39	0.06	XXX
93922		A	Extremity study	0.25	3.10	2.89	NA	NA	0.15	XXX
93922	TC	A	Extremity study	0.00	3.02	2.81	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	4.68	4.35	NA	NA	0.26	XXX
93923	TC	A	Extremity study	0.00	4.54	4.21	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	5.93	5.36	NA	NA	0.30	XXX
93924	TC	A	Extremity study	0.00	5.76	5.19	NA	NA	0.25	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.17	0.17	0.05	XXX
93925		A	Lower extremity study	0.58	8.01	7.39	NA	NA	0.39	XXX
93925	TC	A	Lower extremity study	0.00	7.82	7.20	NA	NA	0.35	XXX
93925	26	A	Lower extremity study	0.58	0.19	0.19	0.19	0.19	0.04	XXX
93926		A	Lower extremity study	0.39	5.14	4.59	NA	NA	0.27	XXX
93926	TC	A	Lower extremity study	0.00	5.03	4.47	NA	NA	0.23	XXX
93926	26	A	Lower extremity study	0.39	0.11	0.12	0.11	0.12	0.04	XXX
93930		A	Upper extremity study	0.46	6.24	5.79	NA	NA	0.41	XXX
93930	TC	A	Upper extremity study	0.00	6.09	5.64	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	4.18	3.83	NA	NA	0.27	XXX
93931	TC	A	Upper extremity study	0.00	4.08	3.73	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	3.00	2.89	NA	NA	0.14	XXX
93965	TC	A	Extremity study	0.00	2.89	2.78	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	6.20	5.72	NA	NA	0.46	XXX
93970	TC	A	Extremity study	0.00	5.99	5.50	NA	NA	0.40	XXX
93970	26	A	Extremity study	0.68	0.21	0.22	0.21	0.22	0.06	XXX
93971		A	Extremity study	0.45	4.07	3.83	NA	NA	0.30	XXX
93971	TC	A	Extremity study	0.00	3.92	3.68	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	8.45	8.03	NA	NA	0.56	XXX
93975	TC	A	Vascular study	0.00	7.82	7.42	NA	NA	0.43	XXX
93975	26	A	Vascular study	1.80	0.63	0.61	0.63	0.61	0.13	XXX
93976		A	Vascular study	1.21	4.57	4.45	NA	NA	0.35	XXX
93976	TC	A	Vascular study	0.00	4.15	4.04	NA	NA	0.30	XXX
93976	26	A	Vascular study	1.21	0.42	0.41	0.42	0.41	0.05	XXX
93978		A	Vascular study	0.65	6.02	5.27	NA	NA	0.43	XXX
93978	TC	A	Vascular study	0.00	5.81	5.05	NA	NA	0.37	XXX
93978	26	A	Vascular study	0.65	0.21	0.22	0.21	0.22	0.06	XXX
93979		A	Vascular study	0.44	4.16	3.69	NA	NA	0.27	XXX
93979	TC	A	Vascular study	0.00	4.02	3.54	NA	NA	0.24	XXX
93979	26	A	Vascular study	0.44	0.14	0.15	0.14	0.15	0.03	XXX
93980		A	Penile vascular study	1.25	3.48	3.16	NA	NA	0.42	XXX
93980	TC	A	Penile vascular study	0.00	3.02	2.73	NA	NA	0.34	XXX
93980	26	A	Penile vascular study	1.25	0.46	0.43	0.46	0.43	0.08	XXX
93981		A	Penile vascular study	0.44	2.84	2.85	NA	NA	0.33	XXX
93981	TC	A	Penile vascular study	0.00	2.68	2.70	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	0.80	0.80	NA	NA	0.01	XXX
93990		A	Doppler flow testing	0.25	5.21	4.61	NA	NA	0.26	XXX
93990	TC	A	Doppler flow testing	0.00	5.15	4.53	NA	NA	0.23	XXX
93990	26	A	Doppler flow testing	0.25	0.06	0.08	0.06	0.08	0.03	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.35	0.34	0.09	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.32	0.32	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	0.70	0.70	NA	NA	0.06	XXX
94010		A	Breathing capacity test	0.17	0.74	0.71	NA	NA	0.03	XXX
94010	TC	A	Breathing capacity test	0.00	0.70	0.66	NA	NA	0.02	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
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	0.78	NA	NA	0.03	XXX
94015		A	Patient recorded spirometry	0.00	0.67	0.63	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.14	0.15	0.14	0.15	0.02	XXX
94060		A	Evaluation of wheezing	0.31	1.32	1.19	NA	NA	0.07	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.24	1.11	NA	NA	0.06	XXX
94060	26	A	Evaluation of wheezing	0.31	0.08	0.08	0.08	0.08	0.01	XXX
94070		A	Evaluation of wheezing	0.60	1.00	0.90	NA	NA	0.13	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.85	0.74	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	0.48	0.47	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.46	0.45	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	0.50	0.47	NA	NA	0.03	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.47	0.44	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	0.81	0.74	NA	NA	0.06	XXX
94240	TC	A	Residual lung capacity	0.00	0.75	0.67	NA	NA	0.05	XXX
94240	26	A	Residual lung capacity	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94250		A	Expired gas collection	0.11	0.51	0.58	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.48	0.55	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	0.75	0.66	NA	NA	0.05	XXX
94260	TC	A	Thoracic gas volume	0.00	0.72	0.63	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	0.61	0.69	NA	NA	0.05	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.55	0.62	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	0.95	0.82	NA	NA	0.07	XXX
94360	TC	A	Measure airflow resistance	0.00	0.89	0.75	NA	NA	0.06	XXX
94360	26	A	Measure airflow resistance	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.60	0.66	NA	NA	0.03	XXX
94370	TC	A	Breath airway closing volume	0.00	0.53	0.59	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	0.73	0.66	NA	NA	0.03	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.65	0.58	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	1.03	0.93	NA	NA	0.09	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.93	0.82	NA	NA	0.06	XXX
94400	26	A	CO2 breathing response curve	0.40	0.10	0.11	0.10	0.11	0.03	XXX
94450		A	Hypoxia response curve	0.40	1.01	0.92	NA	NA	0.04	XXX
94450	TC	A	Hypoxia response curve	0.00	0.92	0.82	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	1.14	NA	NA	0.04	XXX
94452	TC	A	Hast w/report	0.00	1.20	1.06	NA	NA	0.02	XXX
94452	26	A	Hast w/report	0.31	0.07	0.08	0.07	0.08	0.02	XXX
94453		A	Hast w/oxygen titrate	0.40	1.69	1.60	NA	NA	0.04	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.59	1.49	NA	NA	0.02	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.10	0.11	0.10	0.11	0.02	XXX
94610		A	Surfactant admin thru tube	1.16	0.34	0.34	0.34	0.34	0.26	XXX
94620		A	Pulmonary stress test/simple	0.64	0.79	1.64	NA	NA	0.13	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.63	1.46	NA	NA	0.10	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.16	0.18	0.16	0.18	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.18	2.69	NA	NA	0.16	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.73	2.25	NA	NA	0.10	XXX
94621	26	A	Pulm stress test/complex	1.42	0.45	0.44	0.45	0.44	0.06	XXX
94640		A	Airway inhalation treatment	0.00	0.38	0.34	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	0.35	0.35	NA	NA	0.02	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.81	0.73	0.19	0.21	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.20	0.21	0.03	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.40	0.35	NA	NA	0.04	XXX
94667		A	Chest wall manipulation	0.00	0.53	0.53	NA	NA	0.05	XXX
94668		A	Chest wall manipulation	0.00	0.50	0.48	NA	NA	0.02	XXX
94680		A	Exhaled air analysis, o2	0.26	1.06	1.46	NA	NA	0.07	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.00	1.39	NA	NA	0.06	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.06	0.07	0.06	0.07	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.07	1.79	NA	NA	0.13	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	1.02	1.74	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	1.04	1.52	NA	NA	0.05	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
94690	TC	A	Exhaled air analysis	0.00	1.02	1.50	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	1.15	1.08	NA	NA	0.07	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.09	1.01	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	0.98	1.94	NA	NA	0.13	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.91	1.87	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	1.77	1.55	NA	NA	0.05	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.71	1.49	NA	NA	0.04	XXX
94750	26	A	Pulmonary compliance study	0.23	0.06	0.06	0.06	0.06	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.06	0.05	NA	NA	0.02	XXX
94761		T	Measure blood oxygen level	0.00	0.11	0.09	NA	NA	0.06	XXX
94762		A	Measure blood oxygen level	0.00	0.84	0.66	NA	NA	0.10	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.81	0.78	NA	NA	0.08	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.77	0.74	NA	NA	0.07	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.04	0.04	0.01	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.15	0.13	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	0.49	0.49	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.21	0.18	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.17	0.16	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.10	0.12	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.31	0.27	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.15	0.18	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.16	0.20	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.25	0.71	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.73	0.54	0.73	0.54	0.02	XXX
95065		A	Nose allergy test	0.00	0.70	0.45	0.70	0.45	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.81	1.55	NA	NA	0.02	XXX
95071		A	Bronchial allergy tests	0.00	0.98	1.95	NA	NA	0.02	XXX
95075		A	Ingestion challenge test	0.95	0.68	0.75	0.26	0.32	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.23	0.31	NA	NA	0.02	XXX
95117		A	Immunotherapy injections	0.00	0.28	0.39	NA	NA	0.02	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.27	0.23	0.02	0.02	0.01	XXX
95145		A	Antigen therapy services	0.06	0.36	0.34	0.02	0.02	0.01	XXX
95146		A	Antigen therapy services	0.06	0.68	0.56	0.02	0.02	0.01	XXX
95147		A	Antigen therapy services	0.06	0.66	0.54	0.02	0.02	0.01	XXX
95148		A	Antigen therapy services	0.06	0.98	0.78	0.02	0.02	0.01	XXX
95149		A	Antigen therapy services	0.06	1.30	1.05	0.02	0.02	0.01	XXX
95165		A	Antigen therapy services	0.06	0.26	0.23	0.02	0.02	0.01	XXX
95170		A	Antigen therapy services	0.06	0.20	0.17	0.02	0.02	0.01	XXX
95180		A	Rapid desensitization	2.01	1.66	1.85	0.77	0.85	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	3.49	3.80	NA	NA	0.01	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.26	0.22	0.26	0.22	0.02	XXX
95805		A	Multiple sleep latency test	1.88	7.01	12.13	NA	NA	0.43	XXX
95805	TC	A	Multiple sleep latency test	0.00	6.50	11.55	NA	NA	0.34	XXX
95805	26	A	Multiple sleep latency test	1.88	0.51	0.58	0.51	0.58	0.09	XXX
95806		A	Sleep study, unattended	1.66	3.92	3.62	NA	NA	0.39	XXX
95806	TC	A	Sleep study, unattended	0.00	3.45	3.12	NA	NA	0.31	XXX
95806	26	A	Sleep study, unattended	1.66	0.47	0.50	0.47	0.50	0.08	XXX
95807		A	Sleep study, attended	1.66	12.29	12.07	NA	NA	0.50	XXX
95807	TC	A	Sleep study, attended	0.00	11.88	11.60	NA	NA	0.42	XXX
95807	26	A	Sleep study, attended	1.66	0.41	0.47	0.41	0.47	0.08	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
95808		A	Polysomnography, 1–3	2.65	15.74	14.46	NA	NA	0.55	XXX
95808	TC	A	Polysomnography, 1–3	0.00	15.04	13.65	NA	NA	0.42	XXX
95808	26	A	Polysomnography, 1–3	2.65	0.70	0.81	0.70	0.81	0.13	XXX
95810		A	Polysomnography, 4 or more	3.52	17.68	17.58	NA	NA	0.59	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.78	16.54	NA	NA	0.42	XXX
95810	26	A	Polysomnography, 4 or more	3.52	0.90	1.04	0.90	1.04	0.17	XXX
95811		A	Polysomnography w/cpap	3.79	19.68	19.42	NA	NA	0.61	XXX
95811	TC	A	Polysomnography w/cpap	0.00	18.72	18.31	NA	NA	0.43	XXX
95811	26	A	Polysomnography w/cpap	3.79	0.96	1.11	0.96	1.11	0.18	XXX
95812		A	Eeg, 41–60 minutes	1.08	5.89	4.96	NA	NA	0.17	XXX
95812	TC	A	Eeg, 41–60 minutes	0.00	5.59	4.58	NA	NA	0.11	XXX
95812	26	A	Eeg, 41–60 minutes	1.08	0.30	0.38	0.30	0.38	0.06	XXX
95813		A	Eeg, over 1 hour	1.73	6.51	5.76	NA	NA	0.20	XXX
95813	TC	A	Eeg, over 1 hour	0.00	6.03	5.17	NA	NA	0.11	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.48	0.59	0.48	0.59	0.09	XXX
95816		A	Eeg, awake and drowsy	1.08	5.27	4.49	NA	NA	0.16	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	4.97	4.11	NA	NA	0.10	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.30	0.38	0.30	0.38	0.06	XXX
95819		A	Eeg, awake and asleep	1.08	6.13	4.55	NA	NA	0.16	XXX
95819	TC	A	Eeg, awake and asleep	0.00	5.83	4.17	NA	NA	0.10	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.30	0.38	0.30	0.38	0.06	XXX
95822		A	Eeg, coma or sleep only	1.08	5.51	5.05	NA	NA	0.19	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	5.21	4.67	NA	NA	0.13	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.30	0.38	0.30	0.38	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	0.21	0.26	0.21	0.26	0.04	XXX
95827		A	Eeg, all night recording	1.08	11.52	7.11	NA	NA	0.19	XXX
95827	TC	A	Eeg, all night recording	0.00	11.22	6.76	NA	NA	0.14	XXX
95827	26	A	Eeg, all night recording	1.08	0.30	0.35	0.30	0.35	0.05	XXX
95829		A	Surgery electrocorticogram	6.20	24.75	27.87	NA	NA	0.50	XXX
95829	TC	A	Surgery electrocorticogram	0.00	22.99	25.83	NA	NA	0.02	XXX
95829	26	A	Surgery electrocorticogram	6.20	1.76	2.04	1.76	2.04	0.48	XXX
95830		A	Insert electrodes for EEG	1.70	2.96	3.13	0.41	0.57	0.11	XXX
95831		A	Limb muscle testing, manual	0.28	0.40	0.43	0.09	0.11	0.01	XXX
95832		A	Hand muscle testing, manual	0.29	0.37	0.35	0.10	0.11	0.02	XXX
95833		A	Body muscle testing, manual	0.47	0.49	0.54	0.14	0.18	0.02	XXX
95834		A	Body muscle testing, manual	0.60	0.54	0.58	0.17	0.23	0.03	XXX
95851		A	Range of motion measurements	0.16	0.26	0.31	0.04	0.06	0.01	XXX
95852		A	Range of motion measurements	0.11	0.24	0.25	0.04	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.58	0.59	0.16	0.19	0.02	XXX
95860		A	Muscle test, one limb	0.96	1.16	1.29	NA	NA	0.07	XXX
95860	TC	A	Muscle test, one limb	0.00	0.84	0.92	NA	NA	0.02	XXX
95860	26	A	Muscle test, one limb	0.96	0.32	0.37	0.32	0.37	0.05	XXX
95861		A	Muscle test, 2 limbs	1.54	1.66	1.53	NA	NA	0.13	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.15	0.94	NA	NA	0.06	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.51	0.59	0.51	0.59	0.07	XXX
95863		A	Muscle test, 3 limbs	1.87	1.92	1.82	NA	NA	0.15	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.35	1.14	NA	NA	0.06	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.57	0.68	0.57	0.68	0.09	XXX
95864		A	Muscle test, 4 limbs	1.99	2.14	2.40	NA	NA	0.21	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.53	1.66	NA	NA	0.12	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.61	0.74	0.61	0.74	0.09	XXX
95865		A	Muscle test, larynx	1.57	1.39	1.42	NA	NA	0.11	XXX
95865	TC	A	Muscle test, larynx	0.00	0.90	0.79	NA	NA	0.03	XXX
95865	26	A	Muscle test, larynx	1.57	0.49	0.63	0.49	0.63	0.08	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.32	1.03	NA	NA	0.10	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	0.93	0.56	NA	NA	0.03	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.39	0.47	0.39	0.47	0.07	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.15	1.03	NA	NA	0.07	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.91	0.74	NA	NA	0.04	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.24	0.29	0.24	0.29	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.47	1.34	NA	NA	0.10	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.11	0.90	NA	NA	0.05	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.36	0.44	0.36	0.44	0.05	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.03	0.70	NA	NA	0.04	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.91	0.56	NA	NA	0.02	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.12	0.14	0.12	0.14	0.02	XXX
95870		A	Muscle test, nonparaspinal	0.37	0.99	0.68	NA	NA	0.04	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.87	0.54	NA	NA	0.02	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.12	0.14	0.12	0.14	0.02	XXX
95872		A	Muscle test, one fiber	2.88	1.63	1.43	NA	NA	0.13	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
95872	TC	A	Muscle test, one fiber	0.00	0.76	0.68	NA	NA	0.05	XXX
95872	26	A	Muscle test, one fiber	2.88	0.87	0.75	0.87	0.75	0.08	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.02	0.69	NA	NA	0.04	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	0.88	0.54	NA	NA	0.02	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.14	0.15	0.14	0.15	0.02	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	0.95	0.67	NA	NA	0.04	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	0.83	0.52	NA	NA	0.02	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.12	0.15	0.12	0.15	0.02	ZZZ
95875		A	Limb exercise test	1.10	1.46	1.46	NA	NA	0.11	XXX
95875	TC	A	Limb exercise test	0.00	1.08	1.03	NA	NA	0.06	XXX
95875	26	A	Limb exercise test	1.10	0.38	0.43	0.38	0.43	0.05	XXX
95900		A	Motor nerve conduction test	0.42	0.92	1.09	NA	NA	0.04	XXX
95900	TC	A	Motor nerve conduction test	0.00	0.78	0.93	NA	NA	0.02	XXX
95900	26	A	Motor nerve conduction test	0.42	0.14	0.16	0.14	0.16	0.02	XXX
95903		A	Motor nerve conduction test	0.60	0.99	1.09	NA	NA	0.05	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.82	0.88	NA	NA	0.02	XXX
95903	26	A	Motor nerve conduction test	0.60	0.17	0.21	0.17	0.21	0.03	XXX
95904		A	Sense nerve conduction test	0.34	0.84	0.97	NA	NA	0.04	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.74	0.84	NA	NA	0.02	XXX
95904	26	A	Sense nerve conduction test	0.34	0.10	0.13	0.10	0.13	0.02	XXX
95920		A	Intraop nerve test add-on	2.11	1.72	1.97	NA	NA	0.23	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.10	1.20	NA	NA	0.07	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.62	0.77	0.62	0.77	0.16	ZZZ
95921		A	Autonomic nerv function test	0.90	1.16	0.93	NA	NA	0.06	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.91	0.64	NA	NA	0.02	XXX
95921	26	A	Autonomic nerv function test	0.90	0.25	0.29	0.25	0.29	0.04	XXX
95922		A	Autonomic nerv function test	0.96	1.61	1.19	NA	NA	0.07	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.35	0.86	NA	NA	0.02	XXX
95922	26	A	Autonomic nerv function test	0.96	0.26	0.33	0.26	0.33	0.05	XXX
95923		A	Autonomic nerv function test	0.90	2.33	2.14	NA	NA	0.07	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.08	1.82	NA	NA	0.02	XXX
95923	26	A	Autonomic nerv function test	0.90	0.25	0.32	0.25	0.32	0.05	XXX
95925		A	Somatosensory testing	0.54	3.07	2.10	NA	NA	0.10	XXX
95925	TC	A	Somatosensory testing	0.00	2.92	1.91	NA	NA	0.06	XXX
95925	26	A	Somatosensory testing	0.54	0.15	0.19	0.15	0.19	0.04	XXX
95926		A	Somatosensory testing	0.54	3.00	2.07	NA	NA	0.09	XXX
95926	TC	A	Somatosensory testing	0.00	2.85	1.88	NA	NA	0.06	XXX
95926	26	A	Somatosensory testing	0.54	0.15	0.19	0.15	0.19	0.03	XXX
95927		A	Somatosensory testing	0.54	3.12	2.14	NA	NA	0.10	XXX
95927	TC	A	Somatosensory testing	0.00	2.96	1.93	NA	NA	0.06	XXX
95927	26	A	Somatosensory testing	0.54	0.16	0.21	0.16	0.21	0.04	XXX
95928		A	C motor evoked, uppr limbs	1.50	3.94	3.47	NA	NA	0.09	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	3.50	2.93	NA	NA	0.03	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.44	0.54	0.44	0.54	0.06	XXX
95929		A	C motor evoked, lwr limbs	1.50	4.25	3.74	NA	NA	0.09	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	3.81	3.19	NA	NA	0.03	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.44	0.55	0.44	0.55	0.06	XXX
95930		A	Visual evoked potential test	0.35	2.63	2.44	NA	NA	0.03	XXX
95930	TC	A	Visual evoked potential test	0.00	2.53	2.31	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.10	0.13	0.10	0.13	0.02	XXX
95933		A	Blink reflex test	0.59	1.11	1.07	NA	NA	0.10	XXX
95933	TC	A	Blink reflex test	0.00	0.94	0.86	NA	NA	0.06	XXX
95933	26	A	Blink reflex test	0.59	0.17	0.21	0.17	0.21	0.04	XXX
95934		A	H-reflex test	0.51	0.85	0.64	NA	NA	0.04	XXX
95934	TC	A	H-reflex test	0.00	0.70	0.45	NA	NA	0.02	XXX
95934	26	A	H-reflex test	0.51	0.15	0.19	0.15	0.19	0.02	XXX
95936		A	H-reflex test	0.55	0.59	0.52	NA	NA	0.05	XXX
95936	TC	A	H-reflex test	0.00	0.43	0.32	NA	NA	0.02	XXX
95936	26	A	H-reflex test	0.55	0.16	0.20	0.16	0.20	0.03	XXX
95937		A	Neuromuscular junction test	0.65	0.92	0.76	NA	NA	0.10	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.72	0.53	NA	NA	0.02	XXX
95937	26	A	Neuromuscular junction test	0.65	0.20	0.23	0.20	0.23	0.08	XXX
95950		A	Ambulatory eeg monitoring	1.51	4.92	4.42	NA	NA	0.51	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	4.50	3.89	NA	NA	0.43	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.42	0.53	0.42	0.53	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	1.68	2.12	1.68	2.12	0.32	XXX
95953		A	EEG monitoring/computer	3.30	7.21	7.42	NA	NA	0.60	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.29	6.31	NA	NA	0.43	XXX
95953	26	A	EEG monitoring/computer	3.30	0.92	1.11	0.92	1.11	0.17	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.37	4.30	NA	NA	0.19	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
95954	TC	A	EEG monitoring/giving drugs	0.00	3.95	3.57	NA	NA	0.06	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.42	0.73	0.42	0.73	0.13	XXX
95955		A	EEG during surgery	1.01	2.75	2.54	NA	NA	0.22	XXX
95955	TC	A	EEG during surgery	0.00	2.47	2.22	NA	NA	0.17	XXX
95955	26	A	EEG during surgery	1.01	0.28	0.32	0.28	0.32	0.05	XXX
95956		A	Eeg monitoring, cable/radio	3.08	16.28	15.84	NA	NA	0.59	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	15.42	14.76	NA	NA	0.43	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	0.86	1.08	0.86	1.08	0.16	XXX
95957		A	EEG digital analysis	1.98	5.84	4.19	NA	NA	0.23	XXX
95957	TC	A	EEG digital analysis	0.00	5.29	3.49	NA	NA	0.12	XXX
95957	26	A	EEG digital analysis	1.98	0.55	0.70	0.55	0.70	0.11	XXX
95958		A	EEG monitoring/function test	4.24	6.70	5.09	NA	NA	0.34	XXX
95958	TC	A	EEG monitoring/function test	0.00	5.47	3.60	NA	NA	0.13	XXX
95958	26	A	EEG monitoring/function test	4.24	1.23	1.49	1.23	1.49	0.21	XXX
95961		A	Electrode stimulation, brain	2.97	3.05	2.83	NA	NA	0.55	XXX
95961	TC	A	Electrode stimulation, brain	0.00	2.18	1.74	NA	NA	0.07	XXX
95961	26	A	Electrode stimulation, brain	2.97	0.87	1.09	0.87	1.09	0.48	XXX
95962		A	Electrode stim, brain add-on	3.21	2.21	2.45	NA	NA	0.39	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.30	1.30	NA	NA	0.07	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	0.91	1.15	0.91	1.15	0.32	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	2.39	2.90	2.39	2.90	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	1.19	1.45	1.19	1.45	0.19	XXX
95967		C	Meg, evoked, each add'l	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each add'l	3.49	1.01	1.09	1.01	1.09	0.16	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.90	0.87	0.13	0.13	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.58	0.63	0.18	0.20	0.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.14	1.18	0.44	0.46	0.14	XXX
95973		A	Analyze neurostim, complex	0.92	0.49	0.55	0.21	0.28	0.07	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.44	1.57	0.78	1.04	0.16	XXX
95975		A	Cranial neurostim, complex	1.70	0.73	0.81	0.47	0.60	0.12	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.85	1.89	1.02	1.16	0.18	XXX
95979		A	Analyz neurostim brain addon	1.64	0.72	0.79	0.46	0.57	0.08	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.25	0.25	0.07	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.44	0.44	0.12	0.12	0.02	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.47	0.47	0.18	0.18	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	1.62	1.56	NA	NA	0.06	XXX
95991		A	Spin/brain pump refil & main	0.77	1.61	1.55	0.17	0.17	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	0.44	0.48	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.56	0.61	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.10	0.13	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.09	0.10	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.65	0.79	0.65	0.79	0.11	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.07	1.07	1.07	1.07	0.17	XXX
96040		B	Genetic counseling, 30 min	0.00	0.98	0.98	NA	NA	0.01	XXX
96101		A	Psycho testing by psych/phys	1.86	0.35	0.50	0.33	0.48	0.05	XXX
96102		A	Psycho testing by technician	0.50	1.10	0.88	0.09	0.13	0.01	XXX
96103		A	Psycho testing admin by comp	0.51	0.92	0.56	0.10	0.14	0.02	XXX
96105		A	Assessment of aphasia	0.00	1.66	1.71	NA	NA	0.18	XXX
96110		A	Developmental test, lim	0.00	0.19	0.18	NA	NA	0.18	XXX
96111		A	Developmental test, extend	2.60	0.69	0.87	0.58	0.81	0.18	XXX
96116		A	Neurobehavioral status exam	1.86	0.52	0.68	0.40	0.52	0.18	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.84	1.11	0.33	0.48	0.18	XXX
96119		A	Neuropsych testing by tec	0.55	1.53	1.27	0.10	0.14	0.18	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.69	1.21	0.10	0.13	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	0.76	0.76	0.37	0.37	0.16	XXX
96150		A	Assess hlth/behave, init	0.50	0.10	0.14	0.09	0.13	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.10	0.14	0.09	0.13	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.09	0.13	0.08	0.12	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	0.13	0.08	0.12	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.10	0.14	0.10	0.14	0.02	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.86	1.51	NA	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.77	0.89	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	3.69	3.06	0.24	0.24	0.03	000

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
96406		A	Chemo intralesional over 7	0.80	3.61	3.31	0.32	0.31	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.79	2.86	NA	NA	0.06	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.50	1.55	NA	NA	0.06	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	3.63	3.91	NA	NA	0.08	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.66	0.71	NA	NA	0.07	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	4.08	4.34	NA	NA	0.08	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.73	1.83	NA	NA	0.07	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.78	2.72	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.49	4.66	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.99	1.94	NA	NA	0.02	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.67	4.57	NA	NA	0.08	XXX
96440		A	Chemotherapy, intracavitary	2.37	5.55	6.84	0.98	1.10	0.17	000
96445		A	Chemotherapy, intracavitary	2.20	5.41	6.72	0.96	1.07	0.14	000
96450		A	Chemotherapy, into CNS	1.53	4.99	5.97	0.83	1.06	0.09	000
96521		A	Refill/maint, portable pump	0.21	3.15	3.45	NA	NA	0.06	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.78	2.71	NA	NA	0.06	XXX
96523		T	Irrig drug delivery device	0.04	0.64	0.66	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	3.55	3.90	0.32	0.49	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	3.74	2.84	NA	NA	0.04	XXX
96570		A	Photodynamic tx, 30 min	1.10	0.40	0.38	0.40	0.38	0.11	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.19	0.19	0.19	0.19	0.03	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.57	0.50	NA	NA	0.02	XXX
96902		B	Trichogram	0.41	0.11	0.15	0.09	0.13	0.01	XXX
96904		R	Whole body photography	0.00	1.90	1.90	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	2.01	1.50	NA	NA	0.04	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.58	1.92	NA	NA	0.05	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.47	2.57	NA	NA	0.10	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.58	3.05	0.56	0.56	0.02	000
96921		A	Laser tx, skin 250–500 sq cm	1.17	3.32	2.96	0.51	0.54	0.03	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.63	4.06	1.04	0.83	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	0.70	NA	NA	0.05	XXX
97002		A	Pt re-evaluation	0.60	0.41	0.42	NA	NA	0.02	XXX
97003		A	Ot evaluation	1.20	0.76	0.82	NA	NA	0.06	XXX
97004		A	Ot re-evaluation	0.60	0.54	0.60	NA	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.07	0.06	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.14	0.13	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	0.21	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.17	0.13	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.33	0.27	NA	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.08	0.07	NA	NA	0.01	XXX
97026		A	Infrared therapy	0.06	0.07	0.06	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	0.18	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.44	0.36	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.20	0.17	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	0.38	NA	NA	0.01	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.32	0.29	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	0.46	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.27	0.26	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.27	0.25	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.29	0.27	NA	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.22	0.20	NA	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.38	0.35	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	0.25	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.37	0.35	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	0.28	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.09	0.88	0.12	0.39	0.05	XXX
97598		A	Active wound care > 20 cm	0.80	1.27	1.03	0.17	0.48	0.05	XXX
97602		B	Wound(s) care non-selective	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 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
97605		A	Neg press wound tx, < 50 cm	0.55	0.40	0.37	0.11	0.17	0.02	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.41	0.38	0.13	0.18	0.03	XXX
97750		A	Physical performance test	0.45	0.33	0.32	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	0.38	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.33	0.30	NA	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.73	0.57	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	0.14	0.30	0.11	0.29	0.01	XXX
97803		A	Med nutrition, indiv, subseq	0.37	0.12	0.29	0.09	0.28	0.01	XXX
97804		A	Medical nutrition, group	0.25	0.08	0.13	0.07	0.12	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.26	0.32	0.14	0.18	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.15	0.20	0.11	0.15	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.27	0.33	0.15	0.20	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.19	0.24	0.13	0.17	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	0.39	0.17	0.21	0.03	000
98927		A	Osteopathic manipulation	0.87	0.45	0.47	0.22	0.26	0.03	000
98928		A	Osteopathic manipulation	1.03	0.51	0.55	0.26	0.30	0.04	000
98929		A	Osteopathic manipulation	1.19	0.57	0.62	0.30	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	0.29	0.17	0.17	0.01	000
98942		A	Chiropractic manipulation	0.87	0.33	0.35	0.24	0.23	0.02	000
98943		N	Chiropractic manipulation	0.40	0.17	0.21	0.09	0.13	0.01	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.58	0.58	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2–4 pt	0.00	0.28	0.28	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5–8 pt	0.00	0.20	0.20	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5–10 min	0.25	0.09	0.09	0.06	0.06	0.01	XXX
98967		N	Hc pro phone call 11–20 min	0.50	0.14	0.14	0.11	0.11	0.02	XXX
98968		N	Hc pro phone call 21–30 min	0.75	0.20	0.20	0.17	0.17	0.03	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.25	0.25	NA	NA	0.04	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	1.83	1.80	0.61	0.58	0.08	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99175		A	Induction of vomiting	0.00	0.36	0.87	NA	NA	0.10	XXX
99183		A	Hyperbaric oxygen therapy	2.34	2.60	2.92	0.57	0.65	0.16	XXX
99185		A	Regional hypothermia	0.00	1.67	1.15	NA	NA	0.04	XXX
99186		A	Total body hypothermia	0.00	1.63	1.70	NA	NA	0.45	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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99195		A	Phlebotomy	0.00	2.56	1.50	NA	NA	0.02	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.45	0.55	0.52	0.16	0.15	0.03	XXX
99202		A	Office/outpatient visit, new	0.88	0.84	0.81	0.29	0.30	0.05	XXX
99203		A	Office/outpatient visit, new	1.34	1.11	1.12	0.43	0.45	0.09	XXX
99204		A	Office/outpatient visit, new	2.30	1.49	1.49	0.71	0.71	0.12	XXX
99205		A	Office/outpatient visit, new	3.00	1.78	1.78	0.91	0.93	0.15	XXX
99211		A	Office/outpatient visit, est	0.17	0.32	0.36	0.06	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.45	0.55	0.55	0.15	0.15	0.03	XXX
99213		A	Office/outpatient visit, est	0.92	0.76	0.72	0.28	0.26	0.03	XXX
99214		A	Office/outpatient visit, est	1.42	1.10	1.06	0.44	0.42	0.05	XXX
99215		A	Office/outpatient visit, est	2.00	1.38	1.35	0.61	0.63	0.08	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.50	0.51	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.38	0.41	0.06	XXX
99219		A	Observation care	2.14	NA	NA	0.59	0.65	0.10	XXX
99220		A	Observation care	2.99	NA	NA	0.84	0.93	0.14	XXX
99221		A	Initial hospital care	1.88	NA	NA	0.54	0.50	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	1.05	0.13	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.24	0.23	0.03	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.42	0.40	0.04	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.59	0.56	0.06	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	0.78	0.83	0.13	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	0.98	1.06	0.16	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.21	1.32	0.19	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.49	0.52	0.05	XXX
99239		A	Hospital discharge day	1.90	NA	NA	0.67	0.70	0.07	XXX
99241		A	Office consultation	0.64	0.66	0.65	0.22	0.22	0.05	XXX
99242		A	Office consultation	1.34	1.08	1.06	0.48	0.47	0.10	XXX
99243		A	Office consultation	1.88	1.45	1.42	0.67	0.65	0.13	XXX
99244		A	Office consultation	3.02	1.93	1.88	1.08	1.00	0.16	XXX
99245		A	Office consultation	3.77	2.26	2.27	1.31	1.27	0.21	XXX
99251		A	Inpatient consultation	1.00	NA	NA	0.31	0.27	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	0.74	0.11	XXX
99254		A	Inpatient consultation	3.29	NA	NA	1.18	1.08	0.13	XXX
99255		A	Inpatient consultation	4.00	NA	NA	1.38	1.36	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	0.15	0.04	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.25	0.28	0.09	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.46	0.47	0.14	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.67	0.69	0.23	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99289		A	Ped crit care transport	4.79	NA	NA	1.08	1.26	0.24	XXX
99290		A	Ped crit care transport addl	2.40	NA	NA	0.89	0.85	0.12	ZZZ
99291		A	Critical care, first hour	4.50	2.26	2.41	1.10	1.19	0.21	XXX
99292		A	Critical care, add'l 30 min	2.25	0.80	0.85	0.56	0.60	0.11	ZZZ
99293		A	Ped critical care, initial	15.98	NA	NA	3.78	4.26	1.12	XXX
99294		A	Ped critical care, subseq	7.99	NA	NA	1.65	2.03	0.45	XXX
99295		A	Neonate crit care, initial	18.46	NA	NA	4.56	4.97	1.16	XXX
99296		A	Neonate critical care subseq	7.99	NA	NA	2.06	2.30	0.32	XXX
99298		A	Ic for lbw infant < 1500 gm	2.75	NA	NA	0.68	0.80	0.17	XXX
99299		A	Ic, lbw infant 1500–2500 gm	2.50	NA	NA	0.58	0.72	0.16	XXX
99300		A	Ic, infant pbw 2501–5000 gm	2.40	NA	NA	0.71	0.77	0.15	XXX
99304		A	Nursing facility care, init	1.61	0.57	0.53	0.57	0.53	0.05	XXX
99305		A	Nursing facility care, init	2.30	0.74	0.68	0.74	0.68	0.07	XXX
99306		A	Nursing facility care, init	3.00	0.90	0.83	0.90	0.83	0.09	XXX
99307		A	Nursing fac care, subseq	0.76	0.31	0.29	0.31	0.29	0.03	XXX
99308		A	Nursing fac care, subseq	1.16	0.47	0.46	0.47	0.46	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	0.82	0.87	0.82	0.08	XXX
99315		A	Nursing fac discharge day	1.13	0.41	0.43	0.41	0.43	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.50	0.55	0.50	0.55	0.06	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.56	0.53	0.56	0.53	0.05	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.43	0.46	NA	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.55	0.62	NA	NA	0.07	XXX
99326		A	Domicil/r-home visit new pat	2.63	0.82	0.87	NA	NA	0.10	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.02	1.09	NA	NA	0.13	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.16	1.29	NA	NA	0.16	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.43	0.41	NA	NA	0.04	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.59	0.58	NA	NA	0.06	XXX
99336		A	Domicil/r-home visit est pat	2.46	0.77	0.79	NA	NA	0.09	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
99337		A	Domicil/r-home visit est pat	3.58	1.03	1.09	NA	NA	0.13	XXX
99339		B	Domicil/r-home care supervis	1.25	0.58	0.58	NA	NA	0.06	XXX
99340		B	Domicil/r-home care supervis	1.80	0.77	0.77	NA	NA	0.07	XXX
99341		A	Home visit, new patient	1.01	0.43	0.45	NA	NA	0.05	XXX
99342		A	Home visit, new patient	1.52	0.56	0.62	NA	NA	0.07	XXX
99343		A	Home visit, new patient	2.53	0.82	0.88	NA	NA	0.10	XXX
99344		A	Home visit, new patient	3.38	1.00	1.09	NA	NA	0.13	XXX
99345		A	Home visit, new patient	4.09	1.15	1.29	NA	NA	0.16	XXX
99347		A	Home visit, est patient	1.00	0.42	0.41	NA	NA	0.04	XXX
99348		A	Home visit, est patient	1.56	0.56	0.57	NA	NA	0.06	XXX
99349		A	Home visit, est patient	2.33	0.73	0.78	NA	NA	0.09	XXX
99350		A	Home visit, est patient	3.28	0.96	1.07	NA	NA	0.13	XXX
99354		A	Prolonged service, office	1.77	0.65	0.71	0.50	0.58	0.08	ZZZ
99355		A	Prolonged service, office	1.77	0.62	0.68	0.47	0.54	0.07	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.50	0.56	0.07	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.50	0.56	0.08	ZZZ
99358		B	Prolonged serv, w/o contact	2.10	0.51	0.51	0.51	0.51	0.09	ZZZ
99359		B	Prolonged serv, w/o contact	1.00	0.26	0.26	0.26	0.26	0.04	ZZZ
99360		X	Physician standby services	1.20	0.28	0.28	0.28	0.28	0.05	XXX
99363		B	Anticoag mgmt, init	1.65	1.30	1.30	0.38	0.38	0.07	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.38	0.38	0.14	0.14	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.20	0.20	0.19	0.19	0.06	XXX
99367		B	Team conf w/o pat by phys	1.10	0.25	0.25	0.25	0.25	0.05	XXX
99368		B	Team conf w/o pat by hc pro	0.72	0.16	0.16	0.16	0.16	0.03	XXX
99374		B	Home health care supervision	1.10	0.55	0.62	0.25	0.34	0.05	XXX
99375		I	Home health care supervision	1.73	0.75	1.15	0.40	0.97	0.07	XXX
99377		B	Hospice care supervision	1.10	0.55	0.62	0.25	0.34	0.05	XXX
99378		I	Hospice care supervision	1.73	0.75	1.35	0.40	1.17	0.07	XXX
99379		B	Nursing fac care supervision	1.10	0.55	0.62	0.25	0.34	0.04	XXX
99380		B	Nursing fac care supervision	1.73	0.75	0.87	0.40	0.53	0.06	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.00	1.25	0.27	0.36	0.05	XXX
99382		N	Init pm e/m, new pat 1–4 yrs	1.36	1.04	1.29	0.31	0.42	0.05	XXX
99383		N	Prev visit, new, age 5–11	1.36	1.03	1.25	0.31	0.42	0.05	XXX
99384		N	Prev visit, new, age 12–17	1.53	1.07	1.31	0.35	0.47	0.06	XXX
99385		N	Prev visit, new, age 18–39	1.53	1.07	1.31	0.35	0.47	0.06	XXX
99386		N	Prev visit, new, age 40–64	1.88	1.15	1.45	0.43	0.58	0.07	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.28	1.58	0.47	0.63	0.07	XXX
99391		N	Per pm reeval, est pat, inf	1.02	0.86	0.94	0.23	0.31	0.04	XXX
99392		N	Prev visit, est, age 1–4	1.19	0.90	0.99	0.27	0.36	0.05	XXX
99393		N	Prev visit, est, age 5–11	1.19	0.89	0.98	0.27	0.36	0.05	XXX
99394		N	Prev visit, est, age 12–17	1.36	0.93	1.03	0.31	0.42	0.05	XXX
99395		N	Prev visit, est, age 18–39	1.36	0.94	1.05	0.31	0.42	0.05	XXX
99396		N	Prev visit, est, age 40–64	1.53	0.98	1.11	0.35	0.47	0.06	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.12	1.24	0.39	0.53	0.06	XXX
99401		N	Preventive counseling, indiv	0.48	0.36	0.49	0.11	0.15	0.01	XXX
99402		N	Preventive counseling, indiv	0.98	0.48	0.67	0.22	0.30	0.02	XXX
99403		N	Preventive counseling, indiv	1.46	0.59	0.84	0.34	0.45	0.04	XXX
99404		N	Preventive counseling, indiv	1.95	0.70	1.01	0.45	0.60	0.05	XXX
99406		A	Behav chng smoking 3–10 min	0.24	0.11	0.10	0.07	0.08	0.01	XXX
99407		A	Behav chng smoking < 10 min	0.50	0.18	0.18	0.13	0.15	0.01	XXX
99408		N	Audit/dast, 15–30 min	0.65	0.19	0.19	0.15	0.15	0.01	XXX
99409		N	Audit/dast, over 30 min	1.30	0.34	0.34	0.30	0.30	0.03	XXX
99411		N	Preventive counseling, group	0.15	0.22	0.20	0.03	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.24	0.25	0.06	0.08	0.01	XXX
99420		N	Health risk assessment test	0.00	0.22	0.22	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99431		A	Initial care, normal newborn	1.17	NA	NA	0.27	0.32	0.05	XXX
99432		A	Newborn care, not in hosp	1.26	1.01	0.97	0.29	0.34	0.07	XXX
99433		A	Normal newborn care/hospital	0.62	NA	NA	0.17	0.19	0.02	XXX
99435		A	Newborn discharge day hosp	1.50	NA	NA	0.50	0.54	0.06	XXX
99436		A	Attendance, birth	1.50	NA	NA	0.33	0.40	0.06	XXX
99440		A	Newborn resuscitation	2.93	NA	NA	0.67	0.80	0.12	XXX
99441		N	Phone e/m by phys 5–10 min	0.25	0.09	0.09	0.06	0.06	0.02	XXX
99442		N	Phone e/m by phys 11–20 min	0.50	0.14	0.14	0.11	0.11	0.02	XXX
99443		N	Phone e/m by phys 21–30 min	0.75	0.20	0.20	0.17	0.17	0.03	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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
99500		I	Home visit, prenatal	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 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm, np, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm, est, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm, addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.48	0.50	NA	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.32	0.36	0.06	0.06	0.01	XXX
G0103		X	PSA screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.52	2.40	0.62	0.56	0.08	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.38	6.26	1.82	1.64	0.30	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.52	2.40	0.62	0.56	0.08	000
G0106		A	Colon CA screen;barium enema	0.99	4.94	3.74	NA	NA	0.17	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.59	3.41	NA	NA	0.13	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.35	0.33	0.35	0.33	0.04	XXX
G0108		A	Diab manage trn per indiv	0.00	0.59	0.71	NA	NA	0.01	XXX
G0109		A	Diab manage trn ind/group	0.00	0.31	0.40	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.76	0.74	NA	NA	0.01	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.71	0.62	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.94	3.74	NA	NA	0.17	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.59	3.41	NA	NA	0.13	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.35	0.33	0.35	0.33	0.04	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.38	6.26	1.82	1.64	0.30	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.52	2.40	0.62	0.56	0.08	000
G0122		N	Colon ca scrn; barium enema	0.99	5.64	4.10	NA	NA	0.18	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.41	3.80	NA	NA	0.13	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.23	0.30	0.23	0.30	0.05	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.38	0.26	0.38	0.26	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.38	0.32	0.04	0.06	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.02	0.02	0.02	0.02	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.55	0.71	NA	NA	0.06	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.49	0.64	NA	NA	0.05	XXX
G0130	26	A	Single energy x-ray study	0.22	0.06	0.07	0.06	0.07	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.38	0.26	0.38	0.26	0.02	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	4.50	4.03	NA	NA	0.01	XXX
G0168		A	Wound closure by adhesive	0.45	1.58	1.76	0.21	0.21	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	0.48	0.75	NA	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.56	0.91	NA	NA	0.03	XXX
G0181		A	Home health care supervision	1.73	0.80	1.14	NA	NA	0.07	XXX
G0182		A	Hospice care supervision	1.73	0.82	1.24	NA	NA	0.07	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.80	2.78	NA	NA	0.10	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.56	2.55	NA	NA	0.07	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.24	0.23	0.24	0.23	0.03	XXX
G0204		A	Diagnosticmammographydigital	0.87	3.40	3.09	NA	NA	0.11	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.10	2.80	NA	NA	0.07	XXX

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CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
G0204	26	A	Diagnosticmammographydigital	0.87	0.30	0.29	0.30	0.29	0.04	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.66	2.45	NA	NA	0.09	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.42	2.22	NA	NA	0.06	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.24	0.23	0.24	0.23	0.03	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.21	0.34	NA	NA	0.02	XXX
G0238		A	Oth resp proc, indiv	0.00	0.23	0.36	NA	NA	0.02	XXX
G0239		A	Oth resp proc, group	0.00	0.31	0.32	NA	NA	0.02	XXX
G0245		R	Initial foot exam pt lops	0.88	0.84	0.81	0.29	0.30	0.04	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.55	0.55	0.15	0.15	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.68	0.60	0.16	0.18	0.02	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	3.40	5.00	NA	NA	0.01	XXX
G0249		R	Provide test material,equipm	0.00	3.40	3.68	NA	NA	0.01	XXX
G0250		R	MD review interpret of test	0.18	0.08	0.07	NA	NA	0.01	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	PET imaging initial dx	1.50	0.00	0.60	0.00	0.60	0.04	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.66	0.65	0.20	0.22	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.37	0.12	0.29	0.09	0.28	0.01	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.08	0.13	0.07	0.12	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	0.12	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.14	0.12	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.14	0.12	NA	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	1.03	5.82	NA	NA	0.18	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.58	0.69	0.26	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0297		X	Insert single chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0300		X	Insert reposit lead dual+gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10–15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1–9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0308		A	ESRD related svc 4+mo < 2yrs	12.74	5.57	7.05	5.57	7.05	0.42	XXX
G0309		A	ESRD related svc 2–3mo <2yrs	10.61	4.16	5.63	4.16	5.63	0.36	XXX
G0310		A	ESRD related svc 1 vst <2yrs	8.49	2.78	4.23	2.78	4.23	0.28	XXX
G0311		A	ESRD related svs 4+mo 2–11yr	9.73	3.54	4.13	3.54	4.13	0.34	XXX
G0312		A	ESRD relate svs 2–3 mo 2–11y	8.11	2.70	3.31	2.70	3.31	0.29	XXX
G0313		A	ESRD related svs 1 mon 2–11y	6.49	1.83	2.49	1.83	2.49	0.22	XXX
G0314		A	ESRD related svs 4+ mo 12–19	8.28	3.39	3.90	3.39	3.90	0.27	XXX
G0315		A	ESRD related svs 2–3mo/12–19	6.90	2.56	3.11	2.56	3.11	0.23	XXX
G0316		A	ESRD related svs 1vis/12–19y	5.52	1.66	2.30	1.66	2.30	0.17	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.09	2.25	2.55	2.25	2.55	0.17	XXX
G0318		A	ESRD related svs 2–3 mo 20+y	4.24	1.69	2.04	1.69	2.04	0.14	XXX
G0319		A	ESRD related svs 1visit 20+y	3.39	1.13	1.52	1.13	1.52	0.11	XXX
G0320		A	ESD related svs home undr 2	10.61	2.68	4.89	2.68	4.89	0.36	XXX
G0321		A	ESRDrelatedsvs home mo 2–11y	8.11	1.99	2.95	1.99	2.95	0.29	XXX
G0322		A	ESRD related svs hom mo12–19	6.90	1.71	2.69	1.71	2.69	0.23	XXX
G0323		A	ESRD related svs home mo 20+	4.24	1.14	1.76	1.14	1.76	0.14	XXX
G0324		A	ESRD relate svs home/dy <2yr	0.35	0.16	0.20	0.16	0.20	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

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.06	0.07	0.06	0.07	0.01	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.15	0.14	NA	NA	0.01	XXX
G0332		A	Preadmin IV immunoglobulin	0.00	0.00	1.97	NA	NA	0.00	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.34	0.31	0.41	0.31	0.41	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	NA	NA	2.35	2.47	0.48	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	5.06	5.18	1.46	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	8.54	8.65	2.07	090
G0344		A	Initial preventive exam	1.34	1.11	1.12	0.43	0.45	0.10	XXX
G0364		A	Bone marrow aspirate &biopsy	0.16	0.16	0.15	0.07	0.06	0.04	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.21	4.61	NA	NA	0.25	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.15	4.53	NA	NA	0.23	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.06	0.08	0.06	0.08	0.02	XXX
G0366		A	EKG for initial prevent exam	0.17	0.35	0.42	NA	NA	0.03	XXX
G0367		A	EKG tracing for initial prev	0.00	0.28	0.36	NA	NA	0.02	XXX
G0368		A	EKG interpret & report preve	0.17	0.07	0.06	0.07	0.06	0.01	XXX
G0372		A	MD service required for PMD	0.17	0.04	0.22	0.04	0.05	0.01	XXX
G0377		X	Administra Part D vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct admit hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.41	2.41	NA	NA	0.11	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	2.21	2.21	NA	NA	0.08	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.20	0.20	0.20	0.20	0.03	XXX
G0392		A	AV fistula or graft arterial	9.48	48.63	48.63	NA	NA	0.62	000
G0393		A	AV fistula or graft venous	6.03	37.11	37.11	NA	NA	0.34	000
G0394		X	Blood occult test,colorectal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0396		A	Alcohol/subs interv 15–30mn	0.65	0.19	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
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.44	0.10	0.20	0.10	0.20	0.01	XXX
G9042		A	Low vision rehab orient/mobi	0.10	0.02	0.16	0.02	0.16	0.01	XXX
G9043		A	Low vision lowvision therapi	0.10	0.02	0.16	0.02	0.16	0.01	XXX
G9044		A	Low vision rehabilate teache	0.10	0.02	0.13	0.02	0.13	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.91	0.62	0.07	0.09	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.38	0.26	0.38	0.26	0.02	XXX
Q0035		A	Cardiokymography	0.17	0.30	0.37	NA	NA	0.03	XXX
Q0035	TC	A	Cardiokymography	0.00	0.25	0.32	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	0.75	0.71	0.10	0.12	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.47	0.40	0.47	0.40	0.01	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR 2008—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
V5299	.....	R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C.—CODES WITH INTERIM RVUS

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
20555	.....	A	Place ndl musc/tis for rt	6.00	NA	NA	2.18	2.18	0.43	000
20660	.....	A	Apply, rem fixation device	4.00	2.27	2.27	1.55	1.55	0.59	000
20690	.....	A	Apply bone fixation device	8.65	NA	NA	3.71	3.71	0.59	090
20692	.....	A	Apply bone fixation device	16.00	NA	NA	6.78	6.78	1.05	090
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
21073	.....	A	Mnpj of tmj w/anesth	3.33	5.50	5.50	2.31	2.31	0.43	090
22206	.....	A	Cut spine 3 col, thor	37.00	NA	NA	17.71	17.71	6.23	090
22207	.....	A	Cut spine 3 col, lumb	36.50	NA	NA	17.59	17.59	6.07	090
22208	.....	A	Cut spine 3 col, addl seg	9.66	3.72	3.72	3.72	3.72	2.07	ZZZ
23515	.....	A	Treat clavicle fracture	9.53	NA	NA	6.77	6.77	1.28	090
23585	.....	A	Treat scapula fracture	14.07	NA	NA	8.07	8.07	1.54	090
23615	.....	A	Treat humerus fracture	12.12	NA	NA	8.44	8.44	1.62	090
23616	.....	A	Treat humerus fracture	18.19	NA	NA	12.29	12.29	3.70	090
23630	.....	A	Treat humerus fracture	10.39	NA	NA	7.00	7.00	1.27	090
23670	.....	A	Treat dislocation/fracture	12.12	NA	NA	7.37	7.37	1.36	090
23680	.....	A	Treat dislocation/fracture	12.99	NA	NA	8.16	8.16	1.76	090
24357	.....	A	Repair elbow, perc	5.32	NA	NA	5.15	5.15	0.87	090
24358	.....	A	Repair elbow w/deb, open	6.54	NA	NA	5.73	5.73	1.07	090
24359	.....	A	Repair elbow deb/attch open	8.86	NA	NA	6.19	6.19	1.41	090
24545	.....	A	Treat humerus fracture	12.99	NA	NA	8.36	8.36	1.83	090
24546	.....	A	Treat humerus fracture	14.73	NA	NA	10.20	10.20	2.74	090
24575	.....	A	Treat humerus fracture	9.53	NA	NA	7.68	7.68	1.87	090
24579	.....	A	Treat humerus fracture	11.26	NA	NA	8.28	8.28	2.03	090
24635	.....	A	Treat elbow fracture	8.64	NA	NA	10.29	10.29	2.29	090
24685	.....	A	Treat ulnar fracture	8.21	NA	NA	7.01	7.01	1.52	090
25515	.....	A	Treat fracture of radius	8.64	NA	NA	6.96	6.96	1.59	090
25525	.....	A	Treat fracture of radius	10.37	NA	NA	8.70	8.70	2.13	090
25526	.....	A	Treat fracture of radius	12.96	NA	NA	11.09	11.09	2.20	090
25545	.....	A	Treat fracture of ulna	7.78	NA	NA	6.94	6.94	1.53	090
25574	.....	A	Treat fracture radius & ulna	8.64	NA	NA	6.87	6.87	1.21	090
25575	.....	A	Treat fracture radius/ulna	12.10	NA	NA	8.93	8.93	1.82	090
25628	.....	A	Treat wrist bone fracture	9.51	NA	NA	7.33	7.33	1.37	090
26615	.....	A	Treat metacarpal fracture	6.91	NA	NA	5.66	5.66	0.86	090
26650	.....	A	Treat thumb fracture	5.19	NA	NA	5.78	5.78	0.94	090
26665	.....	A	Treat thumb fracture	7.78	NA	NA	6.46	6.46	0.90	090
26685	.....	A	Treat hand dislocation	6.91	NA	NA	6.05	6.05	1.09	090
26715	.....	A	Treat knuckle dislocation	6.87	NA	NA	5.75	5.75	0.91	090
26735	.....	A	Treat finger fracture, each	7.26	NA	NA	5.84	5.84	0.95	090
26746	.....	A	Treat finger fracture, each	9.59	NA	NA	6.38	6.38	0.91	090
26765	.....	A	Treat finger fracture, each	5.70	NA	NA	4.93	4.93	0.66	090
26785	.....	A	Treat finger dislocation	6.44	NA	NA	5.15	5.15	0.68	090
27248	.....	A	Treat thigh fracture	10.64	NA	NA	7.29	7.29	1.82	090
27267	.....	A	Cltx thigh fx	5.38	NA	NA	4.39	4.39	0.89	090
27268	.....	A	Cltx thigh fx w/mnpj	7.00	NA	NA	5.02	5.02	1.16	090
27269	.....	A	Optx thigh fx	18.75	NA	NA	9.88	9.88	2.93	090
27416	.....	A	Osteochondral knee autograft	14.00	NA	NA	8.38	8.38	2.32	090
27511	.....	A	Treatment of thigh fracture	14.97	NA	NA	9.65	9.65	2.38	090
27513	.....	A	Treatment of thigh fracture	19.11	NA	NA	11.81	11.81	3.13	090
27514	.....	A	Treatment of thigh fracture	14.46	NA	NA	10.61	10.61	3.01	090
27519	.....	A	Treat thigh fx growth plate	13.11	NA	NA	9.48	9.48	2.56	090
27535	.....	A	Treat knee fracture	13.27	NA	NA	8.77	8.77	2.01	090
27540	.....	A	Treat knee fracture	11.16	NA	NA	8.44	8.44	2.28	090
27556	.....	A	Treat knee dislocation	12.86	NA	NA	9.45	9.45	2.51	090
27557	.....	A	Treat knee dislocation	15.76	NA	NA	10.78	10.78	2.98	090
27558	.....	A	Treat knee dislocation	18.25	NA	NA	11.16	11.16	3.09	090
27726	.....	A	Repair fibula nonunion	14.20	NA	NA	7.67	7.67	1.43	090
27766	.....	A	Optx medial ankle fx	7.73	NA	NA	6.67	6.67	1.44	090
27767	.....	A	Cltx post ankle fx	2.50	3.62	3.62	3.65	3.65	0.30	090

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT [1]/ HCPCS	Mod	Status	Description	Physician work RVUs [2]	Fully implemented non-facility PE RVUs [2]	Year 2008 transitional non-facility PE RVUs [2]	Fully implemented facility PE RVUs [2]	Year 2008 transitional facility PE RVUs [2]	Malpractice RVUs [2]	Global
27768	.....	A	Cltx post ankle fx w/mnpj	5.00	NA	NA	4.29	4.29	0.79	090
27769	.....	A	Optx post ankle fx	10.00	NA	NA	6.07	6.07	1.45	090
27784	.....	A	Treatment of fibula fracture	9.51	NA	NA	6.65	6.65	1.23	090
27792	.....	A	Treatment of ankle fracture	9.55	NA	NA	6.88	6.88	1.32	090
27814	.....	A	Treatment of ankle fracture	10.46	NA	NA	7.89	7.89	1.86	090
27822	.....	A	Treatment of ankle fracture	11.03	NA	NA	9.42	9.42	1.92	090
27823	.....	A	Treatment of ankle fracture	12.98	NA	NA	10.19	10.19	2.26	090
27826	.....	A	Treat lower leg fracture	10.92	NA	NA	8.51	8.51	1.47	090
27827	.....	A	Treat lower leg fracture	14.56	NA	NA	11.47	11.47	2.44	090
27828	.....	A	Treat lower leg fracture	18.20	NA	NA	12.74	12.74	2.82	090
27829	.....	A	Treat lower leg joint	8.64	NA	NA	6.87	6.87	0.95	090
27832	.....	A	Treat lower leg dislocation	10.01	NA	NA	6.50	6.50	1.03	090
28415	.....	A	Treat heel fracture	15.96	NA	NA	11.75	11.75	2.67	090
28420	.....	A	Treat/graft heel fracture	17.29	NA	NA	11.59	11.59	2.81	090
28445	.....	A	Treat ankle fracture	15.53	NA	NA	10.25	10.25	2.59	090
28446	.....	A	Osteochondral talus autogrft	17.50	NA	NA	10.34	10.34	2.45	090
28465	.....	A	Treat midfoot fracture, each	8.64	NA	NA	6.18	6.18	1.10	090
28485	.....	A	Treat metatarsal fracture	7.28	NA	NA	5.50	5.50	0.83	090
28505	.....	A	Treat big toe fracture	7.28	8.27	8.27	4.36	4.36	0.56	090
28525	.....	A	Treat toe fracture	5.46	7.81	7.81	3.87	3.87	0.49	090
28555	.....	A	Repair foot dislocation	9.49	10.35	10.35	5.98	5.98	1.04	090
28585	.....	A	Repair foot dislocation	10.92	9.44	9.44	6.40	6.40	1.25	090
28615	.....	A	Repair foot dislocation	10.46	NA	NA	8.08	8.08	1.30	090
28645	.....	A	Repair toe dislocation	7.28	6.64	6.64	3.94	3.94	0.57	090
28675	.....	A	Repair of toe dislocation	5.46	7.68	7.68	3.90	3.90	0.45	090
29828	.....	A	Arthroscopy biceps tenodesis	13.00	NA	NA	8.17	8.17	2.17	090
29904	.....	A	Subtalar arthro w/fb rmvl	8.50	NA	NA	5.89	5.89	1.25	090
29905	.....	A	Subtalar arthro w/exc	9.00	NA	NA	6.51	6.51	1.32	090
29906	.....	A	Subtalar arthro w/deb	9.47	NA	NA	6.87	6.87	1.39	090
29907	.....	A	Subtalar arthro w/fusion	12.00	NA	NA	7.86	7.86	1.90	090
31500	.....	A	Insert emergency airway	2.33	NA	NA	0.48	0.48	0.17	000
33257	.....	A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.46	5.46	0.89	ZZZ
33258	.....	A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.98	5.98	1.09	ZZZ
33259	.....	A	Ablate atria w/bypass add-on	14.14	NA	NA	7.79	7.79	1.78	ZZZ
33864	.....	A	Ascending aortic graft	60.00	NA	NA	20.09	20.09	6.73	090
34806	.....	A	Aneurysm press sensor add-on	2.06	0.51	0.51	0.51	0.51	0.30	ZZZ
35523	.....	A	Artery bypass graft	24.00	NA	NA	9.20	9.20	2.14	090
36591	.....	T	Draw blood off venous device	0.00	0.54	0.54	NA	NA	0.01	XXX
36592	.....	T	Collect blood from picc	0.00	0.67	0.67	NA	NA	0.01	XXX
36593	.....	A	Declot vascular device	0.00	0.60	0.60	NA	NA	0.37	XXX
36620	.....	A	Insertion catheter, artery	1.15	NA	NA	0.19	0.19	0.07	000
41019	.....	A	Place needles h&n for rt	8.84	NA	NA	3.28	3.28	0.59	000
43760	.....	A	Change gastrostomy tube	0.90	4.03	4.03	0.39	0.39	0.09	000
49203	.....	A	Exc abd tum 5 cm or less	20.00	NA	NA	7.65	7.65	2.27	090
49204	.....	A	Exc abd tum over 5 cm	26.00	NA	NA	9.26	9.26	2.94	090
49205	.....	A	Exc abd tum over 10 cm	30.00	NA	NA	10.34	10.34	3.40	090
49440	.....	A	Place gastrostomy tube perc	4.18	25.03	25.03	1.81	1.81	0.49	010
49441	.....	A	Place duod/jej tube perc	4.77	30.10	30.10	2.00	2.00	0.29	010
49442	.....	A	Place cecostomy tube perc	4.00	24.43	24.43	1.63	1.63	0.24	010
49446	.....	A	Change g-tube to g-j perc	3.31	25.74	25.74	1.15	1.15	0.18	000
49450	.....	A	Replace g/c tube perc	1.36	18.94	18.94	0.44	0.44	0.08	000
49451	.....	A	Replace duod/jej tube perc	1.84	19.69	19.69	0.64	0.64	0.11	000
49452	.....	A	Replace g-j tube perc	2.86	23.48	23.48	1.00	1.00	0.18	000
49460	.....	A	Fix g/colon tube w/device	0.96	20.56	20.56	0.31	0.31	0.05	000
49465	.....	A	Fluoro exam of g/colon tube	0.62	3.88	3.88	0.22	0.22	0.03	000
50385	.....	A	Change stent via transureth	4.44	30.61	30.61	2.05	2.05	0.27	000
50386	.....	A	Remove stent via transureth	3.30	19.36	19.36	1.60	1.60	0.20	000
50593	.....	A	Perc cryo ablate renal tum	9.08	114.48	114.48	3.44	3.44	0.58	010
51797	26	A	Intraabdominal pressure test	0.80	0.41	0.41	0.41	0.41	0.12	ZZZ
52649	.....	A	2Prostate laser enucleation	17.16	NA	NA	9.31	9.31	1.11	090
55920	.....	A	Place needles pelvic for rt	8.31	NA	NA	3.13	3.13	0.58	000
57284	.....	A	Repair paravag defect, open	14.25	NA	NA	6.56	6.56	1.41	090
57285	.....	A	Repair paravag defect, vag	11.52	NA	NA	5.16	5.16	0.63	090
57423	.....	A	Repair paravag defect, lap	16.00	NA	NA	6.51	6.51	1.65	090
58570	.....	A	Tlh, uterus 250 g or less	15.75	NA	NA	6.45	6.45	1.82	090
58571	.....	A	Tlh w/t/o 250 g or less	17.56	NA	NA	6.94	6.94	1.81	090
58572	.....	A	Tlh, uterus over 250 g	19.96	NA	NA	7.59	7.59	2.31	090
58573	.....	A	Tlh w/t/o uterus over 250 g	22.98	NA	NA	8.41	8.41	2.28	090
67041	.....	A	Vit for macular pucker	19.00	NA	NA	10.36	10.36	0.86	090
67042	.....	A	Vit for macular hole	22.13	NA	NA	11.48	11.48	1.00	090
67043	.....	A	Vit for membrane dissect	22.94	NA	NA	12.34	12.34	1.04	090
67113	.....	A	Repair retinal detach, cplx	22.49	NA	NA	12.75	12.75	1.13	090
67229	.....	A	Tr retinal les preterm inf	16.00	NA	NA	9.51	9.51	0.71	090
68816	.....	A	Probe nl duct w/balloon	3.00	12.73	12.73	2.51	2.51	0.16	010
75557	26	A	Cardiac mri for morph	2.35	0.94	0.94	0.94	0.94	0.10	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.60	0.60	0.60	0.60	0.11	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.27	1.27	1.27	1.27	0.10	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	0.69	0.69	0.69	0.69	0.11	XXX

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1]/ HCPCS	Mod	Status	Description	Physician work RVUs[2]	Fully implemented non-facility PE RVUs[2]	Year 2008 transitional non-facility PE RVUs[2]	Fully implemented facility PE RVUs[2]	Year 2008 transitional facility PE RVUs[2]	Malpractice RVUs[2]	Global
75561	26	A	Cardiac mri for morph w/dye	2.60	1.03	1.03	1.03	1.03	0.11	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	0.66	0.66	0.66	0.66	0.11	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.38	1.38	1.38	1.38	0.11	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	0.77	0.77	0.77	0.77	0.13	XXX
78811	26	A	Pet image, ltd area	1.54	0.53	0.53	0.53	0.53	0.11	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.66	0.66	0.66	0.66	0.11	XXX
78813	26	A	Pet image, full body	2.00	0.68	0.68	0.68	0.68	0.11	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.75	0.75	0.75	0.75	0.11	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.84	0.84	0.84	0.84	0.11	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.85	0.85	0.85	0.85	0.11	XXX
86486		A	Skin test, nos antigen	0.00	0.13	0.13	NA	NA	0.02	XXX
88380	26	A	Microdissection, laser	1.56	0.43	0.43	0.43	0.43	0.07	XXX
88381	26	A	Microdissection, manual	1.18	0.32	0.32	0.32	0.32	0.06	XXX
90769		A	Sc ther infusion, up to 1 hr	0.21	3.92	3.92	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	1.86	1.86	NA	NA	0.01	ZZZ
93503		C	Insert/place heart catheter	0.00	NA	NA	NA	NA	0.00	000
93982		R	Aneurysm pressure sens study	0.30	0.80	0.80	NA	NA	0.01	XXX
95004		A	Percut allergy skin tests	0.01	0.13	0.13	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.16	0.16	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.12	0.12	NA	NA	0.01	XXX
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.25	0.25	0.07	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.44	0.44	0.12	0.12	0.02	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.47	0.47	0.18	0.18	0.05	XXX
96125		A	Cognitive test by hc pro	1.70	0.76	0.76	0.37	0.37	0.16	XXX
98966		N	Hc pro phone call 5–10 min	0.25	0.09	0.09	0.06	0.06	0.01	XXX
98967		N	Hc pro phone call 11–20 min	0.50	0.14	0.14	0.11	0.11	0.02	XXX
98968		N	Hc pro phone call 21–30 min	0.75	0.20	0.20	0.17	0.17	0.03	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99174		N	Ocular photoscreening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.20	0.20	0.19	0.19	0.06	XXX
99367		B	Team conf w/o pat by phys	1.10	0.25	0.25	0.25	0.25	0.05	XXX
99368		B	Team conf w/o pat by hc pro	0.72	0.16	0.16	0.16	0.16	0.03	XXX
99406		A	Behav chng smoking 3–10 min	0.24	0.10	0.10	0.08	0.08	0.01	XXX
99407		A	Behav chng smoking < 10 min	0.50	0.18	0.18	0.15	0.15	0.01	XXX
99408		N	Audit/dast, 15–30 min	0.65	0.19	0.19	0.15	0.15	0.01	XXX
99409		N	Audit/dast, over 30 min	1.30	0.34	0.34	0.30	0.30	0.03	XXX
99441		N	Phone e/m by phys 5–10 min	0.25	0.09	0.09	0.06	0.06	0.02	XXX
99442		N	Phone e/m by phys 11–20 min	0.50	0.14	0.14	0.11	0.11	0.02	XXX
99443		N	Phone e/m by phys 21–30 min	0.75	0.20	0.20	0.17	0.17	0.03	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99477		A	Init day hosp neonate care	7.00	1.98	1.98	1.98	1.98	0.32	XXX
G0396		A	Alcohol/subs interv 15–30 min	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

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[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM D.—2008 GEOGRAPHIC ADJUSTMENT FACTORS (GAFS)

Carrier	Locality	Locality name	GAF
31140	06	San Mateo, CA	1.232
31140	05	San Francisco, CA	1.229
31140	09	Santa Clara, CA	1.207
00803	01	Manhattan, NY	1.174
00803	02	NYC Suburbs/Long I., NY	1.171
31140	07	Oakland/Berkley, CA	1.154
31143	01	Metropolitan Boston	1.143
14330	04	Queens, NY	1.137
31140	03	Marin/Napa/Solano, CA	1.133
00805	01	Northern NJ	1.130
00903	01	DC + MD/VA Suburbs	1.127
31146	26	Anaheim/Santa Ana, CA	1.124
31146	17	Ventura, CA	1.102
31146	18	Los Angeles, CA	1.100
00591	00	Connecticut	1.096
00952	16	Chicago, IL	1.093
00590	04	Miami, FL	1.092
00953	01	Detroit, MI	1.091
00805	99	Rest of New Jersey	1.078
00952	15	Suburban Chicago, IL	1.074
00865	01	Metropolitan Philadelphia, PA	1.072
00836	02	Seattle (King Cnty), WA	1.046

ADDENDUM D.—2008 GEOGRAPHIC ADJUSTMENT FACTORS (GAFS)—Continued

Carrier	Locality	Locality name	GAF
00831	01	Alaska	1.045
00833	01	Hawaii/Guam	1.044
31143	99	Rest of Massachusetts	1.042
00803	03	Poughkpsie/N NYC Suburbs, NY	1.040
00901	01	Baltimore/Surr. Cntys, MD	1.037
00590	03	Fort Lauderdale, FL	1.033
00524	01	Rhode Island	1.030
00511	01	Atlanta, GA	1.024
00900	11	Dallas, TX	1.022
00900	18	Houston, TX	1.021
00834	00	Nevada	1.019
31140	99	Rest of California *	1.015
31146	99	Rest of California *	1.015
00902	01	Delaware	1.012
00900	31	Austin, TX	1.001
00835	01	Portland, OR	0.997
00900	09	Brazoria, TX	0.995
00528	01	New Orleans, LA	0.993
31144	40	New Hampshire	0.993
00952	15	East St. Louis, IL	0.992
00900	28	Fort Worth, TX	0.990
00973	50	Virgin Islands	0.989
00900	15	Galveston, TX	0.985
00824	01	Colorado	0.983
00901	99	Rest of Maryland	0.981
31142	03	Southern Maine	0.981
03102	00	Arizona	0.980
00523	01	Metropolitan Kansas City, MO	0.980
00590	99	Rest of Florida	0.977
00953	99	Rest of Michigan	0.976
00836	99	Rest of Washington	0.973
00740	02	Metropolitan St. Louis, MO	0.971
00883	00	Ohio	0.969
00954	00	Minnesota	0.967
00865	99	Rest of Pennsylvania	0.956
31145	50	Vermont	0.953
00904	00	Virginia	0.950
03502	09	Utah	0.948
00900	20	Beaumont, TX	0.946
00801	99	Rest of New York	0.946
00951	00	Wisconsin	0.942
00952	99	Rest of Illinois	0.940
05535	00	North Carolina	0.937
00521	05	New Mexico	0.936
00630	00	Indiana	0.935
00511	99	Rest of Georgia	0.932
00900	99	Rest of Texas	0.931
00835	99	Rest of Oregon	0.930
00884	16	West Virginia	0.926
00528	99	Rest of Louisiana	0.923
05440	35	Tennessee	0.923
00880	01	South Carolina	0.921
00650	00	Kansas *	0.917
00740	04	Kansas *	0.917
31142	99	Rest of Maine	0.915
00660	00	Kentucky	0.912
00510	00	Alabama	0.910
05130	00	Idaho	0.909
03602	21	Wyoming	0.907
00826	00	Iowa	0.906
00512	00	Mississippi	0.903
00655	00	Nebraska	0.902
03202	01	Montana	0.898
00522	00	Oklahoma	0.898
00740	99	Rest of Missouri *	0.890
03402	02	South Dakota	0.890
00523	99	Rest of Missouri *	0.889
03302	01	North Dakota	0.888
00520	13	Arkansas	0.888
00973	20	Puerto Rico	0.789

ADDENDUM E.—2008 *** GEOGRAPHIC PRACTICE COST INDICES BY STATE AND MEDICARE LOCALITY

Carrier	Locality	Locality name	2008 budget neutral GPCIs		
			Work	PE	MP
00510	00	Alabama	0.982	0.850	0.617
00831	01	Alaska	1.018	1.097	0.828
03102	00	Arizona	0.987	0.975	0.936
00520	13	Arkansas	0.961	0.839	0.439
31146	26	Anaheim/Santa Ana, CA	1.034	1.254	0.875
31146	18	Los Angeles, CA	1.041	1.192	0.871
31140	03	Marin/Napa/Solano, CA	1.035	1.304	0.535
31140	07	Oakland/Berkley, CA	1.054	1.330	0.532
31140	05	San Francisco, CA	1.060	1.494	0.526
31140	06	San Mateo, CA	1.073	1.486	0.511
31140	09	Santa Clara, CA	1.083	1.419	0.485
31146	17	Ventura, CA	1.028	1.223	0.749
31140	99	Rest of California *	1.008	1.056	0.634
31146	99	Rest of California *	.008	1.056	0.634
00824	01	Colorado	0.986	1.003	0.715
00591	00	Connecticut	1.038	1.179	0.934
00903	01	DC + MD/VA Suburbs	1.048	1.235	0.972
00902	01	Delaware	1.012	1.033	0.777
00590	03	Fort Lauderdale, FL	0.988	1.004	1.965
00590	04	Miami, FL	1.001	1.058	2.705
00590	99	Rest of Florida	0.973	0.937	1.490
00511	01	Atlanta, GA	1.010	1.052	0.893
00511	99	Rest of Georgia	0.979	0.879	0.889
00833	01	Hawaii/Guam	0.990	1.137	0.726
05130	00	Idaho	0.967	0.876	0.499
00952	16	Chicago, IL	1.025	1.104	1.889
00952	12	East St. Louis, IL	0.988	0.929	1.758
00952	15	Suburban Chicago, IL	1.018	1.092	1.628
00952	99	Rest of Illinois	0.974	0.877	1.197
00630	00	Indiana	0.985	0.913	0.515
00826	00	Iowa	0.966	0.870	0.506
00650	00	Kansas *	0.968	0.881	0.633
00740	04	Kansas *	0.968	0.881	0.633
00660	00	Kentucky	0.969	0.858	0.755
00528	01	New Orleans, LA	0.986	0.995	1.066
00528	99	Rest of Louisiana	0.970	0.863	0.966
31142	03	Southern Maine	0.980	1.019	0.558
31142	99	Rest of Maine	0.962	0.890	0.558
00901	01	Baltimore/Surr. Cntys, MD	1.013	1.068	1.010
00901	99	Rest of Maryland	0.993	0.981	0.812
31143	01	Metropolitan Boston	1.030	1.311	0.787
31143	99	Rest of Massachusetts	1.008	1.105	0.787
00953	01	Detroit, MI	1.037	1.048	2.300
00953	99	Rest of Michigan	0.998	0.922	1.287
00954	00	Minnesota	0.991	0.994	0.324
00512	00	Mississippi	0.959	0.848	0.760
00523	01	Metropolitan Kansas City, MO	0.989	0.961	1.061
00740	02	Metropolitan St. Louis, MO	0.992	0.943	1.001
00523	99	Rest of Missouri *	0.950	0.812	0.938
00740	99	Rest of Missouri *	0.951	0.812	0.938
03202	01	Montana	0.950	0.846	0.781
00655	00	Nebraska	0.959	0.883	0.345
00834	00	Nevada	1.003	1.035	1.067
31144	40	New Hampshire	0.981	1.034	0.693
00805	01	Northern NJ	1.058	1.225	1.038
00805	99	Rest of New Jersey	1.043	1.124	1.038
00521	05	New Mexico	0.972	0.889	0.989
00803	01	Manhattan, NY	1.065	1.299	1.243
00803	02	NYC Suburbs/Long I., NY	1.052	1.286	1.494
00803	03	Poughkpsie/N NYC Suburbs, NY	1.015	1.076	0.984
14330	04	Queens, NY	1.032	1.235	1.450
00801	99	Rest of New York	0.997	0.920	0.544
05535	00	North Carolina	0.971	0.923	0.632
03302	01	North Dakota	0.946	0.853	0.489
00883	00	Ohio	0.992	0.930	1.097
00522	00	Oklahoma	0.964	0.853	0.503
00835	01	Portland, OR	1.003	1.037	0.453
00835	99	Rest of Oregon	0.968	0.927	0.453
00865	01	Metropolitan Philadelphia, PA	1.017	1.101	1.492

ADDENDUM E.—2008 *** GEOGRAPHIC PRACTICE COST INDICES BY STATE AND MEDICARE LOCALITY—Continued

Carrier	Locality	Locality name	2008 budget neutral GPCIs		
			Work	PE	MP
00865	99	Rest of Pennsylvania	0.992	0.914	0.938
00973	20	Puerto Rico	0.905	0.697	0.253
00524	01	Rhode Island	1.029	1.039	0.946
00880	01	South Carolina	0.975	0.900	0.418
03402	02	South Dakota	0.942	0.871	0.390
05440	35	Tennessee	0.977	0.885	0.614
00900	31	Austin, TX	0.991	1.015	0.970
00900	20	Beaumont, TX	0.983	0.869	1.312
00900	09	Brazoria, TX	1.020	0.942	1.250
00900	11	Dallas, TX	1.010	1.032	1.078
00900	28	Fort Worth, TX	0.998	0.972	1.078
00900	15	Galveston, TX	0.990	0.956	1.250
00900	18	Houston, TX	1,017	1.000	1.311
00900	99	Rest of Texas	0.968	0.873	1.092
03502	09	Utah	0.977	0.922	0.841
31145	50	Vermont	0.968	0.976	0.497
00904	00	Virginia	0.981	0.942	0.613
00973	50	Virgin Islands	0.982	0.996	0.998
00836	02	Seattle (King Cnty), WA	1.015	1.109	0.755
00836	99	Rest of Washington	0.987	0.977	0.749
00884	16	West Virginia	0.973	0.824	1.437
00951	00	Wisconsin	0.987	0.920	0.592
03602	21	Wyoming	0.956	0.849	0.905

* Indicates multiple carriers.
** Transition value for work GPCI does not reflect the 2007 1.000 floor.
*** 2008 GPCIs are the first year of the update transition.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)

HCPCS/ CPT *	Short descriptor
31620	Endobronchial us add-on.
37250	Iv us first vessel add-on.
37251	Iv us each add vessel add-on.
51798	Us urine capacity measure.
70010	Contrast x-ray of brain.
70015	Contrast x-ray of brain.
70030	X-ray eye for foreign body.
70100	X-ray exam of jaw.
70110	X-ray exam of jaw.
70120	X-ray exam of mastoids.
70130	X-ray exam of mastoids.
70134	X-ray exam of middle ear.
70140	X-ray exam of facial bones.
70150	X-ray exam of facial bones.
70160	X-ray exam of nasal bones.
70170	X-ray exam of tear duct.
70190	X-ray exam of eye sockets.
70200	X-ray exam of eye sockets.
70210	X-ray exam of sinuses.
70220	X-ray exam of sinuses.
70240	X-ray exam, pituitary saddle.
70250	X-ray exam of skull.
70260	X-ray exam of skull.
70300	X-ray exam of teeth.
70310	X-ray exam of teeth.
70320	Full mouth x-ray of teeth.
70328	X-ray exam of jaw joint.
70330	X-ray exam of jaw joints.
70332	X-ray exam of jaw joint.
70336	Magnetic image, jaw joint.
70350	X-ray head for orthodontia.
70355	Panoramic x-ray of jaws.
70360	X-ray exam of neck.
70370	Throat x-ray & fluoroscopy.
70371	Speech evaluation, complex.
70373	Contrast x-ray of larynx.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
70380	X-ray exam of salivary gland.
70390	X-ray exam of salivary duct.
70450	Ct head/brain w/o dye.
70460	Ct head/brain w/dye.
70470	Ct head/brain w/o & w/dye.
70480	Ct orbit/ear/fossa w/o dye.
70481	Ct orbit/ear/fossa w/dye.
70482	Ct orbit/ear/fossa w/o & w/dye.
70486	Ct maxillofacial w/o dye.
70487	Ct maxillofacial w/dye.
70488	Ct maxillofacial w/o & w/dye.
70490	Ct soft tissue neck w/o dye.
70491	Ct soft tissue neck w/dye.
70492	Ct sft tsue nck w/o & w/dye.
70496	Ct angiography, head.
70498	Ct angiography, neck.
70540	Mri orbit/face/neck w/o dye.
70542	Mri orbit/face/neck w/dye.
70543	Mri orbt/fac/nck w/o & w/dye.
70544	Mr angiography head w/o dye.
70545	Mr angiography head w/dye.
70546	Mr angiograph head w/o & w/ dye.
70547	Mr angiography neck w/o dye.
70548	Mr angiography neck w/dye.
70549	Mr angiograph neck w/o & w/ dye.
70551	Mri brain w/o dye.
70552	Mri brain w/dye.
70553	Mri brain w/o & w/dye.
70557	Mri brain w/o dye.
70558	Mri brain w/dye.
70559	Mri brain w/o & w/dye.
71010	Chest x-ray.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
71015	Chest x-ray.
71020	Chest x-ray.
71021	Chest x-ray.
71022	Chest x-ray.
71023	Chest x-ray and fluoroscopy.
71030	Chest x-ray.
71034	Chest x-ray and fluoroscopy.
71035	Chest x-ray.
71040	Contrast x-ray of bronchi.
71060	Contrast x-ray of bronchi.
71090	X-ray & pacemaker insertion.
71100	X-ray exam of ribs.
71101	X-ray exam of ribs/chest.
71110	X-ray exam of ribs.
71111	X-ray exam of ribs/chest.
71120	X-ray exam of breastbone.
71130	X-ray exam of breastbone.
71250	Ct thorax w/o dye.
71260	Ct thorax w/dye.
71270	Ct thorax w/o & w/dye.
71275	Ct angiography, chest.
71550	Mri chest w/o dye.
71551	Mri chest w/dye.
71552	Mri chest w/o & w/dye.
71555	Mri angio chest w/ or w/o dye.
72010	X-ray exam of spine.
72020	X-ray exam of spine.
72040	X-ray exam of neck spine.
72050	X-ray exam of neck spine.
72052	X-ray exam of neck spine.
72069	X-ray exam of trunk spine.
72070	X-ray exam of thoracic spine.
72072	X-ray exam of thoracic spine.
72074	X-ray exam of thoracic spine.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/CPT*	Short descriptor
72080	X-ray exam of trunk spine.
72090	X-ray exam of trunk spine.
72100	X-ray exam of lower spine.
72110	X-ray exam of lower spine.
72114	X-ray exam of lower spine.
72120	X-ray exam of lower spine.
72125	Ct neck spine w/o dye.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/dye.
72128	Ct chest spine w/o dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/dye.
72131	Ct lumbar spine w/o dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/dye.
72141	Mri neck spine w/o dye.
72142	Mri neck spine w/dye.
72146	Mri chest spine w/o dye.
72147	Mri chest spine w/dye.
72148	Mri lumbar spine w/o dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye.
72159	Mr angio spine w/o & w/dye.
72170	X-ray exam of pelvis.
72190	X-ray exam of pelvis.
72191	Ct angiograph pelv w/o & w/ dye.
72192	Ct pelvis w/o dye.
72193	Ct pelvis w/dye.
72194	Ct pelvis w/o & w/dye.
72195	Mri pelvis w/o dye.
72196	Mri pelvis w/dye.
72197	Mri pelvis w/o & w/dye.
72198	Mr angio pelvis w/o & w/dye.
72200	X-ray exam sacroiliac joints.
72202	X-ray exam sacroiliac joints.
72220	X-ray exam of tailbone.
72240	Contrast x-ray of neck spine.
72255	Contrast x-ray, thorax spine.
72265	Contrast x-ray, lower spine.
72270	Contrast x-ray, spine.
72275	Epidurography.
72285	X-ray c/t spine disk.
72291	Percut vertebroplasty fluor.
72293	Percut vertebroplasty, ct.
72295	X-ray of lower spine disk.
73000	X-ray exam of collar bone.
73010	X-ray exam of shoulder blade.
73020	X-ray exam of shoulder.
73030	X-ray exam of shoulder.
73040	Contrast x-ray of shoulder.
73050	X-ray exam of shoulders.
73060	X-ray exam of humerus.
73070	X-ray exam of elbow.
73080	X-ray exam of elbow.
73085	Contrast x-ray of elbow.
73090	X-ray exam of forearm.
73092	X-ray exam of arm, infant.
73100	X-ray exam of wrist.
73110	X-ray exam of wrist.
73115	Contrast x-ray of wrist.
73120	X-ray exam of hand.
73130	X-ray exam of hand.
73140	X-ray exam of finger(s).
73200	Ct upper extremity w/o dye.
73201	Ct upper extremity w/dye.
73202	Ct uppr extremity w/o & w/dye.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/CPT*	Short descriptor
73206	Ct angio upr extrm w/o & w/dye.
73218	Mri upper extremity w/o dye.
73219	Mri upper extremity w/dye.
73220	Mri uppr extremity w/o & w/dye.
73221	Mri joint upr extrem w/o dye.
73222	Mri joint upr extrem w/dye.
73223	Mri joint upr extr w/o & w/dye.
73225	Mr angio upr extr w/o & w/dye.
73500	X-ray exam of hip.
73510	X-ray exam of hip.
73520	X-ray exam of hips.
73525	Contrast x-ray of hip.
73530	X-ray exam of hip.
73540	X-ray exam of pelvis & hips.
73542	X-ray exam, sacroiliac joint.
73550	X-ray exam of thigh.
73560	X-ray exam of knee, 1 or 2.
73562	X-ray exam of knee, 3.
73564	X-ray exam, knee, 4 or more.
73565	X-ray exam of knees.
73580	Contrast x-ray of knee joint.
73590	X-ray exam of lower leg.
73592	X-ray exam of leg, infant.
73600	X-ray exam of ankle.
73610	X-ray exam of ankle.
73615	Contrast x-ray of ankle.
73620	X-ray exam of foot.
73630	X-ray exam of foot.
73650	X-ray exam of heel.
73660	X-ray exam of toe(s).
73700	Ct lower extremity w/o dye.
73701	Ct lower extremity w/dye.
73702	Ct lwr extremity w/o & w/dye.
73706	Ct angio lwr extr w/o & w/dye.
73718	Mri lower extremity w/o dye.
73719	Mri lower extremity w/dye.
73720	Mri lwr extremity w/o & w/dye.
73721	Mri jnt of lwr extre w/o dye.
73722	Mri joint of lwr extr w/dye.
73723	Mri joint lwr extr w/o & w/dye.
73725	Mr ang lwr ext w or w/o dye.
74000	X-ray exam of abdomen.
74010	X-ray exam of abdomen.
74020	X-ray exam of abdomen.
74022	X-ray exam series, abdomen.
74150	Ct abdomen w/o dye.
74160	Ct abdomen w/dye.
74170	Ct abdomen w/o & w/dye.
74175	Ct angio abdom w/o & w/dye.
74181	Mri abdomen w/o dye.
74182	Mri abdomen w/dye.
74183	Mri abdomen w/o & w/dye.
74185	Mri angio, abdom w/ or w/o dye.
74190	X-ray exam of peritoneum.
74210	Contrast x-ray exam of throat.
74220	Contrast x-ray, esophagus.
74230	Cine/vid x-ray, throat/esoph.
74235	Remove esophagus obstruction.
74240	X-ray exam, upper gi tract.
74241	X-ray exam, upper gi tract.
74245	X-ray exam, upper gi tract.
74246	Contrast x-ray uppr gi tract.
74247	Contrast x-ray uppr gi tract.
74249	Contrast x-ray uppr gi tract.
74250	X-ray exam of small bowel.
74251	X-ray exam of small bowel.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/CPT*	Short descriptor
74260	X-ray exam of small bowel.
74270	Contrast x-ray exam of colon.
74280	Contrast x-ray exam of colon.
74283	Contrast x-ray exam of colon.
74290	Contrast x-ray, gallbladder.
74291	Contrast x-rays, gallbladder.
74300	X-ray bile ducts/pancreas.
74301	X-rays at surgery add-on.
74305	X-ray bile ducts/pancreas.
74320	Contrast x-ray of bile ducts.
74327	X-ray bile stone removal.
74328	X-ray bile duct endoscopy.
74329	X-ray for pancreas endoscopy.
74330	X-ray bile/panc endoscopy.
74340	X-ray guide for GI tube.
74355	X-ray guide, intestinal tube.
74360	X-ray guide, GI dilation.
74363	X-ray, bile duct dilation.
74400	Contrast x-ray, urinary tract.
74410	Contrast x-ray, urinary tract.
74415	Contrast x-ray, urinary tract.
74420	Contrast x-ray, urinary tract.
74425	Contrast x-ray, urinary tract.
74430	Contrast x-ray, bladder.
74440	X-ray, male genital tract.
74445	X-ray exam of penis.
74450	X-ray, urethra/bladder.
74455	X-ray, urethra/bladder.
74470	X-ray exam of kidney lesion.
74475	X-ray control, cath insert.
74480	X-ray control, cath insert.
74485	X-ray guide, GU dilation.
74710	X-ray measurement of pelvis.
74740	X-ray, female genital tract.
74742	X-ray, fallopian tube.
74775	X-ray exam of perineum.
75557	Cardiac MRI w/o contrast.
75558	Cardiac MRI w/flow/velocity.
75559	Cardiac MRI w/stress imaging.
75560	Cardiac MRI w/flow/velocity/stress.
75561	Cardiac MRI w/ & w/o contrast.
75562	Cardiac MRI w/flow velocity.
75563	Cardiac MRI w/stress imaging.
75564	Cardiac MRI w/flow/velocity/stress.
75600	Contrast x-ray exam of aorta.
75605	Contrast x-ray exam of aorta.
75625	Contrast x-ray exam of aorta.
75630	X-ray aorta, leg arteries.
75635	Ct angio abdominal arteries.
75650	Artery x-rays, head & neck.
75658	Artery x-rays, arm.
75660	Artery x-rays, head & neck.
75662	Artery x-rays, head & neck.
75665	Artery x-rays, head & neck.
75671	Artery x-rays, head & neck.
75676	Artery x-rays, neck.
75680	Artery x-rays, neck.
75685	Artery x-rays, spine.
75705	Artery x-rays, spine.
75710	Artery x-rays, arm/leg.
75716	Artery x-rays, arms/legs.
75722	Artery x-rays, kidney.
75724	Artery x-rays, kidneys.
75726	Artery x-rays, abdomen.
75731	Artery x-rays, adrenal gland.
75733	Artery x-rays, adrenals.
75736	Artery x-rays, pelvis.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
75741	Artery x-rays, lung.
75743	Artery x-rays, lungs.
75746	Artery x-rays, lung.
75756	Artery x-rays, chest.
75774	Artery x-ray, each vessel.
75790	Visualize A–V shunt.
75801	Lymph vessel x-ray, arm/leg.
75803	Lymph vessel x-ray, arms/legs.
75805	Lymph vessel x-ray, trunk.
75807	Lymph vessel x-ray, trunk.
75809	Nonvascular shunt, x-ray.
75810	Vein x-ray, spleen/liver.
75820	Vein x-ray, arm/leg.
75822	Vein x-ray, arms/legs.
75825	Vein x-ray, trunk.
75827	Vein x-ray, chest.
75831	Vein x-ray, kidney.
75833	Vein x-ray, kidneys.
75840	Vein x-ray, adrenal gland.
75842	Vein x-ray, adrenal glands.
75860	Vein x-ray, neck.
75870	Vein x-ray, skull.
75872	Vein x-ray, skull.
75880	Vein x-ray, eye socket.
75885	Vein x-ray, liver.
75887	Vein x-ray, liver.
75889	Vein x-ray, liver.
75891	Vein x-ray, liver.
75893	Venous sampling by catheter.
75894	X-rays, transcath therapy.
75896	X-rays, transcath therapy.
75898	Follow-up angiography.
75900	Intravascular cath exchange.
75901	Remove cva device obstruct.
75902	Remove cva lumen obstruct.
75940	X-ray placement, vein filter.
75945	Intravascular us.
75946	Intravascular us add-on.
75953	Abdom aneurysm endovas rpr.
75956	X-ray, endovasc thor ao repr.
75957	X-ray, endovasc thor ao repr.
75958	X-ray, place prox ext thor ao.
75959	X-ray, place dist ext thor ao.
75960	Transcath iv stent rs&i.
75961	Retrieval, broken catheter.
75962	Repair arterial blockage.
75964	Repair artery blockage, each.
75966	Repair arterial blockage.
75968	Repair artery blockage, each.
75970	Vascular biopsy.
75978	Repair venous blockage.
75980	Contrast x-ray exam bile duct.
75982	Contrast x-ray exam bile duct.
75984	X-ray control catheter change.
75989	Abscess drainage under x-ray.
75992	Atherectomy, x-ray exam.
76000	Fluoroscope examination.
76001	Fluoroscope exam, extensive.
76010	X-ray, nose to rectum.
76080	X-ray exam of fistula.
76098	X-ray exam, breast specimen.
76100	X-ray exam of body section.
76101	Complex body section x-ray.
76102	Complex body section x-rays.
76120	Cine/video x-rays.
76125	Cine/video x-rays add-on.
76140	X-ray consultation.
76150	X-ray exam, dry process.
76350	Special x-ray contrast study.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
76376	3d render w/o postprocess.
76377	3d rendering w/postprocess.
76380	CAT scan follow-up study.
76390	Mr spectroscopy.
76496	Fluoroscopic procedure.
76497	Ct procedure.
76498	Mri procedure.
76506	Echo exam of head.
76510	Ophth us, b & quant a.
76511	Ophth us, quant a only.
76512	Ophth us, b w/non-quant a.
76513	Echo exam of eye, water bath.
76514	Echo exam of eye, thickness.
76516	Echo exam of eye.
76519	Echo exam of eye.
76529	Echo exam of eye.
76536	Us exam of head and neck.
76604	Us exam, chest, b-scan.
76645	Us exam, breast(s).
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76778	Us exam kidney transplant.
76800	Us exam, spinal canal.
76801	Ob us < 14 wks, single fetus.
76802	Ob us < 14 wks, addl fetus.
76805	Ob us > 14 wks, sngl fetus.
76810	Ob us > 14 wks, addl fetus.
76811	Ob us, detailed, sngl fetus.
76812	Ob us, detailed, addl fetus.
76815	Ob us, limited, fetus(s).
76816	Ob us, follow-up, per fetus.
76817	Transvaginal us, obstetric.
76818	Fetal biophys profile w/nst.
76819	Fetal biophys profil w/o nst.
76820	Umbilical artery echo.
76821	Middle cerebral artery echo.
76825	Echo exam of fetal heart.
76826	Echo exam of fetal heart.
76827	Echo exam of fetal heart.
76828	Echo exam of fetal heart.
76830	Transvaginal us, non-ob.
76831	Echo exam, uterus.
76856	Us exam, pelvic, complete.
76857	Us exam, pelvic, limited.
76870	Us exam, scrotum.
76872	Us, transrectal.
76873	Echograp trans r, pros study.
76880	Us exam, extremity.
76885	Us exam infant hips, dynamic.
76886	Us exam infant hips, static.
76930	Echo guide, cardiocentesis.
76932	Echo guide for heart biopsy.
76936	Echo guide for artery repair.
76937	Us guide, vascular access.
76940	Us guide, tissue ablation.
76941	Echo guide for transfusion.
76942	Echo guide for biopsy.
76945	Echo guide, villus sampling.
76946	Echo guide for amniocentesis.
76948	Echo guide, ova aspiration.
76950	Echo guidance radiotherapy.
76965	Echo guidance radiotherapy.
76970	Ultrasound exam follow-up.
76975	GI endoscopic ultrasound.
76977	Us bone density measure.
76998	Ultrasound guide intraoper.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
77001	Fluoroguide for vein device.
77002	Needle localization by x-ray.
77003	Fluoroguide for spine inject.
77011	Ct scan for localization.
77012	Ct scan for needle biopsy.
77013	Ct guide for tissue ablation.
77014	Ct scan for therapy guide.
77021	Mr guidance for needle place.
77022	Mri for tissue ablation.
77031	Stereotactic breast biopsy.
77032	X-ray of needle wire, breast.
77053	X-ray of mammary duct.
77054	X-ray of mammary ducts.
77058	Magnetic image, breast.
77059	Magnetic image, both breasts.
77071	X-ray stress view.
77072	X-rays for bone age.
77073	X-rays, bone evaluation.
77074	X-rays, bone survey.
77075	X-rays, bone survey.
77076	X-rays, bone evaluation.
77077	Joint survey, single view.
77078	Ct bone density, axial.
77079	Ct bone density, peripheral.
77080	Dxa bone density, axial.
77081	Dxa bone density/peripheral.
77082	Dxa bone density/v-fracture.
77083	Radiographic absorptiometry.
77084	Magnetic image, bone marrow.
77417	Radiology port film(s).
77421	Stereoscopic x-ray guidance.
78006	Thyroid imaging with uptake.
78007	Thyroid image, mult uptakes.
78010	Thyroid imaging.
78011	Thyroid imaging with flow.
78015	Thyroid met imaging.
78016	Thyroid met imaging/studies.
78018	Thyroid met imaging, body.
78020	Thyroid met uptake.
78070	Parathyroid nuclear imaging.
78075	Adrenal nuclear imaging.
78102	Bone marrow imaging, ltd.
78103	Bone marrow imaging, mult.
78104	Bone marrow imaging, body.
78135	Red cell survival kinetics.
78140	Red cell sequestration.
78185	Spleen imaging.
78190	Platelet survival, kinetics.
78195	Lymph system imaging.
78201	Liver imaging.
78202	Liver imaging with flow.
78205	Liver imaging (3D).
78206	Liver image (3d) with flow.
78215	Liver and spleen imaging.
78216	Liver & spleen image/flow.
78220	Liver function study.
78223	Hepatobiliary imaging.
78230	Salivary gland imaging.
78231	Serial salivary imaging.
78232	Salivary gland function exam.
78258	Esophageal motility study.
78261	Gastric mucosa imaging.
78262	Gastroesophageal reflux exam.
78264	Gastric emptying study.
78278	Acute GI blood loss imaging.
78282	GI protein loss exam.
78290	Meckels divert exam.
78291	Leveen/shunt patency exam.
78300	Bone imaging, limited area.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
78305	Bone imaging, multiple areas.
78306	Bone imaging, whole body.
78315	Bone imaging, 3 phase.
78320	Bone imaging (3D).
78350	Bone mineral, single photon.
78351	Bone mineral, dual photon.
78428	Cardiac shunt imaging.
78445	Vascular flow imaging.
78456	Acute venous thrombus image.
78457	Venous thrombosis imaging.
78458	Ven thrombosis images, bilat.
78459	Heart muscle imaging (PET).
78460	Heart muscle blood, single.
78461	Heart muscle blood, multiple.
78464	Heart image (3d), single.
78465	Heart image (3d), multiple.
78466	Heart infarct image.
78468	Heart infarct image (ef).
78469	Heart infarct image (3D).
78472	Gated heart, planar, single.
78473	Gated heart, multiple.
78478	Heart wall motion add-on.
78480	Heart function add-on.
78481	Heart first pass, single.
78483	Heart first pass, multiple.
78491	Heart image (pet), single.
78492	Heart image (pet), multiple.
78494	Heart image, spect.
78496	Heart first pass add-on.
78580	Lung perfusion imaging.
78584	Lung V/Q image single breath.
78585	Lung V/Q imaging.
78586	Aerosol lung image, single.
78587	Aerosol lung image, multiple.
78588	Perfusion lung image.
78591	Vent image, 1 breath, 1 proj.
78593	Vent image, 1 proj, gas.
78594	Vent image, mult proj, gas.
78596	Lung differential function.
78600	Brain imaging, ltd static.
78601	Brain imaging, ltd w/flow.
78605	Brain imaging, complete.
78606	Brain imaging, compl w/flow.
78607	Brain imaging (3D).
78608	Brain imaging (PET).
78609	Brain imaging (PET).
78610	Brain flow imaging only.
78630	Cerebrospinal fluid scan.
78635	CSF ventriculography.
78645	CSF shunt evaluation.
78647	Cerebrospinal fluid scan.
78650	CSF leakage imaging.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
78660	Nuclear exam of tear flow.
78700	Kidney imaging, static.
78701	Kidney imaging with flow.
78704	Imaging renogram.
78707	Kidney flow/function image.
78708	Kidney flow/function image.
78709	Kidney flow/function image.
78710	Kidney imaging (3D).
78715	Renal vascular flow exam.
78730	Urinary bladder retention.
78740	Ureteral reflux study.
78760	Testicular imaging.
78761	Testicular imaging/flow.
78800	Tumor imaging, limited area.
78801	Tumor imaging, mult areas.
78802	Tumor imaging, whole body.
78803	Tumor imaging (3D).
78804	Tumor imaging, whole body.
78805	Abscess imaging, ltd area.
78806	Abscess imaging, whole body.
78807	Nuclear localization/abscess.
78811	Tumor imaging (pet), limited.
78812	Tumor image (pet)/skul-thigh.
78813	Tumor image (pet) full body.
78814	Tumor image pet/ct, limited.
78815	Tumorimage pet/ct skul-thigh.
78816	Tumor image pet/ct full body.
78890	Nuclear medicine data proc.
78891	Nuclear med data proc.
92135	Scanning computer ophthalmic.
92235	Fluorscein angioscopy.
92240	IDC green angiography.
92250	Fundus photography.
92285	External ocular photography.
92286	Anterior segment photography.
93303	Echo transthoracic.
93304	Echo transthoracic.
93307	Echo exam of heart.
93308	Echo exam of heart.
93312	Echo transesophageal.
93313	Echo transesophageal.
93314	Echo transesophageal.
93315	Echo transesophageal.
93316	Echo transesophageal.
93317	Echo transesophageal.
93318	Echo transesophageal intraop.
93320	Doppler echo exam, heart.
93321	Doppler echo exam, heart.
93325	Doppler color flow add-on.
93350	Echo transthoracic.
93555	Imaging, cardiac cath.
93556	Imaging, cardiac cath.

ADDENDUM F.—CPT/HCPCS IMAGING CODES DEFINED BY DRA 5102(B)—Continued

HCPCS/ CPT *	Short descriptor
93571	Heart flow reserve measure.
93572	Heart flow reserve measure.
93880	Extracranial study.
93882	Extracranial study.
93886	Intracranial study.
93888	Intracranial study.
93890	Tcd, vasoreactivity study.
93892	Tcd, emboli detect w/o inj.
93893	Tcd, emboli detect w/inj.
93925	Lower extremity study.
93926	Lower extremity study.
93930	Upper extremity study.
93931	Upper extremity study.
93970	Extremity study.
93971	Extremity study.
93975	Vascular study.
93976	Vascular study.
93978	Vascular study.
93979	Vascular study.
93980	Penile vascular study.
93981	Penile vascular study.
93990	Doppler flow testing.
0028T	Dexa body composition study.
0042T	Ct perfusion w/contrast, cbf.
0066T	Ct colonography; screen.
0067T	Ct colonography; dx.
0080T	Endovasc aort repr rad s&i.
0081T	Endovasc visc extnsn s&i.
0144T	CT heart wo dye; qual calc.
0145T	CT heart w/wo dye funct.
0146T	CCTA w/wo dye.
0147T	CCTA w/wo, quan calcium.
0148T	CCTA w/wo, strxr.
0149T	CCTA w/wo, strxr quan calc.
0150T	CCTA w/wo, disease strxr.
0151T	CT heart funct add-on.
0152T	Computer chest add-on.
G0120	Colon ca scrn; barium enema.
G0122	Colon ca scrn; barium enema.
G0130	Single energy x-ray study.
G0219	PET img wholbod melano nonco.
G0235	PET not otherwise specified.
G0275	Renal angio, cardiac cath.
G0278	Iliac art angio, cardiac cath.
G0288	Recon, CTA for surg plan.
G0365	Vessel mapping hemo access.

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Applicable FARS/DFARS apply.

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS

CBSA code	Urban area (constituent counties)	Wage index
10180	Abilene, TX	0.8398
	Callahan County, TX.	
	Jones County, TX.	
	Taylor County, TX.	
10380	Aguadilla-Isabela-San Sebastián, PR	0.7916
	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.	
10420	Akron, OH	0.9282
	Portage County, OH.	
	Summit County, OH.	
10500	Albany, GA	0.8986
	Baker County, GA.	
	Dougherty County, GA.	
	Lee County, GA.	
	Terrell County, GA.	
	Worth County, GA.	
10580	Albany-Schenectady-Troy, NY	0.9064
	Albany County, NY.	
	Rensselaer County, NY.	
	Saratoga County, NY.	
	Schenectady County, NY.	
	Schoharie County, NY.	
10740	Albuquerque, NM	1.0084
	Bernalillo County, NM.	
	Sandoval County, NM.	
	Torrance County, NM.	
	Valencia County, NM.	
10780	Alexandria, LA	0.8422
	Grant Parish, LA.	
	Rapides Parish, LA.	
10900	Allentown-Bethlehem-Easton, PA–NJ	1.0412
	Warren County, NJ.	
	Carbon County, PA.	
	Lehigh County, PA.	
	Northampton County, PA.	
11020	Altoona, PA	0.9096
	Blair County, PA.	
11100	Amarillo, TX	0.9622
	Armstrong County, TX.	
	Carson County, TX.	
	Potter County, TX.	
	Randall County, TX.	
11180	Ames, IA	1.0603
	Story County, IA.	
11260	Anchorage, AK	1.2574
	Anchorage Municipality, AK.	
	Matanuska-Susitna Borough, AK.	
11300	Anderson, IN	0.9317
	Madison County, IN.	
11340	Anderson, SC	0.9590
	Anderson County, SC.	
11460	Ann Arbor, MI	1.1124
	Washtenaw County, MI.	
11500	Anniston-Oxford, AL	0.8366
	Calhoun County, AL.	
11540	Appleton, WI	1.0130
	Calumet County, WI.	
	Outagamie County, WI.	
11700	Asheville, NC	0.9695
	Buncombe County, NC.	
	Haywood County, NC.	
	Henderson County, NC.	
	Madison County, NC.	
12020	Athens-Clarke County, GA	1.1100
	Clarke County, GA.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Madison County, GA.	
	Oconee County, GA.	
	Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0373
	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, NJ	1.2875
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.8539
	Lee County, AL.	
12260	Augusta-Richmond County, GA–SC	1.0180
	Burke County, GA.	
	Columbia County, GA.	
	McDuffie County, GA.	
	Richmond County, GA.	
	Aiken County, SC.	
	Edgefield County, SC.	
12420	Austin-Round Rock, TX	1.0073
	Bastrop County, TX.	
	Caldwell County, TX.	
	Hays County, TX.	
	Travis County, TX.	
	Williamson County, TX.	
12540	Bakersfield, CA	1.1664
	Kern County, CA.	
12580	Baltimore-Towson, MD	1.0696
	Anne Arundel County, MD.	
	Baltimore County, MD.	
	Carroll County, MD.	
	Harford County, MD.	
	Howard County, MD.	
	Queen Anne's County, MD.	
	Baltimore City, MD.	
12620	Bangor, ME	1.0532
	Penobscot County, ME.	
12700	Barnstable Town, MA	1.3302
	Barnstable County, MA.	
12940	Baton Rouge, LA	0.8480
	Ascension Parish, LA.	
	East Baton Rouge Parish, LA.	
	East Feliciana Parish, LA.	
	Iberville Parish, LA.	
	Livingston Parish, LA.	
	Pointe Coupee Parish, LA.	
	St. Helena Parish, LA.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	West Baton Rouge Parish, LA.	
	West Feliciana Parish, LA.	
12980	Battle Creek, MI	1.0744
	Calhoun County, MI.	
13020	Bay City, MI	0.9391
	Bay County, MI.	
13140	Beaumont-Port Arthur, TX	0.9004
	Hardin County, TX.	
	Jefferson County, TX.	
	Orange County, TX.	
13380	Bellingham, WA	1.2110
	Whatcom County, WA.	
13460	Bend, OR	1.1549
	Deschutes County, OR.	
13644	Bethesda-Frederick-Gaithersburg, MD	1.1094
	Frederick County, MD.	
	Montgomery County, MD.	
13740	Billings, MT	0.9147
	Carbon County, MT.	
	Yellowstone County, MT.	
13780	Binghamton, NY	0.9445
	Broome County, NY.	
	Tioga County, NY.	
13820	Birmingham-Hoover, AL	0.9392
	Bibb County, AL.	
	Blount County, AL.	
	Chilton County, AL.	
	Jefferson County, AL.	
	St. Clair County, AL.	
	Shelby County, AL.	
	Walker County, AL.	
13900	Bismarck, ND	0.7916
	Burleigh County, ND.	
	Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA	0.8646
	Giles County, VA.	
	Montgomery County, VA.	
	Pulaski County, VA.	
	Radford City, VA.	
14020	Bloomington, IN	0.9410
	Greene County, IN.	
	Monroe County, IN.	
	Owen County, IN.	
14060	Bloomington-Normal, IL	0.9842
	McLean County, IL.	
14260	Boise City-Nampa, ID	0.9990
	Ada County, ID.	
	Boise County, ID.	
	Canyon County, ID.	
	Gem County, ID.	
	Owyhee County, ID.	
14484	Boston-Quincy, MA	1.2285
	Norfolk County, MA.	
	Plymouth County, MA.	
	Suffolk County, MA.	
14500	Boulder, CO	1.1004
	Boulder County, CO.	
14540	Bowling Green, KY	0.8612
	Edmonson County, KY.	
	Warren County, KY.	
14740	Bremerton-Silverdale, WA	1.1509
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT	1.3441
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX	0.9408
	Cameron County, TX.	
15260	Brunswick, GA	1.0001
	Brantley County, GA.	
	Glynn County, GA.	
	McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY	1.0099

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Erie County, NY.	
	Niagara County, NY.	
15500	Burlington, NC	0.9232
	Alamance County, NC.	
15540	Burlington-South Burlington, VT	1.0196
	Chittenden County, VT.	
	Franklin County, VT.	
	Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA	1.1837
	Middlesex County, MA.	
15804	Camden, NJ	1.0989
	Burlington County, NJ.	
	Camden County, NJ.	
	Gloucester County, NJ.	
15940	Canton-Massillon, OH	0.9431
	Carroll County, OH.	
	Stark County, OH.	
15980	Cape Coral-Fort Myers, FL	0.9917
	Lee County, FL.	
16180	Carson City, NV	1.0558
	Carson City, NV.	
16220	Casper, WY	0.9906
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.9343
	Benton County, IA.	
	Jones County, IA.	
	Linn County, IA.	
16580	Champaign-Urbana, IL	0.9913
	Champaign County, IL.	
	Ford County, IL.	
	Piatt County, IL.	
16620	Charleston, WV	0.8749
	Boone County, WV.	
	Clay County, WV.	
	Kanawha County, WV.	
	Lincoln County, WV.	
	Putnam County, WV.	
16700	Charleston-North Charleston, SC	0.9630
	Berkeley County, SC.	
	Charleston County, SC.	
	Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC SC	1.0048
	Anson County, NC.	
	Cabarrus County, NC.	
	Gaston County, NC.	
	Mecklenburg County, NC.	
	Union County, NC.	
	York County, SC.	
16820	Charlottesville, VA	0.9792
	Albemarle County, VA.	
	Fluvanna County, VA.	
	Greene County, VA.	
	Nelson County, VA.	
	Charlottesville City, VA.	
16860	Chattanooga, TN–GA	0.9493
	Catoosa County, GA.	
	Dade County, GA.	
	Walker County, GA.	
	Hamilton County, TN.	
	Marion County, TN.	
	Sequatchie County, TN.	
16940	Cheyenne, WY	0.9824
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL	1.1331
	Cook County, IL.	
	DeKalb County, IL.	
	DuPage County, IL.	
	Grundy County, IL.	
	Kane County, IL.	
	Kendall County, IL.	
	McHenry County, IL.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Will County, IL.	
17020	Chico, CA	1.1916
	Butte County, CA.	
17140	Cincinnati-Middletown, OH–KY–IN	1.0327
	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	0.8709
	Christian County, KY.	
	Trigg County, KY.	
	Montgomery County, TN.	
	Stewart County, TN.	
17420	Cleveland, TN	0.8499
	Bradley County, TN.	
	Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH	0.9857
	Cuyahoga County, OH.	
	Geauga County, OH.	
	Lake County, OH.	
	Lorain County, OH.	
	Medina County, OH.	
17660	Coeur d'Alene, ID	1.0061
	Kootenai County, ID.	
17780	College Station-Bryan, TX	0.9877
	Brazos County, TX.	
	Burleson County, TX.	
	Robertson County, TX.	
17820	Colorado Springs, CO	1.0258
	El Paso County, CO.	
	Teller County, CO.	
17860	Columbia, MO	0.9138
	Boone County, MO.	
	Howard County, MO.	
17900	Columbia, SC	0.9288
	Calhoun County, SC.	
	Fairfield County, SC.	
	Kershaw County, SC.	
	Lexington County, SC.	
	Richland County, SC.	
	Saluda County, SC.	
17980	Columbus, GA–AL	0.9213
	Russell County, AL.	
	Chattahoochee County, GA.	
	Harris County, GA.	
	Marion County, GA.	
	Muscogee County, GA.	
18020	Columbus, IN	1.0066
	Bartholomew County, IN.	
18140	Columbus, OH	1.0644
	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	0.9064
	Aransas County, TX.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Nueces County, TX.	
	San Patricio County, TX.	
18700	Corvallis, OR	1.1567
	Benton County, OR.	
19060	Cumberland, MD–WV	0.8754
	Allegany County, MD.	
	Mineral County, WV.	
19124	Dallas-Plano-Irving, TX	1.0465
	Collin County, TX.	
	Dallas County, TX.	
	Delta County, TX.	
	Denton County, TX.	
	Ellis County, TX.	
	Hunt County, TX.	
	Kaufman County, TX.	
	Rockwall County, TX.	
19140	Dalton, GA	0.9246
	Murray County, GA.	
	Whitfield County, GA.	
19180	Danville, IL	0.9454
	Vermilion County, IL.	
19260	Danville, VA	0.8697
	Pittsylvania County, VA.	
	Danville City, VA.	
19340	Davenport-Moline-Rock Island, IA–IL	0.9320
	Henry County, IL.	
	Mercer County, IL.	
	Rock Island County, IL.	
	Scott County, IA.	
19380	Dayton, OH	0.9700
	Greene County, OH.	
	Miami County, OH.	
	Montgomery County, OH.	
	Preble County, OH.	
19460	Decatur, AL	0.8322
	Lawrence County, AL.	
	Morgan County, AL.	
19500	Decatur, IL	0.8522
	Macon County, IL.	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9532
	Volusia County, FL.	
19740	Denver-Aurora, CO	1.1313
	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.	
19780	Des Moines-West Des Moines, IA	0.9738
	Dallas County, IA.	
	Guthrie County, IA.	
	Madison County, IA.	
	Polk County, IA.	
	Warren County, IA.	
19804	Detroit-Livonia-Dearborn, MI	1.0554
	Wayne County, MI.	
20020	Dothan, AL	0.7916
	Geneva County, AL.	
	Henry County, AL.	
	Houston County, AL.	
20100	Dover, DE	1.0659
	Kent County, DE.	
20220	Dubuque, IA	0.9560
	Dubuque County, IA.	
20260	Duluth, MN–WI	1.0528
	Carlton County, MN.	
	St. Louis County, MN.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Douglas County, WI.	
20500	Durham, NC	1.0361
	Chatham County, NC.	
	Durham County, NC.	
	Orange County, NC.	
	Person County, NC.	
20740	Eau Claire, WI	1.0001
	Chippewa County, WI.	
	Eau Claire County, WI.	
20764	Edison, NJ	1.1801
	Middlesex County, NJ.	
	Monmouth County, NJ.	
	Ocean County, NJ.	
	Somerset County, NJ.	
20940	El Centro, CA	0.9408
	Imperial County, CA.	
21060	Elizabethtown, KY	0.9194
	Hardin County, KY.	
	Larue County, KY.	
21140	Elkhart-Goshen, IN	1.0144
	Elkhart County, IN.	
21300	Elmira, NY	0.8722
	Chemung County, NY.	
21340	El Paso, TX	0.9488
	El Paso County, TX.	
21500	Erie, PA	0.8966
	Erie County, PA.	
21660	Eugene-Springfield, OR	1.1538
	Lane County, OR.	
21780	Evansville, IN–KY	0.9143
	Gibson County, IN.	
	Posey County, IN.	
	Vanderburgh County, IN.	
	Warrick County, IN.	
	Henderson County, KY.	
	Webster County, KY.	
21820	Fairbanks, AK	1.1663
	Fairbanks North Star Borough, AK.	
21940	Fajardo, PR	0.7916
	Ceiba Municipio, PR.	
	Fajardo Municipio, PR.	
	Luquillo Municipio, PR.	
22020	Fargo, ND–MN	0.8488
	Cass County, ND.	
	Clay County, MN.	
22140	Farmington, NM	1.0119
	San Juan County, NM.	
22180	Fayetteville, NC	0.9888
	Cumberland County, NC.	
	Hoke County, NC.	
22220	Fayetteville-Springdale-Rogers, AR–MO	0.9227
	Benton County, AR.	
	Madison County, AR.	
	Washington County, AR.	
	McDonald County, MO.	
22380	Flagstaff, AZ	1.2335
	Coconino County, AZ.	
22420	Flint, MI	1.1842
	Genesee County, MI.	
22500	Florence, SC	0.8707
	Darlington County, SC.	
	Florence County, SC.	
22520	Florence-Muscle Shoals, AL	0.8106
	Colbert County, AL.	
	Lauderdale County, AL.	
22540	Fond du Lac, WI	1.0203
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO	1.0446
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0796
	Broward County, FL.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
22900	Fort Smith, AR–OK	0.8373
	Crawford County, AR.	
	Franklin County, AR.	
	Sebastian County, AR.	
	Le Flore County, OK.	
	Sequoyah County, OK.	
23020	Fort Walton Beach-Crestview-Destin, FL	0.9228
	Okaloosa County, FL.	
23060	Fort Wayne, IN	0.9799
	Allen County, IN.	
	Wells County, IN.	
	Whitley County, IN.	
23104	Fort Worth-Arlington, TX	1.0231
	Johnson County, TX.	
	Parker County, TX.	
	Tarrant County, TX.	
	Wise County, TX.	
23420	Fresno, CA	1.1603
	Fresno County, CA.	
23460	Gadsden, AL	0.8612
	Etowah County, AL.	
23540	Gainesville, FL	0.9706
	Alachua County, FL.	
	Gilchrist County, FL.	
23580	Gainesville, GA	0.9727
	Hall County, GA.	
23844	Gary, IN	0.9736
	Jasper County, IN.	
	Lake County, IN.	
	Newton County, IN.	
	Porter County, IN.	
24020	Glens Falls, NY	0.8714
	Warren County, NY.	
	Washington County, NY.	
24140	Goldsboro, NC	0.9803
	Wayne County, NC.	
24220	Grand Forks, ND–MN	0.8318
	Polk County, MN.	
	Grand Forks County, ND.	
24300	Grand Junction, CO	1.0411
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI	0.9832
	Barry County, MI.	
	Ionia County, MI.	
	Kent County, MI.	
	Newaygo County, MI.	
24500	Great Falls, MT	0.9156
	Cascade County, MT.	
24540	Greeley, CO	1.0194
	Weld County, CO.	
24580	Green Bay, WI	1.0267
	Brown County, WI.	
	Kewaunee County, WI.	
	Oconto County, WI.	
24660	Greensboro-High Point, NC	0.9510
	Guilford County, NC.	
	Randolph County, NC.	
	Rockingham County, NC.	
24780	Greenville, NC	0.9924
	Greene County, NC.	
	Pitt County, NC.	
24860	Greenville-Maudlin-Easley, SC	1.0407
	Greenville County, SC.	
	Laurens County, SC.	
	Pickens County, SC.	
25020	Guayama, PR	0.7916
	Arroyo Municipio, PR.	
	Guayama Municipio, PR.	
	Patillas Municipio, PR.	
25060	Gulfport-Biloxi, MS	0.9260
	Hancock County, MS.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Harrison County, MS.	
	Stone County, MS.	
25180	Hagerstown-Martinsburg, MD–WV	0.9513
	Washington County, MD.	
	Berkeley County, WV.	
	Morgan County, WV.	
25260	Hanford-Corcoran, CA	1.1081
	Kings County, CA.	
25420	Harrisburg-Carlisle, PA	0.9795
	Cumberland County, PA.	
	Dauphin County, PA.	
	Perry County, PA.	
25500	Harrisonburg, VA	0.9359
	Rockingham County, VA.	
	Harrisonburg City, VA.	
25540	Hartford-West Hartford-East Hartford, CT	1.1536
	Hartford County, CT.	
	Litchfield County, CT.	
	Middlesex County, CT.	
	Tolland County, CT.	
25620	Hattiesburg, MS	0.7916
	Forrest County, MS.	
	Lamar County, MS.	
	Perry County, MS.	
25860	Hickory-Lenoir-Morganton, NC	0.9529
	Alexander County, NC.	
	Burke County, NC.	
	Caldwell County, NC.	
	Catawba County, NC.	
25980	Hinesville-Fort Stewart, GA [3]	0.9697
	Liberty County, GA.	
	Long County, GA.	
26100	Holland-Grand Haven, MI	0.9506
	Ottawa County, MI.	
26180	Honolulu, HI	1.2197
	Honolulu County, HI.	
26300	Hot Springs, AR	0.9614
	Garland County, AR.	
26380	Houma-Bayou Cane-Thibodaux, LA	0.8330
	Lafourche Parish, LA.	
	Terrebonne Parish, LA.	
26420	Houston-Sugar Land-Baytown, TX	1.0490
	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.	
26580	Huntington-Ashland, WV–KY–OH	0.9543
	Boyd County, KY.	
	Greenup County, KY.	
	Lawrence County, OH.	
	Cabell County, WV.	
	Wayne County, WV.	
26620	Huntsville, AL	0.9653
	Limestone County, AL.	
	Madison County, AL.	
26820	Idaho Falls, ID	0.9778
	Bonneville County, ID.	
	Jefferson County, ID.	
26900	Indianapolis-Carmel, IN	1.0390
	Boone County, IN.	
	Brown County, IN.	
	Hamilton County, IN.	
	Hancock County, IN.	
	Hendricks County, IN.	
	Johnson County, IN.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Marion County, IN.	
	Morgan County, IN.	
	Putnam County, IN.	
	Shelby County, IN.	
26980	Iowa City, IA	1.0099
	Johnson County, IA.	
	Washington County, IA.	
27060	Ithaca, NY	1.0164
	Tompkins County, NY.	
27100	Jackson, MI	0.9847
	Jackson County, MI.	
27140	Jackson, MS	0.8455
	Copiah County, MS.	
	Hinds County, MS.	
	Madison County, MS.	
	Rankin County, MS.	
	Simpson County, MS.	
27180	Jackson, TN	0.9157
	Chester County, TN.	
	Madison County, TN.	
27260	Jacksonville, FL	0.9521
	Baker County, FL.	
	Clay County, FL.	
	Duval County, FL.	
	Nassau County, FL.	
	St. Johns County, FL.	
27340	Jacksonville, NC	0.8527
	Onslow County, NC.	
27500	Janesville, WI	1.0240
	Rock County, WI.	
27620	Jefferson City, MO	0.8948
	Callaway County, MO.	
	Cole County, MO.	
	Moniteau County, MO.	
	Osage County, MO.	
27740	Johnson City, TN	0.8103
	Carter County, TN.	
	Unicoi County, TN.	
	Washington County, TN.	
27780	Johnstown, PA	0.7961
	Cambria County, PA.	
27860	Jonesboro, AR	0.8222
	Craighead County, AR.	
	Poinsett County, AR.	
27900	Joplin, MO	0.9448
	Jasper County, MO.	
	Newton County, MO.	
28020	Kalamazoo-Portage, MI	1.1012
	Kalamazoo County, MI.	
	Van Buren County, MI.	
28100	Kankakee-Bradley, IL	1.0806
	Kankakee County, IL.	
28140	Kansas City, MO–KS	1.0031
	Franklin County, KS.	
	Johnson County, KS.	
	Leavenworth County, KS.	
	Linn County, KS.	
	Miami County, KS.	
	Wyandotte County, KS.	
	Bates County, MO.	
	Caldwell County, MO.	
	Cass County, MO.	
	Clay County, MO.	
	Clinton County, MO.	
	Jackson County, MO.	
	Lafayette County, MO.	
	Platte County, MO.	
	Ray County, MO.	
28420	Kennewick-Richland-Pasco, WA	1.0634
	Benton County, WA.	
	Franklin County, WA.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
28660	Killeen-Temple-Fort Hood, TX	0.8707
	Bell County, TX.	
	Coryell County, TX.	
	Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN–VA	0.8083
	Hawkins County, TN.	
	Sullivan County, TN.	
	Bristol City, VA.	
	Scott County, VA.	
	Washington County, VA.	
28740	Kingston, NY	1.0086
	Ulster County, NY.	
28940	Knoxville, TN	0.8482
	Anderson County, TN.	
	Blount County, TN.	
	Knox County, TN.	
	Loudon County, TN.	
	Union County, TN.	
29020	Kokomo, IN	1.0123
	Howard County, IN.	
	Tipton County, IN.	
29100	La Crosse, WI–MN	1.0222
	Houston County, MN.	
	La Crosse County, WI.	
29140	Lafayette, IN	0.9361
	Benton County, IN.	
	Carroll County, IN.	
	Tippecanoe County, IN.	
29180	Lafayette, LA	0.8704
	Lafayette Parish, LA.	
	St. Martin Parish, LA.	
29340	Lake Charles, LA	0.8208
	Calcasieu Parish, LA.	
	Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL–WI	1.0887
	Lake County, IL.	
	Kenosha County, WI.	
29420	Lake Havasu City—Kingman, AZ	0.9851
	Mohave, County, AZ.	
29460	Lakeland, FL	0.9141
	Polk County, FL.	
29540	Lancaster, PA	0.9765
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI	1.0680
	Clinton County, MI.	
	Eaton County, MI.	
	Ingham County, MI.	
29700	Laredo, TX	0.8542
	Webb County, TX.	
29740	Las Cruces, NM	0.9157
	Dona Ana County, NM.	
29820	Las Vegas-Paradise, NV	1.2454
	Clark County, NV.	
29940	Lawrence, KS	0.8683
	Douglas County, KS.	
30020	Lawton, OK	0.8470
	Comanche County, OK.	
30140	Lebanon, PA	0.8646
	Lebanon County, PA.	
30300	Lewiston, ID–WA	0.9978
	Nez Perce County, ID.	
	Asotin County, WA.	
30340	Lewiston-Auburn, ME	0.9703
	Androscoggin County, ME.	
30460	Lexington-Fayette, KY	0.9701
	Bourbon County, KY.	
	Clark County, KY.	
	Fayette County, KY.	
	Jessamine County, KY.	
	Scott County, KY.	
	Woodford County, KY.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
30620	Lima, OH	0.9947
	Allen County, OH.	
30700	Lincoln, NE	1.0609
	Lancaster County, NE.	
	Seward County, NE.	
30780	Little Rock-North Little Rock-Conway, AR	0.9355
	Faulkner County, AR.	
	Grant County, AR.	
	Lonoke County, AR.	
	Perry County, AR.	
	Pulaski County, AR.	
	Saline County, AR.	
30860	Logan, UT–ID	0.9692
	Franklin County, ID.	
	Cache County, UT.	
30980	Longview, TX	0.9201
	Gregg County, TX.	
	Rusk County, TX.	
	Upshur County, TX.	
31020	Longview, WA	1.1428
	Cowlitz County, WA.	
31084	Los Angeles-Long Beach-Glendale, CA	1.2424
	Los Angeles County, CA.	
31140	Louisville-Jefferson County, KY–IN	0.9568
	Clark County, IN.	
	Floyd County, IN.	
	Harrison County, IN.	
	Washington County, IN.	
	Bullitt County, KY.	
	Henry County, KY.	
	Jefferson County, KY.	
	Meade County, KY.	
	Nelson County, KY.	
	Oldham County, KY.	
	Shelby County, KY.	
	Spencer County, KY.	
	Trimble County, KY.	
31180	Lubbock, TX	0.9162
	Crosby County, TX.	
	Lubbock County, TX.	
31340	Lynchburg, VA	0.9216
	Amherst County, VA.	
	Appomattox County, VA.	
	Bedford County, VA.	
	Campbell County, VA.	
	Bedford City, VA.	
	Lynchburg City, VA.	
31420	Macon, GA	1.0070
	Bibb County, GA.	
	Crawford County, GA.	
	Jones County, GA.	
	Monroe County, GA.	
	Twiggs County, GA.	
31460	Madera, CA	0.8517
	Madera County, CA.	
31540	Madison, WI	1.1542
	Columbia County, WI.	
	Dane County, WI.	
	Iowa County, WI.	
31700	Manchester-Nashua, NH	1.0621
	Hillsborough County, NH.	
	Merrimack County, NH.	
31900	Mansfield, OH [1]	0.9785
	Richland County, OH.	
32420	Mayagüez, PR	0.7916
	Hormigueros Municipio, PR.	
	Mayagüez Municipio, PR.	
32580	McAllen-Edinburg-Mission, TX	0.9629
	Hidalgo County, TX.	
32780	Medford, OR	1.0890
	Jackson County, OR.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
32820	Memphis, TN–MS–AR	0.9763
	Crittenden County, AR.	
	DeSoto County, MS.	
	Marshall County, MS.	
	Tate County, MS.	
	Tunica County, MS.	
	Fayette County, TN.	
	Shelby County, TN.	
	Tipton County, TN.	
32900	Merced, CA	1.2792
	Merced County, CA.	
33124	Miami-Miami Beach-Kendall, FL	1.0557
	Miami-Dade County, FL.	
33140	Michigan City-La Porte, IN	0.9408
	LaPorte County, IN.	
33260	Midland, TX	1.0573
	Midland County, TX.	
33340	Milwaukee-Waukesha-West Allis, WI	1.0781
	Milwaukee County, WI.	
	Ozaukee County, WI.	
	Washington County, WI.	
	Waukesha County, WI.	
33460	Minneapolis-St. Paul-Bloomington, MN–WI	1.1708
	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.	
33540	Missoula, MT	0.9450
	Missoula County, MT.	
33660	Mobile, AL	0.8479
	Mobile County, AL.	
33700	Modesto, CA	1.2626
	Stanislaus County, CA.	
33740	Monroe, LA	0.8266
	Ouachita Parish, LA.	
	Union Parish, LA.	
33780	Monroe, MI	0.9936
	Monroe County, MI.	
33860	Montgomery, AL	0.8537
	Autauga County, AL.	
	Elmore County, AL.	
	Lowndes County, AL.	
	Montgomery County, AL.	
34060	Morgantown, WV	0.8783
	Monongalia County, WV.	
	Preston County, WV.	
34100	Morristown, TN	0.7916
	Grainger County, TN.	
	Hamblen County, TN.	
	Jefferson County, TN.	
34580	Mount Vernon-Anacortes, WA	1.1113
	Skagit County, WA.	
34620	Muncie, IN	0.8670
	Delaware County, IN.	
34740	Muskegon-Norton Shores, MI	1.0382
	Muskegon County, MI.	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9113
	Horry County, SC.	
34900	Napa, CA	1.5279
	Napa County, CA.	
34940	Naples-Marco Island, FL	1.0013
	Collier County, FL.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
34980	Nashville-Davidson-Murfreesboro, TN	1.0226
	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.	
35004	Nassau-Suffolk, NY	1.3341
	Nassau County, NY.	
	Suffolk County, NY.	
35084	Newark-Union, NJ–PA	1.2520
	Essex County, NJ.	
	Hunterdon County, NJ.	
	Morris County, NJ.	
	Sussex County, NJ.	
	Union County, NJ.	
	Pike County, PA.	
35300	New Haven-Milford, CT	1.2530
	New Haven County, CT.	
35380	New Orleans-Metairie-Kenner, LA	0.9391
	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.	
35644	New York-Wayne-White Plains, NY–NJ	1.3843
	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.	
35660	Niles-Benton Harbor, MI	0.9648
	Berrien County, MI.	
35980	Norwich-New London, CT	1.2066
	New London County, CT.	
36084	Oakland-Fremont-Hayward, CA	1.6555
	Alameda County, CA.	
	Contra Costa County, CA.	
36100	Ocala, FL	0.9106
	Marion County, FL.	
36140	Ocean City, NJ	1.1598
	Cape May County, NJ.	
36220	Odessa, TX	1.0599
	Ector County, TX.	
36260	Ogden-Clearfield, UT	0.9499
	Davis County, UT.	
	Morgan County, UT.	
	Weber County, UT.	
36420	Oklahoma City, OK	0.9304
	Canadian County, OK.	
	Cleveland County, OK.	
	Grady County, OK.	
	Lincoln County, OK.	
	Logan County, OK.	
	McClain County, OK.	
	Oklahoma County, OK.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
36500	Olympia, WA	1.2151
	Thurston County, WA.	
36540	Omaha-Council Bluffs, NE–IA	1.0091
	Harrison County, IA.	
	Mills County, IA.	
	Pottawattamie County, IA.	
	Cass County, NE.	
	Douglas County, NE.	
	Sarpy County, NE.	
	Saunders County, NE.	
	Washington County, NE.	
36740	Orlando-Kissimmee, FL	0.9738
	Lake County, FL.	
	Orange County, FL.	
	Osceola County, FL.	
	Seminole County, FL.	
36780	Oshkosh-Neenah, WI	1.0081
	Winnebago County, WI.	
36980	Owensboro, KY	0.9132
	Daviess County, KY.	
	Hancock County, KY.	
	McLean County, KY.	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2509
	Ventura County, CA.	
37340	Palm Bay-Melbourne-Titusville, FL	0.9842
	Brevard County, FL.	
37380	Palm Coast, FL	0.9441
	Flagler County, FL.	
37460	Panama City-Lynn Haven, FL	0.8774
	Bay County, FL.	
37620	Parkersburg-Marietta-Vienna, WV–OH	0.8555
	Washington County, OH.	
	Pleasants County, WV.	
	Wirt County, WV.	
	Wood County, WV.	
37700	Pascagoula, MS	0.9127
	George County, MS.	
	Jackson County, MS.	
37764	Peabody, MA	1.1241
	Essex County, MA.	
37860	Pensacola-Ferry Pass-Brent, FL	0.8740
	Escambia County, FL.	
	Santa Rosa County, FL.	
37900	Peoria, IL	0.9815
	Marshall County, IL.	
	Peoria County, IL.	
	Stark County, IL.	
	Tazewell County, IL.	
	Woodford County, IL.	
37964	Philadelphia, PA	1.1531
	Bucks County, PA.	
	Chester County, PA.	
	Delaware County, PA.	
	Montgomery County, PA.	
	Philadelphia County, PA.	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0833
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.8274
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8998
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0651

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Berkshire County, MA.	
38540	Pocatello, ID	0.9990
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.7916
	Juana Díaz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME	1.0599
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR–WA	1.2136
	Clackamas County, OR.	
	Columbia County, OR.	
	Multnomah County, OR.	
	Washington County, OR.	
	Yamhill County, OR.	
	Clark County, WA.	
	Skamania County, WA.	
38940	Port St. Lucie, FL	1.0572
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1591
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	1.0576
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI–MA	1.1278
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	1.0087
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.9342
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.9767
	Charlotte County, FL.	
39540	Racine, WI	1.0025
	Racine County, WI.	
39580	Raleigh-Cary, NC	1.0385
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.9300
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9875
	Berks County, PA.	
39820	Redding, CA	1.4292
	Shasta County, CA.	
39900	Reno-Sparks, NV	1.1309
	Storey County, NV.	
	Washoe County, NV.	
40060	Richmond, VA	0.9948
	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.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	New Kent County, VA.	
	Powhatan County, VA.	
	Prince George County, VA.	
	Sussex County, VA.	
	Colonial Heights City, VA.	
	Hopewell City, VA.	
	Petersburg City, VA.	
	Richmond City, VA.	
40140	Riverside-San Bernardino-Ontario, CA	1.1716
	Riverside County, CA.	
	San Bernardino County, CA.	
40220	Roanoke, VA	0.9173
	Botetourt County, VA.	
	Craig County, VA.	
	Franklin County, VA.	
	Roanoke County, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
40340	Rochester, MN	1.1352
	Dodge County, MN.	
	Olmsted County, MN.	
	Wabasha County, MN.	
40380	Rochester, NY	0.9349
	Livingston County, NY.	
	Monroe County, NY.	
	Ontario County, NY.	
	Orleans County, NY.	
	Wayne County, NY.	
40420	Rockford, IL	1.0358
	Boone County, IL.	
	Winnebago County, IL.	
40484	Rockingham County-Strafford County, NH	1.0672
	Rockingham County, NH.	
	Strafford County, NH.	
40580	Rocky Mount, NC	0.9500
	Edgecombe County, NC.	
	Nash County, NC.	
40660	Rome, GA	0.9544
	Floyd County, GA.	
40900	Sacramento-Arden-Arcade-Roseville, CA	1.4254
	El Dorado County, CA.	
	Placer County, CA.	
	Sacramento County, CA.	
	Yolo County, CA.	
40980	Saginaw-Saginaw Township North, MI	0.9301
	Saginaw County, MI.	
41060	St. Cloud, MN	1.1134
	Benton County, MN.	
	Stearns County, MN.	
41100	St. George, UT	0.9877
	Washington County, UT.	
41140	St. Joseph, MO–KS	0.9248
	Doniphan County, KS.	
	Andrew County, MO.	
	Buchanan County, MO.	
	DeKalb County, MO.	
41180	St. Louis, MO–IL	0.9525
	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.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Warren County, MO.	
	Washington County, MO.	
	St. Louis City, MO.	
41420	Salem, OR	1.1158
	Marion County, OR.	
	Polk County, OR.	
41500	Salinas, CA	1.5595
	Monterey County, CA.	
41540	Salisbury, MD	0.9493
	Somerset County, MD.	
	Wicomico County, MD.	
41620	Salt Lake City, UT	0.9920
	Salt Lake County, UT.	
	Summit County, UT.	
	Tooele County, UT.	
41660	San Angelo, TX	0.9055
	Irion County, TX.	
	Tom Green County, TX.	
41700	San Antonio, TX	0.9324
	Atascosa County, TX.	
	Bandera County, TX.	
	Bexar County, TX.	
	Comal County, TX.	
	Guadalupe County, TX.	
	Kendall County, TX.	
	Medina County, TX.	
	Wilson County, TX.	
41740	San Diego-Carlsbad-San Marcos, CA	1.2129
	San Diego County, CA.	
41780	Sandusky, OH	0.9311
	Erie County, OH.	
41884	San Francisco-San Mateo-Redwood City, CA	1.6038
	Marin County, CA.	
	San Francisco County, CA.	
	San Mateo County, CA.	
41900	San Germán-Cabo Rojo, PR	0.7916
	Cabo Rojo Municipio, PR.	
	Lajas Municipio, PR.	
	Sabana Grande Municipio, PR.	
	San Germán Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.6608
	San Benito County, CA.	
	Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR	0.7916
	Aguas Buenas Municipio, PR.	
	Aibonito Municipio, PR.	
	Arecibo Municipio, PR.	
	Barceloneta Municipio, PR.	
	Barranquitas Municipio, PR.	
	Bayamón Municipio, PR.	
	Caguas Municipio, PR.	
	Camuy Municipio, PR.	
	Canóvanas Municipio, PR.	
	Carolina Municipio, PR.	
	Cataño Municipio, PR.	
	Cayey Municipio, PR.	
	Ciales Municipio, PR.	
	Cidra Municipio, PR.	
	Comerío Municipio, PR.	
	Corozal Municipio, PR.	
	Dorado Municipio, PR.	
	Florida Municipio, PR.	
	Guaynabo Municipio, PR.	
	Gurabo Municipio, PR.	
	Hatillo Municipio, PR.	
	Humacao Municipio, PR.	
	Juncos Municipio, PR.	
	Las Piedras Municipio, PR.	
	Loíza Municipio, PR.	
	Manatí Municipio, PR.	
	Maunabo Municipio, PR.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	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.	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA.	1.3181
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA.	1.2419
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA.	1.2364
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA.	1.7016
42140	Santa Fe, NM Santa Fe County, NM.	1.1329
42220	Santa Rosa-Petaluma, CA Sonoma County, CA.	1.5511
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL. Sarasota County, FL.	1.0484
42340	Savannah, GA Bryan County, GA. Chatham County, GA. Effingham County, GA.	0.9638
42540	Scranton-Wilkes-Barre, PA Lackawanna County, PA. Luzerne County, PA. Wyoming County, PA.	0.8926
42644	Seattle-Bellevue-Everett, WA King County, WA. Snohomish County, WA.	1.2214
42680	Sebastian-Vero Beach, FL Indian River County, FL.	0.9934
43100	Sheboygan, WI Sheboygan County, WI.	0.9473
43300	Sherman-Denison, TX Grayson County, TX.	0.8782
43340	Shreveport-Bossier City, LA Bossier Parish, LA. Caddo Parish, LA. De Soto Parish, LA.	0.8946
43580	Sioux City, IA–NE–SD Woodbury County, IA. Dakota County, NE. Dixon County, NE. Union County, SD.	0.9764
43620	Sioux Falls, SD Lincoln County, SD. McCook County, SD. Minnehaha County, SD. Turner County, SD.	1.0093
43780	South Bend-Mishawaka, IN–MI St. Joseph County, IN. Cass County, MI.	1.0150
43900	Spartanburg, SC Spartanburg County, SC.	0.9945
44060	Spokane, WA Spokane County, WA.	1.1035
44100	Springfield, IL Menard County, IL. Sangamon County, IL.	0.9440
44140	Springfield, MA	1.0941

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Franklin County, MA.	
	Hampden County, MA.	
	Hampshire County, MA.	
44180	Springfield, MO	0.9177
	Christian County, MO.	
	Dallas County, MO.	
	Greene County, MO.	
	Polk County, MO.	
	Webster County, MO.	
44220	Springfield, OH	0.9176
	Clark County, OH.	
44300	State College, PA	0.9254
	Centre County, PA.	
44700	Stockton, CA	1.2513
	San Joaquin County, CA.	
44940	Sumter, SC	0.9076
	Sumter County, SC.	
45060	Syracuse, NY	1.0460
	Madison County, NY.	
	Onondaga County, NY.	
	Oswego County, NY.	
45104	Tacoma, WA	1.1668
	Pierce County, WA.	
45220	Tallahassee, FL	0.9526
	Gadsden County, FL.	
	Jefferson County, FL.	
	Leon County, FL.	
	Wakulla County, FL.	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9520
	Hernando County, FL.	
	Hillsborough County, FL.	
	Pasco County, FL.	
	Pinellas County, FL.	
45460	Terre Haute, IN	0.9293
	Clay County, IN.	
	Sullivan County, IN.	
	Vermillion County, IN.	
	Vigo County, IN.	
45500	Texarkana, TX-Texarkana, AR	0.8201
	Miller County, AR.	
	Bowie County, TX.	
45780	Toledo, OH	0.9954
	Fulton County, OH.	
	Lucas County, OH.	
	Ottawa County, OH.	
	Wood County, OH.	
45820	Topeka, KS	0.9012
	Jackson County, KS.	
	Jefferson County, KS.	
	Osage County, KS.	
	Shawnee County, KS.	
	Wabaunsee County, KS.	
45940	Trenton-Ewing, NJ	1.1293
	Mercer County, NJ.	
46060	Tucson, AZ	0.9758
	Pima County, AZ.	
46140	Tulsa, OK	0.8803
	Creek County, OK.	
	Okmulgee County, OK.	
	Osage County, OK.	
	Pawnee County, OK.	
	Rogers County, OK.	
	Tulsa County, OK.	
	Wagoner County, OK.	
46220	Tuscaloosa, AL	0.8764
	Greene County, AL.	
	Hale County, AL.	
	Tuscaloosa County, AL.	
46340	Tyler, TX	0.9620
	Smith County, TX.	
46540	Utica-Rome, NY	0.8957

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Herkimer County, NY.	
	Oneida County, NY.	
46660	Valdosta, GA	0.8547
	Brooks County, GA.	
	Echols County, GA.	
	Lanier County, GA.	
	Lowndes County, GA.	
46700	Vallejo-Fairfield, CA	1.5480
	Solano County, CA.	
47020	Victoria, TX	0.8763
	Calhoun County, TX.	
	Goliad County, TX.	
	Victoria County, TX.	
47220	Vineland-Millville-Bridgeton, NJ	1.0695
	Cumberland County, NJ.	
47260	Virginia Beach-Norfolk-Newport News, VA–NC	0.9307
	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	1.0651
	Tulare County, CA.	
47380	Waco, TX	0.8991
	McLennan County, TX.	
47580	Warner Robins, GA	0.9634
	Houston County, GA.	
47644	Warren-Troy-Farmington Hills, MI	1.0556
	Lapeer County, MI.	
	Livingston County, MI.	
	Macomb County, MI.	
	Oakland County, MI.	
	St. Clair County, MI.	
47894	Washington-Arlington-Alexandria, DC–VA–MD–WV	1.1457
	District of Columbia, DC.	
	Calvert County, MD.	
	Charles County, MD.	
	Prince George's County, MD.	
	Arlington County, VA.	
	Clarke County, VA.	
	Fairfax County, VA.	
	Fauquier County, VA.	
	Loudoun County, VA.	
	Prince William County, VA.	
	Spotsylvania County, VA.	
	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	0.8992
	Black Hawk County, IA.	
	Bremer County, IA.	
	Grundy County, IA.	
48140	Wausau, WI	1.0216
	Marathon County, WI.	

ADDENDUM G.—CY 2008 ESRD WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
48260	Weirton-Steubenville, WV–OH	0.8364
	Jefferson County, OH.	
	Brooke County, WV.	
	Hancock County, WV.	
48300	Wenatchee, WA	1.2105
	Chelan County, WA.	
	Douglas County, WA.	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0268
	Palm Beach County, FL.	
48540	Wheeling, WV–OH	0.7916
	Belmont County, OH.	
	Marshall County, WV.	
	Ohio County, WV.	
48620	Wichita, KS	0.9565
	Butler County, KS.	
	Harvey County, KS.	
	Sedgwick County, KS.	
	Sumner County, KS.	
48660	Wichita Falls, TX	0.8359
	Archer County, TX.	
	Clay County, TX.	
	Wichita County, TX.	
48700	Williamsport, PA	0.8489
	Lycoming County, PA.	
48864	Wilmington, DE–MD–NJ	1.1424
	New Castle County, DE.	
	Cecil County, MD.	
	Salem County, NJ.	
48900	Wilmington, NC	0.9932
	Brunswick County, NC.	
	New Hanover County, NC.	
	Pender County, NC.	
49020	Winchester, VA–WV	1.0463
	Frederick County, VA.	
	Winchester City, VA.	
	Hampshire County, WV.	
49180	Winston-Salem, NC	0.9624
	Davie County, NC.	
	Forsyth County, NC.	
	Stokes County, NC.	
	Yadkin County, NC.	
49340	Worcester, MA	1.1913
	Worcester County, MA.	
49420	Yakima, WA	1.0837
	Yakima County, WA.	
49500	Yauco, PR	0.7916
	Guánica Municipio, PR.	
	Guayanilla Municipio, PR.	
	Peñuelas Municipio, PR.	
	Yauco Municipio, PR.	
49620	York-Hanover, PA	0.9878
	York County, PA.	
49660	Youngstown-Warren-Boardman, OH–PA	0.9501
	Mahoning County, OH.	
	Trumbull County, OH.	
	Mercer County, PA.	
49700	Yuba City, CA	1.1353
	Sutter County, CA.	
	Yuba County, CA.	
49740	Yuma, AZ	1.0014
	Yuma County, AZ.	

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

ADDENDUM H.—CY 2008 ESRD WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

CBSA code	Nonurban area	Wage index
1	Alabama	0.7951
2	Alaska	1.2781
3	Arizona	0.8949
4	Arkansas	0.7916
5	California	1.2690
6	Colorado	1.0242
7	Connecticut	1.2361
8	Delaware	1.0267
10	Florida	0.8935
11	Georgia	0.8084
12	Hawaii	1.1201
13	Idaho	0.8359
14	Illinois	0.8797
15	Indiana	0.9052
16	Iowa	0.9041
17	Kansas	0.8424
18	Kentucky	0.8225
19	Louisiana	0.7916
20	Maine	0.8946
21	Maryland	0.9535
22	Massachusetts [1]	1.2290
23	Michigan	0.9450
24	Minnesota	0.9583
25	Mississippi	0.8127
26	Missouri	0.8370
27	Montana	0.8844
28	Nebraska	0.9340
29	Nevada	0.9786
30	New Hampshire	1.1466
31	New Jersey [1]	.....
32	New Mexico	0.9436
33	New York	0.8727
34	North Carolina	0.9080
35	North Dakota	0.7916
36	Ohio	0.9197
37	Oklahoma	0.7916
38	Oregon	1.0456
39	Pennsylvania	0.8850
40	Puerto Rico [1]	0.7916
41	Rhode Island [1]	.....
42	South Carolina	0.9136
43	South Dakota	0.9023
44	Tennessee	0.8151
45	Texas	0.8410
46	Utah	0.8566
47	Vermont	1.0469
48	Virgin Islands	0.7916
49	Virginia	0.8334
50	Washington	1.0828
51	West Virginia	0.7916
52	Wisconsin	1.0203
53	Wyoming	0.9802

[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 2008.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT

[Effective Date: January 1, 2008]

CLINICAL LABORATORY SERVICES

INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:

86890	Autologous blood process.
86891	Autologous blood, op salvage.
86927	Plasma, fresh frozen.
86930	Frozen blood prep.
86931	Frozen blood thaw.
86932	Frozen blood freeze/thaw.
86945	Blood product/irradiation.
86950	Leukacyte transfusion.
86960	Vol reduction of blood/prod.
86965	Pooling blood platelets.
86985	Split blood or products.

INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:

0026T	Measure remnant lipoproteins.
0030T	Antiprothrombin antibody.
0041T	Detect ur infect agnt w/cpas.
0043T	Co expired gas analysis.
0058T	Cryopreservation, ovary tiss.
0059T	Cryopreservation, oocyte.
0064T	Spectroscop eval expired gas.
0085T	Breath test heart reject.
0087T	Sperm eval hyaluronan.
0103T	Holotranscobalamin.
0104T	At rest cardio gas rebreathe.
0111T	RBC membranes fatty acids.
0140T	Exhaled breath condensate ph.
36415	Routine venipuncture.
78110	Plasma volume, single.
78111	Plasma volume, multiple.
78120	Red cell mass, single.
78121	Red cell mass, multiple.
78122	Blood volume.
78130	Red cell survival study.
78191	Platelet survival.
78267	Breath tst attain/anal c–14.
78268	Breath test analysis c–14.
78270	Vit B–12 absorption exam.
78271	Vit B–12 absrp exam, int fac.
78272	Vit B–12 absorp, combined.
78725	Kidney function study.
G0027	Semen analysis.
G0103	Psa, total screening.
G0123	Screen cerv/vag thin layer.
G0124	Screen c/v thin layer by MD.
G0141	Scr c/v cyto,autosys and md.
G0143	Scr c/v cyto,thinlayer,rescr.
G0144	Scr c/v cyto,thinlayer,rescr.
G0145	Scr c/v cyto,thinlayer,rescr.
G0147	Scr c/v cyto, automated sys.
G0148	Scr c/v cyto, autosys, rescr.
G0306	CBC/diffwbc w/o platelet.
G0307	CBC without platelet.
G0328	Fecal blood scrn immunoassay.
G0394	Blood occult test colorectal.
P2028	Cephalin floculation test.
P2029	Congo red blood test.
P2033	Blood thymol turbidity.
P2038	Blood mucoprotein.
P3000	Screen pap by tech w md supv.
P3001	Screening pap smear by phys.
P9612	Catheterize for urine spec.
P9615	Urine specimen collect mult.
Q0111	Wet mounts/w preparations.
Q0112	Potassium hydroxide preps.
Q0113	Pinworm examinations.
Q0114	Fern test.
Q0115	Post-coital mucous exam.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: January 1, 2008]

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/speech-language pathology services:

0019T	Extracorp shock wv tx, ms nos.
0029T	Magnetic tx for incontinence.
64550	Apply neurostimulator.
90901	Biofeedback train, any meth.
90911	Biofeedback peri/uro/rectal.
92506	Speech/hearing evaluation.
92507	Speech/hearing therapy.
92508	Speech/hearing therapy.
92526	Oral function therapy.
92597	Oral speech device eval.
92607	Ex for speech device rx, 1hr.
92608	Ex for speech device rx addl.
92609	Use of speech device service.
92610	Evaluate swallowing function.
92611	Motion fluoroscopy/swallow.
92612	Endoscopy swallow tst (fees).
92614	Laryngoscopic sensory test.
92616	Fees w/laryngeal sense test.
93797	Cardiac rehab.
93798	Cardiac rehab/monitor.
94667	Chest wall manipulation.
94668	Chest wall manipulation.
95831	Limb muscle testing, manual.
95832	Hand muscle testing, manual.
95833	Body muscle testing, manual.
95834	Body muscle testing, manual.
95851	Range of motion measurements.
95852	Range of motion measurements.
96000	Motion analysis, video/3d.
96001	Motion test w/ft press meas.
96002	Dynamic surface emg.
96003	Dynamic fine wire emg.
96105	Assessment of aphasia.
96110	Developmental test, lim.
96111	Developmental test, extend.
96125	Cognitive test by HC pro.
97001	Pt evaluation.
97002	Pt re-evaluation.
97003	Ot evaluation.
97004	Ot re-evaluation.
97010	Hot or cold packs therapy.
97012	Mechanical traction therapy.
97016	Vasopneumatic device therapy.
97018	Paraffin bath therapy.
97022	Whirlpool therapy.
97024	Diathermy eg, microwave.
97026	Infrared therapy.
97028	Ultraviolet therapy.
97032	Electrical stimulation.
97033	Electric current therapy.
97034	Contrast bath therapy.
97035	Ultrasound therapy.
97036	Hydrotherapy.
97039	Physical therapy treatment.
97110	Therapeutic exercises.
97112	Neuromuscular reeducation.
97113	Aquatic therapy/exercises.
97116	Gait training therapy.
97124	Massage therapy.
97139	Physical medicine procedure.
97140	Manual therapy.
97150	Group therapeutic procedures.
97530	Therapeutic activities.
97532	Cognitive skills development.
97533	Sensory integration.
97535	Self care mngment training.
97537	Community/work reintegration.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: January 1, 2008]

97542	Wheelchair mngment training.
97545	Work hardening.
97546	Work hardening add-on.
97597	Active wound care/20cm or <.
97598	Active wound care > 20cm.
97602	Wound(s) care nonselective.
97605	Neg press wound tx, < 50 cm.
97606	Neg press wound tx, > 50 cm.
97750	Physical performance test.
97755	Assistive technology assess.
97760	Orthotic mgmt and training.
97761	Prosthetic training.
97762	C/O for orthotic/prosth use.
97799	Physical medicine procedure.
G0281	Elec stim unattend for press.
G0283	Elec stim other than wound.
G0329	Electromagntic tx for ulcers.

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

INCLUDE the following CPT and HCPCS codes:

0028T	Dexa body composition study.
0042T	Ct perfusion w/contrast, cbf.
0067T	Ct colonography; dx.
0144T	Ct heart wo dye; qual calc.
0145T	Ct heart w/wo dye funct.
0146T	Ccta w/wo dye 0147T Ccta w/ wo, quan calcium.
0148T	Ccta w/wo, strxr.
0149T	Ccta w/wo, strxr quan calc.
0150T	Ccta w/wo, disease strxr.
0151T	Ct heart funct add-on.
0159T	Cad breast mri.
0174T	Cad cxr with interp.
0175T	Cad cxr remote.
51798	Us urine capacity measure.
70100	X-ray exam of jaw.
70110	X-ray exam of jaw.
70120	X-ray exam of mastoids.
70130	X-ray exam of mastoids.
70134	X-ray exam of middle ear.
70140	X-ray exam of facial bones.
70150	X-ray exam of facial bones.
70160	X-ray exam of nasal bones.
70190	X-ray exam of eye sockets.
70200	X-ray exam of eye sockets.
70210	X-ray exam of sinuses.
70220	X-ray exam of sinuses.
70240	X-ray exam, pituitary saddle.
70250	X-ray exam of skull.
70260	X-ray exam of skull.
70300	X-ray exam of teeth.
70310	X-ray exam of teeth.
70320	Full mouth x-ray of teeth.
70328	X-ray exam of jaw joint.
70330	X-ray exam of jaw joints.
70336	Magnetic image, jaw joint.
70350	X-ray head for orthodontia.
70355	Panoramic x-ray of jaws.
70360	X-ray exam of neck.
70370	Throat x-ray & fluoroscopy.
70371	Speech evaluation, complex.
70380	X-ray exam of salivary gland.
70450	Ct head/brain w/o dye.
70460	Ct head/brain w/dye.
70470	Ct head/brain w/o & w/dye.
70480	Ct orbit/ear/fossa w/o dye.
70481	Ct orbit/ear/fossa w/dye.
70482	Ct orbit/ear/fossa w/ o& w/dye.
70486	Ct maxillofacial w/o dye.
70487	Ct maxillofacial w/dye.
70488	Ct maxillofacial w/o & w/dye.
70490	Ct soft tissue neck w/o dye.
70491	Ct soft tissue neck w/dye.
70492	Ct sft tsue nck w/o & w/dye.
70496	Ct angiography, head.
70498	Ct angiography, neck.
70540	Mri orbit/face/neck w/o dye.
70542	Mri orbit/face/neck w/dye.
70543	Mri orbt/fac/nck w/o & w/dye.
70544	Mr angiography head w/o dye.
70545	Mr angiography head w/dye.
70546	Mr angiograph head w/o&w/ dye.
70547	Mr angiography neck w/o dye.
70548	Mr angiography neck w/dye.
70549	Mr angiograph neck w/o&w/ dye.
70551	Mri brain w/o dye.
70552	Mri brain w/dye.
70553	Mri brain w/o & w/dye.
70554	Fmri brain by tech.
70555	Fmri brain by phys/psych.
71010	Chest x-ray 71015 Chest x-ray.
71020	Chest x-ray.
71021	Chest x-ray.
71022	Chest x-ray.
71023	Chest x-ray and fluoroscopy.
71030	Chest x-ray.
71034	Chest x-ray and fluoroscopy.
71035	Chest x-ray.
71100	X-ray exam of ribs.
71101	X-ray exam of ribs/chest.
71110	X-ray exam of ribs.
71111	X-ray exam of ribs/chest.
71120	X-ray exam of breastbone.
71130	X-ray exam of breastbone.
71250	Ct thorax w/o dye.
71260	Ct thorax w/dye.
71270	Ct thorax w/o & w/dye.
71275	Ct angiography, chest.
71550	Mri chest w/o dye.
71551	Mri chest w/dye.
71552	Mri chest w/o & w/dye.
71555	Mri angio chest w or w/o dye.
72010	X-ray exam of spine.
72020	X-ray exam of spine.
72040	X-ray exam of neck spine.
72050	X-ray exam of neck spine.
72052	X-ray exam of neck spine.
72069	X-ray exam of trunk spine.
72070	X-ray exam of thoracic spine.
72072	X-ray exam of thoracic spine.
72074	X-ray exam of thoracic spine.
72080	X-ray exam of trunk spine.
72090	X-ray exam of trunk spine.
72100	X-ray exam of lower spine.
72110	X-ray exam of lower spine.
72114	X-ray exam of lower spine.
72120	X-ray exam of lower spine.
72125	Ct neck spine w/o dye.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/dye.
72128	Ct chest spine w/o dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/dye.
72131	Ct lumbar spine w/o dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/dye.
72141	Mri neck spine w/o dye.
72142	Mri neck spine w/dye.
72146	Mri chest spine w/o dye.
72147	Mri chest spine w/dye.
72148	Mri lumbar spine w/o dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye.
72170	X-ray exam of pelvis.
72190	X-ray exam of pelvis.
72191	Ct angiograph pelv w/o & w/ dye.
72192	Ct pelvis w/o dye.
72193	Ct pelvis w/dye.
72194	Ct pelvis w/o & w/dye.
72195	Mri pelvis w/o dye.
72196	Mri pelvis w/dye.
72197	Mri pelvis w/o & w/dye.
72198	Mr angio pelvis w/o & w/dye.
72200	X-ray exam sacroiliac joints.
72202	X-ray exam sacroiliac joints.
72220	X-ray exam of tailbone.
73000	X-ray exam of collar bone.
73010	X-ray exam of shoulder blade.
73020	X-ray exam of shoulder.
73030	X-ray exam of shoulder.
73050	X-ray exam of shoulders.
73060	X-ray exam of humerus.
73070	X-ray exam of elbow.
73080	X-ray exam of elbow.
73090	X-ray exam of forearm.
73092	X-ray exam of arm, infant.
73100	X-ray exam of wrist.
73110	X-ray exam of wrist.
73120	X-ray exam of hand.
73130	X-ray exam of hand.
73140	X-ray exam of finger(s).
73200	Ct upper extremity w/o dye.
73201	Ct upper extremity w/dye.
73202	Ct uppr extremity w/o & w/dye.
73206	Ct angio upr extrm w/o & w/ dye.
73218	Mri upper extremity w/o dye.
73219	Mri upper extremity w/dye.
73220	Mri uppr extremity w/o & w/dye.
73221	Mri joint upr extrem w/o dye.
73222	Mri joint upr extrem w/dye.
73223	Mri joint upr extr w/o & w/dye.
73500	X-ray exam of hip.
73510	X-ray exam of hip.
73520	X-ray exam of hips.
73540	X-ray exam of pelvis & hips.
73550	X-ray exam of thigh.
73560	X-ray exam of knee, 1 or 2.
73562	X-ray exam of knee, 3.
73564	X-ray exam, knee, 4 or more.
73565	X-ray exam of knees.
73590	X-ray exam of lower leg.
73592	X-ray exam of leg, infant.
73600	X-ray exam of ankle.
73610	X-ray exam of ankle.
73620	X-ray exam of foot.
73630	X-ray exam of foot.
73650	X-ray exam of heel.
73660	X-ray exam of toe(s).
73700	Ct lower extremity w/o dye.
73701	Ct lower extremity w/dye.
73702	Ct lwr extremity w/o & w/dye.
73706	Ct angio lwr extr w/o & w/dye.
73718	Mri lower extremity w/o dye.
73719	Mri lower extremity w/dye.
73720	Mri lwr extremity w/o & w/dye.
73721	Mri jnt of lwr extre w/o dye.
73722	Mri joint of lwr extr w/dye.
73723	Mri joint lwr extr w/o & w/dye.
73725	Mr ang lwr ext w or w/o dye.
74000	X-ray exam of abdomen.
74010	X-ray exam of abdomen.
74020	X-ray exam of abdomen.
74022	X-ray exam series, abdomen.
74150	Ct abdomen w/o dye.
74160	Ct abdomen w/dye.
74170	Ct abdomen w/o & w/dye.
74175	Ct angio abdom w/o & w/dye.
74181	Mri abdomen w/o dye.
74182	Mri abdomen w/dye.
74183	Mri abdomen w/o & w/dye.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: January 1, 2008]

74185	Mri angio, abdom w orw/o dye.
74210	Contrst x-ray exam of throat.
74220	Contrast x-ray, esophagus.
74230	Cine/vid x-ray, throat/esoph.
74240	X-ray exam, upper gi tract.
74241	X-ray exam, upper gi tract.
74245	X-ray exam, upper gi tract.
74246	Contrst x-ray uppr gi tract.
74247	Contrst x-ray uppr gi tract.
74249	Contrst x-ray uppr gi tract.
74250	X-ray exam of small bowel.
74290	Contrast x-ray, gallbladder.
74291	Contrast x-rays, gallbladder.
74710	X-ray measurement of pelvis.
75557	Cardiac MRI for morph.
75558	Cardiac MRI flow/velocity.
75559	Cardiac MRI w/stress img.
75560	Cardiac MRI flo/vel/stress.
75561	Cardiac MRI for morph w/dye.
75562	Card MRI flow/vel w/dye.
75563	Card MRI w/stress img & dye.
75564	Ht MRI w/flo/vel/strs & dye.
75635	Ct angio abdominal arteries.
76000	Fluoroscope examination.
76010	X-ray, nose to rectum.
76100	X-ray exam of body section.
76101	Complex body section x-ray.
76102	Complex body section x-rays.
76120	Cine/video x-rays.
76125	Cine/video x-rays add-on.
76150	X-ray exam, dry process.
76376	3d render w/o postprocess.
76377	3d rendering w/postprocess.
76380	CAT scan follow-up study.
76499	Radiographic procedure.
76506	Echo exam of head.
76510	Ophth us, b & quant a.
76511	Ophth us, quant a only.
76512	Ophth us, b w/non-quant a.
76513	Echo exam of eye, water bath.
76514	Echo exam of eye, thickness.
76516	Echo exam of eye.
76519	Echo exam of eye.
76536	Us exam of head and neck.
76604	Us exam, chest.
76645	Us exam, breast(s).
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76776	Us exam k transpl w/Doppler.
76800	Us exam, spinal canal.
76802	Ob us < 14 wks, add'l fetus.
76805	Ob us >/= 14 wks, sngl fetus.
76810	Ob us >/= 14 wks, addl fetus.
76811	Ob us, detailed, sngl fetus.
76812	Ob us, detailed, addl fetus.
76815	Ob us, limited, fetus(s).
76816	Ob us, follow-up, per fetus.
76818	Fetal biophys profile w/nst.
76819	Fetal biophys profil w/o nst.
76820	Umbilical artery echo.
76821	Middle cerebral artery echo.
76825	Echo exam of fetal heart.
76826	Echo exam of fetal heart.
76827	Echo exam of fetal heart.
76828	Echo exam of fetal heart.
76856	Us exam, pelvic, complete.
76857	Us exam, pelvic, limited.
76870	Us exam, scrotum.
76880	Us exam, extremity.
76885	Us exam infant hips, dynamic.
76886	Us exam infant hips, static.
76970	Ultrasound exam follow-up.
76977	Us bone density measure.
76999	Echo examination procedure.
77014	Ct scan for therapy guide.
77051	Computer dx mammogram add-on.
77052	Comp screen mammogram add-on.
77055	Mammogram, one breast.
77056	Mammogram, both breasts.
77057	Mammogram, screening.
77058	Mri, one breast.
77059	Mri, both breasts.
77071	X-ray stress view.
77072	X-rays for bone age.
77073	X-rays, bone length studies.
77074	X-rays, bone survey, limited.
77075	X-rays, bone survey complete.
77076	X-rays, bone survey, infant.
77077	Joint survey, single view.
77078	Ct bone density, axial.
77079	Ct bone density, peripheral.
77080	Dxa bone density, axial.
77081	Dxa bone density/peripheral.
77082	Dxa bone density, vert fx.
77083	Radiographic absorptiometry.
77084	Magnetic image, bone marrow.
78000	Thyroid, single uptake.
78001	Thyroid, multiple uptakes.
78003	Thyroid suppress/stimul.
78006	Thyroid imaging with uptake.
78007	Thyroid image, mult uptakes.
78010	Thyroid imaging.
78011	Thyroid imaging with flow.
78015	Thyroid met imaging.
78016	Thyroid met imaging/studies.
78018	Thyroid met imaging, body.
78020	Thyroid met uptake.
78070	Parathyroid nuclear imaging.
78075	Adrenal nuclear imaging.
78099	Endocrine nuclear procedure.
78102	Bone marrow imaging, ltd.
78103	Bone marrow imaging, mult.
78104	Bone marrow imaging, body.
78135	Red cell survival kinetics.
78140	Red cell sequestration.
78185	Spleen imaging.
78190	Platelet survival, kinetics.
78195	Lymph system imaging.
78199	Blood/lymph nuclear exam.
78201	Liver imaging.
78202	Liver imaging with flow.
78205	Liver imaging (3D).
78206	Liver image (3d) with flow.
78215	Liver and spleen imaging.
78216	Liver & spleen image/flow.
78220	Liver function study.
78223	Hepatobiliary imaging.
78230	Salivary gland imaging.
78231	Serial salivary imaging.
78232	Salivary gland function exam.
78258	Esophageal motility study.
78261	Gastric mucosa imaging.
78262	Gastroesophageal reflux exam.
78264	Gastric emptying study.
78278	Acute GI blood loss imaging.
78282	GI protein loss exam.
78290	Meckel's divert exam.
78291	Leveen/shunt patency exam.
78299	GI nuclear procedure.
78300	Bone imaging, limited area.
78305	Bone imaging, multiple areas.
78306	Bone imaging, whole body.
78315	Bone imaging, 3 phase.
78320	Bone imaging (3D).
78399	Musculoskeletal nuclear exam.
78414	Non-imaging heart function.
78428	Cardiac shunt imaging.
78445	Vascular flow imaging.
78456	Acute venous thrombus image.
78457	Venous thrombosis imaging.
78458	Ven thrombosis images, bilat.
78459	Heart muscle imaging (PET).
78460	Heart muscle blood, single.
78461	Heart muscle blood, multiple.
78464	Heart image (3d), single.
78465	Heart image (3d), multiple.
78466	Heart infarct image.
78468	Heart infarct image (ef).
78469	Heart infarct image (3D).
78472	Gated heart, planar, single.
78473	Gated heart, multiple.
78478	Heart wall motion add-on.
78480	Heart function add-on.
78481	Heart first pass, single.
78483	Heart first pass, multiple.
78491	Heart image (pet), single.
78492	Heart image (pet), multiple.
78494	Heart image, spect.
78496	Heart first pass add-on.
78499	Cardiovascular nuclear exam.
78580	Lung perfusion imaging.
78584	Lung V/Q image single breath.
78585	Lung V/Q imaging.
78586	Aerosol lung image, single.
78587	Aerosol lung image, multiple.
78588	Perfusion lung image.
78591	Vent image, 1 breath, 1 proj.
78593	Vent image, 1 proj, gas.
78594	Vent image, mult proj, gas.
78596	Lung differential function.
78599	Respiratory nuclear exam.
78600	Brain image < 4 views.
78601	Brain image w/flow < 4 views.
78605	Brain image 4+ views.
78606	Brain image w/flow 4 + views.
78607	Brain imaging (3D).
78608	Brain imaging (PET).
78610	Brain flow imaging only.
78630	Cerebrospinal fluid scan.
78635	CSF ventriculography.
78645	CSF shunt evaluation.
78647	Cerebrospinal fluid scan.
78650	CSF leakage imaging.
78660	Nuclear exam of tear flow.
78699	Nervous system nuclear exam.
78700	Kidney imaging, morphol.
78701	Kidney imaging with flow.
78707	K flow/funct image w/o drug.
78708	K flow/funct image w/drug.
78709	K flow/funct image, multiple.
78710	Kidney imaging (3D).
78730	Urinary bladder retention.
78740	Ureteral reflux study.
78761	Testicular imaging w/flow.
78799	Genitourinary nuclear exam.
78800	Tumor imaging, limited area.
78801	Tumor imaging, mult areas.
78802	Tumor imaging, whole body.
78803	Tumor imaging (3D).
78804	Tumor imaging, whole body.
78805	Abscess imaging, ltd area.
78806	Abscess imaging, whole body.
78807	Nuclear localization/abscess.
78811	PET image, ltd area.
78812	PET image, skull-thigh.
78813	PET image, full body.
78814	PET image w/ct, lmtd.
78815	PET image w/ct, skull-thigh.
78816	PET image w/ct, full body.
78890	Nuclear medicine data proc.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

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78891	Nuclear med data proc.
78999	Nuclear diagnostic exam.
91110	Gi tract capsule endoscopy.
91111	Esophageal capsule endoscopy.
93303	Echo transthoracic.
93304	Echo transthoracic.
93307	Echo exam of heart.
93308	Echo exam of heart.
93320	Doppler echo exam, heart [if used in conjunction with 93303–93308].
93321	Doppler echo exam, heart [if used in conjunction with 93303–93308].
93325	Doppler color flow add-on [if used in conjunction with 93303–93308].
93875	Extracranial study.
93880	Extracranial study.
93882	Extracranial study.
93886	Intracranial study.
93888	Intracranial study.
93890	Tcd, vasoreactivity study.
93892	Tcd, emboli detect w/o inj.
93922	Extremity study.
93923	Extremity study.
93924	Extremity study.
93925	Lower extremity study.
93926	Lower extremity study.
93930	Upper extremity study.
93931	Upper extremity study.
93965	Extremity study.
93970	Extremity study.
93971	Extremity study.
93975	Vascular study.
93976	Vascular study.
93978	Vascular study.
93979	Vascular study.
93980	Penile vascular study.
93981	Penile vascular study.
93990	Doppler flow testing.
A4641	Radiopharm dx agent noc.
A4642	In111 satumomab.
A9500	Tc99m sestamibi.
A9501	Technitium TC–99m teboroxime.
A9502	Tc99m tetrofosmin.
A9503	Tc99m medronate.
A9504	Tc99m apcitide.
A9505	TL201 thallium.
A9507	In111 capromab.
A9508	I131 iodobenguate, dx.
A9509	Iodine I–123 sod iodide mil.
A9510	Tc99m disofenin.
A9512	Tc99m pertechnetate.
A9516	Iodine I–123 sod iodide mic.
A9521	Tc99m exametazime.
A9524	I131 serum albumin, dx.
A9526	Nitrogen N–13 ammonia.
A9528	Iodine I–131 iodide cap, dx.
A9529	I131 iodide sol, dx.
A9531	I131 max 100uCi.
A9532	I125 serum albumin, dx.
A9536	TC99m depreotide.
A9537	Tc99m mebrofenin.
A9538	Tc99m pyrophosphate.
A9539	Tc99m pentetate.
A9540	Tc99m MAA.
A9541	Tc99m sulfur colloid.
A9542	In111 ibritumomab, dx.
A9544	I131 tositumomab, dx.
A9546	CO57/58.
A9547	In111 oxyquinoline.
A9548	In111 pentetate.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: January 1, 2008]

A9550	Tc99m gluceptate.
A9551	Tc99m succimer.
A9552	F18 fdg.
A9553	Cr51 chromate.
A9554	I125 iothalamate, dx.
A9555	Rb82 rubidium.
A9556	Ga67 gallium.
A9557	Tc99m bicisate.
A9558	Xe133 xenon 10mci.
A9559	Co57 cyano.
A9560	Tc99m labeled rbc.
A9561	Tc99m oxidronate.
A9562	Tc99m mertiatide.
A9566	Tc99m fanolesomab.
A9567	Technetium TC–99m aerosol.
A9568	Technetium tc99m arcitumomab.
A9569	Technetium TC–99m auto WBC.
A9570	Indium In-111 auto WBC.
A9571	Indium In-111 auto platelet.
A9572	Indium In-111 pentetreotide.
A9576	Inj prohance multipack.
A9577	Inj multihance.
A9578	Inj multihance multipack.
A9579	Gad-base MR contrast NOS,1ml.
A9700	Echocardiography contrast.
G0130	Single energy x-ray study.
G0202	Screeningmammographydigital.
G0204	Diagnosticmammographydigital.
G0206	Diagnosticmammographydigital.
G0288	Recon, CTA for surg plan.
G0389	Ultrasound exam AAA screen.
Q0092	Set up port xray equipment.
Q9951	LOCM>=400 mg/ml iodine,1ml.
Q9953	Inj Fe-base MR contrast,1ml.
Q9954	Oral MR contrast, 100ml.
Q9955	Inj perflexane lip micros,ml.
Q9956	Inj octafluoropropane mic,ml.
Q9957	Inj perflutren lip micros,ml.
Q9958	HOCM <=149 mg/ml iodine, 1ml.
Q9959	HOCM 150–199mg/ml iodine,1ml.
Q9960	HOCM 200–249mg/ml iodine,1ml.
Q9961	HOCM 250–299mg/ml iodine,1ml.
Q9962	HOCM 300–349mg/ml iodine,1ml.
Q9963	HOCM 350–399mg/ml iodine,1ml.
Q9964	HOCM>= 400mg/ml iodine, 1ml.
Q9965	LOCM 100–199mg/ml iodine,1ml.
Q9966	LOCM 200–299mg/ml iodine,1ml.
Q9967	LOCM 300–399mg/ml iodine,1ml.
R0070	Transport portable x-ray.
R0075	Transport port x-ray multipl.

RADIATION THERAPY SERVICES AND SUPPLIES

INCLUDE the following CPT and HCPCS codes:

0073T	Delivery, comp imrt.
0182T	HDR elect brachytherapy.
19296	Place po breast cath for rad.
19297	Place breast cath for rad.
19298	Place breast rad tube/caths.
20555	Place ndl musc/tis for rt.
31643	Diag bronchoscope/catheter.
41019	Place needles h&n for rt.
55875	Transperi needle place, pros.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

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55876	Place rt device/marker, pros.
55920	Place needles pelvic for rt.
57155	Insert uteri tandems/ovoids.
58346	Insert heyman uteri capsule.
61770	Incise skull for treatment.
61793	Focus radiation beam.
77261	Radiation therapy planning.
77262	Radiation therapy planning.
77263	Radiation therapy planning.
77280	Set radiation therapy field.
77285	Set radiation therapy field.
77290	Set radiation therapy field.
77295	Set radiation therapy field.
77299	Radiation therapy planning.
77300	Radiation therapy dose plan.
77301	Radiotherapy dose plan, imrt.
77305	Teletx isodose plan simple.
77310	Teletx isodose plan intermed.
77315	Teletx isodose plan complex.
77321	Special teletx port plan.
77326	Brachytx isodose calc simp.
77327	Brachytx isodose calc interm.
77328	Brachytx isodose plan compl.
77331	Special radiation dosimetry.
77332	Radiation treatment aid(s).
77333	Radiation treatment aid(s).
77334	Radiation treatment aid(s).
77336	Radiation physics consult.
77370	Radiation physics consult.
77371	Srs, multisource.
77372	Srs, linear based.
77373	Sbrt delivery.
77399	External radiation dosimetry.
77401	Radiation treatment delivery.
77402	Radiation treatment delivery.
77403	Radiation treatment delivery.
77404	Radiation treatment delivery.
77406	Radiation treatment delivery.
77407	Radiation treatment delivery.
77408	Radiation treatment delivery.
77409	Radiation treatment delivery.
77411	Radiation treatment delivery.
77412	Radiation treatment delivery.
77413	Radiation treatment delivery.
77414	Radiation treatment delivery.
77416	Radiation treatment delivery.
77417	Radiology port film(s).
77418	Radiation tx delivery, imrt.
77421	Stereoscopic x-ray guidance.
77422	Neutron beam tx, simple.
77423	Neutron beam tx, complex.
77427	Radiation tx management, x5.
77431	Radiation therapy management.
77432	Stereotactic radiation trmt.
77435	Sbrt management.
77470	Special radiation treatment.
77499	Radiation therapy management.
77520	Proton trmt, simple w/o comp.
77522	Proton trmt, simple w/comp.
77523	Proton trmt, intermediate.
77525	Proton treatment, complex.
77600	Hyperthermia treatment.
77605	Hyperthermia treatment.
77610	Hyperthermia treatment.
77615	Hyperthermia treatment.
77620	Hyperthermia treatment.
77750	Infuse radioactive materials.
77761	Apply intrcav radiat simple.
77762	Apply intrcav radiat interm.
77763	Apply intrcav radiat compl.
77776	Apply interstit radiat simpl.
77777	Apply interstit radiat inter.
77778	Apply interstit radiat compl.

ADDENDUM I.—LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: January 1, 2008]

77781	High intensity brachytherapy.
77782	High intensity brachytherapy.
77783	High intensity brachytherapy.
77784	High intensity brachytherapy.
77789	Apply surface radiation.
77790	Radiation handling.
77799	Radium/radioisotope therapy.
79005	Nuclear rx, oral admin.
79101	Nuclear rx, iv admin.
79200	Nuclear rx, intracav admin.
79300	Nuclr rx, interstit colloid.
79403	Hematopoietic nuclear tx.
79440	Nuclear rx, intra-articular.
79445	Nuclear rx, intra-arterial.
79999	Nuclear medicine therapy.
92974	Cath place, cardio brachytx.
A9517	I131 iodide cap, rx.
A9527	Iodine I–125 sodium iodide.
A9530	I131 iodide sol, rx.
A9543	Y90 ibritumomab, rx.
A9545	I131 tositumomab, rx.
A9563	P32 Na phosphate.
A9564	P32 chromic phosphate.
A9600	Sr89 strontium.
A9605	Sm 153 lexidronm.
A9699	Radiopharm rx agent noc.
C1716	Brachytx source, Gold 198.
C1717	Brachytx source, HDR Ir-192.
C1719	Brachytx sour, Non-HDR Ir-192.
C2616	Brachytx source, Yttrium-9.
C2634	Brachytx source, HA, I–125.
C2635	Brachytx source, HA, P–13.
C2636	Brachytx linear source, P–13.
C2637	Brachytx, Ytterbium-169.
C2638	Brachytx, stranded, I–125.
C2639	Brachytx,non-stranded, I–125.
C2640	Brachytx, stranded, P–13.
C2641	Brachytx, non-stranded, P–13.
C2642	Brachytx, stranded, C–131.
C2643	Brachytx, non-stranded, C–131.
C2698	Brachytx, stranded, NOS.
C2699	Brachytx, non-stranded, NOS.
G0173	Linear acc stereo radsur com.
G0251	Linear acc based stero radio.
G0339	Robot lin-radsurg com, first.
G0340	Robt lin-radsurg fractx 2–5.
Q3001	Brachytherapy Radioelements.

EPO AND OTHER DIALYSIS-RELATED DRUGS

The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in § 411.355(g) are satisfied:

J0630	Calcitonin salmon injection.
J0636	Inj calcitriol per 0.1 mcg.
J0882	Darbepoetin alfa, esrd use.
J0895	Deferoxamine mesylate inj.
J1270	Injection, doxercalciferol.
J1751	Iron dextran 165 injection.
J1752	Iron dextran 267 injection.
J1756	Iron sucrose injection.
J1955	Inj levocarnitine per 1 gm.
J2501	Paricalcitol.
J2916	Na ferric gluconate complex.
J2993	Reteplase injection.
J2995	Inj streptokinase/250000 IU.
J2997	Alteplase recombinant.
J3364	Urokinase 5000 IU injection.
P9041	Albumin (human),5%, 50ml.
P9045	Albumin (human), 5%, 250ml.
P9046	Albumin (human), 25%, 20ml.
P9047	Albumin (human), 25%, 50ml.
Q4081	Epoetin alfa, 100 units ESRD.

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in § 411.355(h):

77052	Comp screen mammogram add-on.
77057	Mammogram, screening.
80061	Lipid panel [only when billed with one of the following ICD–9–CM codes: V81.0, V81.1, or V.81.2].
82270	Occult blood, feces.
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD–9–CM codes: V81.0, V81.1, or V.81.2].
82947	Assay, glucose, blood quant [only when billed with ICD–9–CM code V77.1].
82950	Glucose test [only when billed with ICD–9–CM code V77.1].
82951	Glucose tolerance test (GTT) [only when billed with ICD–9–CM code V77.1].
83718	Assay of lipoprotein [only when billed with one of the following ICD–9–CM codes: V81.0, V81.1, or V.81.2].
84478	Assay of triglycerides [only when billed with one of the following ICD–9–CM codes: V81.0, V81.1, or V.81.2].
G0103	Psa, total screening.
G0123	Screen cerv/vag thin layer.
G0124	Screen c/v thin layer by MD.
G0141	Scr c/v cyto,autosys and md.
G0143	Scr c/v cyto,thinlayer,rescr.
G0144	Scr c/v cyto,thinlayer,rescr.
G0145	Scr c/v cyto,thinlayer,rescr.
G0147	Scr c/v cyto, automated sys.
G0148	Scr c/v cyto, autosys, rescr.
G0202	Screeningmammographydigital.
G0328	Fecal blood scrn immunoassay.
G0389	Ultrasound exam AAA screen.
P3000	Screen pap by tech w md supv.
P3001	Screening pap smear by phys.

The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in § 411.355(h):

90655	Flu vaccine no preserv 6–35m.
90656	Flu vaccine no preserv 3 & >.
90657	Flu vaccine, 3 yrs, im.
90658	Flu vaccine 3 yrs & >, im.
90660	Flu vaccine, nasal.
90669	Pneumococcal vacc, ped <5.
90732	Pneumococcal vaccine.
90740	Hepb vacc, ill pat 3 dose im.
90743	Hep b vacc, adol, 2 dose, im.
90744	Hepb vacc ped/adol 3 dose im.
90746	Hep b vaccine, adult, im.
90747	Hepb vacc, ill pat 4 dose im.

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[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to § 411.351. For more information, refer to the CMS Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/.*

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