



# Federal Register

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**Friday,  
June 28, 2002**

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**Part IV**

## **Department of Health and Human Services**

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**Centers for Medicare & Medicaid Services**

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**42 CFR Parts 410 and 414  
Medicare Program; Revisions to Payment  
Policies Under the Physician Fee  
Schedule for Calendar Year 2003;  
Proposed Rule**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 410 and 414**

[CMS-1204-P]

RIN 0938-AL21

**Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003**

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

**ACTION:** Proposed rule.

**SUMMARY:** The proposed rule would refine the resource-based practice expense relative value units (RVUs) and make other changes to Medicare Part B payment policy. The policy changes concern: Medicare Economic Index, pricing of the technical component for positron emission tomography (PET) scans, Medicare qualifications for clinical nurse specialists, a process to add or delete services to the definition of telehealth, definition for ZZZ global periods, global period for surface radiation, and an endoscopic base for urology codes. We also discuss the refinement of anesthesia work values, clinical social worker services, and how drugs are accounted for in the sustainable growth rate.

We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We solicit comments on the proposed policy changes.

This proposed rule also clarifies the enrollment of physical and occupational therapists as therapists in private practice. In addition, this proposed rule discusses physical and occupational therapy payment caps and makes technical changes to outpatient rehabilitation services.

**DATES:** We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 27, 2002.

**ADDRESSES:** In commenting, please refer to file code CMS-1204-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1204-P, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-8013.

(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 if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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

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

**FOR FURTHER INFORMATION CONTACT:** Carolyn Mullen, (410) 786-4589, Marc Hartstein, (410) 786-4539, or Stephanie Monroe (410) 786-6864 (for issues related to resource-based practice expense relative value units).

Jim Menas, (410) 786-4507 (for issues related to anesthesia).

Marc Hartstein, (410) 786-4539 (for issues related to sustainable growth rate).

Gail Addis, (410) 786-4522 (for issues related to PET scans and HCPCS codes).

Craig Dobyski, (410) 786-4584 (for issues related to telehealth).

Terri Harris, (410) 786-6830 (for issues related to physical and occupational therapy).

Latesha Walker, (410) 786-1101 (for all other issues).

**SUPPLEMENTARY INFORMATION:**

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

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

1. Go to the CMS homepage (<http://www.cms.hhs.gov>).
2. Click on "Medicare."
3. Click on "Professional/Technical Information."
4. Select Medicare Payment Systems.
5. Select Physician Fee Schedule.

Or, you can go directly to the Physician Fee Schedule page by typing the following: <http://www.cms.hhs.gov/medicare/pfsmain.htm>.

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 V.

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

AMA—American Medical Association  
 BBA—Balanced Budget Act of 1997  
 BBRA—Balanced Budget Refinement Act of 1999  
 CF—Conversion factor  
 CFR—Code of Federal Regulations  
 CMS—Centers for Medicare & Medicaid Services  
 CNS—Clinical Nurse Specialist  
 CPT—(Physicians') Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)  
 CPEP—Clinical Practice Expert Panel  
 CRNA—Certified Registered Nurse Anesthetist  
 E/M—Evaluation and management  
 FMR—Fair market rental  
 GAF—Geographic adjustment factor  
 GPCI—Geographic practice cost index  
 HCPCS—Healthcare Common Procedure Coding System  
 HHA—Home health agency  
 HHS—(Department of) Health and Human Services  
 IDTFs—Independent Diagnostic Testing Facilities  
 MCM—Medicare Carrier Manual  
 MedPAC—Medicare Payment Advisory Commission  
 MEI—Medicare Economic Index  
 MGMA—Medical Group Management Association  
 MSA—Metropolitan Statistical Area  
 NAMCS—National Ambulatory Medical Care Survey  
 PC—Professional component  
 PEAC—Practice Expense Advisory Committee  
 PET—Positron Emission Tomography  
 PPS—Prospective payment system  
 RUC—(AMA's Specialty Society) Relative (Value) Update Committee  
 RVU—Relative value unit

SGR—Sustainable growth rate  
 SMS—(AMA's) Socioeconomic Monitoring System  
 SNF—Skilled Nursing Facility  
 TC—Technical component

## I. Background

### A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." This section provides for three major elements: (1) A fee schedule for the payment of physicians' services; (2) limits on the amounts that nonparticipating physicians can charge beneficiaries; and (3) a sustainable growth rate for the rates of increase in Medicare expenditures for physicians' services. The Act requires that payments under the fee schedule 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, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than \$20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than \$20 million, we must make adjustments to preserve budget neutrality.

### B. Published Changes to the Fee Schedule

In the July 2000 proposed rule (65 FR 44177), we listed all of the final rules published through November 1999. In the August 2001 proposed rule (66 FR 40372) we discussed the November 2000 final rule relating to the updates to the RVUs and revisions to payment policies under the physician fee schedule.

In the November 2001 final rule with comment period (66 FR 55246), we revised the policy for resource-based practice expense RVUs; services and supplies incident to a physician's professional service; anesthesia base unit variations; recognition of CPT tracking codes; and nurse practitioners, physician assistants, and clinical nurse specialists performing screening sigmoidoscopies. We also addressed comments received on the June 8, 2001 proposed notice (66 FR 31028) for the 5-year review of work RVUs and finalized these work RVUs. In addition, we acknowledged comments received in response to a discussion of modifier-62, which is used to report the work of co-

surgeons. The November 2001 final rule also updated the list of services that are subject to the physician self-referral prohibitions in order to reflect CPT and Healthcare Common Procedure Coding System (HCPCS) code changes that were effective January 1, 2002. All these revisions ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

The Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) modernized the mammography screening benefit and authorized payment under the physician fee schedule effective January 1, 2002. It provided for biennial screening pelvic examinations for certain beneficiaries and expanded coverage for screening colonoscopies to all beneficiaries effective July 1, 2001. It provided for annual glaucoma screenings for high-risk beneficiaries and established coverage for medical nutrition therapy services for certain beneficiaries effective January 1, 2002. It expanded payment for telehealth services effective October 1, 2001; required certain Indian Health Service providers to be paid for some services under the physician fee schedule effective July 1, 2001; and revised the payment for certain physician pathology services effective January 1, 2001. This final rule conformed our regulations to reflect these statutory provisions.

The final rule also announced the calendar year 2002 physician fee schedule conversion factor of \$36.1992.

## II. Provisions of the Proposed Regulations

This proposed rule would affect the regulations set forth at part 410, Supplementary medical insurance (SMI) benefits and part 414, Payment for Part B medical and other health services.

### A. Resource-Based Practice Expense Relative Value Units

#### 1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of

practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), enacted on August 5, 1997, amended section 1848(c)(2)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(ii) of the Act by directing us 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. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (In the 1999 final rule (64 FR 59380), we extended, for an additional 2 years, the period during which we would accept supplementary data.)

## 2. Current Methodology for Computing the Practice Expense Relative Value Unit System

Effective with services furnished on or after January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach.

### a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed

explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by the total number of hours spent in patient care activities.

- *Step 2*—Create a specialty specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. We then calculated the specialty specific practice expense pools by multiplying the specialty practice expenses per hour by the total physician hours.

- *Step 3*—Allocate the specialty specific practice expense pool to the specific services performed by each specialty. For each specialty, we divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

- (i) *Direct costs*—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure specific CPEP data on the staff time, supplies, and equipment as the allocation basis.

- (ii) *Indirect costs*—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs combined with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

- *Step 4*—For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients.

### b. Other Methodological Issues

- (i) *Zero Physician Work Pool*—For services with physician work RVUs equal to zero (including those services with a technical and professional component), we created a separate practice expense pool using the average clinical staff time from the CPEP data

and the "all physicians" practice expense per hour.

We then used the adjusted 1998 practice expense RVUs to allocate this pool to each service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an interim measure to allocate the direct practice expense cost pool for radiology.

### (ii) Crosswalks for Specialties without Practice Expense Survey Data

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty.

- (iii) Because we believe that most physical therapy services furnished in physicians' offices are performed by physical therapists, we crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

## B. Practice Expense Proposals for Calendar Year 2003

### 1. CPEP Data

#### a. Ophthalmology Services—Rank Order Anomalies

Rank order anomalies were created in three ophthalmology families of codes because only certain services in each family were brought to the Practice Expense Advisory Committee (PEAC) for refinement, while CPEP data for the other codes were left unchanged. The American Academy of Ophthalmology has requested that we make the following changes in the CPEP data to ensure that the more complex services in a family of codes are not paid less than the simpler services and we are proposing to do so.

CPT code 67820, Revise eyelashes—remove ophthanal from the supply list.

CPT code 67825, Revise eyelashes—remove the bipolar handpiece from the supply list.

CPT code 65220, Removal foreign body from eye—use the supply list and clinical staff time assigned to CPT code 65222. The exam lane should be the only equipment assigned.

CPT codes 92081 and 92083, Visual field examination(s)—Assign the same supplies and equipment as CPT code 92082; assign 35 minutes of clinical staff time to 92081 and 70 minutes to 92083.

#### b. Practice Expense Inputs for Thermotherapy Procedures

There are three CPT codes for transurethral destruction of prostate tissue: CPT 53850, by microwave

therapy, CPT 53852, by radiofrequency thermotherapy, and CPT 53853, by water-induced thermotherapy (WIT). A manufacturer of WIT equipment has expressed concern that the practice expense inputs currently assigned to CPT 53853 underestimate the costs associated with that procedure relative to the other two codes. We have compared the inputs of the three codes and agree that the WIT procedure has not been assigned many of the basic supply and equipment inputs that are included in the CPEP inputs for the other two procedures. Therefore, we are proposing to add, on an interim basis, the following inputs: Power table, ultrasound unit, mayo stand, endoscopy stretcher, light source, chux, sani-wipe, patient education book, sterile towel, sterile gloves, specimen cup, alcohol swab, gauze, tape, lidocaine, betadine, 10 cc syringe, 30 cc syringe, sterile water, leg bag. These inputs would be in addition to the thermotherapy unit, treatment catheter, drainage bag, cystopak (which contains drapes, syringe, irrigation tubing, surgical lubricant, sterile cup, gauze pad and cysto tubing) and minimum visit package for each visit (which contains patient gown, unsterile gloves, exam table paper, pillow case and thermometer probe cover) that are currently assigned as practice expense inputs for this procedure.

We are also proposing to change on an interim basis the staff type for CPT code 53853 from the RN/LPN/MTA blend to RN in order to make the staff type consistent among these three similar procedures. In addition, we have corrected for all three procedures the minutes assigned to each piece of equipment to reflect the intra- and post-clinical staff times only, rather than the total clinical staff times as we do for all services.

We will request that these three procedures be reexamined by the PEAC at the same time in order to ensure that there is a consistent approach to the assignment of direct cost inputs.

We have also received questions regarding the large disparity in prices that we have used for the three different thermotherapy machines. Currently, the thermotherapy equipment for CPT code 53850 is priced at \$180,000, code 53852 at \$42,995 and code 53853 at \$18,500. The first two prices were given to us in 1999 and we have been sent documentation that indicates that the prices have fallen dramatically since that time. This documentation indicates that the current price for the thermotherapy equipment for CPT 53580 is somewhere between \$55,000 and \$100,000 and for code 53852

between \$25,000 and \$30,000. We are proposing to set the prices at \$60,000 and \$30,000, respectively and are also requesting that commenters furnish any additional available price documentation, particularly invoices for recently purchased equipment, so that we can ensure that any differences in assigned prices accurately reflect actual differences in costs.

#### c. Revision to Inputs for Iontophoresis

It has been brought to our attention that the electrodes assigned to the supply list for CPT code 97033, Iontophoresis, are not the type of electrodes required for this procedure. We are proposing to substitute two electrodes with a medication vesicle as the appropriate supply for iontophoresis.

#### d. Correction to Price for Sterile Water

The current price of \$40.00 for 1000 ml of sterile water that is listed in our CPEP supply database is incorrect. We are proposing to change this to \$3.00.

### 2. Zero Physician Work Pool for Practice Expense

#### a. Discussion of Alternatives to the Zero Physician Work Pool

Within the last year, there have been two reports that have addressed the zero physician work pool. The GAO released a report in October 2001 that recommended eliminating the zero physician work pool (GAO-02-53, page 25). The Lewin Group, under contract with us, provided a draft report on June 5, 2001 analyzing the zero physician work pool and provided several ideas that we could study as alternatives. As we indicated in the November 2, 1998 final rule (63 FR 58821), we created the zero physician work pool as an interim measure until we could further analyze the effect of the top-down methodology on the Medicare payment for services that do not have physician work RVUs. Given our interest in finding alternatives to the zero physician work pool, we have analyzed the following possible ideas:

- *Eliminate the Zero Physician Work Pool.*

The Lewin Group indicated that one idea could be to eliminate the zero physician work pool, as recommended by the GAO (the Lewin Group, page 19). We do not believe that the zero physician work pool should be eliminated at this time. In the absence of a change to the methodology or additional data, eliminating the zero physician work pool would result in large reductions in payments for some of the specialties whose services are included in the pool. The Lewin Group

also indicated that this idea is not a "viable alternative to the current zero (physician) work pool approach." (The Lewin Group, pages 19-20).

- *Develop Specialty-Specific Zero Physician Work Pools.*

Under this approach, the Lewin Group report described an idea for maintaining the general zero physician work pool approach with specialty-specific zero physician work pools (the Lewin Group, page 20). Since the zero physician work pool is an exception to the basic methodology, we are not currently interested in developing another exception to replace it. We are interested in finding a single methodology that would apply to all physicians' services. While we are not adopting this suggestion, we do appreciate the Lewin Group's work in developing this and many other ideas for consideration as we make refinements to the practice expense methodology.

- *Make Technical Component Equal Global Less Professional Component RVUs.*

Many of the services that are affected by the zero physician work pool are services that have both professional and technical components. Under current policy, the technical component practice expense RVU is determined in the zero physician work pool. It is added to the practice expense RVUs for the professional component determined under the basic methodology to determine payment for the global service. This Lewin Group idea would change this to make the technical component RVUs equal the difference between the global and the professional component RVUs while other zero physician work services would be returned to the basic methodology (The Lewin Group, page 21).

If we were to adopt this approach, the zero physician work pool would no longer have any effect. The zero physician work pool would not have any effect on the professional and technical component services since the global service from the basic methodology would be used to derive the technical component value. The practice expense RVUs for other zero physician work services would be priced under the basic methodology. In the absence of a change to the methodology or additional data, this idea would result in large reductions in payments for some of the specialties whose services are included in the pool.

As we have indicated above, we are concerned about adopting this idea at this time. While we are not currently proposing to adopt this idea as an alternative to the zero physician work

pool, we do believe there is merit in making the technical component value equal to the difference between the global and professional component RVU for services that are unaffected by the zero physician work pool. We receive many more bills for the global than the technical component only. Since it is far more common to receive a global than a technical component only bill, it is far more likely that using the global to value the technical component service will result in a payment that is more typical of the relative actual practice expense associated with the service.

For this reason, we are proposing to make the technical component value equal to the difference between the global and the professional component for procedure codes that are not included in the zero physician work pool. We will continue to make the global value equal to the sum of the professional and the technical component values for procedure codes that remain in the zero physician work pool. However, we may revisit this decision in the future if we can address issues related to the zero physician work pool. We have provided more detail on the redistributive impact of this proposal among all physician specialties in the impact section of this proposed rule.

• *Develop Proxy Physician Work RVUs for Zero Physician Work Services.*

Finally, the Lewin Group described an idea that would retain work and direct expenses as the basic allocators of indirect costs but create proxy physician work values for services that have no physician work (the Lewin Group, pages 22–23). The GAO suggests that the basic method for allocating indirect expenses does not adequately account for the indirect costs associated with services that do not have physician work RVUs (GAO–02–53, page 22). We do not believe that the large payment reductions that would occur if some zero physician work services were priced under the basic methodology are necessarily associated with the indirect cost allocation methodology. While the zero physician work pool is of benefit to many of the services that were originally included, some specialties commented that this methodological change negatively affected the particular services they provide. As a result, we allowed specialties to request that their services be removed from the zero physician work pool (see July 22, 1999 proposed rule (64 FR 39620)). If there are shortcomings in the indirect cost allocation for services that have zero physician work, it seems likely that the values for all zero physician work services would be adversely affected.

However, since many zero physician work services are not adversely affected under the top down methodology, it seems unlikely that the indirect cost allocation explains the adverse payment impact that would result for some services from elimination of the zero physician work pool. For this reason, we do not anticipate modifying the indirect cost allocation for zero physician work services.

Based on our analysis of the Lewin suggestions, we do not believe that allocation of either direct or indirect expenses explains the effect of the top down methodology on zero physician work services. Rather, we believe it is likely that a relatively low practice expense per hour for some of the specialties included in the zero physician work pool explains why their payments are adversely affected by its elimination.

The specialties whose services are affected by the zero physician work pool may want to conduct supplemental practice expense surveys if they believe there are shortcomings in the practice expense per hour information that we use as part of the basic methodology. We have published in this issue of the **Federal Register**, an interim final rule with comment that will modify the criteria for acceptance of supplemental data. This should make it easier for specialties to incorporate new practice expense survey information into the methodology. Further, as we indicated previously in the November 1, 2000 **Federal Register** (65 FR 65384), we believe that there are significant advantages to receiving practice cost information through multi-specialty surveys. For this reason, we would welcome a multi-specialty practice expense survey from all of the specialties that have payments affected by the zero physician work pool.

b. Other Proposals for Changes to the Zero Physician Work Pool

(i) Adjustment to Oncology Supplies Practice Expense Per Hour

In the June 5, 1998 proposed rule (63 FR 30832), we proposed an adjustment to the medical supplies practice expense per hour for oncology as a result of a concern that their inordinately high practice expense per hour included expenses associated with separately payable cancer drugs. We proposed to substitute the “all physician” average for the oncology-specific medical supplies practice expense per hour. We received public comments indicating that, even after excluding the effect of higher drug expenses, oncologists have higher medical supply expenses than

the average physician because of high supply costs associated with the administration of chemotherapy. These commenters suggested alternatives to using the average physician rate. In our November 2, 1998 (63 FR 58825) final rule, we made an adjustment to the medical supplies practice expense per hour for oncology and indicated our belief that oncology medical supply expenses would not necessarily exceed those of the average physician. However, the adjustment has largely had no effect since the practice expense RVUs for chemotherapy administration services are determined in the zero physician work pool.

In its October 2001 report, the GAO recommended that we examine the effect of the adjustment made to oncologists’ reported medical supplies expenses per hour. GAO did not suggest a specific alternative to the adjustment we made (GAO–02–53, pages 24–25). Consistent with the GAO recommendation, we have examined this adjustment and its impact on Medicare payments to oncologists. Upon further review, we believe that there is merit in reconsidering the adjustment that we made to the medical supply expenses for oncologists in combination with removing chemotherapy administration services from the zero physician work pool.

At this time, we have no specific information on oncology medical supply expenses net of separately payable drugs. However, we have established a process that would allow specialties to submit supplemental practice expense survey data to us. While the criteria for performing a survey require consistency with the SMS, we are amenable to modifications to the survey instrument so that it can address questions that are of concern to a specific medical specialty. For instance, we would allow an oncology survey to request that respondents distinguish between drug and other medical supply related expenses. We believe that using specific data on this question from a survey would be preferable to developing an alternative adjustment that requires us to make assumptions about oncology medical supply expenses. However, if further survey information is unavailable to us, we are considering information that could be used as a reasonable proxy to determine the portion of the supplies practice expense per hour that is attributable to medical supplies that are not separately payable. Such an idea was suggested in the public comments on the June 5, 1998 proposed rule. We are considering other alternatives as well. These approaches to the supplies

practice expense per hour would apply if chemotherapy administration services were removed from the zero physician work pool.

(ii) Change to Staff Time Used To Create the Pool

In the November 2, 1998 final rule (63 FR 58841), we indicated that average clinical staff time was used in the creation of the zero physician work pool. Since the cost pools are created based on physician time and, by definition, zero physician work services have no physician time, we need to use staff time to create the cost pool. If our database indicates that multiple staff types are typically involved in the service, we have used an average of the different clinical staff times. We are proposing to create the cost pool using the highest staff time in place of average staff time. The impact of this proposal is shown in the impact section of this proposed rule.

(iii) Removal of Non-Invasive Vascular Diagnostic Study Codes From the Zero Physician Work Pool

We are proposing to remove the non-invasive vascular diagnostic study codes (CPT codes 93875–93990) from the zero physician work pool based on a request from the American Association for Vascular Surgery and the Society for Vascular Surgery. The impact of this proposal is also described further in the impact section.

(iv) Removal of Immunization CPT Codes 90471 and 90472 From the Zero Physician Work Pool

As discussed above, in the November 2, 1998 final rule (63 FR 58841), in response to the many commenters who were concerned about the proposed reductions for services with zero physician work RVUs, we created a separate practice expense pool for all services with zero physician work RVUs. The assignment of services to this zero physician work pool was of benefit to most services in this expense pool. However, some specialties were negatively affected by this methodology, and we have allowed specialties to indicate whether their services should be priced in this pool.

Immunization administration services do not have physician work RVUs and have been included in the zero physician work pool. So that the direct practice expense resource costs associated with the immunization administration services are recognized, we propose removing these services from the zero physician work pool methodology and treating them like the vast majority of services on the

physician fee schedule. Using the direct cost practice expense inputs as recommended by the AMA's RUC, the proposed practice expense relative value units will be 0.22 for CPT code 90471 and 0.09 for CPT code 90472. This change will nearly double payment for CPT code 90471 and slightly reduce payment for CPT code 90472. Procedure CPT code 90471 is used for immunization administration and CPT code 90472 is used for each additional vaccine. Since CPT code 90472 must be billed in conjunction with CPT code 90471, the total payment for these procedures will increase when billed together.

We have not assigned immunization administration physician work RVUs because this service does not typically involve a physician. The nurse that administers the vaccine typically provides the necessary counseling to the patient and this time is accounted for in the practice expense RVU.

In addition, we would note that not all services represented by CPT codes 90471 and 90472 are covered by Medicare. For example, medically necessary administrations of tetanus toxoid (such as following a severe injury) would be covered whereas preventive administration of this vaccine would not be covered. Also, we will consider whether the amount of counseling of the patient and/or family may be different for childhood immunizations than for the typical Medicare service. Therefore, we are considering whether coding changes to reflect these differences would be appropriate.

### 3. Utilization Data

As indicated earlier, Medicare utilization is an important data source used in determining the practice expense RVUs. In our final rule published on November 2, 1998 (63 FR 58815), we used 1997 Medicare utilization data to create the original resource-based practice expense RVUs. Based on a public comment, we indicated in our November 2, 1999 final rule (64 FR 59405) that we would use 1998 Medicare utilization to develop the fully implemented RVUs that appear in that final rule. Because these data were unavailable to us for the proposed rule, the first time we could act on this public comment was in the final rule. We have continued our policy of using the latest utilization data to develop each successive year's fully implemented practice expense RVUs during each year of the transition (see 65 FR 65436, published on November 1, 2000, and 66 FR 55322, published on November 1, 2001).

While substituting the latest year's utilization data into the practice expense methodology generally made little difference on total Medicare payments per specialty, it had a larger impact on services that have values affected by the zero physician work pool. The practice expense values for the technical component and other services included in the zero physician work pool declined 4 percent in 2002 as a result of using the most recent Medicare utilization data. Since the technical component is used to derive the global practice expense RVUs for professional and technical component services, there was also a reduction in the practice expense RVU for the global service.

The specialties that provide many of the services that are included in the zero physician work pool have expressed concern about the impact of the most recent data on utilization on values for their services. They recently suggested that we use combined utilization data from 1997 to 2000 to determine the practice expense values. Alternatively, these commenters suggested using either the 1997 or 1999 utilization as a "base year" until an alternative to the zero physician work pool can be developed. These commenters further indicated that, once an option is chosen, we should not use more recent utilization data until comprehensive reform of the zero physician work methodology is adopted.

We believe the suggestion of using multiple years of utilization data in the practice expense methodology has merit. Using multiple years of data has the potential to minimize the effect of year to year case mix changes on practice expense RVUs and improves the stability of our payment systems. We are proposing to develop the practice expense RVUs using Medicare utilization data from 1997–2000. More information on the impact of this proposal can be found in the regulatory impact statement of this proposed rule.

We also agree with the suggestion that the utilization data not change annually until the zero physician work pool is eliminated. In fact, we are reconsidering whether to continue the practice of using the most recent utilization to develop each successive year's practice expense RVUs. As we have indicated elsewhere in this and earlier rules, we are continuing the refinement process beyond the 1998–2002 transition period mandated by the BBA. Once the refinement process is complete, we believe that the physician community has a reasonable expectation that the practice expense RVUs will not change from year to year unless further

refinement is undertaken. Once the initial refinement of practice expense RVUs is complete, we expect to make additional refinements at least every 5 years as provided for in section 1848(c)(2)(B) of the Act. As the refinement process continues, there have been fewer widespread changes to Medicare payments and there has been increased year-to-year consistency in the practice expense RVUs. We believe this stability would improve if we incorporated the most recent utilization data into the practice expense methodology only when we undertake substantial refinement as part of a 5-year review. For this reason, we are proposing to use the 1997–2000 utilization data to develop the CY 2003 practice expense RVUs and not further update the utilization data to incorporate the 2001 utilization data in this year’s final rule. Further, we are proposing to continue using the 1997–2000 utilization data in the practice expense methodology until we undertake the 5-year review of practice expense RVUs. We invite comments on these issues.

4. Site of Service

As part of our resource-based practice expense methodology, we make a distinction between the practice expense RVUs for the non-facility and the facility setting.

This distinction is needed because of the higher resource costs to the physician in the non-facility setting when the practitioner typically bears the cost of the resources associated with the service. In addition, the distinction ensures that we do not make a duplicate payment for any of the practice expenses incurred in performing a service for a Medicare beneficiary. When the beneficiary is a facility patient, we pay the facility for the clinical staff, supplies, and equipment needed to care for the patient. A generally lower facility practice expense rate is paid to the practitioner. Currently, we have designated only hospitals, skilled nursing facilities (SNFs), and community mental health

centers (CMHCs) as facilities for purposes of calculating practice expense. An ambulatory surgical center (ASC) is designated as a facility if it is the place of service for a procedure on the ASC list. All other places of service are currently considered non-facility.

Several new places of service are now in use for which we need to assign a site-of-service designation. Also, we are proposing revisions to the site-of-service designation for several existing places of service. We are proposing to assign a facility site of service where a facility or other payment will be made, in addition to the physician fee schedule payment to the practitioner, to reflect the practice expenses incurred in providing a service to a Medicare patient. We are proposing to designate all other places of service as non-facilities.

The following is a list of the new places of service, along with their place of service numerical codes and their proposed site of service designations using the above criteria:

04—Homeless Shelter—

We are proposing that this be considered a nonfacility setting.

05—Indian Health Service Free-Standing Facility—

We are proposing that this be considered a nonfacility setting.

06—Indian Health Service Provider-Based Facility—

We are proposing that this be considered a facility setting.

07—Tribal 638—Free-Standing Facility—

We are proposing that this be considered a nonfacility setting.

08—Tribal 638—Provider-Based Facility—

We are proposing that this be considered a facility setting.

15—Mobile Unit

We are proposing that this be considered a nonfacility setting.

If a mobile unit provides a service to a facility patient, the appropriate place-of-service code for the facility should be used. For instance, if a portable X-ray service is provided to a patient in a Part

A skilled nursing facility stay, the place of service is 31, Skilled Nursing Facility. No payment is made under Part B for the technical component of a diagnostic test, portable x-ray transportation or portable x-ray set up. Payment is made to the SNF for Part A services and includes payment for diagnostic services that may be needed by the patient. This policy is consistent with recommendations made by the Inspector General in a recent report, Review of Improper Payments Made by Medicare Part B for Covered Services under the Part A Skilled Nursing Facility Prospective Payment System (A–01–00–00538).

20—Urgent Care Facility—

We are proposing that this be considered a nonfacility setting.

We are proposing changes in site of service to the following current designations:

26—Military Treatment Facility—

Currently this is designated as a nonfacility. We are proposing that this be considered a facility setting.

41—Ambulance-Land

42—Ambulance Air or Water—

Currently codes 41 and 42 are designated as nonfacility. We would propose to designate them as facilities because we make payments for ambulance services using the ambulance fee schedule that covers the direct practice expense.

52—Psychiatric Facility Partial Hospitalization—

Currently, this is designated as a nonfacility. We are proposing that this be considered a facility setting.

56—Psychiatric Residential Treatment Facility—

Currently, this is designated as a nonfacility. We are proposing that this be considered a facility setting.

In the chart below is a complete list of all the existing place-of-service codes along with the appropriate site-of-service designation and the descriptor for each. These codes are used on all professional claims to specify the entity where services are furnished.

PLACE OF SERVICE CODES FOR PROFESSIONAL CLAIMS; DATABASE AS OF 1/11/2002

Facility vs non-facility designation	Place of service code(s)	Place of service name	Place of service description
NF .....	01–02	Unassigned .....	N/A.
NF .....	03	School .....	A facility whose primary purpose is education.
NF .....	04	Homeless Shelter .....	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (for example, emergency shelters, individual or family shelters).

## PLACE OF SERVICE CODES FOR PROFESSIONAL CLAIMS; DATABASE AS OF 1/11/2002—Continued

Facility vs non-facility designation	Place of service code(s)	Place of service name	Place of service description
NF .....	05	Indian Health Service Free-standing Facility.	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
F .....	06	Indian Health Service Provider-based Facility.	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
NF .....	07	Tribal 638 Free-standing Facility .....	A facility or location owned and operated by a Federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
F .....	08	Tribal 638 Provider-based Facility .....	A facility or location owned and operated by a Federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
NF .....	09–10	Unassigned .....	N/A.
NF .....	11	Office .....	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
NF .....	12	Home .....	Location, other than a hospital or other facility, where the patient receives care in a private residence.
NF (*See above explanation).	13–14	Unassigned .....	N/A.
NF .....	15	Mobile Unit .....	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
NF .....	16–19	Unassigned .....	N/A.
NF .....	20	Urgent Care Facility .....	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
F .....	21	Inpatient Hospital .....	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
F .....	22	Outpatient Hospital .....	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
F .....	23	Emergency Room—Hospital .....	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
F when performing a service on the Medicare ASC list, otherwise a NF..	24	Ambulatory Surgical Center .....	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
NF .....	25	Birthing Center .....	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
F .....	26	Military Treatment Facility .....	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
F .....	27–30	Unassigned .....	N/A.
F .....	31	Skilled Nursing Facility .....	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

PLACE OF SERVICE CODES FOR PROFESSIONAL CLAIMS; DATABASE AS OF 1/11/2002—Continued

Facility vs non-facility designation	Place of service code(s)	Place of service name	Place of service description
NF .....	32	Nursing Facility .....	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
NF .....	33	Custodial Care Facility .....	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
F .....	34	Hospice .....	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families is provided.
	35-40	Unassigned .....	N/A.
F .....	41	Ambulance—Land .....	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
F .....	42	Ambulance—Air or Water .....	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
	43-49	Unassigned .....	N/A.
NF .....	50	Federally Qualified Health Center .....	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
F .....	51	Inpatient Psychiatric Facility .....	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
F .....	52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
F .....	53	Community Mental Health Center .....	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of that admission; and consultation and education services.
NF .....	54	Intermediate Care Facility/Mentally Retarded.	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
NF .....	55	Residential Substance-Abuse Treatment Facility.	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
NF .....	56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
	57-59	Unassigned .....	N/A.
NF .....	60	Mass Immunization Center .....	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.
NF .....	61	Comprehensive Inpatient Rehabilitation Facility.	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
NF .....	62	Comprehensive Outpatient Rehabilitation Facility.	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
	63-64	Unassigned .....	N/A.

## PLACE OF SERVICE CODES FOR PROFESSIONAL CLAIMS; DATABASE AS OF 1/11/2002—Continued

Facility vs non-facility designation	Place of service code(s)	Place of service name	Place of service description
NF .....	65	End-Stage Renal Disease Treatment Facility.	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
NF .....	66–70 71	Unassigned ..... State or Local Public Health Clinic .....	N/A. A facility maintained by either State or local health departments which provides ambulatory primary medical care under the general direction of a physician.
NF .....	72	Rural Health Clinic .....	A certified facility which is located in a rural medically-underserved area that provides ambulatory primary medical care under the general direction of a physician.
NF .....	73–80 81	Unassigned ..... Independent Laboratory .....	N/A. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
	82–98 99	Unassigned ..... Other Place of Service .....	N/A. Other place of service not identified above.

*B. Anesthesia Issues*

## 1. Five-Year Review of Anesthesia Work

Medical and surgical services paid under the physician fee schedule have three separate relative value components, a work RVU, a practice expense RVU and a malpractice RVU. Physician anesthesia services are paid under the physician fee schedule, but the payment method is different than the payment method for physician medical and surgical services. Payment for anesthesia services is based on the sum of base units and anesthesia time units multiplied by an anesthesia CF that is different from the physician fee schedule CF for medical and surgical services.

The law requires that we review RVUs no less than every 5 years. The first 5-year review of work RVUs was completed and the revised work RVUs were implemented in 1997. The second 5-year review (with the exception of anesthesia services) was completed and the revised work RVUs implemented in CY 2002.

In the first 5-year review of work RVUs, we accepted the American Medical Association's (AMA's) Relative Value Update Committee's (RUC's) recommendation that the work of anesthesia services was undervalued by approximately 23 percent. Since anesthesia services do not have individual work RVUs per code, the adjustment in anesthesia work was made to the anesthesia CF and not to the anesthesia codes themselves. This resulted in a 16-percent increase in the anesthesia CF. Budget neutrality was maintained by making an adjustment to the general physician fee schedule.

For the second 5-year review, the American Society of Anesthesiologists (ASA) submitted comments to us

contending that the work of anesthesia services is still undervalued by almost 31 percent. The Society subsequently reduced this to a request for a 26-percent increase in work based on additional discussions with the RUC.

We can impute an anesthesia work value from the current allowed charge for an anesthesia service. This work value can be compared to the work value for anesthesia services that is derived from a building block approach. Under the building block approach, uniform individual components of the anesthesia service are identified and the work value of each component is estimated on the basis of a comparable physician medical or surgical service. The ASA derived a work value for an anesthesia code by dividing the anesthesia service into five uniform components and compared the work of each component to a comparable medical or surgical service. The five components are—preoperative evaluation, equipment and supply preparation, induction period, postinduction period, and postoperative care and visits. Using this method, the ASA proposed work values for 19 high volume anesthesia codes. The 19 codes represent a reasonable variety of surgical procedure types, including general surgery, vascular surgery, neurosurgery, urology, orthopedics, cardiac surgery, and ophthalmology. The base units of the 19 anesthesia codes reviewed range from three to twenty units.

During this second 5-year review of work, four RUC workgroups have reviewed the ASA comments and received supplemental information through presentations from the ASA. Most of these workgroups have expressed concerns about some of the intensity values that ASA assigned to

the individual anesthesia components, most notably, the induction and postinduction time periods. Each of these workgroups expressed serious concern about extrapolating the imputed work undervaluation from the 19 survey codes to all anesthesia service codes, even though these 19 codes account for more than 40 percent of all anesthesia associated with surgical services.

Despite the efforts of its workgroups, the RUC furnished no recommendation to us on whether the work of anesthesia services is over- or undervalued. In the November 1, 2001 physician fee schedule final rule, we stated that:

The RUC has informed us that it will continue to look at anesthesia work beginning at its first meeting in CY 2002. We will review the RUC recommendation and address anesthesia work in next year's proposed physician fee schedule rule.

The RUC recently presented us with the analysis and findings of its April 2002 anesthesia workgroup. Despite its detailed analysis and laborious discussions of this issue, the RUC concluded that it was unable to make a recommendation regarding modification to the physician work valuation of anesthesia codes. Specifically, the RUC indicated the following:

“The RUC, having carefully considered the information presented, and having a reasonable level of confidence in the data which was presented and developed by the RUC, is unable to make a recommendation to CMS regarding modification to the physician work valuation of anesthesia codes.”

At the April 2002 meeting, the RUC anesthesia workgroup reviewed the postinduction intensity values for the 19 anesthesia codes. The group also

reviewed each anesthesia code, the benchmark surgical code, and the five codes mapped to that anesthesia code that accounted for the largest percentage of total volume. The group considered the extent to which the anesthesia work of the benchmark surgical code is representative of other surgical codes that would be covered by the anesthesia code.

We will review the information forwarded by the RUC and all comments we receive during the comment period to determine if an appropriate adjustment can be made to anesthesia work. We would note that any such adjustment would also require an adjustment to the conversion factor for all physicians' services, as required by section 1848(c)(2)(B)(ii) of the Act. For example, a 26 percent increase in anesthesia work, an amount which was requested last year, would require a reduction of about 0.4 percent in the conversion factor for all services. We welcome comments on these issues.

## 2. Add-on Anesthesia Codes

### Current Policy

As we discuss above, payment for anesthesia services is based on the sum of an anesthesia code-specific base unit value plus anesthesia time units multiplied by an anesthesia CF. If the physician is involved in multiple anesthesia services for the same patient during the same operative session, payment is based on the base unit assigned to the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. This policy was adopted at the start of the physician fee schedule in 1992 and is incorporated in § 414.48(g).

Claims processing manuals instruct the carrier on the method for handling anesthesia associated with multiple or bilateral surgical procedures. Under Medicare Carrier Manual (MCM) 4830 D, the carrier instructs the physician to report the anesthesia procedure with the highest base unit value with the multiple procedures modifier, "51", and to report total time across all surgical procedures. Thus, the carrier is recognizing payment for one anesthesia code, despite the billing of multiple surgical codes by a surgeon.

### Proposed Policy for Add-on Codes

In 2001 and 2002, the CPT has added new anesthesia codes, some of which are add-on codes. The objective is that the add-on code would be billed with a primary code and the base unit of each code would be allowed.

In the burn area, CPT code 01953 (1 base unit) is used in conjunction with

CPT code 01952 (5 base units). In the obstetrical area, CPT code 01968 (2 base units) is used in conjunction with CPT code 01967 (5 base units) and CPT code 01969 (5 base units) is used in conjunction with CPT code 01967 (5 base units).

The application of the multiple anesthesia service policy means that the base units of the add-on codes would never be recognized. Only the base units of the primary code would be allowed. We believe that anesthesia add-on codes should be priced differently than other multiple anesthesia codes. As a result, we are proposing to revise the regulations in § 414.46(g) to include an exception to the usual multiple anesthesia services policy for add-on codes.

### C. Changes to the Physician Fee Schedule Update Calculation and the Sustainable Growth Rate (SGR)

#### 1. Medicare Economic Index Productivity Adjustment

In its March 2002 Report to Congress, MedPAC recommended that "The Secretary should revise the productivity adjustment for physicians' services and make it a multifactor instead of labor-only adjustment." In this section, we review the history of the Medicare Economic Index (MEI) productivity adjustment, describe the current MEI productivity adjustment, and identify and evaluate possible alternative MEI productivity adjustments based on the individual contributions we solicited from experts on this topic. We conclude by proposing that the MEI productivity adjustment be changed to reflect an economy-wide multifactor productivity adjustment.

#### a. History of MEI Productivity Adjustment

The MEI is based on the fourth sentence of section 1842(b)(3) of the Act that 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 such higher level is justified by year-to-year economic changes. S. Rept. No. 92-1230 at 191 (1972) provides slightly more detail on that index, stating that:

Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels combined in a matter consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group.

Based on this legislative intent, in 1975, we determined that the MEI would be based on a broad wage measure reflecting overall earnings growth, rather than direct inclusion of physicians' net income. We used average weekly earnings of nonagricultural production (nonsupervisory) workers, net of worker's productivity, as the wage proxy in the initial MEI. We included the productivity adjustment because it avoided double counting of gains in earnings resulting from growth in productivity and produced a MEI that approximated an economy-wide output price index like the Consumer Price Index (CPI). The productivity adjustment we used was the annual change in economy-wide private nonfarm business labor productivity, applied only to the physicians' earnings portion of the MEI (then 60 percent).

As noted, the productivity adjustment in the MEI serves to avoid the double counting of productivity gains. Absent the adjustment, productivity gains from producing additional outputs (procedures) with a given amount of inputs would be included in both the earnings component of the MEI (reflecting growth in overall economy-wide productivity) and in the additional procedures that are billed (reflecting physicians' own productivity gains). Therefore, general economic labor productivity growth is removed from the labor portion of the price update.

The basic structure of the MEI remained relatively unchanged from its effective date (July 1, 1975) to 1992, although its weights were updated periodically and a component was added for professional liability insurance. Section 9331 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) (OBRA) mandated a study of the MEI and a notice and opportunity for public comment before revision of the methodology for calculating the MEI. Based on this requirement, we held a workshop with experts on the MEI in March 1987 to discuss topics ranging from the specific type of index to use (Laspeyres versus Paasche) to revising the method of reflecting productivity changes. Participants in the meeting included the Federal government, the Physician Payment Review Commission (PPRC), the Congressional Budget Office, the American Medical Association (AMA), and several consulting firms. The meeting participants concluded that a productivity adjustment was appropriate and that an acceptable measure of physician-specific productivity did not exist. Many alternative approaches were discussed,

including the use of a policy-based "target" measure and several existing economic productivity measures.

Using recommendations from the meeting participants, we revised the MEI and the productivity adjustment with the implementation of the physician fee schedule as discussed in the November 1992 final rule (57 FR 55896). While we retained an adjustment for economy-wide labor productivity, it was applied to all of the direct labor categories of the MEI (70.448 percent), not just physicians' earnings, and was based on the 10-year moving average percent change (instead of annual percent changes). This form of the index has been used since that time, and was most recently discussed in the November 1998 final rule (63 FR 58845) when the MEI weights were rebased to a 1996 base year.

The Balanced Budget Act replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR). Section 1848(f) of the Act specifies the formula for establishing yearly SGR target for physicians' services under Medicare. The use of SGR targets is intended to control the actual growth in aggregate Medicare expenditures for physicians' services. The SGR targets are not limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the appropriate fee schedule update, as specified in section 1848(d)(3) of the Act, is adjusted to reflect the success or failure in meeting the SGR target. If expenditures are less than the target, the update is increased. If expenditures exceed the target, the update is reduced. Specifically, expenditures are allowed to increase by fee-for-service Medicare enrollment growth, physician fee increases, increases in real per capita Gross Domestic Product (GDP), and changes in laws or regulations. Consequently, the statute links allowable increases in the volume of services resulting from physician productivity gains—together with volume and intensity increases due to technology and other factors—to the real per capita GDP.

When the SGR was enacted, the Congress specified continued use of the MEI. By 1997, this index, including its productivity adjustment, had been used in updating Medicare payments to physicians for over twenty years. We did not propose any changes to the productivity adjustment used in the MEI because its continued use was consistent with the newly mandated SGR. If we did not make the adjustment in the MEI, general economic productivity gains would be reflected in

two of the SGR factors, the MEI and real per-capita GDP (which reflects real GDP per hour worked, or labor productivity, and hours worked per person). We believe it is reasonable to remove the effect of general economic productivity from one of these factors (the MEI) to avoid double counting.

#### b. Current MEI Productivity Adjustment

The current MEI productivity adjustment is based on the 10-year moving average percent change in private nonfarm business (referred to hereafter as "economy-wide") labor productivity, published by the Bureau of Labor Statistics (BLS) on a quarterly basis. A 10-year moving average is used to limit the impact of cyclical fluctuations in productivity. The productivity adjustment is applied only to the direct labor portions of the MEI (currently estimated at 71.272 percent). Therefore, the MEI is not reduced by the full change in labor productivity, but instead by only a portion of the change.

In addition, the most recently available historical data are used for the update for the upcoming calendar year (for example, data available through the second quarter of CY 2001 was used for the CY 2002 update).

Under this method, the current estimate of the existing MEI for the CY 2003 fee schedule update would be 2.3 percent. The 10-year moving average percent change in economy-wide labor productivity for the CY 2003 update is estimated to be 2.1 percent. However, since this adjustment is applied only to the direct labor portion of the MEI, the actual adjustment would be 1.5 percent. By comparison, the most recent forecast by DRI-WEFA, a Global Insight Company, of the CPI for all items for this same period is 1.6 percent.

As noted previously, since its original development, the MEI productivity adjustment has been based on economy-wide productivity changes. This practice arose from the fact that the physicians' compensation portion of the MEI is proxied to grow at the same rate as general earnings in the overall economy, which reflect growth in overall economy-wide productivity. Removing labor productivity growth reflected in general earnings from the labor portion of the MEI produces an index that is consistent with other economy-wide output price indexes, like the CPI. Although some commenters have argued that use of a physician-specific productivity measure would be more appropriate, no such published measure existed at the time of the MEI's development; nor does one exist today.

#### c. Research on Alternative MEI Productivity Adjustments

We conducted a number of research activities to evaluate whether the current productivity adjustment is still the most appropriate adjustment to use in the MEI. First, we evaluated the currently available productivity estimates that are produced by the BLS to develop a better understanding of the strengths and weaknesses of these measures. We also reviewed the theoretical foundation of the MEI to understand how labor and multifactor productivity relate to the current physician payment system. Then we studied the limited publicly available data to begin to develop preliminary estimates of trends in physician-specific productivity to better understand the current market conditions facing physicians. Finally, we solicited the individual contributions of academic and other professional economic experts on prices and productivity. They included experts from MedPAC, AMA, OMB, Dr. Uwe Reinhardt from Princeton University, Dr. Joe Newhouse from Harvard University, Dr. Ernst Berndt from MIT, and Dr. Joel Popkin from Joel Popkin and Company (former Assistant Commissioner of Prices at BLS). Based on the information we gathered during these research efforts, we evaluated six possible options for a productivity adjustment to the MEI. Our findings on each of the options we investigated are summarized below:

- Option 1—Using a physician-specific productivity adjustment.

This option would entail using an estimate of physician-specific productivity to adjust the MEI. This option may have some theoretical attractiveness, but there are major problems obtaining accurate measures of physician-specific productivity. First, no published measure of physician-specific productivity is available. The Federal agency that produces the official government statistics on productivity, BLS, does not calculate or publish productivity measures for any health sector. Nor are there alternative measures of physician-specific productivity that incorporate the BLS methodology of measuring productivity and that would meet the BLS standard of publication. Second, it is not clear that using physician-specific productivity within the current structure of the MEI would be appropriate. Because we believe the MEI appropriately uses an economy-wide wage measure as the proxy for physician wages, using physician specific productivity could overstate or

understate the appropriate wage increase in the MEI.

We do believe, however, that it is important to understand the rate of change in physician-specific productivity. Toward this end, we have performed our own preliminary analysis of physician-specific productivity, using the limited publicly available data on physician outputs and inputs. Our analysis attempted to simulate the methodology the BLS would use to measure productivity. While this information cannot be interpreted as an official measure of productivity, we do believe it is a rough indication of the current market conditions facing physicians. We used this information to help form our determination of the most appropriate productivity adjustment to incorporate in the MEI, fully recognizing its preliminary nature and other limitations. The results of our preliminary analysis suggest that long-run physician-specific productivity growth is currently at approximately the same level as economy-wide multifactor productivity growth. Prior to the recent period, however, our preliminary estimates suggested that physician productivity gains were generally significantly greater than general economy-wide multifactor productivity gains.

As we have emphasized, our rough estimates are inadequate for establishing a formal basis for the productivity adjustment to the MEI. Nor is the underlying economic theory sufficiently compelling, at this time, to adopt a physician-specific productivity measure, even if a suitable one were available. We conclude, however, that economy-wide multifactor productivity growth appears to be roughly comparable to current physician-specific productivity growth.

- Option 2—Retaining the current productivity adjustment.

We investigated retaining the current productivity adjustment, that is, applying the 10-year moving average percent change in economy-wide labor productivity to the labor portion of the MEI. We have applied economy-wide labor productivity to a portion of the index in some form since the inception of the MEI in 1975. This current form has been used since the last major revision to the index in 1992 and was developed from the contributions of the 1987 expert panel. That panel concluded that using labor productivity applied to the labor portion of the index was a technically sound way to account for productivity in the physician update. This method makes optimal use of the available data since labor productivity data were, and are,

available on a more timely basis than economy-wide multifactor productivity. By applying this measure to the labor portion of the index, the mix of physician-specific labor and nonlabor inputs is reflected. Also, the use of a 10-year moving average percentage change reduces the volatility of annual labor productivity changes.

Our research, however, has indicated that using multifactor productivity applied to the entire index is superior to using an economy-wide labor productivity measure applied only to the labor portion of the index. The experts with whom we consulted believed it was more appropriate to reflect the explicit contribution to output from all inputs. The current measure explicitly reflects the changes in economy-wide labor inputs but does not reflect the actual change in nonlabor inputs. Instead, it implicitly assumes that nonlabor inputs would grow at the rate necessary to produce an economy-wide multifactor measure that is equivalent to the current MEI productivity adjustment. That implicit assumption is less precise than a direct, explicit calculation.

In addition, while the implicit approach produced an MEI productivity adjustment in most years that was reasonably consistent with overall multifactor productivity growth, it now appears less consistent with the actual change in nonlabor inputs in the economy. In recent years, economy-wide labor productivity has grown very rapidly. This acceleration is partly the result of major investments in computers (a nonlabor input) that have helped create a more productive work force. Also, the Bureau of Economic Analysis (BEA) has adopted methodological changes in accounting for computer software purchases in measuring GDP. These changes have significantly increased the measured historical growth rates in real GDP and labor productivity. As a result of these developments, the MEI productivity adjustment based on labor productivity applied only to the labor portion of the MEI has increased very rapidly. Since the multifactor definition is an explicit calculation of the change in economic output relative to the change in both labor and nonlabor inputs, it better reflects the trend changes.

Finally, as noted previously, our preliminary estimates of physician-specific productivity suggest a current growth pattern that is similar to growth in multifactor productivity in the economy overall. In consideration of the economic theory underlying productivity measurement, especially in view of the recent developments in

labor versus nonlabor economic input growth trends, we concluded that using a multifactor productivity adjustment is superior to the current methodology for adjustment for productivity in the MEI.

- Option 3—Changing to using economy-wide multifactor productivity.

One option for adjusting for productivity gains in the MEI would be to continue to use an economy-wide productivity measure, but to use multifactor productivity applied to the entire index, instead of labor productivity applied to the labor portion of the MEI. As noted previously, this approach was recommended by MedPAC in its March 2002 Report to the Congress. This option would better satisfy the theoretical requirements of an output price, in this case the MEI, by explicitly reflecting the productivity gains from all inputs. In addition, the use of economy-wide multifactor productivity would still be consistent with the MEI's use of economy-wide wages as a proxy for physician earnings. While annual multifactor productivity can fluctuate considerably, though usually less than labor productivity, using a moving-average would produce a relatively stable and predictable adjustment.

Each expert with whom we consulted believed that using a multifactor productivity measure was theoretically superior to the existing method because it reflected the actual changes in nonlabor inputs instead of reflecting an implicit assumption. They also believed that the lack of timely data on multifactor productivity was not as important as would have appeared initially. Instead, the experts believed it was more appropriate that the adjustment be based on a long-run average that was stable and predictable rather than on annual changes in productivity. Thus, if a long-run average were used, the increased lag time associated with the availability of published data on multifactor productivity would become less significant. Finally, one expert believed that changing to economy-wide multifactor productivity applied to the entire MEI would make it easier to understand the magnitude of the productivity adjustment.

Use of multifactor productivity to adjust the MEI poses two concerns. First, multifactor productivity is much harder to measure than labor productivity. Economic inputs other than labor hours can be very difficult to identify and calculate properly. The experts at BLS, however, have adequately overcome these difficulties, and we are satisfied that their official published measurements are sound for

the purpose at hand. Moreover, use of a 10-year moving average increase helps to mitigate any remaining measurement variation from year to year.

The second concern relates to the timeliness of the data. BLS publishes multifactor productivity levels and changes only annually (as opposed to the quarterly release of labor productivity data) and with an extended time lag (about 1½ years). These timeframes arise unavoidably from the difficulties of measurement mentioned above, but imply that the timeframe of data used to adjust the MEI would not match that of the historical data on wages and prices underlying the MEI. For the CY 2003 physician payment update, for example, we would use data on wages and prices through the second quarter of CY 2002, but would have to use multifactor productivity data only through CY 2000. Although the misalignment of data periods is a concern, we believe it is a reasonable trade-off in view of the improvement offered by the explicit measurement of nonlabor inputs. Also, since use of a 10-year moving average is intended to reduce fluctuations and provide a more stable level of the productivity adjustment, availability of the most recent data is of less importance.

The 10-year moving average percent change in economy-wide multifactor productivity that would be used for the CY 2003 update (historical data through CY 2000) is currently estimated at 0.8 percent. Our preliminary internal analysis of physician-specific productivity gains suggests that these economy-wide multifactor measures are somewhat consistent with those trends. Thus, using economy-wide multifactor productivity for MEI productivity adjustment theoretically would be superior to using labor productivity growth applied to the labor portion of the MEI. In addition, the use of a 10-year moving average would help alleviate the lag in the availability of the data. Lastly, the current 10-year moving average growth in economy-wide multifactor productivity appears to be within the range we have estimated for physician-specific multifactor productivity. One possible weakness of using economy-wide multifactor productivity is that it does not reflect physician-specific measures, whereas the existing methodology reflects the distribution of labor and nonlabor inputs used in the production of physician services. In practice, however, the balance between these factors of production is not substantially different for physician practices versus the overall economy.

- Option 4—Changing to using economy-wide multifactor productivity with physician-specific input weights.

Another option we explored was using economy-wide labor and capital productivity measures (which, when weighted together, produce multifactor productivity), but with physician-specific input weights. This method would better reflect the proportion of labor and capital inputs used by physicians, yet still reflect the explicit contribution to productivity of labor and nonlabor inputs. The experts with whom we discussed this option thought it was theoretically consistent with a measure of multifactor productivity, even though different productivity measures would be applied to different components of the MEI.

As noted above, the labor and capital shares for the overall economy do not appear to vary enough from the physician-specific shares in the MEI to result in a significantly different measure. A weakness of this method is that the BLS capital productivity series is not widely used or cited; therefore, we are unsure of the accuracy and reliability of this measure. This method also adds another layer of complexity to the formula, however, making it more difficult to understand the adjustment. We would prefer that any method we choose be straightforward so that everyone can readily understand the adjustment. Overall, we believe that this method does not provide enough of a technical improvement to justify the added complexity that would be required to implement it.

- Option 5—Adjusting productivity using a “Policy Standard”.

In its March 2002 Report to the Congress, MedPAC suggested establishing a policy target for the productivity adjustment. Under this methodology, the level of the policy target would be based on the productivity gains that we believe physicians could attain. This level would be set through policy and would likely be based on a long-run average of either economy-wide labor or multifactor productivity (but could reflect other, possibly judgmental, factors). Generally, the level of the policy standard would remain constant for several years; periodically, the policy target would be reviewed, and possibly adjusted.

Some of the experts we consulted believed that a policy target would lessen the volatility of the adjustment since the target would not be changed often. Conversely, others noted the large, abrupt changes that could result if actual economic performance deviated from the policy standard requiring

subsequent adjustments to the standard. Some believed that this method adjusts for the problem of precisely measuring productivity. If we used a policy standard we could avoid having to develop an exact measure. Using a policy target, however, may appear arbitrary without a theoretical basis to support its use.

The policy target recommended by MedPAC was 0.5 percentage points per year. Its justification for this number was the fact that the long-run average of economy-wide multifactor productivity was close to 0.5 percent (the most recent 10-year average is now 0.8 percent). We do not believe this is a preferred option for adjusting the MEI for productivity improvements. Our preference is to use a long-term data-based approach that will produce results that are not inconsistent with a policy standard and that will automatically reflect changes in actual economic performance over time, and not through abrupt periodic large adjustments. Thus, we conclude that a policy target does not provide an improvement over any of the data-based methodologies.

- Option 6—Eliminate Productivity Adjustment from the MEI.

Questions are raised occasionally as to the possibility of eliminating the productivity adjustment from the MEI. We did not consider this to be a viable option. Our research concluded that adjusting for productivity in the MEI is necessary to have a technically correct measure of an output price increase, free of double-counting the impact of productivity. Every expert with whom we consulted agreed that a productivity adjustment was appropriate. They believed that the important question is which adjustment is the most appropriate. Therefore, we conclude, again, that it is not acceptable for the productivity adjustment to be removed from the MEI.

#### d. Use of a Forecasted MEI and Productivity Adjustment

MedPAC, in its March 2002 Report to the Congress, recommended the use of a forecasted MEI value, rather than the current historical increase. However, implementation of this option raises several legal as well as practical issues. The 1972 Senate Finance Committee report language reflects Congress' intent that the MEI should “follow rather than lead” overall inflation. Because of this, updates to the physician fee schedule have always been based on historical, rather than forecasted, MEI data. In this way, increases in the MEI do not lead the current measures of inflation but follow them based on historical trends. Furthermore, at the time of

implementation of the SGR system, the Congress specified that the SGR system should use the MEI that existed at that time, which was based on historical data measures. The law did not recommend or specify a change in the MEI methodology; the assumption is that the Congress was satisfied that the MEI was functioning as designed.

If we were to change to a forecasted MEI and productivity adjustment, there are also several practical issues that would need to be addressed. One is that changing from a historical-based MEI to a projected MEI would cause transitional problems because there would be a period of data that would not be accounted for in the year of implementation. For example, the CY 2002 MEI update was based on historical data through the second quarter of 2001. If we were to use a forecasted MEI in the update for CY 2003, the changes between the second quarter of 2001 and the first quarter of 2003 would not be accounted for in the update. Finally, changing to a forecasted MEI and productivity adjustment raises additional questions about correcting for

forecast errors. Based on these problems, we will continue to use historical data to make updates under the physician fee schedule.

e. Proposed Productivity Adjustment to the MEI

Based on the research we conducted on this issue, we are proposing to change the methodology for adjusting for productivity in the MEI. We propose that the MEI used for the CY 2003 physician payment update reflect changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity applied to the entire index. The current method accounts for productivity by adjusting the labor portion of the MEI by the 10-year moving average change in private nonfarm business (economy-wide) labor productivity.

We propose to make this change because: (1) It is theoretically more appropriate to explicitly reflect the productivity gains associated with all inputs (both labor and nonlabor); (2) the recent growth rate in economy-wide multifactor productivity appears more consistent with the current market

conditions facing physicians; and (3) the MEI still uses economy-wide wage changes as a proxy for physician wage changes. We believe that using a 10-year moving average change in economy-wide multifactor productivity produces a stable and predictable adjustment and is consistent with the moving-average methodology used in the existing MEI. We propose that the adjustment be based on the latest available actual historical economy-wide multifactor productivity data, as measured by BLS. Based on these proposed changes, we currently estimate the MEI to increase 3.0 percent for CY 2003. This is the result of a 3.8-percent increase in the price portion of the MEI, adjusted downward by a 0.8-percent increase in the 10-year moving average change in economy-wide multifactor productivity. Table 1 shows the detailed cost categories of the proposed MEI update for CY 2003. Since the current estimate of the MEI increase for CY 2003 is based on incomplete historical data, it may change slightly before we announce the final MEI no later than November 1, 2002.

TABLE 1.—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2003<sup>1</sup>

Cost categories and price measures	1996 weights <sup>2</sup>	CY 2003 percent changes
Medicare Economic Index Total, productivity adjusted .....	n/a	3.0
Productivity: 10-year moving average of Multifactor productivity, private nonfarm business sector .....	n/a	0.8
Medicare Economic Index Total, without productivity adjustment .....	100.0	3.8
1. Physician's Own Time <sup>3</sup> .....	54.5	4.1
a. Wages and Salaries: Average hourly earnings Private nonfarm .....	44.2	3.9
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm .....	10.3	4.8
2. Physician's Practice Expense <sup>3</sup> .....	45.5	3.6
a. Nonphysician Employee Compensation .....	16.8	4.1
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation .....	12.4	3.7
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar .....	4.4	5.4
b. Office Expense: Consumer Price Index for Urban Consumers (CPI-U), housing .....	11.6	2.6
c. Medical Materials and Supplies: Producer Price Index (PPI), ethical drugs/PPI, surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted) .....	4.5	2.1
d. Professional Liability Insurance: CMS professional liability insurance survey <sup>4</sup> .....	3.2	11.3
e. Medical Equipment: PPI, medical instruments and equipment .....	1.9	1.6
f. Other Professional Expense .....	7.6	1.6
1. Professional Car: CPI-U, private transportation .....	1.3	-2.9
2. Other: CPI-U, all items less food and energy .....	6.3	2.5

<sup>1</sup> The rates of historical change are estimated for the 12-month period ending June 30, 2002, which is the period used for computing the calendar year 2003 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of April 2002.

<sup>2</sup> The weights shown for the MEI components are the 1996 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 calendar year 1996. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 1996 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.

<sup>3</sup> The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics website—<http://stats.bls.gov>.

<sup>4</sup> Derived from a CMS survey of several major insurers (the latest available historical percent change data are for the period ending second quarter of 2002).

n/a Productivity is factored into the MEI compensation categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

## 2. Sustainable Growth Rate (SGR)

Section 1848(f)(2) of the Act specifies a formula for calculating annual SGR targets for Medicare physicians' services. The formula includes four factors. Section 1848(f)(2)(A) of the Act specifies that the first factor is the Secretary's estimate of weighted average percentage increase in fees for all physicians' services. We have calculated this factor as a weighted average of the CY 2002 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR. (For a complete list of these services see the November 1, 2001 **Federal Register** (66 FR 55316).) Drugs furnished in a physician's office that are not usually self-administered are generally covered "incident to" a physician's service under section 1861(s)(2)(A) of the Act and included in the SGR. In the past, we have used the MEI as an approximation of the drug price increase. In the final revisions we make to the CY 2001 SGR later this year, we will account for drug price growth using a refined methodology that uses growth in drug prices instead of the MEI as a proxy. In addition, we will account for drug price growth using this refined methodology in the SGRs for CY 2002 and subsequent years.

Under section 1848(d) of the Act, the update for any year is equal to the MEI increased or decreased by an update adjustment factor determined using a statutory formula. The statute limits the update adjustment factor to +3.0 and -7.0 percentage points. On March 1, 2002, we provided our estimate of the CY 2003 physician fee schedule update to the Medicare Payment Advisory Committee (MedPAC) and made this information available to the public. We estimated the update adjustment factor would be -13.1 percent. If the only change to our March 2002 estimate was accounting for drug price growth in the SGR, we estimate the update adjustment factor would be -12.8 percent. Since the statute limits the update adjustment factor to -7.0 percent, we expect the CY 2002 physician fee schedule update to equal the MEI reduced by 7.0 percentage points.

### D. Pricing of Technical Components (TC) for Positron Emission Tomography (PET) Scans

Currently all components of HCPCS code G0125, Lung image PET scan, are nationally priced. However, the technical component (TC) and global value for all other PET scans are carrier priced. To keep pricing consistent with other PET scans, we propose to have the

carriers price the TC and global values of HCPCS code G0125.

### E. Enrollment of Physical and Occupational Therapists as Therapists in Private Practice

In the November 2, 1998 final rule (63 FR 58814), we defined private practice for physical therapists (PTs) or occupational therapists (OTs) to include a therapist whose practice is in an—

- Unincorporated solo practice;
- Unincorporated partnership; or
- Unincorporated group practice.

Private practice also includes an individual who is furnishing therapy as an employee of one of the above, a professional corporation, or other incorporated therapy practice. Some carriers and fiscal intermediaries have interpreted the regulation to mean that occupational and physical therapists employed by physicians cannot be enrolled as therapists in private practice. In these carrier areas, therapy services provided in a physician's office must instead be billed as incident to a physician's service.

A specialty society representing occupational therapists has requested that carriers be able to enroll OTs in physician-directed groups as occupational therapists in private practice. A group representing PTs believes that provider numbers should be issued only to PTs working as employees in practices owned and operated by therapists.

We are proposing to clarify national policy—we would allow carriers to enroll therapists as physical or occupational therapists in private practice when they are employed by physician groups. We believe that this would reflect actual practice patterns and would permit more flexible employment opportunities for therapists. We also believe that this would increase beneficiaries' access to therapy services, particularly in rural areas. Therefore, we would revise §§ 410.59 and 410.60 to reflect this change.

### F. Clinical Social Worker Services

Currently, § 410.73(b)(2)(ii) states that, for purposes of billing Medicare Part B, clinical social worker (CSW) services do not include services furnished by a CSW to an inpatient of a Medicare-participating skilled nursing facility (SNF). Under this rule, CSWs cannot receive Medicare Part B payment for diagnostic and therapeutic mental health services when the services are furnished to patients in participating SNFs, but they can receive payment for these same mental health services when furnished in most other settings.

Additionally, clinical psychologists (CPs) may receive Medicare Part B payment for these same diagnostic and therapeutic mental health services when furnished to patients in participating SNFs. The effective date of the rule that precluded Medicare Part B payment to CSWs for services furnished to patients in participating SNFs was June 22, 1998. However, the provisions under this rule were suspended for two years beyond the effective date. Accordingly, these provisions that terminated payment for CSW services in the SNF setting were delayed until June 22, 2000.

Announcement of the two-year suspension of the provisions was made in a letter signed by the Administrator to the National Association of Social Workers rather than publishing it in the **Federal Register**.

In order to redress this issue, on October 19, 2000, we published a notice of proposed rulemaking in the **Federal Register** (65 FR 62681), in which we proposed to pay CSWs for CPT psychiatry codes 90801, 90802, 90816, 90818, 90821, 90823, 90826, 90828, 90846, 90847, 90853, and 90857 when furnished to patients in participating SNFs who are not in a covered Part A stay. At this time, we are reprinting our proposal to allow CSWs to bill for the listed CPT psychiatry codes when furnished to patients in participating SNFs who are not under a covered Part A stay. Since we have already received comments on our previously published proposed rule both supporting and opposing our proposal, we are not now seeking comments in this proposed rule. However, we will respond to the comments already received on the issue of CSW services provided to beneficiaries in SNFs when we publish this year's physician fee schedule final rule.

### G. Medicare Qualifications For Clinical Nurse Specialists

Section 4511(d)(3)(B) of the Balanced Budget Act of 1997 (Pub. L. 105-33) (BBA) defined a clinical nurse specialist as an individual who—

(i) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) Holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

When implementing the regulation for this benefit, we added a provision requiring that a CNS must be certified by the American Nurses Credentialing Center (ANCC). It has recently been pointed out to us that the ANCC does not provide certification for CNSs who

specialize in fields such as oncology, critical care, or rehabilitation.

We are proposing to revise § 410.76(b)(3) to read as follows: "Be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary." This revision would be consistent with certification criteria for nurse practitioners.

#### H. Process to Add or Delete Services to the Definition of Telehealth

##### 1. Background

Effective October 1, 2001, section 1834(m) of the Act provides for an expansion of the definition of a Medicare telehealth service. The law defines telehealth services as professional consultations, office and other outpatient visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809 and 90862) and any additional service specified by the Secretary. In addition, the law requires the Secretary to establish a process for adding or deleting services to the list of telehealth services on an annual basis.

In this proposed rule, we are proposing (1) to establish a process for adding or deleting services from the list of telehealth services, and (2) to add specific services to the list of telehealth services for CY 2003.

To evaluate services that may be appropriate for Medicare telehealth, we would accept requests for adding services to, or deleting services from, the list of Medicare telehealth services. We would accept proposals from any interested individuals or organizations from either the public or the private sectors, for example, from medical specialty societies, individual physicians or practitioners, hospitals, and State or Federal agencies. (We may also generate additions or deletions of services internally.) We would post instructions on our website outlining the steps necessary to submit a proposal. Information on applying for a new HCPCS code may be found on our website at [www.hcfa.gov/Medicare/hcpcs.htm](http://www.hcfa.gov/Medicare/hcpcs.htm), then select "HCPCS Coding Request Information."

Each proposal would have to address the items outlined below.

- Name(s), address(es) and contact information of the requestor.
- The HCPCS code(s) that describes the service(s) proposed for addition or deletion to the list of Medicare telehealth services. If the requestor does not know the applicable HCPCS code, the request should include a description

of services furnished during the telehealth session.

- A description of the type(s) of medical professional(s) providing the telehealth service at the distant site.
- A detailed discussion of the reasons the proposed service should be added to the definition of Medicare telehealth.
- An explanation as to why the requested service cannot be billed under the current scope of telehealth services, for example, the reason why the HCPCS codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested.
- An application for a new HCPCS code if the requestor believes that neither the HCPCS codes currently on the list of telehealth services nor any other HCPCS code would be adequate for describing the service requested.
- If available, data showing that the use of a telecommunications system does not change the diagnosis or treatment plan as compared to the face-to-face delivery of the service.
- If available, data showing that patients who receive this service via a telecommunications system are satisfied with the service that is delivered.

##### 2. Categories for Additions

We would assign any request to add a service to the definition of Medicare telehealth services to one of the following categories:

- *Category #1: Services similar to office and other outpatient visits, consultation, and office psychiatry services.* We would review these requests to ensure that the services proposed for addition to the list of Medicare telehealth services are similar to the current telehealth services. For example, we would look for similarities between the proposed and existing telehealth services in terms of the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We would also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment. If a proposed service meets the criteria set forth above, we would add it to the list of Medicare telehealth services.
- *Category #2: Services that are not similar to the current list of telehealth services, for example, physical therapy services, endoscopy services, and distant monitoring of patients in intensive care units.* Our review of these requests would include an assessment of whether the use of a telecommunications system to deliver

the service produces similar diagnostic findings or therapeutic interventions as compared with a face-to-face "hands on" delivery of the same service. In other words, the discrete outcome of the interaction between the clinician and patient facilitated by a telecommunications system should correlate well with the discrete outcome of the clinician-patient interaction when performed face-to-face.

Requestors should submit evidence indicating 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 service. If the evidence shows that the proposed telehealth service is equivalent to the face-to-face delivery of the service, we would add it to the list of telehealth services. However, if we determine that the use of a telecommunications system changes the nature or outcome of the service, for example, the nature of clinical intervention, as compared with the face-to-face delivery of the service, we would view the request as a request for a new service, rather than a different method of delivering an existing Medicare service. Under Medicare, new services: (1) Must fall into a benefit category; (2) must be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act; and (3) must not be specifically excluded from coverage. The requestor would have the option of applying for a national coverage determination. Information on applying for a national coverage determination may be found on our website at <http://www.hcfa.gov>; then select "Coverage Policies," then "Process."

##### 3. Our Review of Requests to Add Services

Our review of submitted requests to add services may result in the following outcomes:

- Adding an existing HCPCS code to the list of Medicare telehealth services.
- Determining that the requested service is already described by an existing telehealth service.
- Creating a new HCPCS code to describe the requested service and adding it to the list of Medicare telehealth services.
- Requesting further information.
- Notifying the requestor that a national coverage determination is necessary before a decision to accept or reject a proposal can be made.
- Rejecting the request.

##### 4. Deletion of Services

We may choose to remove a service currently on the list of Medicare telehealth services. We would remove a

service from that list if, upon review of the available evidence, we determine that a Medicare telehealth service is not safe, effective, or medically beneficial.

#### 5. Implementation

We propose to make additions or deletions to the list of Medicare telehealth services effective on a CY basis. We would use the annual physician fee schedule proposed rule published in the summer and the final rule published by November 1 each year as the vehicle for making these changes.

We will accept requests for adding services to the list of Medicare telehealth services on an ongoing basis; requests must be received no later than December 31 of each CY to be considered for the next proposed rule.

We are requesting specific comments on this approach to adding or deleting services and HCPCS codes to the definition of telehealth services.

#### 6. Proposed Addition to the Definition of Medicare Telehealth for Calendar Year 2003

Section 1834(m) of the Act defines Medicare telehealth services as office and other outpatient visits, consultation, and office psychiatry services as described by the following HCPCS codes: 99201–99215; 99241–99275; 90804–90809; and 90862. We stated in the CY 2002 final rule (66 FR 55283) that we believed it would be inappropriate to expand the definition of Medicare telehealth services beyond the services explicitly listed in the Act until we have developed a process for adding or deleting services.

However, after further review of the comments submitted in response to the proposed rule for CY 2002, we believe that the psychiatric diagnostic interview is similar to the Medicare telehealth services listed in the statute. Specifically, we believe this service would meet the criteria set forth in Category 1 of the proposed process for adding services.

As defined by CPT 2002, a psychiatric diagnostic interview includes “a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.” These components would be comparable to an initial office visit, or consultation services, which are currently Medicare telehealth services. Additionally, an initial psychiatric diagnostic interview is typically the first step in treating mental illness and is required before psychotherapy can begin. Therefore, we propose to add psychiatric diagnostic interview

examination as represented by HCPCS code 90801 to the list of Medicare telehealth services.

We would revise § 410.78 and § 414.65 to reflect this proposed addition to the list of Medicare telehealth services.

#### I. Definition for ZZZ Global Periods

Services with ZZZ global periods are add-on services, which can only be billed along with another service. The current policy associated with a code with a global indicator of ZZZ recognizes only the incremental intra-service work and practice expense associated with the add-on service. Any pre-service or post-service work associated with a service with a global indicator of ZZZ is considered accounted for in the base procedure with which these add-on services must be billed.

Several specialties, as well as the RUC, have stated that some add-on services contain separately identifiable postservice work and practice expense. The RUC has recommended that we revise our current definition of the global indicator ZZZ to clarify that there may be postservice work associated with a limited number of ZZZ global services.

Consistent with this recommendation, we propose to revise the current definition of a ZZZ global period. “ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the post-service time).”

We plan to work with the RUC to identify those services with a global period of ZZZ that also have separately identifiable postservice work.

#### J. Change in Global Period for CPT code 77789 (Surface Application of Radiation Source)

The RUC has suggested a change in the global period for CPT code 77789 (surface application of radiation source) from a 90-day global period to a 000-day global period. We agree that all work is provided on the day of the procedure and no other visits for pre- and post-care are necessary. Therefore, we are proposing to assign a 000-day global period to this service. We have examined this code and believe that the current work value accurately reflects a 000-day global period and, therefore, needs no adjustment. We would adjust the clinical staff practice expense inputs to reflect that there is no post-procedure visit. The supplies and equipment inputs are appropriate for a 000-day global and need no revision.

#### K. Technical Change for § 410.61(d)(1)(iii) Outpatient Rehabilitation Services

The occupational therapists have pointed out that § 410.61(d)(1)(iii) incorrectly references “physical” therapy when it should reference “occupational” therapy. Therefore, we are proposing to revise § 410.61(d)(1)(iii) to correct this error.

#### L. New HCPCS G-Codes

##### 1. Codes for Treatment of Peripheral Neuropathy

Effective for services furnished on or after July 1, 2002, Medicare will cover an evaluation (examination and treatment) of the feet every six months for individuals with a documented diagnosis.

*G0245: Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include the procedure used to diagnose LOPS; a patient history; and a physical examination that consists of at least the following elements—*

- (a) Visual inspection of the forefoot, hindfoot and toeweb spaces;
- (b) Evaluation of protective sensation;
- (c) Evaluation of foot structure and biomechanics;
- (d) Evaluation of vascular status and skin integrity;
- (e) Evaluation and recommendation of footwear; and
- (f) Patient education.

We are proposing to crosswalk the work, practice expense, and malpractice RVUs from CPT code 99202, a level two, new patient office visit code. We are proposing to crosswalk the practice expense inputs from CPT code 99202 and revalue the practice expense RVU using the practice expense methodology once we have utilization for these codes.

*G0246: Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following, a patient history and physical examination that includes—*

- (a) Visual inspection of the forefoot, hindfoot and toeweb spaces;
- (b) Evaluation of protective sensation;
- (c) Evaluation of foot structure and biomechanics;
- (d) Evaluation of vascular status and skin integrity;
- (e) Evaluation and recommendation of footwear; and
- (f) Patient education.

We are proposing to crosswalk the work, practice expense, and malpractice RVUs from CPT code 99212, a level two, established patient office visit code. We

are proposing to crosswalk the practice expense inputs from CPT code 99212 and revalue the practice expense RVU using the practice expense methodology once we have utilization for these codes.

*G0247: Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following—*

- (a) Local care of superficial wounds;
- (b) Debridement of corns and calluses; and
- (c) Trimming and debridement of nails.

We are proposing to crosswalk the work, practice expense, and malpractice RVUs from CPT code 11040, Debridement; skin; partial thickness. We are proposing to crosswalk the practice expense inputs from CPT code 11040 and will revalue the practice expense RVUs using the practice expense methodology once we have utilization for this code.

## 2. Current Perception Sensory Nerve Conduction Threshold Test (SNCT)

*G0255: Current Perception Threshold/Sensory Nerve Conduction Test, (SNCT) per limb, any nerve.*

We have created a G-code that represents SNCT as a diagnostic test used to diagnose sensory neuropathies. The test is noninvasive and uses a transcutaneous electrical stimulus to evoke a sensation. We have determined that there is insufficient scientific or clinical evidence to consider the use of this device as reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Act, and, therefore, Medicare will not pay for this type of test.

## 3. Positron Emission Tomography (PET) Codes for Breast Imaging

Medicare has expanded the coverage indications for PET scanning to include imaging for breast cancer. We have created codes that describe staging and restaging after or prior to the course of treatment of breast cancer. We have also created a PET scan code to evaluate the response to treatment of breast cancer.

PET imaging for initial diagnosis of breast cancer and/or surgical planning for breast cancer are described by a CPT code, but Medicare will not cover this diagnosis.

*G0252: PET imaging for initial diagnosis of breast cancer and/or surgical planning for breast cancer (for example, initial staging of axillary lymph nodes), not covered by Medicare. This code is not covered by Medicare because there is a national non-coverage determination for initial diagnosis of*

breast cancer and initial staging of axillary lymph nodes.

*G0253: PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging after or prior to course of treatment.*

*G0254: PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment.*

We are proposing that the TC and global for both of these codes be carrier priced.

For both procedure codes G0253 and G0254, we propose to make the PC work RVU equal to 1.87. There are no direct inputs for PC services. We propose to use practice expense RVUs of 0.58 and malpractice RVUs of 0.07 for these services.

## 4. Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management

For services furnished on or after July 1, 2002, Medicare will cover the use of home prothrombin time or INR monitoring in a patient's home for anticoagulation management for patients with mechanical heart valves. A physician must prescribe the testing. The patient must have been anticoagulated for at least three months prior to use of the home INR device; and the patient must undergo an education program. The testing with the device is limited to a frequency of once per week.

*G0248: Demonstration, at initial use, of home INR monitoring for a patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample provision of instructions for reporting home INR test results and documentation of a patient's ability to perform testing.*

We are proposing that this code be assigned no work RVUs and .01 malpractice RVUs. For the practice expense inputs, we are proposing 75 minutes of RN/LPN/MTA staff time; a supply list, including four test strips, lancets and alcohol pads, a patient education booklet, and batteries for the monitor; and equipment, consisting of a home INR monitor. Using these proposed inputs in the practice expense methodology will produce an estimated practice expense RVU of 2.92.

*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 of test results to physician; per 4 tests.*

We are proposing that this code be assigned no work RVUs and .01 malpractice RVUs. For the practice expense inputs, we are proposing 13 minutes of RN/LPN/MTA staff time, a supply list, including four test strips, lancets and alcohol pads, and equipment, consisting of a home INR monitor. Using these proposed inputs in the practice expense methodology will produce an estimated practice expense RVU of 2.08.

*G0250: Physician review/interpretation and patient management of home INR test for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service)*

We are proposing that this code be assigned 0.18 work RVUs and .01 malpractice RVUs. There would be no direct practice expense inputs for this code. We will use practice expense methodology to develop a practice expense RVU that will reflect indirect costs of the physicians performing this service. The estimated practice expense RVU will equal 0.07.

## 5. Bone Marrow Aspiration and Biopsy on the Same Date of Service

We are proposing to create a new G-code that reflects a bone marrow biopsy and aspiration procedure that is performed on the same date, at the same encounter, through the same incision. Because it is our understanding that the typical case involves an aspiration and biopsy through the same incision, we are creating a G-code to reflect this service. If the two procedures, aspiration and biopsy, are performed at different sites (for example, contralateral iliac crests, sternum/iliac crest, two separate incisions on the same iliac crest or two patient encounters on the same date of service), the -59 modifier would be appropriate to use. In this instance, the CPT codes for aspiration and biopsy would each be used.

*GXXXX: Bone marrow aspiration and biopsy performed on the same day.*

We are proposing physician work RVUs of 1.56 and malpractice RVUs of 0.04. We propose to crosswalk the practice expense inputs from CPT code 38220, Bone marrow aspiration, with the assignment of an additional five minutes of clinical staff time. Using these proposed inputs in the practice expense methodology will produce an estimated practice expense RVU of 3.32 in the nonfacility setting. The practice expense RVU in the facility setting is estimated at 0.60.

## M. Endoscopic Base for Urology Codes

Cystoscopy and treatment CPT codes 52234, 52235, and 52240 were

inadvertently identified in the Medicare Physician Fee Schedule Database as services subject to multiple procedural reductions as opposed to the procedural reduction rules specific to endoscopic services. Multiple procedural reduction rules allow full payment for the primary services with a 50 percent reduction to the RVUs for each additional service. The endoscopic reduction rules establish payment using the full value of the highest valued endoscopic service plus the difference between the next highest valued service and the base endoscopic service. The inadvertent application of the multiple procedural reduction as opposed to the endoscopic procedural reduction has resulted in our overpaying for these services. We propose applying the endoscopic reduction rules to these services and have identified CPT code 52000 as the endoscopic base code for these services.

#### *N. Physical Therapy and Occupational Therapy Caps*

Section 4541(c) of the Balanced Budget Act of 1997 required application of a payment limitation to all rehabilitation services provided on or after January 1, 1999. The limitation was an annual per beneficiary limit of \$1500 on all outpatient physical therapy services (including speech-language pathology services). A separate \$1500 limit was applied to all occupational therapy services. (The limitation amounts were to be increased to reflect medical inflation.) The annual limitation did not apply to services furnished directly or under arrangement by a hospital to an outpatient or to an inpatient who is not in a covered Part A stay.

Section 221 of the Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, enacted on November 29, 1999) (BBRA) placed a moratorium on the application of the payment limitation for two years from January 1, 2000 through December 31, 2001. Section 421 of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000 (Pub. L. 106-554, enacted on December 21, 2000) (BIPA), extended the moratorium on application of the limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002 through December 31, 2002. Therefore, the moratorium applies to outpatient rehabilitation claims with dates of service January 1, 2001 through December 31, 2002. Outpatient rehabilitation claims for services rendered on or after January 1, 2003 will be subject to the payment limitation unless Congress acts to extend the moratorium.

### **III. Collection of Information Requirements**

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

### **IV. Response to Comments**

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

### **V. 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 16, 1980 Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 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 proposed rules with economically significant effects (that is, a proposed 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). We have simulated the effect of the proposed changes to practice expense RVUs described earlier. The net effect of the changes we are proposing will not materially increase or decrease Medicare expenditures for physicians' services because the statute requires that changes to RVUs cannot increase or decrease expenditures more than \$20 million. Since increases in payments resulting from RVU changes must be offset by decreases in payments for other services, the proposed practice expense changes will result in a

redistribution of payments among physician specialties. The proposed changes to the MEI would result in increases in Medicare expenditures for physicians' services of \$150 million in fiscal year (FY) 2003, \$340 million in FY 2004, and \$550 million in FY 2005. Therefore, this proposed rule is considered to be a major rule because it is economically significant, and, thus, we have prepared a regulatory impact analysis.

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 and less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

For purposes of the RFA, physicians, nonphysicians, and suppliers are considered small businesses if they generate revenues of \$6 million or less. Approximately 95 percent of physicians (except mental health specialists) are considered to be small entities. There are about 700,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule.

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 expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. We have determined that this proposed rule will have no consequential effect on State, local, or tribal governments.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any negative impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which together with the rest of this preamble, meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we propose to use to minimize the burden on small entities. As indicated elsewhere in this proposed rule, we propose to make changes to the Medicare Economic Index, refine resource-based practice based practice expense RVUs and make a variety of other minor changes to our regulations, payments or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We provide information for each of the proposed policy changes in the relevant sections in this proposed rule. As discussed elsewhere in this proposed rule, the provisions of this proposed rule, if adopted, would only change Medicare payment rates for physician fee schedule services. While this rule would allow physical and occupational therapists that are employed by physicians to separately enroll in the Medicare program, it does not impose reporting, recordkeeping and other compliance requirements. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this proposed rule. The relevant sections of this proposed rule contain a description of significant alternatives.

#### *A. Resource-Based Practice Expense Relative Value Units*

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than \$20 million from the amount of expenditures that would have resulted without such adjustments. We are proposing several changes that would result in a change of expenditures that would exceed \$20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense, our policy has been to meet the budget neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodology. That is, we estimate the aggregate number of practice expense relative values that will be paid under current and proposed policy in CY 2003. We apply a uniform adjustment factor to make the aggregate number of proposed practice expense relative values equal the number estimated that would be paid under current policy.

Table 2 shows the specialty level impact on payment of changes being

proposed for CY 2003. In past years, we have shown the Medicare payment impact of redistributive changes in RVUs for all specialties that can bill for Medicare physician fee schedule services. We included some of the smaller specialty categories in closely related larger ones and have shown payment impacts for 35 different specialty categories. For this proposed rule, we are showing separate impacts for 49 different specialty categories. We are separately showing specialties that have more than \$50 million in total Medicare allowed charges for physician fee schedule services. We are changing the way we illustrate impacts based on comments and suggestions that have come to us from the physician community. 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 since 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 physician fee schedule. For instance, independent laboratories receive more than 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. This table shows only the payment impact on physician fee schedule services.

We modeled the impact of five changes to the practice expense methodology. The column labeled "Input Changes" shows the effect of proposed changes described in section II. A. As indicated in that section, we are making several changes to the inputs that are used to value several ophthalmology and thermotherapy procedures and iontophoresis. We also revised the price we are using for sterile water. These changes will result in very little specialty impact with a small reduction in payment to optometry.

The column labeled "Staff Time" shows the impact of our proposal to use staff time in place of average staff time in creation of the zero physician work pool. This proposal would result in increases in payment for services that are included in the zero physician work pool while broadly distributing reductions in payments to all other physician fee schedule services.

The column labeled "Professional Technical Changes" refers to our proposal to change the calculation of the practice expense RVUs for codes with professional and technical components.

As indicated earlier, we are proposing to make the technical component value equal the difference between the global and the professional component for procedure codes that are not included in the zero physician work pool. For procedure codes that would remain in the zero physician work pool, we would continue to make the global equal the sum of the professional and the technical component values.

The column labeled "Zero Physician Work Pool" refers to our proposal to remove several services from the zero physician work pool based on requests from the physician specialties that perform the predominant number of services for a given family of codes. The practice expense RVUs for these codes would no longer be determined under the zero physician work methodology. If the services have professional and technical components, the professional component practice expense RVU would be subtracted from the global practice expense RVU to determine the technical component practice value.

The column labeled "Multi-Year Utilization" refers to our proposal to use multiple years of utilization data in the practice expense methodology. The figures shown in Table 2 may change if we make any changes to the zero physician work pool following the consideration of public comments.

Several physician specialties (Allergy/Immunology, Cardiology, Hematology/Oncology, Interventional Radiology, Radiation Oncology, Radiology) that derive a significant portion of their Medicare revenues from services affected by the zero physician work pool calculations would see an increase in payment from the proposed changes. Other physician specialties would see an increase in payment from the change to the practice expense RVUs for professional and technical component services and/or from removing services from the zero physician work pool (neurology, physical medicine, vascular surgery).

Payments to pathology would be reduced by approximately 2 percent. This is largely attributable to the change in the practice expense RVU calculations for professional and technical component services. While payments for pathology would decline, as we noted earlier, since it is far more common for our carriers to receive a global than a technical-component-only bill, we believe it is far more likely that using the global to value the technical component service would result in a payment that is more typical of the practice expense associated with the service. We reviewed the Medicare utilization and found 42.8 million

allowed services associated with a global pathology service and 4.3 million for the technical component only. Several other specialties may also experience small reductions in aggregate payments from these proposed changes.

As a result of changing the practice expense RVU calculation for professional and technical component services, payments for physician fee schedule services to independent laboratories would decline by approximately 8 percent. However, physician fee schedule services account for approximately 17 percent of total Medicare revenues for independent laboratories. The impact on total Medicare revenues from this reduction would be approximately -1 percent.

The figures in Table 2 may change if we if we make any changes to the zero physician work pool following the consideration of public comments.

The net effect of these proposals would also increase payments for several types of suppliers that provide services that are affected by the zero physician work pool methodology. Payments to Independent Diagnostic and Treatment Facilities would increase by approximately 9 percent. Portable X-ray suppliers would receive an approximate increase of 8 percent in payments for services paid under the physician fee schedule. However, we would note that only about 47 percent of Medicare revenues received by portable X-ray suppliers are attributable

to physician fee schedule services. The other Medicare revenues received by portable X-ray suppliers are attributed to the transportation of X-ray equipment paid at rates determined by the Medicare carrier. Any change to the rates for carrier priced services would be made at local carrier discretion. The total change in payments (before application of the estimated 4.4 percent reduction to the physician fee schedule conversion factor discussed next) will be about 3 percent.

Table 2 shows the estimated change in payment rates based on provisions of this proposed rule. If we change any of these proposals following our consideration of comments, these figures may change.

TABLE 2.—IMPACT OF PRACTICE EXPENSE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY

Category	Medicare allowed charges (\$ in billions)	Input changes (percent)	Maximum staff time (percent)	Professional technical changes (percent)	Zero physician work pool (percent)	Multi-year utilization	Total (percent)
Physicians:							
ALLERGY/IMMUNOLOGY .....	\$0.14	0	1	0	0	0	2
ANESTHESIOLOGY .....	1.17	0	0	0	0	0	-1
CARDIAC SURGERY .....	0.27	0	0	0	0	0	0
CARDIOLOGY .....	4.28	0	1	0	0	1	1
CLINICS .....	1.81	0	0	0	0	0	0
DERMATOLOGY .....	1.43	0	-1	0	0	0	-2
EMERGENCY MEDICINE .....	1.04	0	0	0	0	0	0
ENDOCRINOLOGY .....	0.20	0	0	0	0	0	0
FAMILY PRACTICE .....	3.27	0	0	0	0	0	0
GASTROENTEROLOGY .....	1.25	0	0	0	0	-1	-1
GENERAL PRACTICE .....	0.87	0	0	0	0	0	0
GENERAL SURGERY .....	1.94	0	0	0	0	0	-1
GERIATRICS .....	0.08	0	0	0	0	0	0
HEMATOLOGY/ONCOLOGY .....	0.90	0	1	0	0	1	1
INFECTIOUS DISEASE .....	0.25	0	0	0	0	0	-1
INTERNAL MEDICINE .....	6.42	0	0	0	0	0	0
INTERVENTIONAL RADIOLOGY .....	0.13	0	0	0	0	0	1
NEPHROLOGY .....	1.03	0	0	0	0	0	-1
NEUROLOGY .....	0.85	0	1	3	0	0	-1
NEUROSURGERY .....	0.35	0	0	0	0	0	-1
OBSTETRICS/GYNECOLOGY .....	0.45	0	0	0	0	0	0
OPHTHALMOLOGY .....	3.69	0	-1	0	0	-1	-1
ORTHOPEDIC SURGERY .....	2.22	0	0	0	0	0	0
OTOLARNGOLOGY .....	0.63	0	0	0	0	0	0
PATHOLOGY .....	0.63	0	0	-2	0	0	-2
PEDIATRICS .....	0.05	0	0	0	0	0	0
PHYSICAL MEDICINE .....	0.48	0	0	1	0	0	1
PLASTIC SURGERY .....	0.23	0	0	0	0	-1	-1
PSYCHIATRY .....	1.00	0	0	0	0	0	0
PULMONARY DISEASE .....	1.07	0	0	1	0	0	0
RADIATION ONCOLOGY .....	0.72	0	2	0	0	2	3
RADIOLOGY .....	3.12	0	1	0	0	1	2
RHEUMATOLOGY .....	0.30	0	0	0	0	0	0
THORACIC SURGERY .....	0.44	0	0	0	0	0	0
UROLOGY .....	0.44	0	0	0	0	-1	-1
VASCULAR SURGERY .....	0.34	0	0	0	2	0	2
Other Practitioners:							
CHIROPRACTOR .....	0.44	0	0	0	0	-1	-1
CLINICAL PSYCHOLOGIST .....	0.38	0	0	0	0	1	1
CLINICAL SOCIAL WORKER .....	0.21	0	0	0	0	1	0
NURSE ANESTHETIST .....	0.35	0	0	0	0	0	-1
NURSE PRACTITIONER .....	0.21	0	0	0	0	0	0
OPTOMETRY .....	0.50	-1	-1	0	0	-1	-2
PHYSICAL/OCCUPATIONAL THERAPY .....	0.47	0	0	0	0	0	0

TABLE 2.—IMPACT OF PRACTICE EXPENSE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY—Continued

Category	Medicare allowed charges (\$ in billions)	Input changes (percent)	Maximum staff time (percent)	Professional technical changes (percent)	Zero physician work pool (percent)	Multi-year utilization	Total (percent)
PHYSICIAN ASSISTANTS .....	0.17	0	0	0	0	0	0
PODIATRY .....	1.10	0	0	0	0	0	-1
Suppliers:							
DIAGNOSTIC TREATMENT FACILITY .....	0.35	0	3	1	1	3	9
INDEPENDENT LABORATORY .....	0.38	0	-1	-9	0	2	-8
PORTABLE XRAY SUPPLIER .....	0.06	0	4	0	0	3	8
ALL OTHER .....	0.29	0	0	0	0	0	0
TOTAL .....	49.21	0	0	0	0	0	0

In previous years, we have not included the effect of the physician fee schedule update in our impact tables. The statutory methodology for updating physician rates for CY 2001 and subsequent years is specified in section 1848(d)(4) of the Act. Section 1848(d)(4) of the Act indicates that physician fee schedule rates are updated by the MEI increased or decreased by an "update adjustment factor." The update adjustment factor reflects a comparison of actual and target expenditures under the sustainable growth rate system (SGR) under section 1848(f) of the Act. If actual expenditures exceed target expenditures, the update adjustment factor is negative. If actual expenditures are less than target expenditures, the update adjustment factor is positive. The update adjustment factor is limited to +3.0 and -7.0 percentage points. We do not have authority to change physician fee schedule update formula specified in statute. Since the application of the update cannot be changed through the rulemaking process, we have not shown the effect of the physician fee schedule update in our impact tables. However, public comment indicates an interest in our

illustrating the effect of the update on payments to physicians in the impact section of our regulation.

Consistent with the requirements of section 1848(d)(1)(E) of the Act, we made an estimate of the physician fee schedule update for CY 2003 available to the Medicare Payment Advisory Commission (MedPAC) and the public on March 1, 2002. At that time, we provided our latest estimate of the MEI for CY 2003 and indicated that the update adjustment factor would likely equal the -7.0 percentage point limit established in statute. That is, the CY 2003 update would equal the MEI reduced by 7.0 percentage points. Section 1848(d)(4)(F) of the Act requires the update to be reduced by an additional -0.2 percentage points.

We currently estimate that the CY 2003 MEI will equal 2.3 percent using an adjustment based on a 10-year average economy-wide labor productivity. If we substitute a 10-year average economy-wide multifactor productivity as proposed in this proposed rule, the CY 2003 MEI is estimated to be 3.0 percent. Substituting multifactor for labor productivity increases the MEI by 0.7 percentage points. We believe that it remains likely

that the update adjustment factor will equal the statutory limit of -7.0 percentage points specified in section 1848(d)(4) of the Act. Taking the following factors into account, we estimate that the CY 2003 physician fee schedule update will equal the product of the following 3 factors:

MEI 3.0% (1.030)  
 Update Adjustment Factor -7.0% (0.930)  
 Legislative Factor -0.2% (0.998)  
 Update -4.4% (0.956)

The MEI is based on the 3 complete quarters and 1 projected quarter of information and may change slightly before we announce the final MEI no later than November 1, 2002. Incorporating the estimated update with the practice expense impacts shown above will produce the following estimated impact on payments for physician fee schedule services. Table 3 shows the estimated change in average payments by specialty based on provisions of this proposed rule and the estimated physician fee schedule update. If we change any of these provisions based on public comment or if the actual MEI is different than our estimate, these figures may change.

TABLE 3.—ESTIMATED IMPACT PRACTICE EXPENSE AND UPDATE ON TOTAL MEDICARE ALLOWED CHARGES BY SPECIALTY

Specialty	Medicare allowed charges (\$ in billions)	Combined practice expense changes (percent)	Estimated update (percent)	Total (percent)
Physicians:				
ALLERGY/IMMUNOLOGY .....	\$0.14	2	-4.4	-3
ANESTHESIOLOGY .....	1.17	-1	-4.4	-5
CARDIAC SURGERY .....	0.27	0	-5.5	-5
CARDIOLOGY .....	4.28	1	-4.4	-4
CLINICS .....	1.81	0	-4.4	-5
DERMATOLOGY .....	1.43	-2	-4.4	-6
EMERGENCY MEDICINE .....	1.04	0	-4.4	-4
ENDOCRINOLOGY .....	0.20	0	-4.4	-5
FAMILY PRACTICE .....	3.27	0	-4.4	-5
GASTROENTEROLOGY .....	1.25	-1	-4.4	-5
GENERAL PRACTICE .....	0.87	0	-4.4	-4

TABLE 3.—ESTIMATED IMPACT PRACTICE EXPENSE AND UPDATE ON TOTAL MEDICARE ALLOWED CHARGES BY SPECIALTY—Continued

Specialty	Medicare allowed charges (\$ in billions)	Combined practice expense changes (percent)	Estimated update (percent)	Total (percent)
GENERAL SURGERY .....	1.94	-1	-4.4	-5
GERIATRICS .....	0.08	0	-4.4	-5
HEMATOLOGY/ONCOLOGY .....	0.90	1	-4.4	-3
INFECTIOUS DISEASE .....	0.25	-1	-4.4	-5
INTERNAL MEDICINE .....	6.42	0	-4.4	-5
INTERVENTIONAL RADIOLOGY .....	0.13	1	-4.4	-4
NEPHROLOGY .....	1.03	-1	-4.4	-5
NEUROLOGY .....	0.85	2	-4.4	-1
NEUROSURGERY .....	0.35	-1	-4.4	-5
OBSTETRICS/GYNECOLOGY .....	0.45	0	-4.4	-5
OPHTHALMOLOGY .....	3.69	-1	-4.4	-5
ORTHOPEDIC SURGERY .....	2.22	0	-4.4	-5
OTOLARNGOLOGY .....	0.63	0	-4.4	-5
PATHOLOGY .....	0.63	-2	-4.4	-6
PEDIATRICS .....	0.05	0	-4.4	-4
PHYSICAL MEDICINE .....	0.48	1	-4.4	-3
PLASTIC SURGERY .....	0.23	-1	-4.4	-5
PSYCHIATRY .....	1.00	0	-4.4	-5
PULMONARY DISEASE .....	1.07	0	-4.4	-4
RADIATION ONCOLOGY .....	0.72	3	-4.4	-3
RADIOLOGY .....	3.12	2	-4.4	-3
RHEUMATOLOGY .....	0.30	0	-4.4	-4
THORACIC SURGERY .....	0.44	0	-4.4	-4
UROLOGY .....	1.28	-1	-4.4	-4
VASCULAR SURGERY .....	0.34	2	-4.4	-3
Other Practitioners:				
CHIROPRACTOR .....	0.44	-1	-4.4	-5
CLINICAL PSYCHOLOGIST .....	0.38	1	-4.4	-4
CLINICAL SOCIAL WORKER .....	0.21	0	-4.4	-4
NURSE ANESTHETIST .....	0.35	-1	-4.4	-5
NURSE PRACTITIONER .....	0.21	0	-4.4	-5
OPTOMETRY .....	0.50	-2	-4.4	-4
PHYSICAL/OCCUPATIONAL THERAPY .....	0.47	0	-4.4	-5
PHYSICIANS ASSISTANT .....	0.17	0	-4.4	-5
PODIATRY .....	1.10	-1	-4.4	-5
Suppliers:				
DIAGNOSTIC TREATMENT FACILITY .....	0.35	9	-4.4	1
INDEPENDENT LABORATORY .....	0.38	-8	-4.4	-9
PORTABLE X-RAY SUPPLIER .....	0.06	8	-4.4	-1
ALL OTHER .....	0.29	0	-4.4	-5
TOTAL .....	49.21	0	-4.4	-4.4

Table 4 shows the impact on payments for selected high volume procedures of all of the changes previously discussed. This table shows the combined impact of the change in the practice expense RVUs and the estimated physician fee schedule update

on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and non-facility practice expense refer to § 414.22(b)(5)(i). The table shows the estimated change in

payment rates based on provisions of this proposed rule and the estimated physician fee schedule update. If we change any of the provisions following the consideration of public comments or if the actual MEI is different than our estimate, these figures may change.

TABLE 4.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	DESC	Facility payment			Nonfacility payment		
			Old	New	% Change	Old	New	% Change
11721 .....		Debride nail, 6 or more .....	\$28.96	\$27.34	-6	\$36.92	\$34.95	-5
17000 .....		Detroy benign/premal lesion .....	32.94	31.15	-5	62.62	58.48	-7
27130 .....		Total hip arthroplasty .....	1,452.31	1,376.62	-5	N/A	N/A	N/A
27236 .....		Treat thigh fracture .....	1,113.85	1,053.40	-5	N/A	N/A	N/A
27244 .....		Treat thigh fracture .....	1,137.38	1,074.86	-5	N/A	N/A	N/A

TABLE 4.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	DESC	Facility payment			Nonfacility payment		
			Old	New	% Change	Old	New	% Change
27447		Total knee arthroplasty	1,514.21	1,433.72	-5	N/A	N/A	N/A
33533		CABG, arterial, single	1,827.34	1,742.75	-5	N/A	N/A	N/A
35301		Rechanneling of artery	1,061.36	1,011.18	-5	N/A	N/A	N/A
43239		Upper GI endoscopy, biopsy	154.93	146.73	-5	354.75	316.30	-11
45385		Lesion removal colonoscopy	287.78	273.04	-5	571.22	511.82	-10
66821		After cataract laser surgery	213.94	203.83	-5	229.50	219.40	-4
66984		Cataract surg w/iol, i stage	669.32	636.06	-5	N/A	N/A	N/A
67210		Treatment of retinal lesion	546.61	519.09	5	603.08	575.15	-5
71010	26	Chest x-ray	9.05	8.65	-4	9.05	8.65	-4
71020	26	Chest x-ray	11.22	10.38	-7	11.22	10.38	-7
76091		Mammogram, both breasts	N/A	N/A	N/A	90.50	90.32	0
76091	26	Mammogram, both breasts	43.44	41.53	-4	43.44	41.53	-4
76092		Mammogram, screening	N/A	N/A	N/A	81.81	78.21	-4
76092	26	Mammogram, screening	35.48	33.91	-4	35.48	33.91	-4
77427		Radiation tx management, x5	167.96	159.88	-5	167.96	159.88	-5
78465	26	Heart image (3d), multiple	74.93	70.94	-5	74.93	70.94	-5
88305	26	Tissue exam by pathologist	40.54	38.41	-5	40.54	38.41	-5
90801		Psy dx interview	137.19	130.81	-5	144.80	138.08	-5
90806		Psytx, off, 45-50 min	91.22	87.55	-4	95.93	92.05	-4
90807		Psytx, off, 45-50 min w/e&m	98.82	94.13	-5	103.53	98.28	-5
90862		Medication management	46.33	43.95	-5	51.04	48.45	-5
90921		ESRD related services, month	273.30	258.16	-6	273.30	258.16	-6
90935		Hemodialysis, one evaluation	76.38	71.98	-6	N/A	N/A	N/A
92004		Eye exam, new patient	87.96	83.05	-6	123.44	117.66	-5
92012		Eye exam established pat	35.84	33.91	-5	61.18	58.48	-4
92014		Eye exam & treatment	58.64	55.37	-6	91.22	86.86	-5
92980		Insert intracoronary stent	790.59	748.18	-5	N/A	N/A	N/A
92982		Coronary artery dilation	584.26	553.00	-5	N/A	N/A	N/A
93000		Electrocardiogram, complete	N/A	N/A	N/A	25.34	25.26	0
93010		Electrocardiogram report	9.05	8.31	-8	9.05	8.31	-8
93015		Cardiovascular stress test	N/A	N/A	N/A	99.91	100.01	0
93307	26	Echo exam of heart	48.14	45.33	-6	48.14	45.33	-6
93510	26	Left heart catheterization	230.59	218.02	-5	230.59	218.02	-5
98941		Chiropractic manipulation	31.13	29.42	-5	35.48	33.57	-5
99202		Office/outpatient visit, new	45.61	43.26	-5	61.54	58.14	-6
99203		Office/outpatient visit, new	69.50	66.10	-5	91.95	86.86	-6
99204		Office/outpatient visit, new	102.81	97.93	-5	130.68	123.89	-5
99205		Office/outpatient visit, new	136.47	129.43	-5	166.15	157.46	-5
99211		Office/outpatient visit, est	8.69	8.31	-4	20.27	19.03	-6
99212		Office/outpatient visit, est	23.17	21.80	-6	36.20	33.91	-6
99213		Office/outpatient visit, est	34.03	32.53	-4	50.32	47.76	-5
99214		Office/outpatient visit, est	56.11	53.29	-5	78.91	74.75	-5
99215		Office/outpatient visit, est	90.50	85.82	-5	115.84	109.35	-6
99221		Initial hospital care	65.16	61.94	-5	N/A	N/A	N/A
99222		Initial hospital care	108.24	102.78	-5	N/A	N/A	N/A
99223		Initial hospital care	150.95	143.27	-5	N/A	N/A	N/A
99231		Subsequent hospital care	32.58	30.80	-5	N/A	N/A	N/A
99232		Subsequent hospital care	53.57	50.87	-5	N/A	N/A	N/A
99233		Subsequent hospital care	76.38	72.33	-5	N/A	N/A	N/A
99236		Observ/hosp same date	214.66	204.87	-5	N/A	N/A	N/A
99238		Hospital discharge day	66.24	62.98	-5	N/A	N/A	N/A
99239		Hospital discharge day	90.86	86.17	-5	N/A	N/A	N/A
99241		Office consultation	33.30	31.15	-6	47.06	44.64	-5
99242		Office consultation	68.05	64.02	-6	87.24	82.36	-6
99243		Office consultation	90.14	85.48	-5	115.84	109.35	-6
99244		Office consultation	133.58	126.66	-5	164.34	155.38	-5
99245		Office consultation	177.01	167.84	-5	212.85	201.41	-5
99251		Initial inpatient consult	34.75	32.88	-5	N/A	N/A	N/A
99252		Initial inpatient consult	69.86	66.10	-5	N/A	N/A	N/A
99253		Initial inpatient consult	95.20	90.32	-5	N/A	N/A	N/A
99254		Initial inpatient consult	136.83	129.77	-5	N/A	N/A	N/A
99255		Initial inpatient consult	188.60	178.57	-5	N/A	N/A	N/A
99261		Follow-up inpatient consult	21.72	20.76	-4	N/A	N/A	N/A
99262		Follow-up inpatient consult	43.44	41.18	-5	N/A	N/A	N/A
99263		Follow-up inpatient consult	64.80	61.25	-5	N/A	N/A	N/A
99282		Emergency dept visit	26.43	25.26	-4	N/A	N/A	N/A
99283		Emergency dept visit	59.37	56.75	-4	N/A	N/A	N/A
99284		Emergency dept visit	92.67	88.59	-4	N/A	N/A	N/A

TABLE 4.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	DESC	Facility payment			Nonfacility payment		
			Old	New	% Change	Old	New	% Change
99285 .....		Emergency dept visit .....	144.80	138.08	-5	N/A	N/A	N/A
99291 .....		Critical care, first hour .....	198.37	188.60	-5	208.87	197.60	-5
99292 .....		Critical care, addl 30 min .....	98.82	94.13	-5	108.24	101.05	-7
99301 .....		Nursing facility care .....	60.09	57.45	-4	70.23	66.79	-5
99302 .....		Nursing facility care .....	80.72	76.83	-5	95.57	91.01	-5
99303 .....		Nursing facility care .....	100.27	95.51	-5	118.73	112.82	-5
99311 .....		Nursing fac care, subseq .....	30.05	28.72	-4	40.18	38.41	-4
99312 .....		Nursing fac care, subseq .....	49.95	47.41	-5	61.90	58.83	-5
99313 .....		Nursing fac care, subseq .....	70.95	67.48	-5	84.34	80.29	-5
99348 .....		Home visit, est patient .....	N/A	N/A	N/A	73.85	69.90	-5
99350 .....		Home visit, est patient .....	N/A	N/A	N/A	166.52	157.46	-5

### B. Proposed Productivity Adjustment to the MEI

As indicated in section II.D of this proposed rule, we are proposing to change the methodology for adjusting for productivity in the MEI. We propose that the MEI used for the CY 2003 physician payment update reflect changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity applied to the entire index. The prior method accounted for productivity by adjusting the labor portion of the MEI by the 10-year moving average change in private nonfarm business (economy-wide) labor productivity. Our reasons for proposing this change and the alternatives we considered are discussed in detail in section II.D.

We believe that we have developed a revised MEI methodology that is technically superior to the current MEI and more adequately reflects annual changes in the cost of furnishing services in efficient physicians' practices. We estimate that the proposed changes to the MEI would raise the index by 0.7 percentage points from 2.3 percent to 3.0 percent for CY 2003 based on 3 complete quarters and 1 projected quarter of information. This figure may change based on complete data. We estimate that this proposed change would increase Federal expenditures by \$150 million in FY 2003. The outyear impact is a function of numerous economic variables that fluctuate unpredictably. Our estimate of the impact beyond FY 2003 is based on projections of both the current and proposed revised index. We estimate the proposed change would increase Federal expenditures by \$340 million in FY 2004 and \$550 million in FY 2005.

### C. Site of Service

Relative values for practice expense are determined for both "facility" and

"nonfacility" settings. (See Addendum B.) We propose to clarify which place of service codes are assigned to facility relative values and which place of service codes are assigned to nonfacility relative values. This clarification should benefit physicians, providers, and Medicare contractors by making the payment rules clearer. We are proposing to update facility and nonfacility designations for several new place of service codes and change the designations for several place of service codes already in existence. The update for the new place of service codes will have no effect on Medicare spending. The place of service codes in which we are changing the designation are infrequently used for physician fee schedule services. Any effect of this proposal would result in very minor redistribution in payment among physician fee schedule services through the practice expense budget-neutrality adjustments.

### D. Pricing of Technical Components (TC) for Positron Emission Tomography (PET) Scans

As stated earlier, to keep pricing consistent with the manner in which other PET scan services are paid, we are proposing a change from national pricing to having the carriers price the TC and global value for HCPCS code G0125 Lung Image PET scans. The budgetary impact on the Medicare program and providers would be uncertain since we do not know the payment amounts that carriers would use for this service.

### E. Medicare Qualifications for Clinical Nurse Specialists (CNSs)

As previously stated, we are proposing to revise regulations regarding qualifications for CNSs by allowing flexibility as to certifying bodies. We believe this change would

make the Medicare requirements more consistent with criteria for other practitioners. We also believe there would be additional enrollment of CNSs that would qualify for Medicare enrollment. We expect that this proposal would have little effect on Medicare expenditures.

### F. Process To Add or Delete Services to the Definition of Telehealth

We are proposing a process for adding or deleting services from the list of telehealth services, as well as for adding specific services to the list for CY 2003. There are no costs or savings to the Medicare program associated with this proposal. In addition, we are proposing to add psychiatric diagnostic interview examination, as represented by HCPCS code 90801, to the list of Medicare telehealth services. We believe this would have little effect on Medicare expenditures.

### G. Change in Global Period for CPT Code 77789 (Surface Application of Radiation Source)

We are proposing a change in the global period for CPT code 77789 (surface application of radiation source) from a 90-day global period to a 000-day global period. We believe physicians that furnish these services would benefit from this change because it would simplify their billing processes. We do not expect it would have a significant impact on the Medicare program because the change would reflect current practices.

### H. New HCPCS G-Codes

We are proposing to add new G-codes to describe evaluation (examination and treatment) of the feet no more often than every 6 months for individuals with a documented diagnosis of diabetic peripheral neuropathy with loss of protective sensation. We established

payment for these codes in CY 2002 to allow for payment consistent with a national coverage decision clarifying coverage for routine foot exams. This provision would have no impact on the program because the codes will be implemented through a program memorandum to reflect new national policy effective July 1, 2002.

I. Endoscopic Base for Urology Codes

We are proposing to correct the pricing of certain endoscopic services. As we indicated in section II.N., we propose to use CPT procedure code 52000 as the endoscopic base code for CPT procedure codes 52234, 52235, and 52240. This proposed change would result in a reduction in payment in instances when these codes are billed in conjunction with either CPT procedure code 52000 or other codes that have CPT procedure code 52000 as the endoscopic base code. We expect the savings would be negligible.

J. Physical Therapy and Occupational Therapy Caps

There were no proposals made in this area. The imposition of the physical and occupational therapy caps will occur as a result of application of section 4541(c) of the BBA. While section 221 of the BBRA and section 421 of BIPA placed a moratorium on application of these caps, the moratorium expires for physical and occupational therapy services rendered after December 31, 2002. We estimate that application of the caps will reduce Medicare expenditures for physical and occupational therapy services by \$240 million in 2003.

K. Enrollment of Physical and Occupational Therapists as Therapists in Private Practice

This proposal would clarify Medicare enrollment criteria for therapists and provide consistency among Medicare contractors. This would allow flexibility for therapists in how they choose to practice by allowing all therapists that met the enrollment criteria to enroll in Medicare.

L. Alternatives Considered

This proposed rule contains a range of policies. The preamble identifies those policies when discretion has been exercised and presents rationale for our decisions, including a presentation of nonselected options.

M. Impact on Beneficiaries

Although changes in physicians' payments were large when the physician fee schedule was implemented in 1992, we detected no

problems with beneficiary access to care. We do not believe that there would be any problem with access to care as a result of the proposed changes in this rule. While it has been suggested that the negative update for 2003 may affect beneficiary access to care, we note that the formula to determine this update is set by statute and this regulation cannot, and does not, change it. Furthermore, since beginning our transition to a resource-based practice expense system in CY 1999, we have not found that there are problems with beneficiary access to care.

As indicated above, the imposition of the physical and occupational therapy caps will occur as a result of application of section 4541(c) of the BBA. It is possible that application of physical and occupational therapy caps will have an impact on Medicare beneficiaries either through increased liability for services exceeding the cap or fewer services being provided. We contracted with the Urban Institute to perform analyses related to the implementation of the therapy caps, based on an analysis of a sample of therapy services provided from 1998 through 2000. The draft reports are available on the CMS website. The contractor report indicated that in 2000, about 12 percent of patients who received therapy services would have exceeded the caps. More than 50 percent of those who exceeded the caps did so by \$500 or more. The caps are more likely to be exceeded in skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and other rehabilitation facility settings. The caps do not apply to outpatient therapy services provided in an outpatient hospital. The report does not make assumptions about changes in behavior in response to the caps. Without more experience with the caps, it is difficult to predict the precise impact on beneficiaries.

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

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

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

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

Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for Part 410 continues to read as follows:

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

2. Section 410.59 is amended as follows:

- A. Paragraph (c)(1)(ii)(C) is revised.
B. A new paragraph (c)(1)(ii)(D) is added.

The revision and addition read as follows:

§ 410.59 Outpatient occupational therapy services: conditions.

(c) \* \* \*
(1) \* \* \*
(ii) \* \* \*

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated occupational therapy practice.

(D) A physician group.

3. Section 410.60 is amended as follows:

- A. Paragraph (c)(1)(ii)(C) is revised.
B. A new paragraph (c)(1)(ii)(D) is added.

The revision and addition read as follows:

§ 410.60 Outpatient physical therapy services: conditions.

(c) \* \* \*
(1) \* \* \*
(ii) \* \* \*

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice.

(D) An employee of a physician group.

4. Section 410.61 is amended by revising paragraph (d)(1)(iii) to read as follows:

§ 410.61 Outpatient rehabilitation services.

(d) \* \* \*
(1) \* \* \*

(iii) The occupational therapist that furnishes the occupational therapy services.

5. Section 410.76 is amended by revising paragraph (b)(3) to read as follows:

**§ 410.76 Clinical nurse specialists' services.**

\* \* \* \* \*

(b) \* \* \*

(3) Be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.

\* \* \* \* \*

6. Section 410.78 is amended as follows:

a. Revise the heading of the section.  
b. Revise paragraph (b) introductory text.

c. Revise paragraph (b)(1).

The revisions 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, and pharmacologic management furnished by an interactive telecommunications system if the following conditions are met:

(1) The physician or practitioner at the distant site must be licensed to furnish the service under State law. The physician or practitioner at the distant site who is licensed under State law to furnish a covered telehealth service described in this section may bill, and receive payment for, the service when it is delivered via a telecommunications system.

\* \* \* \* \*

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

1. The authority citation for part 414 continues to read as follows:

**Authority:** Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. Section 414.46 is amended by revising paragraph (g) to read as follows:

**§ 414.46 Additional rules for payment of anesthesia services.**

\* \* \* \* \*

(g) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. If the multiple anesthesia services involve add-on anesthesia codes, as described in program operating instructions, the

carrier makes payment for the add-on codes according to the usual anesthesia payment rules in paragraph (b) of this section.

3. Section 414.65, is amended as follows:

a. Revise the heading of the section.  
b. Revise paragraph (a)(1).  
c. Revise paragraph (b) introductory text.

The revisions 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, and pharmacologic management furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

\* \* \* \* \*

(b) *Originating site facility fee.* For telehealth services furnished on or after October 1, 2001:

\* \* \* \* \*

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

Dated: May 21, 2002.

**Thomas A. Scully,***Administrator, Centers for Medicare & Medicaid Services.*

Approved: June 5, 2002.

**Tommy G. Thompson,***Secretary.*

**Note:** These addenda will not appear in the Code of Federal Regulations.

**Addendum A—Explanation and Use of Addenda B**

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2003. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule. *Addendum B will no longer publish alpha numeric codes for which there is no physician fee schedule coverage or payment or services paid on the clinical lab fee schedule.*

**Addendum B—2003 Relative Value Units and Related Information Used in Determining Medicare Payments for 2003**

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.

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: One for the global values (both professional and technical); one for modifier -26 (PC); and one for 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. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule 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 decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is 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 = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for

these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

N = Noncovered 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.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician’s service and is furnished on the same day as a physician’s service, payment for it is bundled into the payment for the physician’s service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician’s service).

—If the item or service is covered as other than incident to a physician’s service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the

service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of “physicians’ services” for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (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 2003. Codes that are not used for Medicare payment are identified with a “+.”

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2003.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

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 = The 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 practice expense are associated with intra service time and in some instances the post service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
0001T .....	.....	C	Endovas repr abdo ao aneurys .....	0.00	0.00	0.00	0.00	XXX
0002T .....	.....	C	Endovas repr abdo ao aneurys .....	0.00	0.00	0.00	0.00	XXX
0003T .....	.....	C	Cervicography .....	0.00	0.00	0.00	0.00	XXX
0005T .....	.....	C	Perc cath stent/brain cv art .....	0.00	0.00	0.00	0.00	XXX
0006T .....	.....	C	Perc cath stent/brain cv art .....	0.00	0.00	0.00	0.00	XXX
0007T .....	.....	C	Perc cath stent/brain cv art .....	0.00	0.00	0.00	0.00	XXX
0008T .....	.....	C	Upper gi endoscopy w/suture .....	0.00	0.00	0.00	0.00	XXX
0009T .....	.....	C	Endometrial cryoablation .....	0.00	0.00	0.00	0.00	XXX
0010T .....	.....	C	Tb test, gamma interferon .....	0.00	0.00	0.00	0.00	XXX
0012T .....	.....	C	Osteochondral knee autograft .....	0.00	0.00	0.00	0.00	XXX
0013T .....	.....	C	Osteochondral knee allograft .....	0.00	0.00	0.00	0.00	XXX
0014T .....	.....	C	Meniscal transplant, knee .....	0.00	0.00	0.00	0.00	XXX
0016T .....	.....	C	Thermotx choroid vasc lesion .....	0.00	0.00	0.00	0.00	XXX
0017T .....	.....	C	Photocoagulat macular drusen .....	0.00	0.00	0.00	0.00	XXX
0018T .....	.....	C	Transcranial magnetic stimul .....	0.00	0.00	0.00	0.00	XXX
0019T .....	.....	C	Extracorp shock wave tx, ms .....	0.00	0.00	0.00	0.00	XXX
0020T .....	.....	C	Extracorp shock wave tx, ft .....	0.00	0.00	0.00	0.00	XXX
0021T .....	.....	C	Fetal oximetry, trnsvag/cerv .....	0.00	0.00	0.00	0.00	XXX
0023T .....	.....	C	Phenotype drug test, hiv 1 .....	0.00	0.00	0.00	0.00	XXX
0024T .....	.....	C	Transcath cardiac reduction .....	0.00	0.00	0.00	0.00	XXX
0025T .....	.....	C	Ultrasonic pachymetry .....	0.00	0.00	0.00	0.00	XXX
0026T .....	.....	C	Measure remnant lipoproteins .....	0.00	0.00	0.00	0.00	XXX
10021 .....	.....	A	Fna w/o image .....	1.27	NA	1.00	0.10	XXX
10022 .....	.....	A	Fna w/image .....	1.27	NA	1.26	0.08	XXX

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2 Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).

3 +Indicates RVUs are not use for Medicare payments.

4 PE RVUs = Practice Expense Relative Value Units.

## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
10040		A	Acne surgery	1.18	0.53	0.93	0.05	010
10060		A	Drainage of skin abscess	1.17	0.67	1.47	0.08	010
10061		A	Drainage of skin abscess	2.40	1.42	1.83	0.17	010
10080		A	Drainage of pilonidal cyst	1.17	0.73	2.12	0.09	010
10081		A	Drainage of pilonidal cyst	2.45	1.54	2.88	0.19	010
10120		A	Remove foreign body	1.22	0.36	1.48	0.10	010
10121		A	Remove foreign body	2.69	1.78	2.93	0.25	010
10140		A	Drainage of hematoma/fluid	1.53	0.87	1.49	0.15	010
10160		A	Puncture drainage of lesion	1.20	0.42	0.72	0.11	010
10180		A	Complex drainage, wound	2.25	1.26	1.47	0.25	010
11000		A	Debride infected skin	0.60	0.24	0.63	0.05	000
11001		A	Debride infected skin add-on	0.30	0.11	0.37	0.02	ZZZ
11010		A	Debride skin, fx	4.20	1.98	2.39	0.45	010
11011		A	Debride skin/muscle, fx	4.95	2.59	3.82	0.53	000
11012		A	Debride skin/muscle/bone, fx	6.88	4.21	5.47	0.89	000
11040		A	Debride skin, partial	0.50	0.21	0.54	0.05	000
11041		A	Debride skin, full	0.82	0.33	0.69	0.08	000
11042		A	Debride skin/tissue	1.12	0.46	1.04	0.11	000
11043		A	Debride tissue/muscle	2.38	1.38	2.65	0.24	010
11044		A	Debride tissue/muscle/bone	3.06	1.82	3.26	0.34	010
11055		R	Trim skin lesion	0.43	0.18	0.51	0.02	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.26	0.57	0.03	000
11057		R	Trim skin lesions, over 4	0.79	0.33	0.64	0.04	000
11100		A	Biopsy of skin lesion	0.81	0.37	1.46	0.04	000
11101		A	Biopsy, skin add-on	0.41	0.19	0.69	0.02	ZZZ
11200		A	Removal of skin tags	0.77	0.31	1.16	0.04	010
11201		A	Remove skin tags add-on	0.29	0.12	0.51	0.02	ZZZ
11300		A	Shave skin lesion	0.51	0.22	1.01	0.03	000
11301		A	Shave skin lesion	0.85	0.39	1.09	0.04	000
11302		A	Shave skin lesion	1.05	0.47	1.18	0.05	000
11303		A	Shave skin lesion	1.24	0.54	1.31	0.06	000
11305		A	Shave skin lesion	0.67	0.28	0.74	0.04	000
11306		A	Shave skin lesion	0.99	0.43	1.00	0.05	000
11307		A	Shave skin lesion	1.14	0.50	1.12	0.05	000
11308		A	Shave skin lesion	1.41	0.61	1.26	0.07	000
11310		A	Shave skin lesion	0.73	0.33	1.11	0.04	000
11311		A	Shave skin lesion	1.05	0.50	1.20	0.05	000
11312		A	Shave skin lesion	1.20	0.57	1.27	0.06	000
11313		A	Shave skin lesion	1.62	0.74	1.55	0.09	000
11400		A	Removal of skin lesion	0.91	0.35	1.63	0.06	010
11401		A	Removal of skin lesion	1.32	0.51	1.76	0.09	010
11402		A	Removal of skin lesion	1.61	0.95	2.51	0.12	010
11403		A	Removal of skin lesion	1.92	1.07	2.75	0.16	010
11404		A	Removal of skin lesion	2.20	1.15	2.91	0.18	010
11406		A	Removal of skin lesion	2.76	1.36	3.21	0.25	010
11420		A	Removal of skin lesion	1.06	0.43	1.46	0.08	010
11421		A	Removal of skin lesion	1.53	0.62	1.77	0.11	010
11422		A	Removal of skin lesion	1.76	1.04	2.53	0.14	010
11423		A	Removal of skin lesion	2.17	1.22	2.92	0.17	010
11424		A	Removal of skin lesion	2.62	1.38	3.04	0.21	010
11426		A	Removal of skin lesion	3.78	1.82	3.70	0.34	010
11440		A	Removal of skin lesion	1.15	0.51	2.18	0.08	010
11441		A	Removal of skin lesion	1.61	0.72	2.38	0.11	010
11442		A	Removal of skin lesion	1.87	1.25	2.79	0.14	010
11443		A	Removal of skin lesion	2.49	1.57	3.30	0.18	010
11444		A	Removal of skin lesion	3.42	1.98	3.75	0.25	010
11446		A	Removal of skin lesion	4.49	2.45	4.20	0.30	010
11450		A	Removal, sweat gland lesion	2.73	0.97	4.11	0.26	090
11451		A	Removal, sweat gland lesion	3.95	1.44	4.91	0.39	090
11462		A	Removal, sweat gland lesion	2.51	0.95	4.08	0.23	090
11463		A	Removal, sweat gland lesion	3.95	1.57	5.55	0.40	090
11470		A	Removal, sweat gland lesion	3.25	1.24	4.66	0.30	090
11471		A	Removal, sweat gland lesion	4.41	1.72	5.69	0.40	090
11600		A	Removal of skin lesion	1.41	1.02	2.41	0.09	010
11601		A	Removal of skin lesion	1.93	1.30	2.46	0.12	010
11602		A	Removal of skin lesion	2.09	1.35	2.58	0.13	010

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<sup>3</sup> +Indicates RVUs are not use for Medicare payments.

<sup>4</sup> PE RVUs = Practice Expense Relative Value Units.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
11603		A	Removal of skin lesion	2.35	1.42	2.83	0.16	010
11604		A	Removal of skin lesion	2.58	1.49	3.15	0.18	010
11606		A	Removal of skin lesion	3.43	1.77	3.76	0.28	010
11620		A	Removal of skin lesion	1.34	1.03	2.39	0.09	010
11621		A	Removal of skin lesion	1.97	1.37	2.50	0.12	010
11622		A	Removal of skin lesion	2.34	1.54	2.78	0.15	010
11623		A	Removal of skin lesion	2.93	1.76	3.18	0.20	010
11624		A	Removal of skin lesion	3.43	1.98	3.59	0.25	010
11626		A	Removal of skin lesion	4.30	2.46	4.36	0.35	010
11640		A	Removal of skin lesion	1.53	1.23	2.45	0.10	010
11641		A	Removal of skin lesion	2.44	1.71	2.85	0.15	010
11642		A	Removal of skin lesion	2.93	1.94	3.26	0.18	010
11643		A	Removal of skin lesion	3.50	2.21	3.69	0.24	010
11644		A	Removal of skin lesion	4.55	2.81	4.65	0.33	010
11646		A	Removal of skin lesion	5.95	3.62	5.52	0.46	010
11719		R	Trim nail(s)	0.17	0.07	0.25	0.01	000
11720		A	Debride nail, 1-5	0.32	0.13	0.34	0.02	000
11721		A	Debride nail, 6 or more	0.54	0.21	0.43	0.04	000
11730		A	Removal of nail plate	1.13	0.44	0.81	0.09	000
11732		A	Remove nail plate, add-on	0.57	0.23	0.30	0.05	ZZZ
11740		A	Drain blood from under nail	0.37	0.14	0.81	0.03	000
11750		A	Removal of nail bed	1.86	0.77	1.71	0.16	010
11752		A	Remove nail bed/finger tip	2.67	1.74	2.10	0.33	010
11755		A	Biopsy, nail unit	1.31	0.56	1.07	0.06	000
11760		A	Repair of nail bed	1.58	1.24	1.78	0.17	010
11762		A	Reconstruction of nail bed	2.89	1.86	2.23	0.32	010
11765		A	Excision of nail fold, toe	0.69	0.49	1.13	0.05	010
11770		A	Removal of pilonidal lesion	2.61	1.23	2.93	0.24	010
11771		A	Removal of pilonidal lesion	5.74	3.91	5.50	0.56	090
11772		A	Removal of pilonidal lesion	6.98	4.36	6.35	0.68	090
11900		A	Injection into skin lesions	0.52	0.22	0.75	0.02	000
11901		A	Added skin lesions injection	0.80	0.36	0.87	0.03	000
11920		R	Correct skin color defects	1.61	0.80	2.21	0.17	000
11921		R	Correct skin color defects	1.93	1.00	2.60	0.21	000
11922		R	Correct skin color defects	0.49	0.25	0.39	0.05	ZZZ
11950		R	Therapy for contour defects	0.84	0.42	1.20	0.06	000
11951		R	Therapy for contour defects	1.19	0.52	1.57	0.10	000
11952		R	Therapy for contour defects	1.69	0.70	2.01	0.17	000
11954		R	Therapy for contour defects	1.85	0.93	2.62	0.19	000
11960		A	Insert tissue expander(s)	9.08	11.15	NA	0.88	090
11970		A	Replace tissue expander	7.06	5.01	NA	0.77	090
11971		A	Remove tissue expander(s)	2.13	3.88	6.27	0.21	090
11975		N	Insert contraceptive cap	1.48	0.57	1.56	0.14	XXX
11976		R	Removal of contraceptive cap	1.78	0.70	1.67	0.17	000
11977		N	Removal/reinsert contra cap	3.30	1.28	2.27	0.31	XXX
11980		A	Implant hormone pellet(s)	1.48	0.56	1.12	0.10	000
11981		A	Insert drug implant device	1.48	0.57	1.56	0.14	XXX
11982		A	Remove drug implant device	1.78	0.69	1.68	0.17	XXX
11983		A	Remove/insert drug implant	3.30	1.28	2.27	0.31	XXX
12001		A	Repair superficial wound(s)	1.70	0.44	2.09	0.13	010
12002		A	Repair superficial wound(s)	1.86	0.93	2.15	0.15	010
12004		A	Repair superficial wound(s)	2.24	1.04	2.41	0.17	010
12005		A	Repair superficial wound(s)	2.86	1.23	2.96	0.23	010
12006		A	Repair superficial wound(s)	3.67	1.54	3.61	0.31	010
12007		A	Repair superficial wound(s)	4.12	1.83	4.05	0.37	010
12011		A	Repair superficial wound(s)	1.76	0.45	2.25	0.14	010
12013		A	Repair superficial wound(s)	1.99	0.96	2.39	0.16	010
12014		A	Repair superficial wound(s)	2.46	1.09	2.68	0.18	010
12015		A	Repair superficial wound(s)	3.19	1.28	3.28	0.24	010
12016		A	Repair superficial wound(s)	3.93	1.56	3.76	0.32	010
12017		A	Repair superficial wound(s)	4.71	1.90	NA	0.39	010
12018		A	Repair superficial wound(s)	5.53	2.27	NA	0.46	010
12020		A	Closure of split wound	2.62	1.42	2.48	0.24	010
12021		A	Closure of split wound	1.84	1.02	1.61	0.19	010
12031		A	Layer closure of wound(s)	2.15	0.77	2.15	0.15	010
12032		A	Layer closure of wound(s)	2.47	1.28	2.77	0.15	010

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
12034	.....	A	Layer closure of wound(s) .....	2.92	1.45	3.04	0.21	010
12035	.....	A	Layer closure of wound(s) .....	3.43	1.67	3.08	0.30	010
12036	.....	A	Layer closure of wound(s) .....	4.05	2.45	5.20	0.41	010
12037	.....	A	Layer closure of wound(s) .....	4.67	2.79	5.49	0.49	010
12041	.....	A	Layer closure of wound(s) .....	2.37	0.83	2.34	0.17	010
12042	.....	A	Layer closure of wound(s) .....	2.74	1.42	2.98	0.17	010
12044	.....	A	Layer closure of wound(s) .....	3.14	1.61	3.15	0.24	010
12045	.....	A	Layer closure of wound(s) .....	3.64	1.86	3.53	0.34	010
12046	.....	A	Layer closure of wound(s) .....	4.25	2.52	5.48	0.40	010
12047	.....	A	Layer closure of wound(s) .....	4.65	2.88	5.92	0.41	010
12051	.....	A	Layer closure of wound(s) .....	2.47	1.41	3.00	0.16	010
12052	.....	A	Layer closure of wound(s) .....	2.77	1.38	2.92	0.17	010
12053	.....	A	Layer closure of wound(s) .....	3.12	1.54	3.09	0.20	010
12054	.....	A	Layer closure of wound(s) .....	3.46	1.65	3.44	0.25	010
12055	.....	A	Layer closure of wound(s) .....	4.43	2.18	4.49	0.35	010
12056	.....	A	Layer closure of wound(s) .....	5.24	3.05	6.55	0.43	010
12057	.....	A	Layer closure of wound(s) .....	5.96	3.75	6.07	0.50	010
13100	.....	A	Repair of wound or lesion .....	3.12	1.82	3.34	0.21	010
13101	.....	A	Repair of wound or lesion .....	3.92	2.29	3.54	0.22	010
13102	.....	A	Repair wound/lesion add-on .....	1.24	0.57	0.73	0.10	ZZZ
13120	.....	A	Repair of wound or lesion .....	3.30	1.87	3.45	0.23	010
13121	.....	A	Repair of wound or lesion .....	4.33	2.39	3.76	0.25	010
13122	.....	A	Repair wound/lesion add-on .....	1.44	0.65	0.86	0.12	ZZZ
13131	.....	A	Repair of wound or lesion .....	3.79	2.21	3.70	0.25	010
13132	.....	A	Repair of wound or lesion .....	5.95	3.25	4.48	0.32	010
13133	.....	A	Repair wound/lesion add-on .....	2.19	1.01	1.19	0.17	ZZZ
13150	.....	A	Repair of wound or lesion .....	3.81	2.66	5.17	0.29	010
13151	.....	A	Repair of wound or lesion .....	4.45	3.10	5.04	0.28	010
13152	.....	A	Repair of wound or lesion .....	6.33	4.00	5.71	0.38	010
13153	.....	A	Repair wound/lesion add-on .....	2.38	1.09	1.32	0.18	ZZZ
13160	.....	A	Late closure of wound .....	10.48	6.28	NA	1.19	090
14000	.....	A	Skin tissue rearrangement .....	5.89	4.68	7.31	0.46	090
14001	.....	A	Skin tissue rearrangement .....	8.47	5.99	8.55	0.65	090
14020	.....	A	Skin tissue rearrangement .....	6.59	5.39	7.78	0.50	090
14021	.....	A	Skin tissue rearrangement .....	10.06	7.15	9.05	0.69	090
14040	.....	A	Skin tissue rearrangement .....	7.87	6.10	8.03	0.53	090
14041	.....	A	Skin tissue rearrangement .....	11.49	7.93	9.73	0.68	090
14060	.....	A	Skin tissue rearrangement .....	8.50	6.95	8.54	0.59	090
14061	.....	A	Skin tissue rearrangement .....	12.29	8.79	10.70	0.75	090
14300	.....	A	Skin tissue rearrangement .....	11.76	8.44	9.90	0.88	090
14350	.....	A	Skin tissue rearrangement .....	9.61	6.37	NA	1.09	090
15000	.....	A	Skin graft .....	4.00	1.88	2.44	0.37	000
15001	.....	A	Skin graft add-on .....	1.00	0.43	0.58	0.11	ZZZ
15050	.....	A	Skin pinch graft .....	4.30	3.96	5.05	0.46	090
15100	.....	A	Skin split graft .....	9.05	6.16	6.25	0.94	090
15101	.....	A	Skin split graft add-on .....	1.72	0.74	1.20	0.18	ZZZ
15120	.....	A	Skin split graft .....	9.83	6.75	8.40	0.87	090
15121	.....	A	Skin split graft add-on .....	2.67	1.22	1.60	0.27	ZZZ
15200	.....	A	Skin full graft .....	8.03	5.57	9.30	0.73	090
15201	.....	A	Skin full graft add-on .....	1.32	0.64	1.07	0.14	ZZZ
15220	.....	A	Skin full graft .....	7.87	6.23	9.26	0.68	090
15221	.....	A	Skin full graft add-on .....	1.19	0.58	0.92	0.12	ZZZ
15240	.....	A	Skin full graft .....	9.04	7.06	8.90	0.77	090
15241	.....	A	Skin full graft add-on .....	1.86	0.94	1.46	0.17	ZZZ
15260	.....	A	Skin full graft .....	10.06	7.53	8.86	0.63	090
15261	.....	A	Skin full graft add-on .....	2.23	1.14	1.56	0.17	ZZZ
15342	.....	A	Cultured skin graft, 25 cm .....	1.00	1.03	2.14	0.09	010
15343	.....	A	Culture skn graft addl 25 cm .....	0.25	0.10	0.41	0.02	ZZZ
15350	.....	A	Skin homograft .....	4.00	4.40	8.43	0.42	090
15351	.....	A	Skin homograft add-on .....	1.00	0.41	0.92	0.11	ZZZ
15400	.....	A	Skin heterograft .....	4.00	4.79	4.79	0.40	090
15401	.....	A	Skin heterograft add-on .....	1.00	0.46	1.11	0.11	ZZZ
15570	.....	A	Form skin pedicle flap .....	9.21	6.11	8.17	0.96	090
15572	.....	A	Form skin pedicle flap .....	9.27	5.83	7.68	0.93	090
15574	.....	A	Form skin pedicle flap .....	9.88	6.85	8.31	0.92	090
15576	.....	A	Form skin pedicle flap .....	8.69	6.34	8.80	0.72	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
15600		A	Skin graft	1.91	2.39	6.22	0.19	090
15610		A	Skin graft	2.42	2.67	3.38	0.25	090
15620		A	Skin graft	2.94	3.42	6.82	0.28	090
15630		A	Skin graft	3.27	3.71	6.10	0.28	090
15650		A	Transfer skin pedicle flap	3.97	3.77	6.11	0.36	090
15732		A	Muscle-skin graft, head/neck	17.84	11.31	NA	1.50	090
15734		A	Muscle-skin graft, trunk	17.79	11.18	NA	1.91	090
15736		A	Muscle-skin graft, arm	16.27	10.73	NA	1.78	090
15738		A	Muscle-skin graft, leg	17.92	11.17	NA	1.95	090
15740		A	Island pedicle flap graft	10.25	7.05	8.55	0.62	090
15750		A	Neurovascular pedicle graft	11.41	8.17	NA	1.12	090
15756		A	Free muscle flap, microvasc	35.23	20.87	NA	3.11	090
15757		A	Free skin flap, microvasc	35.23	22.03	NA	3.37	090
15758		A	Free fascial flap, microvasc	35.10	22.06	NA	3.52	090
15760		A	Composite skin graft	8.74	6.66	8.88	0.72	090
15770		A	Derma-fat-fascia graft	7.52	6.03	NA	0.78	090
15775		R	Hair transplant punch grafts	3.96	1.55	3.07	0.43	000
15776		R	Hair transplant punch grafts	5.54	2.88	3.90	0.60	000
15780		A	Abrasion treatment of skin	7.29	6.41	6.41	0.41	090
15781		A	Abrasion treatment of skin	4.85	4.74	4.84	0.27	090
15782		A	Abrasion treatment of skin	4.32	4.13	4.21	0.21	090
15783		A	Abrasion treatment of skin	4.29	3.47	4.55	0.26	090
15786		A	Abrasion, lesion, single	2.03	1.27	1.73	0.11	010
15787		A	Abrasion, lesions, add-on	0.33	0.16	0.31	0.02	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	1.03	2.90	0.11	090
15789		R	Chemical peel, face, dermal	4.92	3.46	5.92	0.27	090
15792		R	Chemical peel, nonfacial	1.86	2.08	2.78	0.10	090
15793		A	Chemical peel, nonfacial	3.74	3.33	NA	0.17	090
15810		A	Salabrasion	4.74	3.83	3.83	0.42	090
15811		A	Salabrasion	5.39	4.75	6.10	0.52	090
15819		A	Plastic surgery, neck	9.38	6.69	NA	0.77	090
15820		A	Revision of lower eyelid	5.15	7.08	11.63	0.30	090
15821		A	Revision of lower eyelid	5.72	7.22	12.14	0.31	090
15822		A	Revision of upper eyelid	4.45	6.47	10.50	0.22	090
15823		A	Revision of upper eyelid	7.05	7.55	11.57	0.32	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	000
15831		A	Excise excessive skin tissue	12.40	7.66	NA	1.30	090
15832		A	Excise excessive skin tissue	11.59	7.75	NA	1.21	090
15833		A	Excise excessive skin tissue	10.64	7.04	NA	1.17	090
15834		A	Excise excessive skin tissue	10.85	6.98	NA	1.18	090
15835		A	Excise excessive skin tissue	11.67	6.80	NA	1.13	090
15836		A	Excise excessive skin tissue	9.34	6.19	NA	0.95	090
15837		A	Excise excessive skin tissue	8.43	6.34	7.48	0.78	090
15838		A	Excise excessive skin tissue	7.13	5.68	NA	0.58	090
15839		A	Excise excessive skin tissue	9.38	5.77	7.29	0.88	090
15840		A	Graft for face nerve palsy	13.26	9.80	NA	1.15	090
15841		A	Graft for face nerve palsy	23.26	14.52	NA	2.65	090
15842		A	Flap for face nerve palsy	37.96	22.95	NA	3.99	090
15845		A	Skin and muscle repair, face	12.57	8.54	NA	0.80	090
15850		B	Removal of sutures	0.78	0.30	1.43	0.04	XXX
15851		A	Removal of sutures	0.86	0.34	1.61	0.05	000
15852		A	Dressing change,not for burn	0.86	0.36	1.77	0.07	000
15860		A	Test for blood flow in graft	1.95	0.80	1.31	0.13	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	7.95	5.50	NA	0.83	090
15922		A	Removal of tail bone ulcer	9.90	7.35	NA	1.06	090
15931		A	Remove sacrum pressure sore	9.24	5.56	NA	0.95	090
15933		A	Remove sacrum pressure sore	10.85	8.00	NA	1.14	090
15934		A	Remove sacrum pressure sore	12.69	8.34	NA	1.35	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
15935		A	Remove sacrum pressure sore	14.57	10.04	NA	1.56	090
15936		A	Remove sacrum pressure sore	12.38	8.86	NA	1.32	090
15937		A	Remove sacrum pressure sore	14.21	10.36	NA	1.51	090
15940		A	Remove hip pressure sore	9.34	5.94	NA	0.98	090
15941		A	Remove hip pressure sore	11.43	9.87	NA	1.23	090
15944		A	Remove hip pressure sore	11.46	8.67	NA	1.21	090
15945		A	Remove hip pressure sore	12.69	9.63	NA	1.38	090
15946		A	Remove hip pressure sore	21.57	14.05	NA	2.32	090
15950		A	Remove thigh pressure sore	7.54	5.16	NA	0.80	090
15951		A	Remove thigh pressure sore	10.72	8.02	NA	1.14	090
15952		A	Remove thigh pressure sore	11.39	7.43	NA	1.19	090
15953		A	Remove thigh pressure sore	12.63	8.87	NA	1.38	090
15956		A	Remove thigh pressure sore	15.52	10.48	NA	1.64	090
15958		A	Remove thigh pressure sore	15.48	10.79	NA	1.66	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.27	1.07	0.06	000
16010		A	Treatment of burn(s)	0.87	0.36	1.18	0.07	000
16015		A	Treatment of burn(s)	2.35	0.94	1.88	0.22	000
16020		A	Treatment of burn(s)	0.80	0.26	1.21	0.06	000
16025		A	Treatment of burn(s)	1.85	0.67	1.87	0.16	000
16030		A	Treatment of burn(s)	2.08	0.90	3.03	0.18	000
16035		A	Incision of burn scab, initi	3.75	1.50	NA	0.36	090
16036		A	Incise burn scab, addl incis	1.50	0.60	NA	0.11	ZZZ
17000		A	Detroy benign/premal lesion	0.60	0.27	1.06	0.03	010
17003		A	Destroy lesions, 2-14	0.15	0.07	0.23	0.01	ZZZ
17004		A	Destroy lesions, 15 or more	2.79	1.28	2.51	0.12	010
17106		A	Destruction of skin lesions	4.59	2.76	4.58	0.28	090
17107		A	Destruction of skin lesions	9.16	4.94	6.88	0.53	090
17108		A	Destruction of skin lesions	13.20	7.18	8.80	0.89	090
17110		A	Destruct lesion, 1-14	0.65	0.26	1.09	0.04	010
17111		A	Destruct lesion, 15 or more	0.92	0.38	1.16	0.04	010
17250		A	Chemical cautery, tissue	0.50	0.21	0.74	0.04	000
17260		A	Destruction of skin lesions	0.91	0.40	1.34	0.04	010
17261		A	Destruction of skin lesions	1.17	0.55	1.45	0.05	010
17262		A	Destruction of skin lesions	1.58	0.74	1.65	0.07	010
17263		A	Destruction of skin lesions	1.79	0.82	1.76	0.08	010
17264		A	Destruction of skin lesions	1.94	0.85	1.83	0.08	010
17266		A	Destruction of skin lesions	2.34	0.96	2.04	0.11	010
17270		A	Destruction of skin lesions	1.32	0.60	1.54	0.06	010
17271		A	Destruction of skin lesions	1.49	0.71	1.61	0.06	010
17272		A	Destruction of skin lesions	1.77	0.84	1.75	0.07	010
17273		A	Destruction of skin lesions	2.05	0.95	1.89	0.09	010
17274		A	Destruction of skin lesions	2.59	1.18	2.15	0.11	010
17276		A	Destruction of skin lesions	3.20	1.68	2.47	0.15	010
17280		A	Destruction of skin lesions	1.17	0.53	1.37	0.05	010
17281		A	Destruction of skin lesions	1.72	0.82	1.72	0.07	010
17282		A	Destruction of skin lesions	2.04	0.97	1.88	0.09	010
17283		A	Destruction of skin lesions	2.64	1.23	2.18	0.11	010
17284		A	Destruction of skin lesions	3.21	1.49	2.47	0.14	010
17286		A	Destruction of skin lesions	4.44	2.48	3.12	0.22	010
17304		A	Chemosurgery of skin lesion	7.60	3.65	7.57	0.31	000
17305		A	2nd stage chemosurgery	2.85	1.37	3.51	0.12	000
17306		A	3rd stage chemosurgery	2.85	1.38	3.51	0.12	000
17307		A	Followup skin lesion therapy	2.85	1.40	3.52	0.12	000
17310		A	Extensive skin chemosurgery	0.95	0.47	1.50	0.05	000
17340		A	Cryotherapy of skin	0.76	0.26	0.37	0.04	010
17360		A	Skin peel therapy	1.43	0.71	1.45	0.06	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	0.29	1.23	0.07	000
19001		A	Drain breast lesion add-on	0.42	0.14	0.84	0.03	ZZZ
19020		A	Incision of breast lesion	3.57	3.38	6.84	0.35	090
19030		A	Injection for breast x-ray	1.53	0.52	3.74	0.07	000
19100		A	Bx breast percut w/o image	1.27	0.44	1.46	0.10	000
19101		A	Biopsy of breast, open	3.18	1.93	5.24	0.20	010
19102		A	Bx breast percut w/image	2.00	0.69	5.11	0.13	000

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
19103		A	Bx breast percut w/device	3.70	1.27	12.71	0.16	000
19110		A	Nipple exploration	4.30	4.40	8.56	0.44	090
19112		A	Excise breast duct fistula	3.67	3.07	9.11	0.38	090
19120		A	Removal of breast lesion	5.56	3.09	4.92	0.56	090
19125		A	Excision, breast lesion	6.06	3.25	5.03	0.61	090
19126		A	Excision, addl breast lesion	2.93	1.03	NA	0.30	ZZZ
19140		A	Removal of breast tissue	5.14	3.65	9.29	0.52	090
19160		A	Removal of breast tissue	5.99	4.48	NA	0.61	090
19162		A	Remove breast tissue, nodes	13.53	7.93	NA	1.38	090
19180		A	Removal of breast	8.80	5.97	NA	0.88	090
19182		A	Removal of breast	7.73	5.01	NA	0.79	090
19200		A	Removal of breast	15.49	9.09	NA	1.51	090
19220		A	Removal of breast	15.72	9.14	NA	1.56	090
19240		A	Removal of breast	16.00	8.78	NA	1.62	090
19260		A	Removal of chest wall lesion	15.44	9.02	NA	1.64	090
19271		A	Revision of chest wall	18.90	11.09	NA	2.27	090
19272		A	Extensive chest wall surgery	21.55	11.93	NA	2.54	090
19290		A	Place needle wire, breast	1.27	0.43	3.00	0.06	000
19291		A	Place needle wire, breast	0.63	0.22	1.76	0.03	ZZZ
19295		A	Place breast clip, percut	0.00	NA	2.88	0.01	ZZZ
19316		A	Suspension of breast	10.69	7.64	NA	1.15	090
19318		A	Reduction of large breast	15.62	10.30	NA	1.69	090
19324		A	Enlarge breast	5.85	4.29	NA	0.63	090
19325		A	Enlarge breast with implant	8.45	6.29	NA	0.90	090
19328		A	Removal of breast implant	5.68	4.59	NA	0.61	090
19330		A	Removal of implant material	7.59	5.27	NA	0.81	090
19340		A	Immediate breast prosthesis	6.33	3.19	NA	0.68	ZZZ
19342		A	Delayed breast prosthesis	11.20	7.92	NA	1.21	090
19350		A	Breast reconstruction	8.92	6.87	13.93	0.95	090
19355		A	Correct inverted nipple(s)	7.57	5.47	13.39	0.80	090
19357		A	Breast reconstruction	18.16	13.88	NA	1.96	090
19361		A	Breast reconstruction	19.26	11.98	NA	2.08	090
19364		A	Breast reconstruction	41.00	23.88	NA	3.91	090
19366		A	Breast reconstruction	21.28	11.71	NA	2.27	090
19367		A	Breast reconstruction	25.73	15.24	NA	2.78	090
19368		A	Breast reconstruction	32.42	18.77	NA	3.51	090
19369		A	Breast reconstruction	29.82	18.13	NA	3.24	090
19370		A	Surgery of breast capsule	8.05	6.15	NA	0.86	090
19371		A	Removal of breast capsule	9.35	7.24	NA	1.01	090
19380		A	Revise breast reconstruction	9.14	7.13	NA	0.98	090
19396		A	Design custom breast implant	2.17	0.92	6.66	0.23	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.12	1.19	2.15	0.17	010
20005		A	Incision of deep abscess	3.42	2.19	2.99	0.34	010
20100		A	Explore wound, neck	10.08	4.37	5.83	0.99	010
20101		A	Explore wound, chest	3.22	1.48	2.82	0.24	010
20102		A	Explore wound, abdomen	3.94	1.76	3.39	0.35	010
20103		A	Explore wound, extremity	5.30	3.00	4.25	0.57	010
20150		A	Excise epiphyseal bar	13.69	8.96	NA	0.96	090
20200		A	Muscle biopsy	1.46	0.60	1.69	0.17	000
20205		A	Deep muscle biopsy	2.35	0.95	3.86	0.23	000
20206		A	Needle biopsy, muscle	0.99	0.35	3.18	0.06	000
20220		A	Bone biopsy, trocar/needle	1.27	3.02	5.05	0.06	000
20225		A	Bone biopsy, trocar/needle	1.87	3.06	4.46	0.11	000
20240		A	Bone biopsy, excisional	3.23	4.12	NA	0.33	010
20245		A	Bone biopsy, excisional	7.78	6.74	NA	0.44	010
20250		A	Open bone biopsy	5.03	4.25	NA	0.50	010
20251		A	Open bone biopsy	5.56	4.78	NA	0.79	010
20500		A	Injection of sinus tract	1.23	3.88	5.68	0.10	010
20501		A	Inject sinus tract for x-ray	0.76	0.26	3.22	0.03	000
20520		A	Removal of foreign body	1.85	3.46	5.49	0.17	010
20525		A	Removal of foreign body	3.50	4.26	6.93	0.40	010
20526		A	Ther injection carpal tunnel	0.86	0.38	0.77	0.06	000
20550		A	Inject tendon/ligament/cyst	0.86	0.26	0.84	0.06	000
20551		A	Inject tendon origin/insert	0.86	0.38	0.77	0.06	000
20552		A	Inject trigger point, 1 or 2	0.86	0.38	0.77	0.06	000

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
20553		A	Inject trigger points, > 3	0.86	0.38	0.77	0.06	000
20600		A	Drain/inject, joint/bursa	0.66	0.35	0.64	0.06	000
20605		A	Drain/inject, joint/bursa	0.68	0.36	0.75	0.06	000
20610		A	Drain/inject, joint/bursa	0.79	0.41	0.93	0.08	000
20615		A	Treatment of bone cyst	2.28	2.63	4.68	0.19	010
20650		A	Insert and remove bone pin	2.23	3.18	4.94	0.28	010
20660		A	Apply, remove fixation device	2.51	1.46	NA	0.48	000
20661		A	Application of head brace	4.89	6.61	NA	0.92	090
20662		A	Application of pelvis brace	6.07	5.27	NA	0.81	090
20663		A	Application of thigh brace	5.43	4.70	NA	0.77	090
20664		A	Halo brace application	8.06	8.30	NA	1.49	090
20665		A	Removal of fixation device	1.31	1.24	2.30	0.17	010
20670		A	Removal of support implant	1.74	3.30	5.63	0.23	010
20680		A	Removal of support implant	3.35	5.10	5.10	0.46	090
20690		A	Apply bone fixation device	3.52	1.84	NA	0.47	090
20692		A	Apply bone fixation device	6.41	3.07	NA	0.60	090
20693		A	Adjust bone fixation device	5.86	12.41	NA	0.85	090
20694		A	Remove bone fixation device	4.16	6.12	8.77	0.57	090
20802		A	Replantation, arm, complete	41.15	29.57	NA	5.81	090
20805		A	Replant, forearm, complete	50.00	44.44	NA	3.95	090
20808		A	Replantation hand, complete	61.65	48.81	NA	6.49	090
20816		A	Replantation digit, complete	30.94	46.19	NA	3.01	090
20822		A	Replantation digit, complete	25.59	42.70	NA	3.07	090
20824		A	Replantation thumb, complete	30.94	44.93	NA	3.48	090
20827		A	Replantation thumb, complete	26.41	44.52	NA	3.21	090
20838		A	Replantation foot, complete	41.41	28.98	NA	5.85	090
20900		A	Removal of bone for graft	5.58	6.14	6.31	0.77	090
20902		A	Removal of bone for graft	7.55	8.77	NA	1.06	090
20910		A	Remove cartilage for graft	5.34	6.69	8.56	0.50	090
20912		A	Remove cartilage for graft	6.35	7.57	NA	0.55	090
20920		A	Removal of fascia for graft	5.31	5.57	NA	0.54	090
20922		A	Removal of fascia for graft	6.61	6.32	9.03	0.88	090
20924		A	Removal of tendon for graft	6.48	6.98	NA	0.82	090
20926		A	Removal of tissue for graft	5.53	6.22	NA	0.73	090
20930		B	Spinal bone allograft	0.00	0.00	0.00	0.00	XXX
20931		A	Spinal bone allograft	1.81	0.95	NA	0.34	ZZZ
20936		B	Spinal bone autograft	0.00	0.00	0.00	0.00	XXX
20937		A	Spinal bone autograft	2.79	1.47	NA	0.43	ZZZ
20938		A	Spinal bone autograft	3.02	1.58	NA	0.52	ZZZ
20950		A	Fluid pressure, muscle	1.26	2.08	NA	0.16	000
20955		A	Fibula bone graft, microvasc	39.21	29.77	NA	4.35	090
20956		A	Iliac bone graft, microvasc	39.27	28.02	NA	5.77	090
20957		A	Mt bone graft, microvasc	40.65	20.15	NA	5.74	090
20962		A	Other bone graft, microvasc	39.27	27.75	NA	5.19	090
20969		A	Bone/skin graft, microvasc	43.92	32.44	NA	4.34	090
20970		A	Bone/skin graft, iliac crest	43.06	29.88	NA	4.64	090
20972		A	Bone/skin graft, metatarsal	42.99	18.59	NA	6.07	090
20973		A	Bone/skin graft, great toe	45.76	27.95	NA	4.65	090
20974		A	Electrical bone stimulation	0.62	0.33	0.41	0.09	000
20975		A	Electrical bone stimulation	2.60	1.37	NA	0.42	000
20979		A	Us bone stimulation	0.62	0.24	0.57	0.04	000
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.14	7.22	NA	0.54	090
21015		A	Resection of facial tumor	5.29	7.27	NA	0.52	090
21025		A	Excision of bone, lower jaw	10.06	6.80	7.27	0.79	090
21026		A	Excision of facial bone(s)	4.85	5.05	5.30	0.40	090
21029		A	Contour of face bone lesion	7.71	6.14	6.85	0.74	090
21030		A	Removal of face bone lesion	6.46	4.76	5.33	0.60	090
21031		A	Remove exostosis, mandible	3.24	2.12	3.31	0.28	090
21032		A	Remove exostosis, maxilla	3.24	2.24	3.28	0.27	090
21034		A	Removal of face bone lesion	16.17	10.58	10.58	1.37	090
21040		A	Removal of jaw bone lesion	2.11	1.80	2.98	0.19	090
21041		A	Removal of jaw bone lesion	6.71	4.33	5.55	0.56	090
21044		A	Removal of jaw bone lesion	11.86	7.93	NA	0.87	090
21045		A	Extensive jaw surgery	16.17	10.23	NA	1.20	090
21050		A	Removal of jaw joint	10.77	11.68	NA	0.84	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
21060		A	Remove jaw joint cartilage	10.23	10.19	NA	1.16	090
21070		A	Remove coronoid process	8.20	5.97	NA	0.67	090
21076		A	Prepare face/oral prosthesis	13.42	7.17	9.54	1.36	010
21077		A	Prepare face/oral prosthesis	33.75	18.03	23.99	3.43	090
21079		A	Prepare face/oral prosthesis	22.34	12.47	16.96	1.59	090
21080		A	Prepare face/oral prosthesis	25.10	14.01	19.05	2.55	090
21081		A	Prepare face/oral prosthesis	22.88	12.77	17.36	1.87	090
21082		A	Prepare face/oral prosthesis	20.87	11.15	14.83	1.46	090
21083		A	Prepare face/oral prosthesis	19.30	10.77	14.65	1.96	090
21084		A	Prepare face/oral prosthesis	22.51	12.56	17.08	1.57	090
21085		A	Prepare face/oral prosthesis	9.00	4.81	6.40	0.65	010
21086		A	Prepare face/oral prosthesis	24.92	13.91	18.91	1.86	090
21087		A	Prepare face/oral prosthesis	24.92	13.31	17.71	2.22	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090
21100		A	Maxillofacial fixation	4.22	3.95	5.67	0.18	090
21110		A	Interdental fixation	5.21	4.25	5.18	0.28	090
21116		A	Injection, jaw joint x-ray	0.81	0.29	7.90	0.05	000
21120		A	Reconstruction of chin	4.93	6.06	9.69	0.29	090
21121		A	Reconstruction of chin	7.64	6.18	7.71	0.56	090
21122		A	Reconstruction of chin	8.52	7.53	NA	0.59	090
21123		A	Reconstruction of chin	11.16	8.13	NA	1.16	090
21125		A	Augmentation, lower jaw bone	10.62	8.01	9.32	0.72	090
21127		A	Augmentation, lower jaw bone	11.12	7.38	9.51	0.76	090
21137		A	Reduction of forehead	9.82	8.13	NA	0.53	090
21138		A	Reduction of forehead	12.19	9.40	NA	1.47	090
21139		A	Reduction of forehead	14.61	8.88	NA	1.02	090
21141		A	Reconstruct midface, left	18.10	10.71	NA	1.63	090
21142		A	Reconstruct midface, left	18.81	12.16	NA	1.16	090
21143		A	Reconstruct midface, left	19.58	10.98	NA	0.90	090
21145		A	Reconstruct midface, left	19.94	11.18	NA	2.09	090
21146		A	Reconstruct midface, left	20.71	11.91	NA	2.13	090
21147		A	Reconstruct midface, left	21.77	12.00	NA	1.52	090
21150		A	Reconstruct midface, left	25.24	16.28	NA	1.09	090
21151		A	Reconstruct midface, left	28.30	20.03	NA	1.98	090
21154		A	Reconstruct midface, left	30.52	19.05	NA	4.86	090
21155		A	Reconstruct midface, left	34.45	20.69	NA	5.48	090
21159		A	Reconstruct midface, left	42.38	27.58	NA	6.74	090
21160		A	Reconstruct midface, left	46.44	26.69	NA	4.39	090
21172		A	Reconstruct orbit/forehead	27.80	15.81	NA	1.91	090
21175		A	Reconstruct orbit/forehead	33.17	20.14	NA	5.16	090
21179		A	Reconstruct entire forehead	22.25	17.94	NA	2.48	090
21180		A	Reconstruct entire forehead	25.19	18.89	NA	2.15	090
21181		A	Contour cranial bone lesion	9.90	8.49	NA	0.97	090
21182		A	Reconstruct cranial bone	32.19	21.96	NA	2.53	090
21183		A	Reconstruct cranial bone	35.31	23.64	NA	2.75	090
21184		A	Reconstruct cranial bone	38.24	24.65	NA	4.12	090
21188		A	Reconstruction of midface	22.46	15.57	NA	1.85	090
21193		A	Reconst lwr jaw w/o graft	17.15	10.69	NA	1.53	090
21194		A	Reconst lwr jaw w/graft	19.84	12.65	NA	1.39	090
21195		A	Reconst lwr jaw w/o fixation	17.24	12.28	NA	1.20	090
21196		A	Reconst lwr jaw w/fixation	18.91	12.87	NA	1.62	090
21198		A	Reconst lwr jaw segment	14.16	11.59	NA	1.05	090
21199		A	Reconst lwr jaw w/advance	16.00	10.19	NA	1.26	090
21206		A	Reconstruct upper jaw bone	14.10	9.66	NA	1.01	090
21208		A	Augmentation of facial bones	10.23	8.44	9.46	0.92	090
21209		A	Reduction of facial bones	6.72	5.81	7.84	0.60	090
21210		A	Face bone graft	10.23	8.14	8.78	0.88	090
21215		A	Lower jaw bone graft	10.77	7.01	8.71	1.04	090
21230		A	Rib cartilage graft	10.77	10.20	NA	0.96	090
21235		A	Ear cartilage graft	6.72	8.12	12.04	0.52	090
21240		A	Reconstruction of jaw joint	14.05	11.42	NA	1.15	090
21242		A	Reconstruction of jaw joint	12.95	11.21	NA	1.40	090
21243		A	Reconstruction of jaw joint	20.79	13.90	NA	1.85	090
21244		A	Reconstruction of lower jaw	11.86	9.13	NA	0.95	090
21245		A	Reconstruction of jaw	11.86	10.17	13.17	0.88	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
21246		A	Reconstruction of jaw	12.47	10.04	10.04	1.21	090
21247		A	Reconstruct lower jaw bone	22.63	16.47	NA	2.21	090
21248		A	Reconstruction of jaw	11.48	7.75	8.79	1.01	090
21249		A	Reconstruction of jaw	17.52	10.11	11.33	1.39	090
21255		A	Reconstruct lower jaw bone	16.72	11.37	NA	1.13	090
21256		A	Reconstruction of orbit	16.19	13.42	NA	1.04	090
21260		A	Revise eye sockets	16.52	11.01	NA	1.25	090
21261		A	Revise eye sockets	31.49	19.83	NA	2.20	090
21263		A	Revise eye sockets	28.42	14.74	NA	2.16	090
21267		A	Revise eye sockets	18.90	14.58	NA	1.35	090
21268		A	Revise eye sockets	24.48	16.16	NA	0.79	090
21270		A	Augmentation, cheek bone	10.23	9.48	9.48	0.73	090
21275		A	Revision, orbitofacial bones	11.24	11.04	NA	1.03	090
21280		A	Revision of eyelid	6.03	6.19	NA	0.27	090
21282		A	Revision of eyelid	3.49	5.30	NA	0.21	090
21295		A	Revision of jaw muscle/bone	1.53	4.33	NA	0.13	090
21296		A	Revision of jaw muscle/bone	4.25	4.65	NA	0.30	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	YYY
21300		A	Treatment of skull fracture	0.72	0.27	2.76	0.09	000
21310		A	Treatment of nose fracture	0.58	0.15	2.66	0.05	000
21315		A	Treatment of nose fracture	1.51	1.28	3.41	0.12	010
21320		A	Treatment of nose fracture	1.85	2.03	4.81	0.15	010
21325		A	Treatment of nose fracture	3.77	3.69	NA	0.31	090
21330		A	Treatment of nose fracture	5.38	5.55	NA	0.48	090
21335		A	Treatment of nose fracture	8.61	7.14	NA	0.64	090
21336		A	Treat nasal septal fracture	5.72	5.55	NA	0.45	090
21337		A	Treat nasal septal fracture	2.70	3.27	5.22	0.22	090
21338		A	Treat nasoethmoid fracture	6.46	6.07	NA	0.53	090
21339		A	Treat nasoethmoid fracture	8.09	6.73	NA	0.76	090
21340		A	Treatment of nose fracture	10.77	9.18	NA	0.85	090
21343		A	Treatment of sinus fracture	12.95	9.77	NA	1.06	090
21344		A	Treatment of sinus fracture	19.72	13.45	NA	1.72	090
21345		A	Treat nose/jaw fracture	8.16	7.92	9.46	0.60	090
21346		A	Treat nose/jaw fracture	10.61	10.05	NA	0.85	090
21347		A	Treat nose/jaw fracture	12.69	9.56	NA	1.14	090
21348		A	Treat nose/jaw fracture	16.69	11.03	NA	1.50	090
21355		A	Treat cheek bone fracture	3.77	2.28	4.37	0.29	010
21356		A	Treat cheek bone fracture	4.15	3.25	NA	0.36	010
21360		A	Treat cheek bone fracture	6.46	5.65	NA	0.52	090
21365		A	Treat cheek bone fracture	14.95	11.39	NA	1.30	090
21366		A	Treat cheek bone fracture	17.77	11.96	NA	1.41	090
21385		A	Treat eye socket fracture	9.16	7.53	NA	0.64	090
21386		A	Treat eye socket fracture	9.16	8.06	NA	0.76	090
21387		A	Treat eye socket fracture	9.70	8.27	NA	0.78	090
21390		A	Treat eye socket fracture	10.13	8.57	NA	0.70	090
21395		A	Treat eye socket fracture	12.68	9.83	NA	1.09	090
21400		A	Treat eye socket fracture	1.40	1.06	3.16	0.12	090
21401		A	Treat eye socket fracture	3.26	3.19	4.70	0.34	090
21406		A	Treat eye socket fracture	7.01	6.80	NA	0.59	090
21407		A	Treat eye socket fracture	8.61	7.84	NA	0.67	090
21408		A	Treat eye socket fracture	12.38	10.11	NA	1.24	090
21421		A	Treat mouth roof fracture	5.14	6.03	7.17	0.42	090
21422		A	Treat mouth roof fracture	8.32	7.52	NA	0.69	090
21423		A	Treat mouth roof fracture	10.40	8.07	NA	0.95	090
21431		A	Treat craniofacial fracture	7.05	6.81	NA	0.58	090
21432		A	Treat craniofacial fracture	8.61	7.67	NA	0.55	090
21433		A	Treat craniofacial fracture	25.35	17.13	NA	2.46	090
21435		A	Treat craniofacial fracture	17.25	12.51	NA	1.66	090
21436		A	Treat craniofacial fracture	28.04	17.24	NA	2.32	090
21440		A	Treat dental ridge fracture	2.70	3.55	5.46	0.22	090
21445		A	Treat dental ridge fracture	5.38	5.15	6.85	0.55	090
21450		A	Treat lower jaw fracture	2.97	2.71	6.49	0.23	090
21451		A	Treat lower jaw fracture	4.87	5.55	6.44	0.39	090
21452		A	Treat lower jaw fracture	1.98	4.10	9.17	0.14	090
21453		A	Treat lower jaw fracture	5.54	6.36	7.31	0.49	090
21454		A	Treat lower jaw fracture	6.46	5.64	NA	0.55	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
21461		A	Treat lower jaw fracture	8.09	7.93	9.06	0.73	090
21462		A	Treat lower jaw fracture	9.79	8.03	10.31	0.80	090
21465		A	Treat lower jaw fracture	11.91	7.79	NA	0.84	090
21470		A	Treat lower jaw fracture	15.34	9.88	NA	1.36	090
21480		A	Reset dislocated jaw	0.61	0.18	1.58	0.05	000
21485		A	Reset dislocated jaw	3.99	3.32	3.76	0.31	090
21490		A	Repair dislocated jaw	11.86	7.46	NA	1.31	090
21493		A	Treat hyoid bone fracture	1.27	3.58	NA	0.10	090
21494		A	Treat hyoid bone fracture	6.28	4.85	NA	0.44	090
21495		A	Treat hyoid bone fracture	5.69	5.02	NA	0.41	090
21497		A	Interdental wiring	3.86	3.91	4.64	0.31	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.81	3.53	4.35	0.36	090
21502		A	Drain chest lesion	7.12	7.29	NA	0.79	090
21510		A	Drainage of bone lesion	5.74	6.92	NA	0.67	090
21550		A	Biopsy of neck/chest	2.06	1.23	2.20	0.13	010
21555		A	Remove lesion, neck/chest	4.35	2.43	4.18	0.41	090
21556		A	Remove lesion, neck/chest	5.57	3.21	NA	0.51	090
21557		A	Remove tumor, neck/chest	8.88	7.58	NA	0.85	090
21600		A	Partial removal of rib	6.89	7.47	NA	0.81	090
21610		A	Partial removal of rib	14.61	10.91	NA	1.85	090
21615		A	Removal of rib	9.87	7.85	NA	1.20	090
21616		A	Removal of rib and nerves	12.04	9.08	NA	1.31	090
21620		A	Partial removal of sternum	6.79	7.96	NA	0.77	090
21627		A	Sternal debridement	6.81	12.18	NA	0.82	090
21630		A	Extensive sternum surgery	17.38	13.60	NA	1.95	090
21632		A	Extensive sternum surgery	18.14	11.81	NA	2.16	090
21700		A	Revision of neck muscle	6.19	6.97	8.43	0.31	090
21705		A	Revision of neck muscle/rib	9.60	7.55	NA	0.92	090
21720		A	Revision of neck muscle	5.68	6.72	8.25	0.80	090
21725		A	Revision of neck muscle	6.99	7.43	NA	0.90	090
21740		A	Reconstruction of sternum	16.50	12.21	NA	2.03	090
21750		A	Repair of sternum separation	10.77	9.44	NA	1.35	090
21800		A	Treatment of rib fracture	0.96	1.06	2.27	0.09	090
21805		A	Treatment of rib fracture	2.75	4.46	NA	0.29	090
21810		A	Treatment of rib fracture(s)	6.86	6.73	NA	0.60	090
21820		A	Treat sternum fracture	1.28	1.50	2.72	0.15	090
21825		A	Treat sternum fracture	7.41	9.85	NA	0.84	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.06	0.75	2.27	0.12	010
21925		A	Biopsy soft tissue of back	4.49	4.61	11.73	0.44	090
21930		A	Remove lesion, back or flank	5.00	2.61	4.50	0.49	090
21935		A	Remove tumor, back	17.96	13.13	NA	1.87	090
22100		A	Remove part of neck vertebra	9.73	8.62	NA	1.55	090
22101		A	Remove part, thorax vertebra	9.81	8.86	NA	1.51	090
22102		A	Remove part, lumbar vertebra	9.81	8.93	NA	1.46	090
22103		A	Remove extra spine segment	2.34	1.24	NA	0.37	ZZZ
22110		A	Remove part of neck vertebra	12.74	10.73	NA	2.20	090
22112		A	Remove part, thorax vertebra	12.81	10.64	NA	1.96	090
22114		A	Remove part, lumbar vertebra	12.81	10.88	NA	1.98	090
22116		A	Remove extra spine segment	2.32	1.19	NA	0.40	ZZZ
22210		A	Revision of neck spine	23.82	16.92	NA	4.23	090
22212		A	Revision of thorax spine	19.42	14.62	NA	2.78	090
22214		A	Revision of lumbar spine	19.45	15.07	NA	2.78	090
22216		A	Revise, extra spine segment	6.04	3.14	NA	0.98	ZZZ
22220		A	Revision of neck spine	21.37	15.34	NA	3.65	090
22222		A	Revision of thorax spine	21.52	12.81	NA	3.08	090
22224		A	Revision of lumbar spine	21.52	15.67	NA	3.20	090
22226		A	Revise, extra spine segment	6.04	3.15	NA	1.01	ZZZ
22305		A	Treat spine process fracture	2.05	1.93	3.17	0.29	090
22310		A	Treat spine fracture	2.61	3.45	4.65	0.37	090
22315		A	Treat spine fracture	8.84	9.14	NA	1.37	090
22318		A	Treat odontoid fx w/o graft	21.50	14.70	NA	4.26	090
22319		A	Treat odontoid fx w/graft	24.00	17.01	NA	4.76	090
22325		A	Treat spine fracture	18.30	14.66	NA	2.61	090
22326		A	Treat neck spine fracture	19.59	15.40	NA	3.54	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
22327		A	Treat thorax spine fracture	19.20	15.11	NA	2.75	090
22328		A	Treat each add spine fx	4.61	2.31	NA	0.66	ZZZ
22505		A	Manipulation of spine	1.87	2.98	4.57	0.27	010
22520		A	Percut vertebroplasty thor	8.91	4.13	NA	0.99	010
22521		A	Percut vertebroplasty lumb	8.34	3.90	NA	0.93	010
22522		A	Percut vertebroplasty addl	4.31	1.74	NA	0.33	ZZZ
22548		A	Neck spine fusion	25.82	17.74	NA	4.98	090
22554		A	Neck spine fusion	18.62	13.67	NA	3.51	090
22556		A	Thorax spine fusion	23.46	16.51	NA	3.78	090
22558		A	Lumbar spine fusion	22.28	14.98	NA	3.18	090
22585		A	Additional spinal fusion	5.53	2.82	NA	0.98	ZZZ
22590		A	Spine & skull spinal fusion	20.51	15.32	NA	3.81	090
22595		A	Neck spinal fusion	19.39	14.31	NA	3.62	090
22600		A	Neck spine fusion	16.14	12.63	NA	2.89	090
22610		A	Thorax spine fusion	16.02	12.73	NA	2.66	090
22612		A	Lumbar spine fusion	21.00	15.47	NA	3.28	090
22614		A	Spine fusion, extra segment	6.44	3.39	NA	1.04	ZZZ
22630		A	Lumbar spine fusion	20.84	15.73	NA	3.79	090
22632		A	Spine fusion, extra segment	5.23	2.68	NA	0.90	ZZZ
22800		A	Fusion of spine	18.25	13.89	NA	2.71	090
22802		A	Fusion of spine	30.88	21.32	NA	4.42	090
22804		A	Fusion of spine	36.27	23.91	NA	5.23	090
22808		A	Fusion of spine	26.27	18.18	NA	4.36	090
22810		A	Fusion of spine	30.27	19.74	NA	4.49	090
22812		A	Fusion of spine	32.70	21.34	NA	4.67	090
22818		A	Kyphectomy, 1-2 segments	31.83	20.75	NA	5.01	090
22819		A	Kyphectomy, 3 or more	36.44	21.64	NA	5.20	090
22830		A	Exploration of spinal fusion	10.85	9.91	NA	1.73	090
22840		A	Insert spine fixation device	12.54	6.50	NA	2.03	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.58	6.57	NA	2.04	ZZZ
22843		A	Insert spine fixation device	13.46	6.74	NA	2.10	ZZZ
22844		A	Insert spine fixation device	16.44	8.94	NA	2.42	ZZZ
22845		A	Insert spine fixation device	11.96	6.13	NA	2.22	ZZZ
22846		A	Insert spine fixation device	12.42	6.38	NA	2.26	ZZZ
22847		A	Insert spine fixation device	13.80	7.19	NA	2.36	ZZZ
22848		A	Insert pelv fixation device	6.00	3.26	NA	0.88	ZZZ
22849		A	Reinsert spinal fixation	18.51	13.89	NA	2.87	090
22850		A	Remove spine fixation device	9.52	8.72	NA	1.51	090
22851		A	Apply spine prosth device	6.71	3.39	NA	1.11	ZZZ
22852		A	Remove spine fixation device	9.01	8.51	NA	1.40	090
22855		A	Remove spine fixation device	15.13	11.41	NA	2.74	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	5.80	4.30	NA	0.58	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.36	7.10	8.92	0.50	090
23020		A	Release shoulder joint	8.93	10.37	NA	1.23	090
23030		A	Drain shoulder lesion	3.43	4.30	6.00	0.42	010
23031		A	Drain shoulder bursa	2.74	4.06	5.82	0.33	010
23035		A	Drain shoulder bone lesion	8.61	15.80	NA	1.19	090
23040		A	Exploratory shoulder surgery	9.20	11.54	NA	1.28	090
23044		A	Exploratory shoulder surgery	7.12	10.28	NA	0.97	090
23065		A	Biopsy shoulder tissues	2.27	1.33	2.52	0.14	010
23066		A	Biopsy shoulder tissues	4.16	6.17	7.65	0.50	090
23075		A	Removal of shoulder lesion	2.39	3.13	5.27	0.25	010
23076		A	Removal of shoulder lesion	7.63	8.17	NA	0.87	090
23077		A	Remove tumor of shoulder	16.09	14.36	NA	1.81	090
23100		A	Biopsy of shoulder joint	6.03	8.64	NA	0.81	090
23101		A	Shoulder joint surgery	5.58	8.53	NA	0.77	090
23105		A	Remove shoulder joint lining	8.23	10.09	NA	1.13	090
23106		A	Incision of collarbone joint	5.96	8.75	NA	0.82	090
23107		A	Explore treat shoulder joint	8.62	10.28	NA	1.19	090
23120		A	Partial removal, collar bone	7.11	9.58	NA	0.99	090
23125		A	Removal of collar bone	9.39	10.54	NA	1.27	090
23130		A	Remove shoulder bone, part	7.55	9.62	NA	1.06	090
23140		A	Removal of bone lesion	6.89	8.23	NA	0.82	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
23145		A	Removal of bone lesion	9.09	11.43	NA	1.24	090
23146		A	Removal of bone lesion	7.83	10.60	NA	1.11	090
23150		A	Removal of humerus lesion	8.48	9.84	NA	1.14	090
23155		A	Removal of humerus lesion	10.35	11.93	NA	1.20	090
23156		A	Removal of humerus lesion	8.68	10.27	NA	1.18	090
23170		A	Remove collar bone lesion	6.86	10.65	NA	0.84	090
23172		A	Remove shoulder blade lesion	6.90	10.05	NA	0.95	090
23174		A	Remove humerus lesion	9.51	11.76	NA	1.30	090
23180		A	Remove collar bone lesion	8.53	15.70	NA	1.18	090
23182		A	Remove shoulder blade lesion	8.15	16.31	NA	1.08	090
23184		A	Remove humerus lesion	9.38	16.25	NA	1.24	090
23190		A	Partial removal of scapula	7.24	8.36	NA	0.97	090
23195		A	Removal of head of humerus	9.81	10.62	NA	1.38	090
23200		A	Removal of collar bone	12.08	13.91	NA	1.48	090
23210		A	Removal of shoulder blade	12.49	13.95	NA	1.61	090
23220		A	Partial removal of humerus	14.56	15.15	NA	2.03	090
23221		A	Partial removal of humerus	17.74	16.33	NA	2.51	090
23222		A	Partial removal of humerus	23.92	20.37	NA	3.37	090
23330		A	Remove shoulder foreign body	1.85	3.57	5.69	0.18	010
23331		A	Remove shoulder foreign body	7.38	9.51	NA	1.02	090
23332		A	Remove shoulder foreign body	11.62	11.93	NA	1.62	090
23350		A	Injection for shoulder x-ray	1.00	0.34	7.63	0.05	000
23395		A	Muscle transfer, shoulder/arm	16.85	13.82	NA	2.29	090
23397		A	Muscle transfers	16.13	14.11	NA	2.24	090
23400		A	Fixation of shoulder blade	13.54	13.98	NA	1.91	090
23405		A	Incision of tendon & muscle	8.37	9.37	NA	1.12	090
23406		A	Incise tendon(s) & muscle(s)	10.79	11.52	NA	1.48	090
23410		A	Repair of tendon(s)	12.45	12.33	NA	1.72	090
23412		A	Repair of tendon(s)	13.31	12.90	NA	1.86	090
23415		A	Release of shoulder ligament	9.97	9.97	NA	1.39	090
23420		A	Repair of shoulder	13.30	13.81	NA	1.86	090
23430		A	Repair biceps tendon	9.98	11.10	NA	1.40	090
23440		A	Remove/transplant tendon	10.48	11.33	NA	1.47	090
23450		A	Repair shoulder capsule	13.40	12.82	NA	1.86	090
23455		A	Repair shoulder capsule	14.37	13.39	NA	2.01	090
23460		A	Repair shoulder capsule	15.37	13.99	NA	2.17	090
23462		A	Repair shoulder capsule	15.30	13.69	NA	2.16	090
23465		A	Repair shoulder capsule	15.85	13.73	NA	1.61	090
23466		A	Repair shoulder capsule	14.22	13.36	NA	2.00	090
23470		A	Reconstruct shoulder joint	17.15	14.91	NA	2.40	090
23472		A	Reconstruct shoulder joint	21.10	17.03	NA	2.37	090
23480		A	Revision of collar bone	11.18	11.52	NA	1.56	090
23485		A	Revision of collar bone	13.43	12.95	NA	1.84	090
23490		A	Reinforce clavicle	11.86	11.82	NA	1.11	090
23491		A	Reinforce shoulder bones	14.21	13.26	NA	2.00	090
23500		A	Treat clavicle fracture	2.08	2.50	3.77	0.26	090
23505		A	Treat clavicle fracture	3.69	3.91	5.79	0.50	090
23515		A	Treat clavicle fracture	7.41	8.12	NA	1.03	090
23520		A	Treat clavicle dislocation	2.16	2.55	3.83	0.26	090
23525		A	Treat clavicle dislocation	3.60	3.82	5.95	0.44	090
23530		A	Treat clavicle dislocation	7.31	7.83	NA	0.85	090
23532		A	Treat clavicle dislocation	8.01	8.17	NA	1.13	090
23540		A	Treat clavicle dislocation	2.23	2.50	4.40	0.24	090
23545		A	Treat clavicle dislocation	3.25	3.56	4.89	0.39	090
23550		A	Treat clavicle dislocation	7.24	8.12	NA	0.94	090
23552		A	Treat clavicle dislocation	8.45	8.73	NA	1.18	090
23570		A	Treat shoulder blade fx	2.23	2.62	3.76	0.29	090
23575		A	Treat shoulder blade fx	4.06	4.16	6.01	0.53	090
23585		A	Treat scapula fracture	8.96	9.26	NA	1.25	090
23600		A	Treat humerus fracture	2.93	3.58	5.50	0.39	090
23605		A	Treat humerus fracture	4.87	6.36	8.10	0.67	090
23615		A	Treat humerus fracture	9.35	10.05	NA	1.31	090
23616		A	Treat humerus fracture	21.27	15.83	NA	2.98	090
23620		A	Treat humerus fracture	2.40	3.32	5.21	0.32	090
23625		A	Treat humerus fracture	3.93	5.41	7.18	0.53	090
23630		A	Treat humerus fracture	7.35	8.12	NA	1.03	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
23650		A	Treat shoulder dislocation	3.39	3.50	5.46	0.31	090
23655		A	Treat shoulder dislocation	4.57	4.21	NA	0.52	090
23660		A	Treat shoulder dislocation	7.49	7.91	NA	1.01	090
23665		A	Treat dislocation/fracture	4.47	5.66	7.41	0.60	090
23670		A	Treat dislocation/fracture	7.90	8.56	NA	1.10	090
23675		A	Treat dislocation/fracture	6.05	6.53	8.15	0.83	090
23680		A	Treat dislocation/fracture	10.06	9.65	NA	1.39	090
23700		A	Fixation of shoulder	2.52	3.39	NA	0.35	010
23800		A	Fusion of shoulder joint	14.16	14.08	NA	1.97	090
23802		A	Fusion of shoulder joint	16.60	13.40	NA	2.34	090
23900		A	Amputation of arm & girdle	19.72	15.42	NA	2.47	090
23920		A	Amputation at shoulder joint	14.61	13.65	NA	1.92	090
23921		A	Amputation follow-up surgery	5.49	6.51	NA	0.78	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.94	3.89	5.98	0.32	010
23931		A	Drainage of arm bursa	1.79	3.61	5.67	0.21	010
23935		A	Drain arm/elbow bone lesion	6.09	12.53	NA	0.84	090
24000		A	Exploratory elbow surgery	5.82	5.91	NA	0.77	090
24006		A	Release elbow joint	9.31	8.43	NA	1.27	090
24065		A	Biopsy arm/elbow soft tissue	2.08	3.25	5.34	0.14	010
24066		A	Biopsy arm/elbow soft tissue	5.21	6.53	8.66	0.61	090
24075		A	Remove arm/elbow lesion	3.92	5.96	7.99	0.43	090
24076		A	Remove arm/elbow lesion	6.30	7.14	NA	0.70	090
24077		A	Remove tumor of arm/elbow	11.76	14.01	NA	1.32	090
24100		A	Biopsy elbow joint lining	4.93	5.85	NA	0.62	090
24101		A	Explore/treat elbow joint	6.13	6.70	NA	0.84	090
24102		A	Remove elbow joint lining	8.03	7.72	NA	1.09	090
24105		A	Removal of elbow bursa	3.61	5.08	NA	0.49	090
24110		A	Remove humerus lesion	7.39	9.51	NA	0.99	090
24115		A	Remove/graft bone lesion	9.63	10.31	NA	1.15	090
24116		A	Remove/graft bone lesion	11.81	12.01	NA	1.66	090
24120		A	Remove elbow lesion	6.65	6.67	NA	0.87	090
24125		A	Remove/graft bone lesion	7.89	7.07	NA	0.88	090
24126		A	Remove/graft bone lesion	8.31	7.77	NA	0.90	090
24130		A	Removal of head of radius	6.25	6.73	NA	0.87	090
24134		A	Removal of arm bone lesion	9.73	15.85	NA	1.31	090
24136		A	Remove radius bone lesion	7.99	6.40	NA	0.85	090
24138		A	Remove elbow bone lesion	8.05	7.76	NA	1.12	090
24140		A	Partial removal of arm bone	9.18	16.80	NA	1.23	090
24145		A	Partial removal of radius	7.58	11.15	NA	1.01	090
24147		A	Partial removal of elbow	7.54	11.09	NA	1.04	090
24149		A	Radical resection of elbow	14.20	10.98	NA	1.90	090
24150		A	Extensive humerus surgery	13.27	14.58	NA	1.81	090
24151		A	Extensive humerus surgery	15.58	16.06	NA	2.19	090
24152		A	Extensive radius surgery	10.06	9.58	NA	1.19	090
24153		A	Extensive radius surgery	11.54	7.21	NA	0.64	090
24155		A	Removal of elbow joint	11.73	9.34	NA	1.42	090
24160		A	Remove elbow joint implant	7.83	7.59	NA	1.07	090
24164		A	Remove radius head implant	6.23	6.71	NA	0.84	090
24200		A	Removal of arm foreign body	1.76	3.29	5.66	0.15	010
24201		A	Removal of arm foreign body	4.56	6.68	8.70	0.56	090
24220		A	Injection for elbow x-ray	1.31	0.46	11.20	0.07	000
24300		A	Manipulate elbow w/anesth	3.75	5.26	NA	0.52	090
24301		A	Muscle/tendon transfer	10.20	9.03	NA	1.30	090
24305		A	Arm tendon lengthening	7.45	7.49	NA	0.98	090
24310		A	Revision of arm tendon	5.98	8.14	NA	0.74	090
24320		A	Repair of arm tendon	10.56	10.72	NA	1.00	090
24330		A	Revision of arm muscles	9.60	8.62	NA	1.21	090
24331		A	Revision of arm muscles	10.65	9.19	NA	1.41	090
24332		A	Tenolysis, triceps	7.45	5.13	NA	0.77	090
24340		A	Repair of biceps tendon	7.89	7.61	NA	1.08	090
24341		A	Repair arm tendon/muscle	7.90	7.61	NA	1.08	090
24342		A	Repair of ruptured tendon	10.62	9.17	NA	1.48	090
24343		A	Repr elbow lat ligmnt w/tiss	8.65	7.60	NA	1.21	090
24344		A	Reconstruct elbow lat ligmnt	14.00	10.42	NA	1.95	090
24345		A	Repr elbw med ligmnt w/tiss	8.65	7.60	NA	1.21	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
24346		A	Reconstruct elbow med ligmnt	14.00	10.42	NA	1.95	090
24350		A	Repair of tennis elbow	5.25	6.11	NA	0.72	090
24351		A	Repair of tennis elbow	5.91	6.59	NA	0.82	090
24352		A	Repair of tennis elbow	6.43	6.90	NA	0.90	090
24354		A	Repair of tennis elbow	6.48	6.84	NA	0.88	090
24356		A	Revision of tennis elbow	6.68	7.02	NA	0.90	090
24360		A	Reconstruct elbow joint	12.34	9.93	NA	1.69	090
24361		A	Reconstruct elbow joint	14.08	10.92	NA	1.95	090
24362		A	Reconstruct elbow joint	14.99	10.88	NA	1.92	090
24363		A	Replace elbow joint	18.49	13.42	NA	2.52	090
24365		A	Reconstruct head of radius	8.39	7.93	NA	1.11	090
24366		A	Reconstruct head of radius	9.13	8.34	NA	1.28	090
24400		A	Revision of humerus	11.06	12.49	NA	1.53	090
24410		A	Revision of humerus	14.82	13.83	NA	1.89	090
24420		A	Revision of humerus	13.44	16.46	NA	1.82	090
24430		A	Repair of humerus	12.81	12.66	NA	1.80	090
24435		A	Repair humerus with graft	13.17	13.78	NA	1.84	090
24470		A	Revision of elbow joint	8.74	6.47	NA	1.23	090
24495		A	Decompression of forearm	8.12	10.00	NA	0.92	090
24498		A	Reinforce humerus	11.92	12.18	NA	1.67	090
24500		A	Treat humerus fracture	3.21	3.24	4.96	0.41	090
24505		A	Treat humerus fracture	5.17	6.63	8.63	0.72	090
24515		A	Treat humerus fracture	11.65	11.15	NA	1.63	090
24516		A	Treat humerus fracture	11.65	11.68	NA	1.63	090
24530		A	Treat humerus fracture	3.50	4.68	6.02	0.47	090
24535		A	Treat humerus fracture	6.87	6.56	8.59	0.96	090
24538		A	Treat humerus fracture	9.43	10.31	NA	1.25	090
24545		A	Treat humerus fracture	10.46	9.97	NA	1.47	090
24546		A	Treat humerus fracture	15.69	13.38	NA	2.18	090
24560		A	Treat humerus fracture	2.80	3.04	4.74	0.35	090
24565		A	Treat humerus fracture	5.56	5.73	7.73	0.74	090
24566		A	Treat humerus fracture	7.79	9.79	NA	1.10	090
24575		A	Treat humerus fracture	10.66	8.21	NA	1.44	090
24576		A	Treat humerus fracture	2.86	3.14	4.52	0.38	090
24577		A	Treat humerus fracture	5.79	5.98	7.94	0.81	090
24579		A	Treat humerus fracture	11.60	10.66	NA	1.62	090
24582		A	Treat humerus fracture	8.55	10.24	NA	1.20	090
24586		A	Treat elbow fracture	15.21	10.83	NA	2.12	090
24587		A	Treat elbow fracture	15.16	10.68	NA	2.14	090
24600		A	Treat elbow dislocation	4.23	4.90	6.63	0.49	090
24605		A	Treat elbow dislocation	5.42	4.87	NA	0.72	090
24615		A	Treat elbow dislocation	9.42	7.76	NA	1.31	090
24620		A	Treat elbow fracture	6.98	6.42	NA	0.90	090
24635		A	Treat elbow fracture	13.19	16.18	NA	1.84	090
24640		A	Treat elbow dislocation	1.20	1.78	3.35	0.11	010
24650		A	Treat radius fracture	2.16	2.79	4.44	0.28	090
24655		A	Treat radius fracture	4.40	5.10	7.13	0.58	090
24665		A	Treat radius fracture	8.14	9.27	NA	1.13	090
24666		A	Treat radius fracture	9.49	10.03	NA	1.32	090
24670		A	Treat ulnar fracture	2.54	2.99	4.37	0.33	090
24675		A	Treat ulnar fracture	4.72	5.36	7.32	0.65	090
24685		A	Treat ulnar fracture	8.80	9.64	NA	1.23	090
24800		A	Fusion of elbow joint	11.20	9.64	NA	1.41	090
24802		A	Fusion/graft of elbow joint	13.69	11.21	NA	1.89	090
24900		A	Amputation of upper arm	9.60	10.94	NA	1.18	090
24920		A	Amputation of upper arm	9.54	12.50	NA	1.22	090
24925		A	Amputation follow-up surgery	7.07	9.22	NA	0.95	090
24930		A	Amputation follow-up surgery	10.25	11.52	NA	1.23	090
24931		A	Amputate upper arm & implant	12.72	11.44	NA	1.56	090
24935		A	Revision of amputation	15.56	12.31	NA	1.58	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.38	7.25	NA	0.45	090
25001		A	Incise flexor carpi radialis	3.38	4.22	NA	0.45	090
25020		A	Decompress forearm 1 space	5.92	11.04	NA	0.75	090
25023		A	Decompress forearm 1 space	12.96	16.91	NA	1.50	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
25024		A	Decompress forearm 2 spaces	9.50	7.91	NA	1.20	090
25025		A	Decompress forearm 2 spaces	16.54	11.74	NA	1.91	090
25028		A	Drainage of forearm lesion	5.25	9.85	NA	0.61	090
25031		A	Drainage of forearm bursa	4.14	9.83	NA	0.50	090
25035		A	Treat forearm bone lesion	7.36	16.18	NA	0.98	090
25040		A	Explore/treat wrist joint	7.18	9.13	NA	0.96	090
25065		A	Biopsy forearm soft tissues	1.99	2.38	2.38	0.12	010
25066		A	Biopsy forearm soft tissues	4.13	8.15	NA	0.49	090
25075		A	Remove forearm lesion subcut	3.74	7.22	NA	0.40	090
25076		A	Remove forearm lesion deep	4.92	12.49	NA	0.59	090
25077		A	Remove tumor, forearm/wrist	9.76	15.45	NA	1.10	090
25085		A	Incision of wrist capsule	5.50	10.81	NA	0.71	090
25100		A	Biopsy of wrist joint	3.90	7.28	NA	0.50	090
25101		A	Explore/treat wrist joint	4.69	7.67	NA	0.60	090
25105		A	Remove wrist joint lining	5.85	10.73	NA	0.77	090
25107		A	Remove wrist joint cartilage	6.43	11.20	NA	0.82	090
25110		A	Remove wrist tendon lesion	3.92	8.38	NA	0.48	090
25111		A	Remove wrist tendon lesion	3.39	6.44	NA	0.42	090
25112		A	Reremove wrist tendon lesion	4.53	7.30	NA	0.54	090
25115		A	Remove wrist/forearm lesion	8.82	16.72	NA	1.11	090
25116		A	Remove wrist/forearm lesion	7.11	15.66	NA	0.90	090
25118		A	Excise wrist tendon sheath	4.37	7.78	NA	0.55	090
25119		A	Partial removal of ulna	6.04	11.06	NA	0.80	090
25120		A	Removal of forearm lesion	6.10	14.75	NA	0.81	090
25125		A	Remove/graft forearm lesion	7.48	15.74	NA	1.02	090
25126		A	Remove/graft forearm lesion	7.55	15.44	NA	1.00	090
25130		A	Removal of wrist lesion	5.26	8.12	NA	0.66	090
25135		A	Remove & graft wrist lesion	6.89	8.89	NA	0.89	090
25136		A	Remove & graft wrist lesion	5.97	8.13	NA	0.58	090
25145		A	Remove forearm bone lesion	6.37	15.22	NA	0.82	090
25150		A	Partial removal of ulna	7.09	11.83	NA	0.96	090
25151		A	Partial removal of radius	7.39	15.63	NA	0.93	090
25170		A	Extensive forearm surgery	11.09	17.44	NA	1.52	090
25210		A	Removal of wrist bone	5.95	8.47	NA	0.73	090
25215		A	Removal of wrist bones	7.89	12.05	NA	1.02	090
25230		A	Partial removal of radius	5.23	7.95	NA	0.66	090
25240		A	Partial removal of ulna	5.17	10.49	NA	0.69	090
25246		A	Injection for wrist x-ray	1.45	0.50	10.63	0.07	000
25248		A	Remove forearm foreign body	5.14	10.05	NA	0.54	090
25250		A	Removal of wrist prosthesis	6.60	8.76	NA	0.84	090
25251		A	Removal of wrist prosthesis	9.57	12.73	NA	1.15	090
25259		A	Manipulate wrist w/anesthes	3.75	5.23	NA	0.52	090
25260		A	Repair forearm tendon/muscle	7.80	16.77	NA	0.97	090
25263		A	Repair forearm tendon/muscle	7.82	16.43	NA	0.94	090
25265		A	Repair forearm tendon/muscle	9.88	17.18	NA	1.19	090
25270		A	Repair forearm tendon/muscle	6.00	15.70	NA	0.76	090
25272		A	Repair forearm tendon/muscle	7.04	16.21	NA	0.89	090
25274		A	Repair forearm tendon/muscle	8.75	16.53	NA	1.11	090
25275		A	Repair forearm tendon sheath	8.50	7.32	NA	1.11	090
25280		A	Revise wrist/forearm tendon	7.22	15.52	NA	0.91	090
25290		A	Incise wrist/forearm tendon	5.29	17.77	NA	0.66	090
25295		A	Release wrist/forearm tendon	6.55	15.16	NA	0.84	090
25300		A	Fusion of tendons at wrist	8.80	10.05	NA	1.07	090
25301		A	Fusion of tendons at wrist	8.40	9.74	NA	1.08	090
25310		A	Transplant forearm tendon	8.14	16.12	NA	1.01	090
25312		A	Transplant forearm tendon	9.57	17.04	NA	1.22	090
25315		A	Revise palsy hand tendon(s)	10.20	17.68	NA	1.26	090
25316		A	Revise palsy hand tendon(s)	12.33	19.36	NA	1.74	090
25320		A	Repair/revise wrist joint	10.77	11.21	NA	1.32	090
25332		A	Revise wrist joint	11.41	11.65	NA	1.46	090
25335		A	Realignment of hand	12.88	14.66	NA	1.66	090
25337		A	Reconstruct ulna/radioulnar	10.17	13.29	NA	1.31	090
25350		A	Revision of radius	8.78	16.51	NA	1.17	090
25355		A	Revision of radius	10.17	17.17	NA	1.44	090
25360		A	Revision of ulna	8.43	16.47	NA	1.17	090
25365		A	Revise radius & ulna	12.40	18.00	NA	1.67	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
25370		A	Revise radius or ulna	13.36	17.37	NA	1.88	090
25375		A	Revise radius & ulna	13.04	18.01	NA	1.84	090
25390		A	Shorten radius or ulna	10.40	17.23	NA	1.38	090
25391		A	Lengthen radius or ulna	13.65	18.62	NA	1.73	090
25392		A	Shorten radius & ulna	13.95	17.19	NA	1.73	090
25393		A	Lengthen radius & ulna	15.87	19.88	NA	1.87	090
25394		A	Repair carpal bone, shorten	10.40	8.24	NA	1.15	090
25400		A	Repair radius or ulna	10.92	17.53	NA	1.50	090
25405		A	Repair/graft radius or ulna	14.38	20.00	NA	1.95	090
25415		A	Repair radius & ulna	13.35	19.08	NA	1.87	090
25420		A	Repair/graft radius & ulna	16.33	20.93	NA	2.20	090
25425		A	Repair/graft radius or ulna	13.21	26.13	NA	1.61	090
25426		A	Repair/graft radius & ulna	15.82	19.87	NA	2.23	090
25430		A	Vasc graft into carpal bone	9.25	7.60	NA	0.56	090
25431		A	Repair nonunion carpal bone	10.44	6.28	NA	0.56	090
25440		A	Repair/graft wrist bone	10.44	10.99	NA	1.41	090
25441		A	Reconstruct wrist joint	12.90	12.22	NA	1.83	090
25442		A	Reconstruct wrist joint	10.85	11.22	NA	1.24	090
25443		A	Reconstruct wrist joint	10.39	13.58	NA	1.30	090
25444		A	Reconstruct wrist joint	11.15	13.83	NA	1.43	090
25445		A	Reconstruct wrist joint	9.69	13.12	NA	1.26	090
25446		A	Wrist replacement	16.55	14.38	NA	2.20	090
25447		A	Repair wrist joint(s)	10.37	11.02	NA	1.34	090
25449		A	Remove wrist joint implant	14.49	17.69	NA	1.77	090
25450		A	Revision of wrist joint	7.87	12.63	NA	0.88	090
25455		A	Revision of wrist joint	9.49	14.17	NA	1.07	090
25490		A	Reinforce radius	9.54	16.27	NA	1.19	090
25491		A	Reinforce ulna	9.96	17.52	NA	1.41	090
25492		A	Reinforce radius and ulna	12.33	16.91	NA	1.62	090
25500		A	Treat fracture of radius	2.45	2.82	4.14	0.28	090
25505		A	Treat fracture of radius	5.21	5.50	7.55	0.69	090
25515		A	Treat fracture of radius	9.18	9.59	NA	1.22	090
25520		A	Treat fracture of radius	6.26	6.12	7.72	0.85	090
25525		A	Treat fracture of radius	12.24	11.46	NA	1.68	090
25526		A	Treat fracture of radius	12.98	14.97	NA	1.80	090
25530		A	Treat fracture of ulna	2.09	2.77	4.10	0.27	090
25535		A	Treat fracture of ulna	5.14	5.54	7.36	0.68	090
25545		A	Treat fracture of ulna	8.90	9.70	NA	1.23	090
25560		A	Treat fracture radius & ulna	2.44	2.81	4.15	0.27	090
25565		A	Treat fracture radius & ulna	5.63	5.71	7.77	0.76	090
25574		A	Treat fracture radius & ulna	7.01	8.63	NA	0.96	090
25575		A	Treat fracture radius/ulna	10.45	10.51	NA	1.46	090
25600		A	Treat fracture radius/ulna	2.63	2.98	4.41	0.34	090
25605		A	Treat fracture radius/ulna	5.81	5.94	7.97	0.81	090
25611		A	Treat fracture radius/ulna	7.77	9.77	NA	1.08	090
25620		A	Treat fracture radius/ulna	8.55	9.47	NA	1.17	090
25622		A	Treat wrist bone fracture	2.61	2.97	4.38	0.33	090
25624		A	Treat wrist bone fracture	4.53	5.20	7.19	0.61	090
25628		A	Treat wrist bone fracture	8.43	9.54	NA	1.14	090
25630		A	Treat wrist bone fracture	2.88	3.03	4.53	0.37	090
25635		A	Treat wrist bone fracture	4.39	4.52	7.16	0.39	090
25645		A	Treat wrist bone fracture	7.25	9.13	NA	0.93	090
25650		A	Treat wrist bone fracture	3.05	3.12	4.61	0.37	090
25651		A	Pin ulnar styloid fracture	5.36	4.32	NA	0.73	090
25652		A	Treat fracture ulnar styloid	7.60	6.74	NA	0.97	090
25660		A	Treat wrist dislocation	4.76	5.24	NA	0.59	090
25670		A	Treat wrist dislocation	7.92	9.34	NA	1.07	090
25671		A	Pin radioulnar dislocation	6.00	5.89	NA	0.75	090
25675		A	Treat wrist dislocation	4.67	5.17	7.08	0.57	090
25676		A	Treat wrist dislocation	8.04	9.33	NA	1.10	090
25680		A	Treat wrist fracture	5.99	6.29	NA	0.61	090
25685		A	Treat wrist fracture	9.78	10.12	NA	1.25	090
25690		A	Treat wrist dislocation	5.50	6.77	NA	0.78	090
25695		A	Treat wrist dislocation	8.34	9.43	NA	1.07	090
25800		A	Fusion of wrist joint	9.76	10.62	NA	1.30	090
25805		A	Fusion/graft of wrist joint	11.28	11.48	NA	1.51	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
25810		A	Fusion/graft of wrist joint	10.57	11.05	NA	1.37	090
25820		A	Fusion of hand bones	7.45	9.43	NA	0.96	090
25825		A	Fuse hand bones with graft	9.27	10.37	NA	1.20	090
25830		A	Fusion, radioulnar jnt/ulna	10.06	16.56	NA	1.27	090
25900		A	Amputation of forearm	9.01	14.17	NA	1.08	090
25905		A	Amputation of forearm	9.12	15.42	NA	1.06	090
25907		A	Amputation follow-up surgery	7.80	14.95	NA	1.01	090
25909		A	Amputation follow-up surgery	8.96	14.98	NA	1.07	090
25915		A	Amputation of forearm	17.08	18.26	NA	2.41	090
25920		A	Amputate hand at wrist	8.68	9.69	NA	1.06	090
25922		A	Amputate hand at wrist	7.42	8.88	NA	0.93	090
25924		A	Amputation follow-up surgery	8.46	9.99	NA	1.07	090
25927		A	Amputation of hand	8.80	13.97	NA	1.02	090
25929		A	Amputation follow-up surgery	7.59	7.68	NA	0.89	090
25931		A	Amputation follow-up surgery	7.81	15.33	NA	0.88	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.54	3.82	5.06	0.14	010
26011		A	Drainage of finger abscess	2.19	6.23	7.16	0.25	010
26020		A	Drain hand tendon sheath	4.67	12.63	NA	0.59	090
26025		A	Drainage of palm bursa	4.82	12.62	NA	0.60	090
26030		A	Drainage of palm bursa(s)	5.93	13.31	NA	0.72	090
26034		A	Treat hand bone lesion	6.23	14.59	NA	0.79	090
26035		A	Decompress fingers/hand	9.51	15.91	NA	1.12	090
26037		A	Decompress fingers/hand	7.25	12.45	NA	0.87	090
26040		A	Release palm contracture	3.33	12.35	NA	0.45	090
26045		A	Release palm contracture	5.56	13.61	NA	0.74	090
26055		A	Incise finger tendon sheath	2.69	7.49	7.83	0.36	090
26060		A	Incision of finger tendon	2.81	7.56	NA	0.35	090
26070		A	Explore/treat hand joint	3.69	10.87	NA	0.35	090
26075		A	Explore/treat finger joint	3.79	11.81	NA	0.40	090
26080		A	Explore/treat finger joint	4.24	12.65	NA	0.52	090
26100		A	Biopsy hand joint lining	3.67	8.19	NA	0.45	090
26105		A	Biopsy finger joint lining	3.71	12.40	NA	0.45	090
26110		A	Biopsy finger joint lining	3.53	11.82	NA	0.44	090
26115		A	Remove hand lesion subcut	3.86	7.53	7.53	0.48	090
26116		A	Remove hand lesion, deep	5.53	13.37	NA	0.69	090
26117		A	Remove tumor, hand/finger	8.55	15.03	NA	1.01	090
26121		A	Release palm contracture	7.54	15.37	NA	0.94	090
26123		A	Release palm contracture	9.29	16.33	NA	1.17	090
26125		A	Release palm contracture	4.61	2.53	NA	0.57	ZZZ
26130		A	Remove wrist joint lining	5.42	15.51	NA	0.65	090
26135		A	Revise finger joint, each	6.96	16.70	NA	0.87	090
26140		A	Revise finger joint, each	6.17	15.80	NA	0.76	090
26145		A	Tendon excision, palm/finger	6.32	16.06	NA	0.77	090
26160		A	Remove tendon sheath lesion	3.15	7.62	7.63	0.39	090
26170		A	Removal of palm tendon, each	4.77	8.46	NA	0.60	090
26180		A	Removal of finger tendon	5.18	8.79	NA	0.64	090
26185		A	Remove finger bone	5.25	8.79	NA	0.67	090
26200		A	Remove hand bone lesion	5.51	13.62	NA	0.71	090
26205		A	Remove/graft bone lesion	7.70	15.10	NA	0.95	090
26210		A	Removal of finger lesion	5.15	13.97	NA	0.64	090
26215		A	Remove/graft finger lesion	7.10	14.34	NA	0.77	090
26230		A	Partial removal of hand bone	6.33	12.72	NA	0.84	090
26235		A	Partial removal, finger bone	6.19	12.25	NA	0.78	090
26236		A	Partial removal, finger bone	5.32	12.30	NA	0.66	090
26250		A	Extensive hand surgery	7.55	16.60	NA	0.92	090
26255		A	Extensive hand surgery	12.43	19.40	NA	1.05	090
26260		A	Extensive finger surgery	7.03	16.45	NA	0.83	090
26261		A	Extensive finger surgery	9.09	12.97	NA	0.84	090
26262		A	Partial removal of finger	5.67	14.23	NA	0.70	090
26320		A	Removal of implant from hand	3.98	12.78	NA	0.49	090
26340		A	Manipulate finger w/anesth	2.50	4.48	NA	0.32	090
26350		A	Repair finger/hand tendon	5.99	19.56	NA	0.73	090
26352		A	Repair/graft hand tendon	7.68	19.76	NA	0.93	090
26356		A	Repair finger/hand tendon	8.07	20.93	NA	0.99	090
26357		A	Repair finger/hand tendon	8.58	20.73	NA	1.02	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
26358		A	Repair/graft hand tendon	9.14	20.89	NA	1.07	090
26370		A	Repair finger/hand tendon	7.11	20.10	NA	0.90	090
26372		A	Repair/graft hand tendon	8.76	21.36	NA	1.06	090
26373		A	Repair finger/hand tendon	8.16	21.27	NA	0.98	090
26390		A	Revise hand/finger tendon	9.19	16.47	NA	1.09	090
26392		A	Repair/graft hand tendon	10.26	22.37	NA	1.26	090
26410		A	Repair hand tendon	4.63	15.82	NA	0.57	090
26412		A	Repair/graft hand tendon	6.31	16.90	NA	0.80	090
26415		A	Excision, hand/finger tendon	8.34	15.74	NA	0.77	090
26416		A	Graft hand or finger tendon	9.37	18.18	NA	1.20	090
26418		A	Repair finger tendon	4.25	15.67	NA	0.50	090
26420		A	Repair/graft finger tendon	6.77	17.31	NA	0.83	090
26426		A	Repair finger/hand tendon	6.15	16.47	NA	0.77	090
26428		A	Repair/graft finger tendon	7.21	17.52	NA	0.84	090
26432		A	Repair finger tendon	4.02	12.82	NA	0.48	090
26433		A	Repair finger tendon	4.56	13.74	NA	0.56	090
26434		A	Repair/graft finger tendon	6.09	14.25	NA	0.71	090
26437		A	Realignment of tendons	5.82	13.75	NA	0.74	090
26440		A	Release palm/finger tendon	5.02	17.99	NA	0.62	090
26442		A	Release palm & finger tendon	8.16	19.45	NA	0.94	090
26445		A	Release hand/finger tendon	4.31	17.85	NA	0.54	090
26449		A	Release forearm/hand tendon	7.00	19.18	NA	0.84	090
26450		A	Incision of palm tendon	3.67	8.30	NA	0.46	090
26455		A	Incision of finger tendon	3.64	8.16	NA	0.47	090
26460		A	Incise hand/finger tendon	3.46	7.79	NA	0.44	090
26471		A	Fusion of finger tendons	5.73	13.37	NA	0.73	090
26474		A	Fusion of finger tendons	5.32	13.83	NA	0.69	090
26476		A	Tendon lengthening	5.18	13.19	NA	0.62	090
26477		A	Tendon shortening	5.15	13.34	NA	0.60	090
26478		A	Lengthening of hand tendon	5.80	14.10	NA	0.77	090
26479		A	Shortening of hand tendon	5.74	14.56	NA	0.76	090
26480		A	Transplant hand tendon	6.69	19.03	NA	0.84	090
26483		A	Transplant/graft hand tendon	8.29	19.62	NA	1.03	090
26485		A	Transplant palm tendon	7.70	19.60	NA	0.94	090
26489		A	Transplant/graft palm tendon	9.55	16.48	NA	0.98	090
26490		A	Revise thumb tendon	8.41	14.89	NA	1.05	090
26492		A	Tendon transfer with graft	9.62	15.61	NA	1.19	090
26494		A	Hand tendon/muscle transfer	8.47	15.87	NA	1.13	090
26496		A	Revise thumb tendon	9.59	15.10	NA	1.17	090
26497		A	Finger tendon transfer	9.57	15.87	NA	1.17	090
26498		A	Finger tendon transfer	14.00	18.34	NA	1.74	090
26499		A	Revision of finger	8.98	16.54	NA	0.94	090
26500		A	Hand tendon reconstruction	5.96	14.55	NA	0.66	090
26502		A	Hand tendon reconstruction	7.14	14.85	NA	0.87	090
26504		A	Hand tendon reconstruction	7.47	14.56	NA	0.84	090
26508		A	Release thumb contracture	6.01	14.04	NA	0.76	090
26510		A	Thumb tendon transfer	5.43	13.79	NA	0.71	090
26516		A	Fusion of knuckle joint	7.15	14.41	NA	0.90	090
26517		A	Fusion of knuckle joints	8.83	15.76	NA	0.96	090
26518		A	Fusion of knuckle joints	9.02	15.46	NA	1.13	090
26520		A	Release knuckle contracture	5.30	18.02	NA	0.65	090
26525		A	Release finger contracture	5.33	18.22	NA	0.66	090
26530		A	Revise knuckle joint	6.69	18.75	NA	0.86	090
26531		A	Revise knuckle with implant	7.91	19.26	NA	1.01	090
26535		A	Revise finger joint	5.24	10.66	NA	0.66	090
26536		A	Revise/implant finger joint	6.37	17.39	NA	0.80	090
26540		A	Repair hand joint	6.43	14.40	NA	0.81	090
26541		A	Repair hand joint with graft	8.62	15.99	NA	1.12	090
26542		A	Repair hand joint with graft	6.78	14.13	NA	0.87	090
26545		A	Reconstruct finger joint	6.92	15.10	NA	0.79	090
26546		A	Repair nonunion hand	8.92	15.75	NA	1.14	090
26548		A	Reconstruct finger joint	8.03	15.67	NA	0.98	090
26550		A	Construct thumb replacement	21.24	23.51	NA	1.80	090
26551		A	Great toe-hand transfer	46.58	26.34	NA	6.57	090
26553		A	Single transfer, toe-hand	46.27	28.71	NA	1.99	090
26554		A	Double transfer, toe-hand	54.95	33.50	NA	7.76	090

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## ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
26555		A	Positional change of finger	16.63	20.49	NA	2.13	090
26556		A	Toe joint transfer	47.26	29.09	NA	6.67	090
26560		A	Repair of web finger	5.38	12.75	NA	0.60	090
26561		A	Repair of web finger	10.92	17.37	NA	0.69	090
26562		A	Repair of web finger	15.00	19.74	NA	0.98	090
26565		A	Correct metacarpal flaw	6.74	14.45	NA	0.84	090
26567		A	Correct finger deformity	6.82	14.29	NA	0.84	090
26568		A	Lengthen metacarpal/finger	9.08	19.51	NA	1.10	090
26580		A	Repair hand deformity	18.18	16.16	NA	1.46	090
26585		D	Repair finger deformity	14.05	12.93	NA	1.08	090
26587		A	Reconstruct extra finger	14.05	NA	5.98	1.08	090
26590		A	Repair finger deformity	17.96	16.68	NA	1.32	090
26591		A	Repair muscles of hand	3.25	13.51	NA	0.37	090
26593		A	Release muscles of hand	5.31	13.02	NA	0.64	090
26596		A	Excision constricting tissue	8.95	9.78	NA	0.87	090
26597		D	Release of scar contracture	9.82	11.29	NA	1.20	090
26600		A	Treat metacarpal fracture	1.96	2.71	4.04	0.25	090
26605		A	Treat metacarpal fracture	2.85	4.18	5.88	0.38	090
26607		A	Treat metacarpal fracture	5.36	8.18	NA	0.70	090
26608		A	Treat metacarpal fracture	5.36	8.54	NA	0.73	090
26615		A	Treat metacarpal fracture	5.33	8.14	NA	0.70	090
26641		A	Treat thumb dislocation	3.94	4.71	6.40	0.42	090
26645		A	Treat thumb fracture	4.41	5.13	7.10	0.54	090
26650		A	Treat thumb fracture	5.72	8.72	NA	0.77	090
26665		A	Treat thumb fracture	7.60	9.17	NA	0.97	090
26670		A	Treat hand dislocation	3.69	4.63	6.18	0.36	090
26675		A	Treat hand dislocation	4.64	4.42	6.35	0.56	090
26676		A	Pin hand dislocation	5.52	8.82	NA	0.76	090
26685		A	Treat hand dislocation	6.98	8.77	NA	0.95	090
26686		A	Treat hand dislocation	7.94	9.30	NA	1.05	090
26700		A	Treat knuckle dislocation	3.69	2.92	4.99	0.35	090
26705		A	Treat knuckle dislocation	4.19	4.26	6.20	0.50	090
26706		A	Pin knuckle dislocation	5.12	5.80	NA	0.64	090
26715		A	Treat knuckle dislocation	5.74	8.29	NA	0.75	090
26720		A	Treat finger fracture, each	1.66	1.66	2.99	0.20	090
26725		A	Treat finger fracture, each	3.33	3.17	5.14	0.43	090
26727		A	Treat finger fracture, each	5.23	8.73	NA	0.69	090
26735		A	Treat finger fracture, each	5.98	8.65	NA	0.77	090
26740		A	Treat finger fracture, each	1.94	2.55	3.74	0.24	090
26742		A	Treat finger fracture, each	3.85	5.11	6.98	0.49	090
26746		A	Treat finger fracture, each	5.81	8.77	NA	0.74	090
26750		A	Treat finger fracture, each	1.70	2.36	3.56	0.19	090
26755		A	Treat finger fracture, each	3.10	3.05	4.97	0.37	090
26756		A	Pin finger fracture, each	4.39	8.61	NA	0.56	090
26765		A	Treat finger fracture, each	4.17	7.78	NA	0.51	090
26770		A	Treat finger dislocation	3.02	2.68	4.74	0.27	090
26775		A	Treat finger dislocation	3.71	3.94	5.90	0.43	090
26776		A	Pin finger dislocation	4.80	8.58	NA	0.63	090
26785		A	Treat finger dislocation	4.21	7.62	NA	0.54	090
26820		A	Thumb fusion with graft	8.26	15.82	NA	1.11	090
26841		A	Fusion of thumb	7.13	14.94	NA	0.97	090
26842		A	Thumb fusion with graft	8.24	15.72	NA	1.10	090
26843		A	Fusion of hand joint	7.61	14.38	NA	0.99	090
26844		A	Fusion/graft of hand joint	8.73	15.70	NA	1.12	090
26850		A	Fusion of knuckle	6.97	14.21	NA	0.89	090
26852		A	Fusion of knuckle with graft	8.46	15.08	NA	1.05	090
26860		A	Fusion of finger joint	4.69	13.11	NA	0.60	090
26861		A	Fusion of finger jnt, add-on	1.74	0.96	NA	0.22	ZZZ
26862		A	Fusion/graft of finger joint	7.37	14.75	NA	0.92	090
26863		A	Fuse/graft added joint	3.90	2.16	NA	0.51	ZZZ
26910		A	Amputate metacarpal bone	7.60	13.76	NA	0.90	090
26951		A	Amputation of finger/thumb	4.59	12.67	NA	0.56	090
26952		A	Amputation of finger/thumb	6.31	13.99	NA	0.74	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.48	15.56	NA	0.92	090
26991		A	Drainage of pelvis bursa	6.68	9.38	11.53	0.85	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	MOD	Status	Description	Physician Work RVUs 3	Facility PE RVUs	Non- Facility PE RVUs	Mal- Practice RVUs	Global
26992		A	Drainage of bone lesion	13.02	19.43	NA	1.75	090
27000		A	Incision of hip tendon	5.62	7.33	NA	0.76	090
27001		A	Incision of hip tendon	6.94	8.22	NA	0.95	090
27003		A	Incision of hip tendon	7.34	9.11	NA	0.93	090
27005		A	Incision of hip tendon	9.66	10.42	NA	1.36	090
27006		A	Incision of hip tendons	9.68	10.43	NA	1.33	090
27025		A	Incision of hip/thigh fascia	11.16	10.31	NA	1.38	090
27030		A	Drainage of hip joint	13.01	12.23	NA	1.81	090
27033		A	Exploration of hip joint	13.39	12.33	NA	1.87	090
27035		A	Denervation of hip joint	16.69	18.01	NA	1.70	090
27036		A	Excision of hip joint/muscle	12.88	13.67	NA	1.80	090
27040		A	Biopsy of soft tissues	2.87	4.01	5.90	0.21	010
27041		A	Biopsy of soft tissues	9.89	8.47	NA	1.01	090
27047		A	Remove hip/pelvis lesion	7.45	7.01	9.27	0.79	090
27048		A	Remove hip/pelvis lesion	6.25	7.86	NA	0.73	090
27049		A	Remove tumor, hip/pelvis	13.66	13.36	NA	1.60	090
27050		A	Biopsy of sacroiliac joint	4.36	6.97	NA	0.53	090
27052		A	Biopsy of hip joint	6.23	8.29	NA	0.85	090
27054		A	Removal of hip joint lining	8.54	10.53	NA	1.17	090
27060		A	Removal of ischial bursa	5.43	7.70	NA	0.60	090
27062		A	Remove femur lesion/bursa	5.37	7.17	NA	0.74	090
27065		A	Removal of hip bone lesion	5.90	8.66	NA	0.76	090
27066		A	Removal of hip bone lesion	10.33	12.36	NA	1.42	090
27067		A	Remove/graft hip bone lesion	13.83	14.25	NA	1.95	090
27070		A	Partial removal of hip bone	10.72	17.92	NA	1.36	090
27071		A	Partial removal of hip bone	11.46	18.86	NA	1.51	090
27075		A	Extensive hip surgery	35.00	25.41	NA	2.22	090
27076		A	Extensive hip surgery	22.12	19.90	NA	2.86	090
27077		A	Extensive hip surgery	40.00	28.73	NA	3.18	090
27078		A	Extensive hip surgery	13.44	15.54	NA	1.67	090
27079		A	Extensive hip surgery	13.75	15.04	NA	1.86	090
27080		A	Removal of tail bone	6.39	7.56	NA	0.80	090
27086		A	Remove hip foreign body	1.87	3.81	5.53	0.17	010
27087		A	Remove hip foreign body	8.54	8.85	NA	1.09	090
27090		A	Removal of hip prosthesis	11.15	11.14	NA	1.55	090
27091		A	Removal of hip prosthesis	22.14	16.20	NA	3.11	090
27093		A	Injection for hip x-ray	1.30	0.50	12.79	0.09	000
27095		A	Injection for hip x-ray	1.50	0.54	11.77	0.10	000
27096		A	Inject sacroiliac joint	1.40	0.38	9.84	0.08	000
27097		A	Revision of hip tendon	8.80	8.91	NA	1.22	090
27098		A	Transfer tendon to pelvis	8.83	9.53	NA	1.24	090
27100		A	Transfer of abdominal muscle	11.08	12.54	NA	1.57	090
27105		A	Transfer of spinal muscle	11.77	12.21	NA	1.66	090
27110		A	Transfer of iliopsoas muscle	13.26	13.43	NA	1.38	090
27111		A	Transfer of iliopsoas muscle	12.15	11.85	NA	1.48	090
27120		A	Reconstruction of hip socket	18.01	14.46	NA	2.45	090
27122		A	Reconstruction of hip socket	14.98	14.13	NA	2.08	090
27125		A	Partial hip replacement	14.69	13.66	NA	2.05	090
27130		A	Total hip arthroplasty	20.12	16.84	NA	2.82	090
27132		A	Total hip arthroplasty	23.30	18.59	NA	3.26	090
27134		A	Revise hip joint replacement	28.52	21.23	NA	3.97	090
27137		A	Revise hip joint replacement	21.17	17.42	NA	2.97	090
27138		A	Revise hip joint replacement	22.17	17.87	NA	3.11	090
27140		A	Transplant femur ridge	12.24	11.79	NA	1.67	090
27146		A	Incision of hip bone	17.43	16.11	NA	2.27	090
27147		A	Revision of hip bone	20.58	17.18	NA	2.61	090
27151		A	Incision of hip bones	22.51	12.41	NA	3.12	090
27156		A	Revision of hip bones	24.63	19.70	NA	3.48	090
27158		A	Revision of pelvis	19.74	15.55	NA	2.60	090
27161		A	Incision of neck of femur	16.71	14.13	NA	2.32	090
27165		A	Incision/fixation of femur	17.91	14.67	NA	2.51	090
27170		A	Repair/graft femur head/neck	16.07	13.84	NA	2.20	090
27175		A	Treat slipped epiphysis	8.46	7.08	NA	1.19	090
27176		A	Treat slipped epiphysis	12.05	9.88	NA	1.68	090
27177		A	Treat slipped epiphysis	15.08	11.61	NA	2.11	090
27178		A	Treat slipped epiphysis	11.99	9.30	NA	1.68	090

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